Government Structure, Service System Design and Equity in Access to Psychotherapy in the UK, Australia and Canada

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May 22, 2018

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This paper was prepared for the Canadian Political Science Association Annual Conference in Regina, 2018, and is based on research conducted for the author's doctoral dissertation (completed in December, 2017).

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Abstract

This paper reports on the results of a small-N comparative study of the relationship between government structure, service system design and equity in access to psychotherapy in the UK, Australia and Canada. Interviews with 22 key informants provided an opportunity to explore the equity dimensions of three contrasting mental health systems in three contrasting governance contexts. In keeping with evolving theories on government capacity and welfare state regimes, each service system has its unique mix of elements: centralized and decentralized, private and public, universal and targeted, and insured and programmatic. Two key findings will be presented. First, the comparative analysis of efforts to expand access to psychotherapy confirmed the relationship between centralized government structures and capacity for policy reform in the UK and Australia, and de-centralization as the greatest barrier to reform in the Canadian context. Second, achieving equity in access requires explicit focus regardless of government structure, service system design or social insurance model. While the financial barriers to access under Canada's two-tier system were considered self-evident, key informants in Australia and the UK noted that removing financial barriers alone may increase absolute rates of access for all parts of the population, but is no guarantee of equity. Rather, progress requires making equity an explicit objective and careful monitoring.

Government Structure, Service System Design and Equity in Access to Psychotherapy in the UK, Australia and Canada

Both Australia and the United Kingdom (UK) have implemented wide-reaching reforms to improve access to psychotherapy over the past 10-15 years. The Australian government launched the *Better Access to Psychiatrists, Psychologists and General Practitioners through the Medical Benefits Schedule (Better Access)* initiative in 2006, expanding universal Medicare coverage to include psychologists and other mental health professionals (Australia, 2015). *Improving Access to Psychological Therapies* (*IAPT*) is a stand-alone psychotherapy service that was launched by the UK government in 2008, and directly implemented in every district of England with oversight from National Health Service England (NHS England, n.d.). This kind of population-wide reform has yet to be introduced in Canada, where a decentralized government structure has constrained public funding for psychotherapy and other mental health services (Bartram, 2016; Bartram & Lurie, 2017). While physician and hospital services are covered by public health insurance, access to psychological services and other non-physician mental health professionals is not. As a result, higher-income Canadians either pay out-of-pocket or through employment-based insurance, and lower-income Canadians face considerable financial barriers or long waits for limited community-based services.

Through interviews with key informants in Australia, the United Kingdom (UK) and Canada, this study provides an in-depth exploration of the relationship between government structure, service system design and equity in access to psychotherapy. The findings are particularly timely and relevant as Canadian provincial and territorial governments are in the midst of planning how to spend new targeted federal transfers, In March 2017, the Canadian federal government announced a targeted transfer of $5 billion over ten years ($500 million per year on average, starting in 2017-18) to support provincial and territorial governments in improving access to mental health services (Finance Canada, 2017). It remains to be seen how far this new transfer will go toward improving access to mental health services, and how much will go toward improving access (and equity in access) to psychotherapy in particular (Bartram & Lurie, 2017).

Guiding Literature regarding Government Capacity and Equitable Access

The interviews with key informants from Australia, the UK and Canada are guided by the literature on two key policy questions. First, the interviews go in to depth regarding the capacity of more and less centralized forms of government for policy reform. Second, the interviews explore the equity impacts of various service system designs.

More centralized forms of government are generally associated with greater capacity for policy reform. Parliamentary systems are more centralized than presidential systems, and thus have greater capacity to push through policy reform even over the objectives of powerful stakeholders (Weaver & Rockman, 1993). At the same time, in federal parliamentary systems agreement from both regional and national levels of government is required in many policy domains, which in turn creates incentives for shifting blame and gives rise to jurisdictional tensions (Banting & Corbett, 2002; Pierson, 1995). While the UK, Australia and Canada all have parliamentary systems, the UK is by far the most unitary (at least as far as England is concerned), with a command-and-control health system run by the National Health Service.

Australia and Canada are both federated but the Australian federal goverment has jurisdiction over Medicare and contributes 61% of total public spending on health (Australia, Australian Institute of Health and Welfare, 2017; Flood, 2001). The Canadian federation is much more decentralized and transfers from the Canadian federal government amount to only 23% of provincial and territorial spending on health (Banting & Corbett, 2002; Ouimet, 2014; Phillips, 2016). By asking key informants from these three countries for their perspectives on the key factors driving (or preventing) reforms to improve access to psychotherapy, this study explores the relationship between government structure and other contributing factors such as the fiscal environment, public support, and evidence of effectiveness.

The literature on service system design and equity also guided the questions for key informants. Much of this literature developed as a critical response to Esping-Andersen's 1990 theory regarding welfare state regimes, which grouped western countries into three broad types of redistributive social policies. According to the original theory, the United States, the United Kingdom, Australia and Canada were grouped under the so-called liberal regime, with a relatively minimal role for the state and stronger role for the market and families in comparison to European corporatist and Scandinavian social democratic approaches to social policy. New welfare regime typologies have considered class, gender, non-western countries, and the complex mix of social policies and program designs within a particular country, and have even zeroed in on the healthcare system (Bambra, 2005; Korpi, 2000; Mahon, 2008; Myles, 1998; Wendt, 2009; Wood & Gough, 2006).

Other literature on service system design and equity has taken a more normative approach, assessing the redistributive effectiveness of different social policy approaches. Korpi and Palme (1998) argue that there is paradox of redistribution, whereby the more social policies are targeted to the most disadvantaged, the less effective they are at reducing inequality. Liberal states where the market and families play a strong role in welfare provision (such as Canada, Australia, and the UK) tend to favour more targeted approaches, European states tend to have more corporatist policies that are tied to employment, and social democratic Scandinavian countries tend to have either universal or encompassing policies (that is to say, a mix of universal and employment-based). According to Korpi and Palme (1998), targeted approaches generate less political buy-in and thus a smaller pool of financial resources to support redistribution than either universal or encompassing approaches. Encompassing approaches are the most effective at reducing inequality, to the extent that employment-based benefits remove the incentive for middle and upper-class citizens to purchase premium insurance on the private market. By contrast, Marmot (2010) advocates for proportional universality, which works to improve everyone's health while at the same time working to flatten the health gradient by improving the health of those who are most disadvantaged the fastest, and which also has the advantage of garnering broad political support (National Health Services, Health Scotland, 2014).

In keeping with the evolving theory on government structure and welfare state regimes, each service system has its unique mix of elements: centralized and decentralized, private and public, universal and targeted, and insured and programmatic. The interviews with key informants in the Australia, the UK and Canada provided an opportunity to explore the equity dimensions of three contrasting mental health systems in three contrasting governance contexts.

Methodology

This is a small-N comparative study of the relationship between government structure, service system design and equity in access to psychotherapy in the UK, Australia and Canada. The analysis of UK policy was limited to England where *IAPT* has been implemented. Psychotherapy is defined broadly to include psychotherapy, psychological therapies, clinical counselling, and talk therapy.

The primary source of data is 22 key informant interviews with policy-makers, stakeholders and researchers, supplemented by studies of the outcomes of these policy initiatives and related government reports. Interviews were conducted by Skype, by telephone or in-person between April and June 2017, with approval from Carleton University's Research Ethics Board. Quotes are attributed by country and type of key informant (for example, AUS_R1 is an Australian researcher, UK_PM1 is policy-maker from the UK, and CDA_SH1 is a Canadian stakeholder). Interviews were transcribed and analysed using NVivo. Initial coding was based on the themes identified in the literature on government capacity, service system design and equity as reviewed above, and refined over the course of the analysis.

Results

Findings from the interviews and document review are grouped under two headings: key factors driving or preventing policy reform (including government/constitutional structure) and equity (including both equity impacts and efforts to address these impacts). Key informants' reflections on lessons learned are divided accordingly.

Key factors for policy reform

Key informants were asked to identify the key factors that have either enabled Australia and the UK to introduce wide-scale initiatives to expand access to psychotherapy over the past decade, or that have prevented Canada from doing the same. Prompts included stakeholders, evidence, professionals, stigma, business case, constitutional structure, economic context, and political context. Three contrasting narratives emerge from the three countries, with government structure playing a strong role throughout.

In Australia, survey data regarding high rates of unmet need coupled with the Commonwealth government's jurisdiction over Medicare were the key factors behind the introduction of the *Better Access* program in 2006, with its expansion of public health insurance to include psychologists and other allied mental health professionals. The 1997 National Survey of Mental Health and Wellbeing found that one out of every five Australian adults had experienced one or more mood, anxiety or substance use disorder in the past year, but that nearly two thirds of people with these mental disorders were not using health services (McLennan & Australian Bureau of Statistics, 1998).

> That was the first time we'd done a big national, epidemiological survey of that kind. And one of the findings was for anxiety and depression, and they hadn't been catered for very well in the early national mental health plans. But also, people with those conditions, the vast majority of them didn't go anywhere near mental healthcare. (AUS_R3)

The Commonwealth government's jurisdiction over Medicare was a deciding factor in extending Medicare coverage through the *Better Access* program, rather than expanding a smaller grant-based program called *Access to Allied Psychological Services (ATAPS)*. The Commonwealth government's jurisdiction over Medicare also made it easier to push through a Medicare-based reform without having to negotiate across levels of government.

> The Commonwealth government wanted something done and wanted something done quickly. There is the question of what levers they can pull. The levers of things like the ATAPS services were more complex, and involved taking on a whole lot of additional responsibility, you have to set up and plan and deliver some kind of a stepped care model and you have to triage and you have to run in effect 100 little different mental health care systems one for each division. In contrast to which, what you have to do to get the funding out through Medicare is you create some Medicare benefit schedule entitlements and you create a process which legitimizes people to use them and away they go, the rest of it is done by the private sector. (AUS_R1)

> There is no question that Australia is different than Canada as I understand it, where we have the Australian government federally having responsibility for primary health care and for the specialist medical and allied health care in the ambulatory setting. …The commonwealth government didn't need the states to be on board, they could do it regardless. (AUS_SH2)

In the UK, a more unitary state coupled with a very strong business case were the key factors behind the introduction of *IAPT* in 2008, with targets and standards set by the government of the UK, administered by NHS England, and delivered by local clinical commission groups or trusts. Key informants from Canada were more likely than key informants from the UK to make the connection between government structure and reform approaches.

> Australia and the UK have both been more nimble. The reason why, I think, is that the UK has the NHS, and in Australia primary care is also a federal responsibility. It is easier to get it done, there is only one governmental authority for the service. (CDA_SH2)

> Australia has a more powerful federal government. And the UK has a more unitary system. What is odd in Canada is that provincial systems are large, they have resources, they could tax and expand services but they don't. (CDA_PM3)

Key informants in the UK pointed to the high potential return on investment as a key factor in the development of *IAPT*, coupled with a well-connected influencer in the form of Lord Richard Layard. The case for investment was essentially that if access to evidence-based treatments could be increased, people's mental health status could improve such that productivity would increase (Layard, Clark, Knapp, & Mayraz, 2007). This case for investment aligned with political interests, and the strong evidence-base made *IAPT* a compelling option.

> The thing that probably swung it, influenced the government, is that [Lord Richard Layard] is also married to a Labour politician, so he got in to see Gordon Brown who at the time was Chancellor of the Exchequer, shortly before he become Prime Minister. He

> made an economic case that if we were more effective at implementing NICE guidelines, it would get people back into work and therefore it would increase the tax income and reduce the benefit costs to the country. (UK_R1)

In Canada's highly decentralized federation, neither high rates of unmet need nor the strong case for public investment have overcome barriers to reform as yet. Key informants stressed jurisdictional tensions as a key barrier.

> How to get from where you are to where you want to go is extremely complicated and most of the provinces don't have the horsepower to figure it out. (CDA_PM1)

> Laying out a plan in Canada is a very complicated thing, you have provinces who say that is not quite my plan, those aren't quite my priorities, I have already done that therefore compensate me for something we have already done, it is just very difficult form of government that we have. (CDA_PM2)

> There is … an underlying dysfunctional relationship between the federal, provincial and territorial governments, where provinces and territories have greater autonomy and don't want conditions, and the federal government is increasingly needing to be more accountable for public investments. It is a prisoner's dilemma which prevents us from moving forward. (CDA_PM3)

Key informants also pointed to policy legacies associated with the 1984 Canada Health Act (CHA), with its entrenchment of decisions from the 50s and 60s to provide first-dollar coverage but only of services provided by physicians and hospitals (often referred to as deep but narrow coverage). Some people linked these legacies to underlying jurisdictional dynamics.

> We can't have the same first dollar coverage [for psychotherapy], we can't be prescriptive. (CDA_PM3)

> The key factor was that Medicare was defined as covering doctors and hospitals. That is how it got defined, there are reasons in history for that, and that is what we are stuck with… (CDA_SH1)

> The real challenge for us to get even close to what the UK and Australia have done is the nature of our constitutional reality and how healthcare is administered. What the CHA means and how it is interpreted. We have no pharmacare program and while the bulk of psychotherapy is delivered by psychologists and others, only the services of physicians are covered by our public health insurance plans. (CDA_SH2)

Fiscal constraints on provincial and territorial governments, while clearly related to jurisdictional dynamics and policy legacies, were identified as another key barrier to reform in and of themselves.

> The road block to what they did in the UK and Australia is the first dollar coverage for everything [in Canadian Medicare]. …The reason the provinces didn't do it is because there is no way they could possibly afford to add anything under the CHA. (CDA_SH3)

> Most provinces and territories (except Quebec) would love to have the federal government take on full responsibility for some aspect of the health system. The fiscal pressures they face are greater than their concerns about jurisdiction. (CDA_R1)

The unique features of Canada's context, from its decentralized structure to its deep but narrow style of public health insurance to the vertical fiscal imbalance that leaves provincial and territorial governments with little fiscal room, have been key barriers to reform. While these factors were all at play during the 2016 Health Accord negotiations between federal, provincial and territorial governments, a window of opportunity for reform has opened with the new federal transfer for mental health that started in 2017/18 (Bartram, 2016; Bartram, 2017; Bartram & Lurie, 2017). Many of the same factors which contributed to reform in Australia and the UK have also been central to the introduction of this new transfer, including high rates of unmet need, a clear case for public investment coupled with the potential for measureable outcomes, and political leadership. According to one key informant:

> The key opportunities are strong federal leadership, backed by significant federal investment, and a strong commitment to showing results. (CDA_PM3)

Nevertheless, the long-standing challenges remain, and the impact of the new transfer is a work in progress.

> The new [$5B for mental health] that has been promised in the bilateral agreements of 2017 may be so dissipated that it has little impact. …[I]t will be up to provinces and territories and they only have so many levers. (CDA_R1)

Lessons learned regarding factors for policy reform. Key informants identified several lessons learned regarding factors for both introducing, implementing and sustaining policy reform, including government structure, accountability, scope and implementation support (see Table 1). There was considerable consensus that the policy levers associated with particular constitutional structures play a key role in determining the approach to reform. This relationship helps to explain why the commonwealth government in Australia opted to pull the "lever they can pull" (AUS_R1) by expanding Medicare, while the "more unitary" (CDA_PM3) UK government opted instead to roll out a program through NHS England. Canada, with the "prisoner's dilemma" (CDA_PM3) built into its decentralized federation and first-dollar *CHA*, has had limited success to date in negotiating terms for a reform.

Whatever approach to reform is taken, setting clear objectives, gathering appropriate data and reporting publicly on results are viewed as having been critical for sustained funding in both the UK and Australia.

> [W]hy would you want to invest in something that's set up in a way where you won't know whether it works. Aren't you accountable to your electorate? You want to be able to show when you next run for office that it worked. (UK_R3)

At the same time, in Australia where most data come from Medicare billings, concerns have been raised regarding quality overall.

> I think we're getting access to care by paying more providers, but that is only the first step. … [T]he missing thing is peering inside the box of the services that you'll be paying for, if you put taxpayer's money into it. The thing we commonly don't know is what actually, what intervention the person gets. (AUS_R4)

In the UK, where *IAPT* collects data at every session and reports results by local area teams on a monthly basis, there are concerns about not paying enough attention to the experience of service users and providers.

> [W]hen *IAPT* was set up, there were very, very strict targets and expectations set …, and it's tight and managed within an inch of its life. Often, what strikes me is it's set up to work in a way that really work[s] against what's best for the patient... You end up distorting good clinical practice to meet targets... (UK_R2)

> What you need to do is create a situation where you put in charge of these services really inspirational clinical leaders who are interested in the data, not because it's meeting targets and things, but instead because it's telling them … how they can achieve what they want to achieve with patients. (UK_R3)

In Canada, where accountability for federal transfers to provincial and territorial governments has proven to be particularly challenging, the role of stakeholders in holding governments to account is viewed as particularly critical.

> There was no way you could track [federal investments in childcare], except, and this is where it is effective, the childcare advocates in the provinces could go to the province and say, hey the federal government gave you $200M. …In the same way that you could hope that if there was a coordinated mental health lobby, tell us where is the money going. (CDA_PM2)

Another lesson learned regarding implementation is the importance of focusing reforms rather than trying to be all things to all people. Part of *IAPT*'s success has been its ability to focus on people with less complex needs.

> [F]or the sake of staff and clients…, mainly [I'm] trying to be adherent to an *IAPT* model for that part of the service, and not expecting that that service can meet everyone's needs. (UK_SH1)

In Australia, *Better Access* was scoped very broadly, uptake far exceeded expectations, and the commonwealth government had to reduce the cap on the number of sessions to contain both supply and demand. In Canada, where policy-makers face greater political, jurisdictional and financial barriers, some kind of narrow scope would seem to make sense, whether for different levels of acuity, different population groups, or different levels of socio-economic advantage.

> [W]hat governments need to do is identify pressure points, and focus on something thoughtfully, planfully, to address whatever their priority issue is instead of trying to cover everything with one solution. (CDA_SH2)

Table 1

Key Factors for Policy Reform regarding Access to Psychotherapy - Summary of Results

	Australia	UK (England)	Canada
Factors			
Government structure	Strong commonwealth government with jurisdiction over Medicare	Unitary state with jurisdiction over NHS England	Decentralized federation with jurisdictional tensions, particularly over healthcare
Second key factor	Survey data showing high rates of unmet need	Strong case for public investment	Related policy legacies from *CHA* and fiscal constraints on provincial/territorial governments
Resulting service system design	*Better Access* expanded Medicare coverage to psychologists etc.	*IAPT* with targets/standards set by UK government, administered by NHS England	Two-tier, with impact of new federal transfer to be determined
Lessons learned	Align reform with policy levers available in particular government context Establish strong accountability mechanisms including both statistics and experiential data Focus the scope of reform rather than trying to do everything at once Support implementation, including workforce planning		

Lastly, key informants pointed to the essential role of implementation planning and supports for the success of policy reform, including workforce considerations. In Australia, little implementation planning was undertaken for the expansion of Medicare under *Better Access,* and the commonwealth government was caught off-guard by the surge in demand. In England, hands-on support was a key feature of the *IAPT* roll-out.

> I think that it is often not realized that just announcing a policy and setting out targets and some money is not a very good way of getting things to happen. If you are rolling out something that is genuinely innovative and not just fine-tuning something that already exists, we really need to put the support in place at a local level… (UK_PM1)

In Canada, similar implementation challenges arise, but between different governments as well as between different agencies.

> [W]e are going to have a dozen different governments developing new service delivery models and programs to spend this [$5 billion]… It is important to find out which ones are working best so that that information can be shared… That is a key challenge I think. How to set up a learning system in relation to these new investments. (CDA_PM1)

The importance of including workforce considerations in implementation planning was a strong theme throughout the interviews, whether in relation to supply, the range of eligible providers, incentives, training, or clinical leadership. While the UK had to train up the *IAPT* workforce, in Australia *Better Access* was introduced after a period of expansion in the psychological workforce.

> When it became evident to the membership of the Australian Psychological Society that they were likely to get into the Medicare rebate system … the demand for university places exploded. (AUS_R4)

Equity

While equity concerns were only mentioned occasionally as contributing factors in the introduction of reforms, several interview questions specifically asked about the equity impacts of current policies, and efforts to address such impacts.

Equity impacts. Key informants were asked to identify the equity impacts of the approach to psychotherapy service provision in all or any of Australia, the UK and Canada. Specifically, to what extent is access to psychotherapy determined by need as opposed to by other factors? Prompts included income, rurality, education, cultural background, and language spoken. Annual reports, evaluations, and other research are also important sources of data for this question and are woven through the analysis of the key informant interviews below. Despite the introduction of major reforms in Australia and the UK, all three countries have struggled in different ways with equity issues related to the provision of psychotherapy services.

The focus of attention in Australia has been on inequities in utilization in rural and more socially-disadvantage regions, with a tentative consensus emerging around inequitable access after a period of significant controversy that started from the outset of *Better Access* in 2006. A primary concern was that a Medicare-based model would create incentives for psychologists and other non-physician providers to target their services to higher-income clients who can afford co-payments (which are allowed under Australian Medicare). Controversy heightened when the 2011 evaluation finding that inequities in access were not a significant problem, only to be criticized for basing this conclusion on too small a sample (Hickie, Rosenberg, & Davenport,

2011; Pirkis, Harris, Hall & Ftanou, 2011). A more recent study concluded that utilization of *Better Access* services is much higher in urban than in rural areas, and much lower in areas with greater socio-economic disadvantage (Meadows, Enticott, Inder, Russell, & Gurr, 2015).

There was a fair degree of consensus among key informants from Australia regarding the at least some degree of inequity in access to psychotherapy, and a belief that workforce supply and incentives were key factors driving this inequity.

> I think as an example of trying to get services out in an equitable way, this a train wreck. It is getting more services to more people but those funds are not in a targeted way blowing to the areas that need it most. (AUS_R1)

> In theory, access is equitable, in practice it is much more limited. You are much more likely to get that if you live in a capital city as opposed to in a rural area, and you are much more likely to get it if you are in a higher socio-economic group. … (AUS_SH2)

Notwithstanding this recognition of inequities in access, key informants also stressed how many people living in rural and/or socio-economically disadvantaged areas were benefiting from *Better Access.*

> It made psychological services including psychotherapy affordable to the masses. …Farmers tell me that they will sit on their tractors and nobody knows that they are participating in an e-mental health program. … [F]rom my experience from the streets of highly multicultural disadvantaged communities to outback towns, … I know the difference people having access to psychological services is making. (AUS_R2)

> Prior to *Better Access*, psychology services were only available to people who could pay the full weight or had private health insurance…. In those circumstances, virtually no one in the lower SES groups would have been receiving services. (AUS_R3)

In the UK, more attention has focused on inequities between districts and ethnic groups, with an emerging interest in social disadvantage. Data have showed considerable variability in access between Local Area Teams and between ethnic groups. While white people made up 86% of population, they made up 89% of the 70% of people accessing *IAPT* who declared an ethnicity (Community and Mental Health statistics team, Health and Social Care Information Centre, 2014). Referral rates increase as deprivation increases, but treatment completion rates drop off and recovery rates in the most deprived decile have only been 35% compared with 55% in the least deprived decile (Community and Mental Health team, 2016). These inequity findings suggest that in England, as in Australia, overall improvements in access may not be narrowing the gap.

> We did wonder if there could be an irony, if while you are simultaneously improving access you are also simultaneously further increasing health inequalities. (UK_R2)

The way in which targets constrain the ability of *IAPT* to reach out to more disadvantaged people on the ground came through very strongly as a possible explanation.

> When *IAPT* was set up, the mandate was to go for big numbers and get big coverage and get the first … 15% of the population. …Some of the groups that we are talking about would be the bottom 15% not the top 15%. That requires a lot more effort, and so that is going to vary enormously from borough to borough. (UK_R1)

> We're oversubscribed from [more affluent part of district]. And the challenge for us is that we are commissioned based on our activity by the Clinical Commissioning Group… I need to put the staff resource where the demand is, because if I don't do that, then I've got an issue around my Key Performance Indicators that are linked to waiting times. I've got to deliver 95 per cent within 18 weeks, 75 per cent within six weeks. … I've got this challenge between I need to deliver the activity in [less affluent, undersubscribed part of district] and promote referrals there, but I need to be careful of my waiting times in [more affluent part of district]. (UK_SH1)

Other possible explanations for inequity issues with *IAPT* were related to broader social determinants of health, and to lower-quality services being just another aspect of living in a more deprived area.

> You've got to look for the community and social context in which you are providing therapy and not just assume that by providing high-quality evidence-based psychological therapies you will be meeting the needs of the full community. (UK_PM1)

> [B]roadly speaking in psychology they are two views… One of them was to say, is to say, look, if you're in a socially deprived area, then your environment is just so difficult, that psychology … can only do so much for you. The alternative view is that in most societies if you live in a socially deprived area, you're deprived of almost everything, and that includes good mental health services. (UK_R3)

While inequities in access have generally taken a back seat to broader concerns over unmet need in Australia and productivity in the UK, income-based inequities in access to psychotherapy are considered to be self-evident and serious in Canada.

> Obviously there is a profound lack of equity of access, of parity, when you have treatments that are out of sight financially [and] when they require private payment for people in lower SES groups. (CDA_SH1)

Canadian quantitative research has borne out these qualitative findings. Both income and education have been found to be significant predictors of mental health service utilization (Vasiliadis, Tempier, Lesage & Kates, 2009).

At the same time, Canadian key informants pointed to the broader range of psychotherapy benefits that the federal government provides to populations under its jurisdiction (such as indigenous people, military personnel, and federal inmates), and to the relatively minor role of access to psychotherapy in tackling inequities in mental health outcomes among vulnerable populations.

> To the extent that the federal populations have higher mental health needs, which I think is accurate across the board, the fact that they are federal populations does result in more targeted programing for those groups. (CDA_PM1)

> If you are trying to tackle inequity, part of it and only part of it is access, is this covered or not. The big part of it is do I have housing, am I hungry, am I unhealthy in pure simple physical terms, therefore I have a mental health issue. (CDA_PM2)

Equity efforts. Key informants were asked to describe the efforts being made to reduce inequities in access to psychotherapy, and whether or not these efforts are working. In response to recommendations from an extensive review of the Australia mental health system (National Mental Health Commission, 2014), coverage of e-mentalhealth and telemental health services are being expanded under *Better Access*, and funding for the smaller but more targeted *ATAPS* initiative is being rolled into new Primary Health Networks (PHNs).

> [W]ith this initiative we will see some of those *Better Access* services delivered by telehealth and yet still billable to Medicare. One of the problems with *Better Access* has been geographic maldistribution based on the location of providers largely, so I think this is a step in the right direction. (AUS_SH1)

> [I]f you want to really try to address specific levels of needs that might not be catered for well by Medicare, then you might need parallel programs that are specifically designed to try to address things. For example, the PHNs have all had to do these mental health needs assessments in their areas. And that's guiding the commissioning processes. (AUS_R3)

In the UK, e-mental health approaches have been integrated into *IAPT* from the start, with a large share of programming delivered through low-intensity manualized Cognitive Behavioural Therapy (supported by entry-level psychologists). Moreover, while *IAPT* efforts to reduce socio-economic inequities are relatively recent, there is wealth of data at the Clinical Commission Group and Local Area Team-level (not to mention at the level of individual therapists and clients) to guide these efforts.

> Basically *IAPT* is devolved to Clinical Commission Groups to make sure that they are meeting the needs of their local populations. It is up to them to make sure that they meet needs related to equality and diversity. If there is anything specific and tailored going on, it would be going on at that level. (UK_PM2)

> In terms of recovery, we historically have very low recovery rates in our city area, which was always linked to the demographic, predominantly BME [black and ethnic minority], high rates of deprivation, etc. And they were hovering around recovery rate of 10 per cent. …[L]ast year we averaged 47 per cent, so we were close to the 50 per cent target. … [T]here were several things that we did. ...[I]t just happened that that particular team was probably the least *IAPT* adherent. …[W]e introduced … a recovery master class for staff ... and we also moved to an *IAPT*-based IT system. That meant the staff … could analyze the data … and use that in therapy. [In terms of engagement], we've rebranded

> ourselves as a wellbeing college. ...People are coming in as students and they're enrolling on classes. [W]e seem to be doing better at engaging those groups. (UK_SH1)

Nevertheless, concerns were expressed regarding the capacity of Clinical Commissioning Groups to tailor *IAPT* to local needs with any degree of consistency.

> Although they had the biggest population they had the lowest provision [for *IAPT*]. …At the time, they as a borough received less money to spend on the population. Part of it was they had less central funding. But also it was partly I suspect because the commissioners gave lower priority to mental health. (UK_R1)

> [T]his is where public health supposedly does a needs assessment of the local area and the priorities, and in so doing should be trying to ensure that people who may benefit from the service but are less likely to take it up even if it's been offered get a chance. That isn't as strong as it could be. There is still work going on to try and improve it. (UK_PM1)

In Canada, the barriers described above have thus far prevented wide-scale reforms to reduce inequities in access to psychotherapy. However, there is some expectation that new federal funding could go toward removing financial barriers. In pointing out that most people who require counselling "have to pay out-of-pocket, or more often, try to manage without," former federal Minister of Health Jane Philpott indicated that financial barriers are an important part of the rationale for the new federal transfer (Canada, 2016). Opinions from key informants ranged from the rather blunt "it would be really stupid" (CDA_SH3) to expand public funding for psychotherapy services to those who are already covered by employment-based benefits or able to afford to pay out-of-pocket, to the more tentative:

> Maybe on the accountability side [of the new federal transfer], to the extent that the focus on results focuses on unmet need, this might loop back to financial equity. (CDA_PM3)

Moreover, key informants identified the Quebec pharmacare model as a promising approach that has been able to move forward with available policy levers at the provincial/territorial level. This model provides universal coverage for medications through a mix of employment-based coverage and public coverage for residents who do not have employment-based coverage.

> [B]ecause there are also the EAP programs, that medication-type drug coverage, if we were to use it here, I think that would work very very well. …[T]hat just concentrates on people who do not have access to it. (CDA_R2)

> It is a little more complicated now, but what Quebec said is exactly what I am saying, if somebody is covered by an employer plan we are not going to replace it. (CDA_SH3)

However, political factors have played a key role, including timing and whether more universal or more targeted approaches have the most political appeal for a specific policy reform. In the run-up to the 2018 provincial election the Ontario government announced universal coverage of

medications for children and youth under 25, but this policy reform only covers a small percentage of the population.

> Anyone that is on the eve of an election, that is why the broader Ontario under 25 plan made it out. It is a straight political calculus. Somebody right after a majority government will do a targeted program, [when] they have got four years to weather it. (CDA_SH3)

Whichever approach meets the political feasibility test has the potential to improve access, both at the population level and for more socio-economically disadvantage groups.

> When you are starting at the floor, no one has access, arguably anything we do is better. (CDA_SH2)

Lessons learned regarding equity. Key informants identified two complementary lessons learned regarding equity (see Table 2). First and foremost, improving equity in access to psychotherapy requires making this objective explicit, and diligently monitoring progress. In discussing equity impacts of both the *Better Access* and *IAPT* reforms, key informants noted that universal public funding has provided equitable access in theory but not always in practice.

> Consider the equity issues from the outset, and embed them in reform. Because the other challenge of big reforms is that they are hard to revisit. So I think that a clear focus on those issues from the outset might help [Canada] to embed some of the principles around equity and so forth. (AUS_SH1)

At the same time, universal approaches may reach more absolute numbers of people with low socio-economic status. To the "farmer on his tractor" (AUS_R2) who is able to afford telemental health services for the first time as a result of *Better Access*, it does not matter whether the equity gap is not getting narrower.

Discussion

The comparative analysis of key informant interviews provides further evidence for the role of centralization in a government's capacity for policy reform. While *IAPT* is not without critics, the unitary nature of the UK government (and NHS England) has made it possible to launch and sustain a program with a strong record of success. Australia less unitary federation nevertheless features a strong role for the commonwealth government. The commonwealth government's jurisdiction over Medicare has made it politically expedient to expand Medicare coverage of psychotherapy with *Better Access*, but more challenging to introduce the same level of accountability as *IAPT*. Canadian key informants confirmed the critical role of Canada's decentralized government structure, as well as related policy legacies embedded in the *Canada Health Act* and fiscal constraints, in impeding reform. The lessons learned regarding factors for policy reform that were identified by key informants are largely related to government structure. The more centralized the government, the fewer the fiscal constraints, the stronger the approach to accountability, the sharper the focus, and the stronger the support for implementation. At the same time, key informants provided insight into the interplay between government structure and

Table 2

Equity and Access to Psychotherapy – Summary of Results

	Australia	UK (England)	Canada
Equity impacts			
Population-level concerns	Rural; socio-economically disadvantaged regions	BME (black minority ethnic) groups; district-level; deprivation	Inequities considered self-evident, particularly income-based; federal populations distinct (more coverage but higher needs)
Explanation	Workforce supply/incentives	Targets provide disincentives; broader social determinants of health	*CHA* exclusion of non-physician psychotherapy; broader social determinants of health
Equity efforts	Expanded coverage of telemental health; Primary Health Networks with mandate for local planning	Using data to improve quality; tailoring to local needs by district commissioning groups	Hopes re: new federal transfer; interest in Quebec pharmacare model
Lessons learned	Improving equity requires making this an explicit objective and tracking progress		
	Universal approaches increase access at lower-income levels in absolute terms even if equity gaps remain		

at least one other critical factor for policy reform, whether the survey evidence regarding high rates of unmet need in Australia or the strong case for public investment put forward in the UK.

With regards to equity, the comparative analysis of key informant interviews suggests that neither centralized government structure, service system design, nor social insurance model can guarantee equitable access to psychotherapy. Canadian key informants confirmed that the absence of both universal and targeted coverage of non-physician psychotherapy has had significant equity impacts, particularly with regard to income. The evidence from Australian key informants and other quantitative studies suggests that uptake has been inequitable in rural and socio-economically disadvantaged areas, but also that *Better Access* has increased access in absolute terms for lower-income Australians (such as the "farmer on his tractor"). *IAPT* data shows that uptake has been somewhat equitable but recovery rates have not, and key informants in the UK expressed considerable concern regarding inequitable access. As a result of these equity concerns, key informants suggested that progress requires making equity an explicit objective and careful monitoring.

The comparative analysis points to a dynamic tension between universal and targeted approaches, whereby universal approaches can potentially result in higher absolute levels of

access at lower income levels even if an equity gaps remain. This tension is consistent with Korpi and Palme's paradox of redistribution (1998). According to this theory, targeted approaches are likely to be the last effective because they garner the narrowest political support, and thus the smallest pool of funds to put toward redistribution. The bigger the pie, the more funds are distributed to everyone, the more that lower-income people benefit in absolute terms. With its mix of universal and targeted approaches, Marmot's proportionate universalism might be more effective, but could also weaken the political impetus for better-funded universal approaches. These complexities further underscore the need to track and monitor progress toward clear equity objectives.

The comparative qualitative design of this study has both strengths and limitations. The interviews with 22 key informants and document review have provided rich insights into the relationship between government structure, service system design and equity in access to psychotherapy. However, the analysis would have been more objective if the interviews and coding had been done by more than one person. Further, while Australia, the UK and Canada provide a sharp contrast with regard to government structure and service system design, the findings could have been strengthened by including other public funding models for psychotherapy in countries such as the United States and the Netherlands (Peachey, Hicks & Adams, 2013).

Despite these limitations, this study provides timely and relevant guidance from experiences in comparable countries to Canadian policy-makers at the outset of the new ten-year federal transfer. The comparative analysis highlights the importance of aligning reforms with the strongest available policy levers. While the federal government in Canada does not have access to the same levers as its UK and Australian counterparts, Canadian provincial and territorial governments do have full jurisdiction over mental health services and are thus actually well-placed to institute strong accountability mechanisms and implementation supports. The federal government for its part is well-placed to set high-level targets for the new transfer and to foster a learning system (Forest & Martin, 2018). If clear equity objectives are set and monitored, Canada stands to make significant progress in reducing long-standing inequities in access and in mental health outcomes.

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