The ‘Rise and Rise’ of New Professional Groups: Mental Health Professions under Medicare

Darrel P. Doessel* and Ruth F. G. Williams**

Abstract

From November 2006, three paramedical professions that provide mental health services—eligible or approved psychologists, social workers and occupational therapists—came within the scope of Medicare. The purpose of this article is to place that historic decision in context, first by examining several key secular trends in psychiatry as a profession, and then by presenting some data on the professional groups newly subsidised under Medicare. The trends in psychiatry give the context of that decision and point to the structural forces that are likely to be associated with the provision of mental health services in Australia.

1. Introduction

The purpose of this paper is to document some recent changes in the workforce relevant to the provision of mental health services in Australia. In particular we document the relative decline of services provided by psychiatrists, and the expansion of mental health services provided by allied health professionals

*Australian Institute for Suicide Research and Prevention, Griffith University, Australia
**Regional School of Business, La Trobe University, Bendigo, Australia and Australian Institute for Suicide Research and Prevention, Griffith University, Australia

We express our gratitude to Elyse Gryl for the paper’s preparation and to Allison Milner and Carol Beaver for their comments. Remaining errors are the responsibility of the authors.
since 2006 when specific services produced by psychologists, social workers and occupational therapists came under Medicare.

The paper has two specific objectives. First, we provide an explanation for the Australian government's decision to bring a specified group of mental health services provided by three paramedical professions (psychologists, social workers and occupational therapists who are eligible) into the web of Australia's universal and compulsory health-funding arrangements, commonly called Medicare. This important change took effect on 1 November 2006. At Medicare's inception in February 1984 (and for its precursor, the 1975 Medibank system), the only professions included in the general Medicare system have been registered medical practitioners (general practitioners and all medical specialists) and registered optometrists (Scotton and Macdonald 1993). In November 2006, most allied health professions attained eligibility status for Medicare funding. These professions are chiropractors, diabetes educators, exercise physiologists, Indigenous health workers, osteopaths, physiotherapists, podiatrists and speech pathologists (see endnote 1). Excluded in 1974 and 1985, and still largely excluded, are dentists. In April 2010, the extension of Medicare funding to nurse practitioners was expected to be implemented in November 2010. Thus, the 2006 decision may be regarded as historic.

Our second objective is to describe the effect of bringing a new type of labour (the three paramedical professional groups) into the Medicare system to provide mental health services. We determine the extent to which this decision has reversed the relative decline of government subsidies for mental health services.

It is relevant initially to recognise that mental health issues were on the public agenda in the lead up to the Australian government's decision to place some other professionals within Medicare's scope. A community-based epidemiological sample survey of mental disorders in Australia in 1997 (ABS 1998), and a repeat of it in 2007 (ABS 2008a), are representative samples of the Australian population and provide various indications of the prevalence of mental disorders. There also have been the various Burden of Disease studies, which indicated that the impact of mental illness is considerable (Mathers, Vos and Stevenson 1999; Mathers et al. 2000; Vos and Mathers 2000). The Australian Institute of Health and Welfare's (AIHW) reports on relative health expenditures by disease groups indicate that mental illness is an expensive disease category in Australia (AIHW 2004a; AIHW 2004b).
Also relating to the context of this study is the issue of people with mental disorders who are not receiving mental health treatment, or not receiving it as required. The extent of this problem is known now not to be trivial. In the mental health literature, this issue is referred to as unmet need (Andrews 2000; Whiteford 2000) and it is a problem that exists in other countries such as the United States (Regier et al. 1993; Kessler et al. 1994) and Canada (Lin et al. 1996). In a recent paper, using Australian data from the 1997 epidemiological study, it was determined that 1,477,500 adult Australians with mental disorders were not receiving mental health services. These data represented 61 per cent of all adults with mental disorders (Doessel, Williams and Nolan, 2008). A policy issue implied by this—assuming that the measurement of unmet need is approximately correct—is whether the existing supply of mental health workers can cope with this problem. While this paper does not answer that question, it does provide some context to the need for more attention to be directed to workforce issues.

On the agenda at the time were two prominent stories of mental illness that were constantly on the front pages of the nation's newspapers, namely those of Cornelia Rau (in 2004–05) and Vivian Solon (in 2001). Some details of how these tragic occurrences happened are now available (Palmer 2005; Commonwealth Ombudsman 2005). In addition, Not for Service was a major report from the Mental Health Council of Australia (2005) which provided evidence of how mental health services throughout the country were still inadequate, despite the years of reform under the National Mental Health Strategy (see also Hickie et al. 2005; Whiteford and Buckingham 2005; Singh and Castle 2007). In addition to Not for Service, a Senate Report (Senate Select Committee on Mental Health 2006) also contributed to the growing body of concern that serious issues existed in the mental health sector. A message which emerges from the numerous and varied reports is that the problems of the mental health sector are of long standing. While scandals in the mental health sector motivate political action to some extent, several problems remain unaddressed, which suggests that more quantification work is needed. That task is the impetus underlying this study.

On 5 April 2006 the Australian government announced details of its intention to allocate an additional $1.8 billion for the treatment of mental disorders in Australia as part of a five-year action plan. One important component of the action plan was a 'new teamwork approach... with psychologists... able to work alongside GPs and psychiatrists' (Howard 2006). The funding mechanism for this approach was to have those new services provided by psychologists, social workers and occupational therapists (operating on a fee-for-service basis) subsidised by the Australian
government under Medicare. While announcing the Australian government’s component of the funding, Prime Minister Howard said that it was his ‘hope that the States will be in a position to match what the Commonwealth is proposing’, by allocating additional funds to ‘supported accommodation, improvements in emergency and crisis services and hospital and prison care’. Some three months later (14 July 2008) the Council of Australian Governments (COAG) announced both the Australian government’s and State governments’ programs in a joint document entitled National Action Plan on Mental Health (COAG 2008). In all, there were 14 components to that plan, including New Funding for Mental Health Nurses; Improving the Capacity of Workers in Indigenous Communities; Mental Health Services in Rural and Remote Areas. This paper is only concerned with the incorporation of specified mental health services by the three professional groups under Medicare—the new teamwork approach.

The article proceeds by a series of snapshots of the mental health sector. These depict time-series data on various measures, thus shedding some light on the structural forces at play in the sector. In particular, Section 2 presents some time-series data on the size of the psychiatry workforce. Particular attention is directed to private practice psychiatry operating on a fee-for-service basis under Medicare. Although there has been growth in the absolute number of psychiatrists since 1984–85, this growth has been dominated by part-time workforce participation, and, on average, hours worked have fallen. Section 3 presents data on the number of psychiatry services produced (per hundred thousand of the population) from 1984–85 and shows that this measure of the profession’s output reached a maximum in 1995–96; since then it has consistently fallen. Section 4 indicates government subsidies (via Medicare) for those services. These also reached a maximum and have subsequently declined (relatively) since 1995–96. It is argued in Section 5 that under any health insurance system, there are two important concepts of price—gross prices and net prices—which ought to be measured and analysed. The difference between them is explained by the subsidy paid under Medicare. It is shown that gross prices have risen slightly on average, and that the average Medicare subsidy for these services has fallen through time, both in absolute terms and as a proportion of average gross prices. It is therefore not surprising that regression analysis shows that net out-of-pocket prices have risen over time. Section 6 shows the rise in the services of approved psychologists, social workers and occupational therapists under the government subsidies via Medicare, thus providing an answer to the second question addressed in this paper. Section 7 presents a conclusion, which is a story of the relative decline of the psychiatry profession in Australia’s mental health workforce.
2. The Psychiatry Workforce

The first snapshot of the structural forces operating in the mental health sector is now provided. We examine the number of workers in the psychiatry workforce. Psychiatry is a small but important component of the medical workforce; in 2006, there were 3,258 psychiatrists (and psychiatrists in training, including overseas psychiatrists in training) which represented 10.8 per cent of all medical specialists, and 5.2 per cent of all employed medical practitioners in Australia (AIHW 2008a, tables 1.1, 5.8 and 5.11). We are unable to consider the total mental health workforce in this study. Some professions that work in the mental health sector, such as mental health nurses, are not analysed here; our concern initially is with the profession of psychiatry. This sub-set of medical practitioners is defined as those who have a specialist qualification in psychiatry (Mental Health Workforce Advisory Committee 2008, p.1). Details on other professionals, for example those in the nursing workforce (including those working in mental health clinical settings) are available elsewhere (AIHW, 2009).

Several sources of data on the medical workforce are available in Australia but only two are used here. First, the annual re-registration survey data that are consolidated by the Australian Institute of Health and Welfare (AIHW, 2008a) are presented. Second, given the all-pervasive nature of Medicare, Australia’s national scheme of health financing, there is also a detailed data set of full-time equivalent (FTE) medical practitioners. This disaggregates the workforce into part-time and full-time members. A discussion on the relative merits of these two sources of data (and other data sets) is provided in AIHW (2008a, Chapter 1 and Appendices B to D).

Figure 1 presents some available time-series data on the psychiatry workforce from 1984–85 to 2004–05. Note that, as with all workforce data, these estimates are subject to various limitations arising from administrative processes that produce these data as by-products. In the case of the two data sets here, the processes are Australia’s Medicare system, which maintains records of services, and the annual re-registration surveys from medical practitioners which the AIHW compiles.
Figure 1 – Number of psychiatrists (various categories) per 100,000 of the Australian population: 1984-85 to 2004-05

SOURCES: Calculated from Commonwealth Department of Health and Ageing (2002) Table A-42; Department of Health and Ageing (2005), Table A-49; Department of Health and Ageing (2005), Table A-45; AIHW (2008a), Table 13.6; and Australian Bureau of Statistics (2008a), Time Series Spreadsheets, Table 4.

NOTE: (a) FTE: Full-time equivalent
     (b) Includes Psychiatrists in training
Consider first the graph labelled ‘total (FTE) Psychiatrists (Public and Private Practice)’ per 100 thousand of the population at the top of Figure 1. These data are for the five years 2000–01 to 2004–05. These data provide the best measure of the total psychiatry workforce in Australia. This is because they have been generated from the annual re-registration surveys, and are not dependent on employment in either the public or the private sectors. By comparison, the Medicare data on the workforce relate only to medical practitioners working in private practice. They include as part-time workers those whose full-time employment is in the public sector, and who additionally see private patients. Unfortunately, comparable data are not available prior to 2000–01 due to a difference in the calculation of the FTE. For details, see AIHW (2008a, p.139). This data set indicates a small increase in the population-adjusted workforce from 16.1 per 100 thousand of the population in 2000–01 to a maximum of 17.16 in 2003–04, and then a slight decrease to 16.98 in 2004–05.

The other three graphs in Figure 1 are for the 21 years from 1984–85 and are derived from claims for psychiatry services provided under Medicare; these data relate only to private medical practitioners operating on a fee-for-service basis and are adjusted for full-time equivalence. It is notable that there is a marked difference in the behaviour of part-time and full-time psychiatrists over the relevant period. At the beginning of the period (1984–85), there were 2.39 private-practice psychiatrists per 100 thousand of the population working on a part-time basis. This workforce category increased markedly during the period, reaching a maximum of 4.22 in 2002–03; there were small decreases, to 4.19 and 4.14, in the last two years of the period. The full-time workforce, although larger in absolute size compared to the part-time workforce, decreased in relative size over the 21-year period. In 1984–85, there were 4.17 full-time psychiatrists per 100 thousand of the population, a maximum (6.22) was reached in 1995–96, and subsequently fell to 5.31 in 2004–05.

The overall outcome for the total private-practice workforce is the net result of these two different stories about the part-time and full-time work provided by psychiatrists; overall an increase in the total workforce from 6.56 per 100 thousand of the population in 1984–85 occurred, reaching a maximum of 9.72 in 2003–04 and then falling to 9.44 in 2004–05. Note the sizeable difference between the two data sets. This difference relates to registration surveys capturing more of the profession than the Medicare data set does, such as those working wholly in the public sector, psychiatrists in training, retired psychiatrists and Australian psychiatrists practising overseas and those on maternity, or sick leave and so on.
Although not central to this study, it is helpful to consider in general terms the factors that underlie these trends. The AIHW argues that the main contributor is that both public and private sector psychiatrists have been working fewer hours in more recent times. In the five-year period to 2004–05, (average) hours worked by males fell from 44.5 hours to 42.8 hours (an annual decrease of 1.0 per cent), and female hours worked fell from 39.2 in 2000–01 to 36.9 hours in 2004–05, an annual decrease of 1.5 per cent. The psychiatry workforce (like the total medical workforce) is subject to ‘feminisation’; that is, the share of females in psychiatry rose steadily from 30 per cent in 1998 to 37.4 per cent in 2004–05. (AIHW 2002, Table 4.1; AIHW 2008b, Table 13.1). This process will continue in future years as 58.2 per cent of psychiatrists in training were female in 2005 (AIHW 2008b, p. 143). It is also noteworthy that the psychiatry workforce is older than ‘All Specialists’ (AIHW 2008a, Table 5.3).

Aggregation of the workforce at the national level illustrates nothing about its spatial distribution, which is an issue of considerable policy concern. Disaggregated data at the level of state and territory are also available, but these data are not a particularly appropriate measure of consumer access to medical services in the Australian context. A more meaningful geographic classification is the Australian Standard Geographical Classification employed by the ABS. For Australia overall, in 2005 the average number of FTE psychiatrists per thousand of the population was 17. The rate for Major Cities was 22, for Inner Regional was 8, Outer Regional was 4 and for Remote and Very Remote was 3 (AIHW 2008b, Table 13.4).

The demographic issues just discussed serve as background; some substantive economic issues need to be considered and it is to these that we turn.

3. Services Provided in Private Practice

Public sector psychiatry largely deals with a narrow range of psychiatric disorders, and that range is concentrated towards the serious end of the spectrum of the psychoses (Burgess et al. 2002). Since the process of deinstitutionalisation in Australia (Doessel, 2009), many of those with disorders that were previously treated in public psychiatric institutions are now treated in the community, in a non-institutional—or ambulatory—approach, such as clinical visits, outpatient care, home visits, brief in-patient stays, and so forth. The dedicated capacity of psychiatric institutions is now a small fraction of their previous capacity, as people with serious mental illness are now treated in psychiatric wards in general hospitals. This is a process commonly called mainstreaming; that is, expanding
'the proportion of acute psychiatric inpatient care provided in hospitals rather than separate psychiatric hospitals' (Australian Health Ministers 1992, p. 18). Details of activity in hospital-based public practice are now reported in the National Mental Health Report, the latest report available in April 2010 being the Department of Health and Ageing (2008). As indicated already, we concentrate here on private practice psychiatry operating on a fee-for-service basis since the advent of Medicare. In an overview of the Australian mental health sector since 1992–93, Doessel, Tonmukayakul and Williams (2010)—in a paper complementary to the present work—also look at the public sector, and they examine the various expenditures that are nationally classified under public sector Specialised Mental Health Services.

In the 21-year period from 1984–85 the number of specialist medical services of a psychiatric nature—as listed in the Medicare Benefits Schedule (Department of Health and Ageing 2009)—has increased from 1,288,413 to 2,013,591. This growth represents an annual compound increase of 2.23 per cent. A more useful way of depicting the time series of services provided is to consider Figure 2, which indicates the number of private practice psychiatry services per 100 thousand of the population.

The data exhibit an inverted U-shape: in 1984–85 there were 8,091 services per 100 thousand of the population, reaching a maximum of 12,591 in 1995–96 and falling to 10,062 per 100 thousand in 2004–05. The falling hours of work for both males and females discussed above has resulted in a population-adjusted relative decrease in psychiatric services since the mid-1990s, despite the small increase in the relative number of FTE psychiatrists in private practice. Thus data on outputs produced reflect the decrease in inputs (hours worked) reported above.

Another way of looking at the profession’s output is to consider the number of patients seen by psychiatrists. Figure 3 shows this population-adjusted variable for the 21 years from 1984–85. The inverted U-shape in Figure 2 also exists in Figure 3. In 1984–85, the number of patients treated per 100 thousand of the population was 1,113, rising to a maximum of 1,613 in 1995–96 and then falling consistently since then to 1,360 in 2004–05.
Figure 2 – Number of private practice psychiatry services per 100,000 of the Australian population: 1984-85 to 2004-05

The picture of a slightly increasing profession (numerically)—but with declining average hours of work per FTE psychiatrist—is confirmed by considering another measure of labour activity, the number of psychiatric services per FTE provider. In 1984–85 this measure was 1,234, rising to a maximum of 1,400 in 1995–96, and falling consistently to 1,085 in 2004–05. See Figure 4.
Figure 4 – Number of psychiatric services per FTE provider, Australia, 1984-85 to 2004-05

SOURCES: Calculated from Commonwealth Department of Health and Ageing (2002) Table A-42; Department of Health and Ageing (2005), Table A-49; Department of Health and Ageing (2008), Table A-48; and Australian Bureau of Statistics (2008a), Time Series Spreadsheets, Table 4.

A major determinant of activity in the health sector is the government's role. We turn to consider how the government affects private fee-for-service practice in Australia.
4. Government (Medicare) Subsidies for Fee-for-service Medical Procedures

Since the introduction of Medicare, the general framework of Australia's health financing arrangements has largely remained fixed. There have been some changes (for example, the rebate on hospital-based private medical services falling from 85 per cent to 75 per cent of Schedule Fees), but relative to the overall structure of Medicare these changes have been minor. Medicare is a constant. This section does not take public hospital services provided under Medicare into consideration; the focus here is only on the fee-for-service part of Medicare. Doessel (1994) provides a detailed account of public and private medical practice. For a straightforward account of Medicare and its precursor, the 1975 Medibank scheme, see Scotton (1968); Scotton and Deeble (1968); Scotton and Macdonald (1993).

Essentially, the operations of Medicare entail all medical services being listed in the Medicare Benefits Schedule (Department of Health and Ageing 2009). If they are provided to Australian citizens and permanent residents, then these services are subject to an Australian government subsidy. These subsidies are generally referred to as Medicare Benefits or Medicare Rebates. The subsidy is set at 85 per cent of the Schedule Fee for out-of-hospital medical services and 75 per cent of the Schedule Fee for in-hospital medical services.

From 1984–85, the number of specialist psychiatry items in the Medicare Benefits Schedule has varied somewhat, as different issues have arisen in the mental health sector. For example, 12 new items have been introduced since the advent of telepsychiatry. (All items are listed in Group A8—Consultant Psychiatrist Attendances in Category 1—Professional Attendances of the Medicare Benefits Schedule.) In total, there are 45 specialist items in the January 2010 version of the schedule (Department of Health and Ageing, 2010). Apart from these core items there are some other items of a co-ordination nature (clinical or case management) that can be used by psychiatrists. In this paper we concentrate on the core items.

Figure 5 shows Medicare Benefits per 100 thousand of the population. This measure rises from $969,499 in 1984–85, reaches a maximum of $1,511,246 in 1995–96, and then falls to $1,024,898 in 2007–08. It is noteworthy that this financial measure closely reflects the physical measure (Psychiatric Services per 100 thousand of the population) shown in Figure 2.
Figure 5 – Medicare benefits for psychiatric services per 100,000 of the Australian population, in constant prices ($2006-07), 1984-85 to 2006-07

SOURCES: Calculated from Commonwealth Department of Health and Ageing (2002) Table A-42; Department of Health and Ageing (2005), Table A-49; Department of Health and Ageing (2008), Table A-48; Australian Bureau of Statistics (2008), Time Series Spreadsheets, Table 4; and Australian Bureau of Statistics (2008c), Table 30.
Given the objective of placing the psychiatry workforce in perspective, it is useful now to indicate the proportion, through time, of all government subsidies for medical services which psychiatrists have received. Figure 6 presents government subsidies to psychiatry as a percentage of government subsidies to all medical services provided under Medicare. Figure 6 shows how this share changes from 3.01 per cent in 1984–85, reaches a maximum of 3.41 in 1993–94 and falls to a minimum of 1.72 per cent in 2007–08.

A general conclusion is that all measures of the psychiatry profession considered so far indicate a relative decline in activity since the mid-1990s. Let us now examine fees.

5. Fees Charged

Medicare is a compulsory system of health financing. It involves a threefold system of inter-related prices: Schedule Fees, gross (or total) fees and net (out-of-pocket or gap) fees. In this paper we refer to the latter two concepts as gross prices and net prices. The gross prices of all medical services are subsidised by the Australian government under Medicare. This government subsidy, when subtracted from the gross price, determines the net price to the consumer (patient), that is, the out-of-pocket or gap expense. For details on the relationships between these three prices in the context of psychiatry services see Doessel and Williams (2004).

Attention is directed here to a measure of the psychiatry industry, namely pricing, which gives further insight into the activity of this profession. Figure 7 presents time-series data from 1984–85 on the two concepts of price: gross price and net (out-of-pocket) price. These concepts are central to any analysis of health services under a system of health insurance. Figure 7 also shows average Medicare Benefits, for completeness. The data in Figure 7 once again involve calculations on the core psychiatry items in the Medicare Benefits Schedule. The prices reported are a weighted average for these core items.
Figure 6 – Medicare benefits for psychiatric services as a percentage of all Medicare benefits for all services listed in the Medicare Benefits Schedule, Australia, 1984-85 to 2004-05

Figure 7 – Average gross price, average net price and average Medicare benefit for psychiatric services, Australia, in constant prices ($2006-07), 1984-85 to 2004-05

It is useful to show the extent of net price outcomes for consumers (patients). Table 1 shows, the actual values for Average Gross Price, Average Medicare Benefits and Average Net Price, and the Medicare Benefits and Net Price as a percentage of Gross Price. These percentage shares can be interpreted as system-wide ex post co-insurance rates.

Table 1: Average Gross Price, Average Medicare Benefit, and Average Net Price, and Co-Insurance Rates for Government and Consumers, Psychiatric Services, $S (Constant 2006–07 Prices)

<table>
<thead>
<tr>
<th>Year</th>
<th>Average Gross Price ($S)</th>
<th>Average Medicare Benefit</th>
<th>Average Net Price</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Percentage of Average Gross Price</td>
<td>Percentage of Average Gross Price</td>
</tr>
<tr>
<td>1984-85</td>
<td>128.90</td>
<td>119.83</td>
<td>92.96</td>
</tr>
<tr>
<td>1985-86</td>
<td>126.54</td>
<td>117.82</td>
<td>93.11</td>
</tr>
<tr>
<td>1986-87</td>
<td>127.80</td>
<td>118.15</td>
<td>92.45</td>
</tr>
<tr>
<td>1987-88</td>
<td>130.92</td>
<td>120.12</td>
<td>91.76</td>
</tr>
<tr>
<td>1988-89</td>
<td>127.74</td>
<td>116.72</td>
<td>91.38</td>
</tr>
<tr>
<td>1989-90</td>
<td>126.80</td>
<td>115.54</td>
<td>91.12</td>
</tr>
<tr>
<td>1990-91</td>
<td>127.51</td>
<td>115.76</td>
<td>90.78</td>
</tr>
<tr>
<td>1991-92</td>
<td>130.13</td>
<td>117.04</td>
<td>89.84</td>
</tr>
<tr>
<td>1992-93</td>
<td>133.15</td>
<td>120.88</td>
<td>90.79</td>
</tr>
<tr>
<td>1993-94</td>
<td>134.48</td>
<td>122.03</td>
<td>90.75</td>
</tr>
<tr>
<td>1994-95</td>
<td>134.68</td>
<td>121.61</td>
<td>90.20</td>
</tr>
<tr>
<td>1995-96</td>
<td>133.64</td>
<td>120.02</td>
<td>89.81</td>
</tr>
<tr>
<td>1996-97</td>
<td>132.36</td>
<td>117.66</td>
<td>88.90</td>
</tr>
<tr>
<td>1997-98</td>
<td>132.87</td>
<td>116.17</td>
<td>87.63</td>
</tr>
<tr>
<td>1998-99</td>
<td>135.60</td>
<td>118.44</td>
<td>87.35</td>
</tr>
<tr>
<td>1999-00</td>
<td>136.72</td>
<td>119.73</td>
<td>86.84</td>
</tr>
<tr>
<td>2000-01</td>
<td>134.02</td>
<td>116.01</td>
<td>86.18</td>
</tr>
<tr>
<td>2001-02</td>
<td>133.82</td>
<td>113.66</td>
<td>84.87</td>
</tr>
<tr>
<td>2002-03</td>
<td>135.16</td>
<td>113.08</td>
<td>83.66</td>
</tr>
<tr>
<td>2003-04</td>
<td>135.59</td>
<td>112.77</td>
<td>83.17</td>
</tr>
<tr>
<td>2004-05</td>
<td>136.06</td>
<td>116.62</td>
<td>85.21</td>
</tr>
</tbody>
</table>

The average net price for psychiatry services in 1984–85 was $7.04, expressed in constant (2006–07) prices. This variable rose to a maximum of $16.83 in 2003–04, and subsequently fell slightly to $14.79 in 2004–05. Table 1 clearly shows the rising net price, (gap price or out-of-pocket price) over the study period. For a statistical analysis of this trend, see Williams et al. (2006).

We employed OLS regression analysis to shed more light on the changes in prices during the period considered. As pointed out above, net prices (on average) have risen. We direct our attention to the ratio of average net price to average gross price, that is, what we have referred to above as the system-wide, ex post co-insurance rate, which has also risen. Our first step was to estimate a linear regression equation on the 21 annual observations for the system-wide co-insurance rate. This equation was subject to serial correlation (seen in the value of the Breusch–Godfrey test), and we inserted an AR1 term to address this problem. The re-estimated equation is $0.061 + 0.0005t$, where $t$ is time. The intercept term and the slope coefficient in this equation have p-values of 0.000. The equation has a very high goodness of fit; adjusted $R^2$ is 0.94 and the $F$-statistic of 154.51 is highly significant. The equation passed the serial correlation test, as well as all other diagnostic tests for heteroscedasticity, the Ramsey RESET specification test, the Jarque-Bera test for normality of the residuals and the Augmented Dickey-Fuller test for stationarity of the residuals. The statistically significant coefficient on time shows that the proportion of out-of-pocket expenses of the gross prices rose by 0.5 per cent per annum. The visual impression of the rise in net prices for psychiatry services since 1994–95 is confirmed statistically. This is not a surprising result, given the relative decline in the quantity of psychiatry services provided, as documented earlier.

6. The Expansion of Medicare: Paramedical Mental Health Services

In November 2006 the Australian government expanded Medicare funding to cover specific mental health services provided by approved clinical psychologists, other psychologists, social workers and occupational therapists. This was part of a larger reform package involving the Australian government and the governments of the States and Territories. This reform package was formed under the aegis of the inter-governmental institutional processes of COAG. The 2006 COAG initiatives in mental health included not only the extension of Medicare funding to the paramedical services discussed here, but also funding for Mental Health Nurses, the strategy Alerting the Community to Links between Illicit Drugs and Mental Illness, Mental Health Services in Rural and Remote Areas and so on.
Details of the paramedical mental health services have been provided elsewhere (see Whiteford, Doessel and Sheridan 2008; Doessel, Williams and Nolan 2008; Littlefield and Giese 2008).

The available data on these services are as yet limited. It is possible to indicate expenditures of subsidies by multiplying the number of psychiatry services by the government subsidy (Medicare Benefits) paid for them, and also by multiplying the number of paramedical services by their relevant Medicare Benefits to depict the significance of the new services relative to the existing trend in psychiatry (see Figure 8). The heavy line depicting Medicare Benefits for psychiatry services per 100 thousand of the population is copied from Figure 5. This (population-adjusted) line can be regarded as what would have happened without the changes brought by COAG. The dotted light line depicts the subsidies associated with the new paramedical services, summed with that for psychiatry services to depict the post-COAG Australian government subsidies.

Figure 8 clearly shows the effect of the introduction of the new paramedical services: subsidies for mental health services have risen sharply. For the first (financial) year of operation—which entailed just eight months from 1 November 2006 to 30 June 2007—Australian government subsidies for paramedical services totalled $53,198,844. Added to the subsidies for psychiatry services ($230,755,000), the entire subsidy was $283,953,844. Per 100 thousand of the population, paramedical services accounted for an increase of $258,950, generating a population-adjusted increase from $1,123,220 (psychiatry services alone) to $1,382,170 (paramedical and psychiatry combined). In the second year of operation (the financial year 2007–08), the subsidies for the new paramedical services increased markedly to $168,993,835 (at constant 2006–07 prices). In population-adjusted terms, both types of mental health services entailed Medicare subsidies rising to $1,835,468 per 100 thousand of the population.

This evidence concerning the magnitude of the government expenditures on the allied health professions, although for a relatively short period, indicates that the 2006 decision to bring these professions under the scope of Medicare can justifiably be described as historic.
Figure 8 – Medicare benefits for psychiatry services and paramedical mental health services per 100,000 of the Australian population, in constant prices ($2006-07), 1984-85 to 2006-07

7. Conclusion

This paper has briefly described the state of mental health in Australia for the purpose of placing in context the temporal growth of that very important component of the mental health workforce, which is specialist psychiatry. The focus has been on private-practice psychiatry, operating on a fee-for-service basis, since the advent of Medicare in 1984. A further focus has been to examine the impact of new allied mental health professions now eligible for a Medicare subsidy. Although this paper is a study of the workforce of the private sector, a companion paper (Doessel, Tonmukayakul and Williams 2010) analyses the key changes within the public sector.

The term historic was used in the introduction of this paper to describe the 2006 policy to cover the services of some allied health professionals under Medicare, and it is relevant to explain why we invoked this term. Since the advocacy work of Scotton and Deeble (1968) on compulsory health insurance in Australia, and the description of their system in operation (Scotton and Macdonald 1993), the broad outlines of the Australian system have changed little since 1984 when the current Medicare system became operational. In terms of 'gaps' or 'government failures' (Le Grand 1991) in insurance coverage for Australians' health status, the most glaring omission has been that of dental health; dentists' services have hardly rated a mention under Medicare. It is a puzzle that although the provision of mental health services in Australia was far from perfect, major structural change took place in this sector in 2006; in contrast, the problems of oral health remained unaddressed. Why these decisions came to be made is beyond the scope of this paper. In this context, it is also relevant that consumer access to these services has been constrained: such services are not 'unreferred' services, that is, they can be provided—up to a maximum of 12 services per year—if a GP or a psychiatrist makes a mental health plan and refers the patient to an allied mental health provider. For some details of this see Whiteford, Doessel and Sheridan (2008). Comparative work needs to be done with the policy formation processes of the Department of Health and Ageing.

The paper has brought together published data from various sources (the National Mental Health Report, the Australian Bureau of Statistics, Medicare Australia, the Australian Institute of Health and Welfare, and others) to present as coherent a picture as possible of the demographics of the labour force, which are numbers, age and gender, and also of key economic variables. More specifically, attention is focussed on time-series data on hours worked, labour force participation
(part-time or full-time) in general, as well as outputs (services) produced for the mentally ill in Australia since 1984–85.

No attention has been given to either the short-run pressure group politics, or to the bureaucratic processes that took place in the time leading up to the funding of allied health professionals. For some information on these basic issues, see Littlefield and Guise (2008). It is for other scholars (for example in public policy or administration, and sociology) to search for and uncover the forces that underlie these decisions. Those forces may include the following: the small number of psychiatrists; the tendency for many people with a mental illness to present first to a primary care provider—a general practitioner (GP)—and that those providers have minimal training in the diagnosis and treatment of mental illness; that the Medicare payment system for these providers does not suit long consultations; that psychologists, social workers and some mental health nurses are better trained and better placed than GPs are to deal with these chronic conditions; that GPs are hardly able to refer patients to psychiatrists given the few psychiatrists in private practice; and so forth. Thus, our concern has been with the structural outcomes associated with some service professions in the mental health sector, specialist psychiatry in particular, for which some useful time-series data are now available.

Another important qualification is that the conclusions of this study provide no discussion of mental health status. That is, this study does not enable comment to be made on whether, or by how much, mental health status has changed in Australia as a result of the changes reported in this study in the quantity of psychiatry service since the mid-1990s. This comment also applies to the effect of the new allied health professional groups. It should also be kept in mind in this context that there are no data on the content of, and processes undertaken within, Medicare items of psychiatry. What are the processes of psychiatry that are being subsidised under Medicare? It would be relevant to ask this question also with respect to the new allied mental health items.

The next qualification relates to the relative reduction in the size and output of the psychiatry profession. This is largely the outcome of the cumulative decisions of the annual cohorts of graduating medical practitioners from Australian universities since the late 1980s. The two specific decisions that are relevant here are the occupational choices within medicine, which are entering general practice or specialist further studies via the colleges, and choosing among obstetrics and gynaecology, dermatology, ophthalmology, psychiatry and so on. It is irrelevant to this study to speculate on the factors that have determined those decisions. Detailed interviews could have been undertaken to discover what may have been
the determining factors in young medical practitioners' decisions not to choose psychiatry above other specialist professions.

Although there has been population-adjusted growth in the psychiatry labour force, there is a mixed picture of the outputs produced by it. Population-adjusted services reached a maximum in the mid-1990s and have consistently fallen since that time. There is empirical evidence to indicate that, on average, relatively fewer consumers (patients) have been treated by the psychiatry labour force since the 1990s. The average decline in hours worked is also reflected in the declining number of services provided per psychiatrist (since the mid-1990s) by the psychiatry labour force. This measure reached a maximum of 1,400 in 1995–96, and in 2004–05 it had fallen to 1,065. Reflecting this relative decline, government subsidies for specialist psychiatry services have also fallen relative to all government subsidies for all medical services provided under Medicare. At the start of Medicare (1984–85), subsidies for psychiatry services represented 3.01 per cent of all Medicare subsidies, and this share had fallen to 1.97 per cent in 2006–07. In addition, there is some evidence to indicate that net prices (out-of-pocket prices to consumers (patients)) have risen since the advent of Medicare.

Thus, despite a modest growth in the number of psychiatrists per 100 thousand of the population, there has been a relative decrease in hours worked. This fall in (average) labour effort has produced an outcome of a relative decline in services. This same process has also resulted in falling average numbers of patients seen per psychiatrist, and falling numbers of services provided per psychiatrist. The general picture is one of relative decline of this important segment of the medical labour force. Further comparative work needs to be done on psychiatry and other specialties.

The increases in psychology services since November 2006 (documented here) may involve an overestimation of psychologists' clinical services. Prior to the inclusion of these services under Medicare, psychologists provided mental health services to people without private health insurance, such people paying the full fees (that is, the charges in full), as well as people who had (some) coverage under their private health insurance policies, thus paying net fees. If, post-November 2006, such people have consulted their general practitioner, who developed a Mental Health Plan for them, and they were then referred to one of the allied mental health professionals now under Medicare, then there would simply be a substitution of financing these services into the public health insurance system, that is Medicare. Given the absence of relevant data, we are unable to determine the magnitude of such substitution as may have occurred.
If one takes the view that more mental health services are needed for those people subject to mental illness (but who are not receiving any mental health services), then there seems little hope of obtaining those increased services from the psychiatry labour force. It is in this context that the Australian government expanded Medicare coverage for the specified mental health services provided by the three groups of paramedical professions. Although the effect of this decision cannot be seen in terms of total expenditure on mental health services (as these data are unavailable), the evidence from the available data relating to government subsidies under Medicare is sufficient to indicate the importance of the November 2006 decision. It is concluded that the structural change in the provision of mental health services that incorporated allied mental health services under Medicare since 2006 can be regarded as an historic change.

Endnotes

¹ There are criteria developed by the Australian government for eligibility. These are expressed in a Medicare document entitled 'Eligibility Criteria for Allied Health Professionals Providing Medicare Services', Medicare Australia (2008b).

² There are now stand-alone mental health units and (or) hospitals on the same site as public hospitals. For an analysis of expenditure data on the services of this type of facility, see Doessel et al. (2010).

³ The most recent financial year for which data are available is 2004–05, available in the latest National Mental Health Report of 2008 (see Department of Health and Ageing, 2010).

⁴ All financial and (or) economic data reported here are converted to constant prices (base year 2006–07) using the Implicit Price Deflators for Non-farm GDP (ABS 2008b).

⁵ Clinical psychologists are registered psychologists eligible for membership of the Australian Psychological Society College of Clinical Psychologists; other psychologists are ineligible, although registered.

⁶ Mental Health Services in Rural and Remote Areas is a COAG initiative to provide allied and nursing mental health services in rural and remote communities throughout Australia. Alerting the Community to Links between Illicit Drugs and Mental Illness is a community-awareness strategy.
References


Australian Health Ministers (1992), National Mental Health Policy, AGPS, Canberra.

Australian Institute of Health and Welfare (AIHW) (2002), Mental Health Services in Australia 1999-00, AIHW, Canberra.

Australian Institute of Health and Welfare (AIHW) (2004a), Health System Expenditure on Disease and Injury in Australia 2000-01, AIHW, Canberra.

Australian Institute of Health and Welfare (AIHW) (2004b), Health System Expenditure on Disease and Injury in Australia 2000-01—Update Tables and Figures, AIHW, Canberra.


Doessel & Williams


Mental Health Council of Australia (2005), Not for Service: Experiences of Injustice and Despair in Mental Health Care in Australia, Mental Health Council of Australia, Canberra.


Senate Select Committee on Mental Health (2006), A National Approach to Mental Health: From Crisis to Community, Select Committee on Mental Health, Canberra.

Vos, T. and Mathers, C. (2000), 'Burden of Mental Disorders: Australian and
Global Burden of Disease Studies'. Bulletin of the World Health Organization,
vol. 78, pp. 427-438.

G. and Henderson, S. (eds), Unmet Need in Psychiatry: Problems, Resources,

Whiteford, H. A and Buckingham, W. J. (2005), 'Ten Years of Mental Health
Reform in Australia: Are We Getting it Right?' Medical Journal of Australia,
vol. 182, pp. 396-400.

Benefits Schedule Items by Psychologists and Other Mental Health
Practitioners', Clinical Psychologist, vol.12, pp. 50-56.

'Some Economic Dimensions of the Mental Health Jigsaw in Australia',