Submission on Differential Weighting of Psychiatric Consultation Items

(With reference to the International Mid-Term Review of the Second National Mental Health Plan for Australia of November 2001)

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Introduction

The National Association of Practising Psychiatrists (NAPP) has, through a number of sources, been given to understand that the federal government is seriously considering a number of options contained within the International Mid-Term Review of the Second National Mental Health Plan for Australia (*The Review*).

In particular, a proposal contained within *The Review* to introduce differential patient MBS rebates or front-end loading of patient MBS rebates for psychiatric outpatient consultations which reward at a higher rate initial consultations over subsequent visits is being seriously considered.

This proposal appears to be aimed at alleviating federal government concerns related to perceptions of inadequate access to psychiatric services and maldistribution issues which have been the subject of previous attempted remedies contained in the National Mental Health Strategies, 1and 2, and other policy measures.

The rationale behind this proposal appears to be that financial incentives will increase the number of "consulting opinions" to primary health carers and other providers, thereby increasing access to mental health specialist opinion generally, while ongoing management is discouraged, and perhaps devolved to other less specialised professionals.

NAPP is strongly of the view that this proposal has been based on several faulty assumptions and a marked misunderstanding of the nature of psychiatric work in general.

NAPP believes that *The Review* is flawed in a number of ways, more particularly because Psychiatrists working in private practice were not consulted as to the realities of their work in drafting the report. Further, the authors of *The Review* do not acknowledge to what degree their views may have been influenced by particular perceptions of quality care arising from within vastly different medical systems in their home countries.

NAPP recommends that these proposals be urgently reconsidered in the light of the following submission, and the detrimental consequences for patients that will flow of necessity from such ill-founded policy options.

NAPP further submits that the general thrust of policy initiatives since the mid-1990's is arguably aimed at making the practise of psychiatry more controlled, but these same policies are having the effect of making the profession unattractive, and one in which the exercise of clinical autonomy and expertise is not valued. This can only produce adverse outcomes, worsen the already acute access issues, and is contrary to recommendations made in AMWAC reports.

Differential Rebates

Differential rebates were first canvassed in the MacKay Report[1] (Optimum Supply and Effective Use of Psychiatrists, 1996, p58.). Indeed, many policy initiatives such as rationing access to long term intensive treatment, pooled funding models in "demonstration projects", and closure of dedicated facilities are seemingly taken directly from the same Report. It is of some note that the MacKay Report and its predecessors were severely criticised for their faulty assumptions and poor methodology by the RANZCP.

This critique however appears to have gone unheeded – to the detriment of quality care. It is no surprise then, that suggestions to limit the provision of provider numbers, to force a geographical redistribution of psychiatrists, appear again in *The Review* but were first mooted in the MacKay Report, albeit with reservation.

NAPP is of the view that the National Mental Health Strategies, in all their forms, concern, in essence, ways in which the recommendations of the MacKay Report can be uncritically introduced.

The option of differential rebates is thus canvassed in *The Review* as part of a range of measures,

> *"Introduce item numbers and other financial measures to act as incentives for private psychiatrists to:*
> - *(i) consult to primary care staff;*
> - *(ii) consult to rural and remote practitioners;*
> - *(iii) routinely conduct initial and crisis assessments, for example, by differential rebates favouring first assessments over follow-up appointments;(emphasis ours)*
> - *(iv) provide to the Commonwealth details of the outcomes of their interventions; and*
> - *(v) act in collaboration with other components of the wider mental health service system."*[2]

NAPP is a national organisation comprised of practising psychiatrists, and hence we speak with some authority in regard to actual work practices.

Given that all rebateable referrals to private psychiatrists must of necessity come from medical practitioners, NAPP is mystified by statements in *The Review*, which lead to the erroneous conclusions above, such as:

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[1] McKay, B., *Proposals for change Final report: Optimum supply and effective use of psychiatrists*, 1996, Bernie McKay and Associates. & McKay, B., *Issues and Options Supplementary paper: Optimum supply and effective use of psychiatrists*, 1996, Bernie McKay and Associates.

[2] Thornicroft G & V Betts 2002, *International Mid-Term Review of the Second National Mental Health Plan for Australia*. Mental Health and Special Programs Branch, Department of Health and Ageing, Canberra. pg 6.

> *"Psychiatrists working in private practice do so in substantial isolation from most other parts of the mental health service system. Their contributions are made largely to pre-planned out-patient sessions, and they do not commonly liaise with emergency department and crisis services or local mental health teams."*[3]

and

> *"Many psychiatric sessions are in private practice, which plays relatively little part in the consultation to primary care services"*[4]

NAPP rejects these generalisations that seemingly have no basis in fact. They arguably arise out of a misunderstanding of the nature and practice of psychiatry in Australia. Whether this arises from preconceived ideas the authors bring with them is unacknowledged, but it must be said that the medical systems within their countries are vastly different from that in Australia. Solutions to our problems therefore, may also be different from those described by the authors of *The Review*.

It is our belief and experience that private psychiatrists are only too willing to liaise if it is made possible, and do in fact liaise with crisis teams on a regular basis especially if their practice encompasses the acute illnesses. It hardly needs to be pointed out that private psychiatric hospitals - which considerably reduce the strains on the public system - would not exist if psychiatrists worked in the manner described in *The Review*.

Further, for *The Review* to state that private psychiatry contributions are "*largely to pre-planned outpatient sessions"*[5] seemingly betrays a profound misconception of the nature of psychiatric work.

NAPP can only surmise that this may have resulted from a perception that the current political agenda needed to be reinforced - indeed this view arguably finds support in the significant critical findings of *The Review*, which nevertheless lead the authors to state

> *"..the reviewers were most impressed with the progress made in mental health across Australia."*[6]

NAPP can only assume that the reference to "*pre-planned outpatient sessions*" bears directly on a misperception in some quarters that brief, short-term and long term non-intensive, as well as long term intensive psychiatric treatment is of no or little value.

It needs to be restated that all medical practice (barring emergencies and crises) are of necessity pre-planned. Planning is part of the normal process of formulating patient management plans and supervising patient progress.

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[3] *ibid.* pg 17.
[4] *ibid.* pg 11.
[5] *ibid.* pg 17.
[6] *ibid.* pg 11.

Long term intensive psychiatric treatment too, is of necessity "pre-planned" and has been the subject of a separate Submission to the Medicare Benefits Consultative Committee (MBCC). That Submission describes international and local research that attest to long term intensive psychiatric treatment's usefulness in specific targeted patient groups, and details the economic and social benefits that flow from its availability.

In addition, it is of note that psychiatrists are trained in a unique way, which allows them the flexibility to view the problems of patients from either a biological perspective, or a psychological perspective depending on need. This is referred to as the "biopsychosocial model" of the practice of psychiatry. Depending on patient need and diagnosis therefore, a management plan for a particular patient might emphasise one aspect over the other - and is entirely consistent with the high standards of care sought in training. It also leads to certain psychiatrists choosing to specialise even further in one particular area - much like a surgeon deciding to be a neurosurgeon, or a physician deciding to concentrate on heart disease. This diversity is to be encouraged, and is not to be seen in the prejudicial light implied in the text of *The Review*.

If *The Review* seeks to imply that all private psychiatric practice involves long term treatment, that would be factually incorrect. If "pre-planned" refers to ongoing management of acute or sub-acute cases that require specialised supervision, then private psychiatrists would see this as the provision of ethical treatment and complying with their duty of care to their patients.

NAPP is of the view that many psychiatrists are only too happy to devolve ongoing management, if clinically appropriate, to GPs or community teams. There remains a group, however, who do require specialist supervision, and this fact cannot be denied.

Indeed, it is the opinion of NAPP that when *The Review* baldly states:

> *"…they do not commonly liaise with emergency department and crisis services or local mental health teams"*[7]

that this is not just wrong in fact, but represents a severe misreading of the situation 'in the field'.

NAPP Members have repeatedly pointed out that community teams, crisis teams, and emergency departments are too often beset by inadequate financial resources and very low staffing levels so that making time to liaise becomes near impossible. In short, the liaison problems arise from the well documented deficiencies of the public system which has been severely run down. Millions of dollars have been 'saved' by cutting down psychiatric beds, outpatient clinics and long term psychiatric treatment, and eliminating consultant psychiatrists in the public mental health system.

Liaising between GPs, emergency departments and private sector psychiatrists happens routinely until the capacity of the practitioners can no longer meet the demand.

[7] *ibid.* pg 17.

Equally though, the consultation model being mooted as "the new psychiatry" is arguably one in which no-one will end up getting adequate treatment. An analogy would be giving everyone one day's worth antibiotics, which in fact is inappropriate care.

There would seem to be, given the inaccuracies of the arguments put forward in *The Review*, no justification for the introduction of differential weighting of rebates for psychiatric consultation items.
NAPP would however, accept the principle of rebated liaison items, but if suitable mechanisms and safeguards could be instituted to safeguard patient care.

The Review

Although the International Mid-Term Review of the Second National Mental Health Plan for Australia (*The Review*) of November 2001 does make some worthwhile points (eg in the increasing participation of consumers and carers in debating policy). Nevertheless, NAPP views its recommendations as markedly problematic. NAPP believes that the recommendations will not ease access and distribution issues of the workforce, and those who will suffer most are patients and their families, particularly those on lower incomes.

The latter view is supported by the need for the current Select Committee inquiry into Mental Health Services in NSW, which NAPP was instrumental in establishing. The problems in NSW that have left patients deprived of quality psychiatric care have been brought about, in our view, by an inappropriate use of management models to address issues which might have been addressed differently if psychiatrists in practice were consulted and their advice heeded. For example, it is of note that the attempt to ration care in psychiatric services generally started with the questionable decision in the public system to treat only "serious mental illness" ie psychosis. This had the unfortunate effect of cherry-picking the "most deserving" and has been a failure that now needs to be reversed. All it did was deprive patients (who are now classified in *The Review* as having "high-prevalence disorders") of care, create deficits in training of psychiatrists and overload GPs.

These problems were not brought about by inappropriate work practices in the private psychiatric sector.

It is also of note that a similar inquiry, conducted by the Ombudsman, is currently underway in South Australia. The problems in public mental health provision have been indicted, by the SA Coroner, as a major contributor to several suicides.

Similarly, homicides in Victoria and Queensland have been linked to declining public outpatient services, and not problems in the private sector.

The opinions expressed in *The Review* therefore, are arguably seriously skewed and flawed. We re-iterate our view that the public sector is not there to be liaised with, leaving private psychiatrists to cope as best they can.

In particular, NAPP makes the following observations about specific content in *The Review*.

Acknowledgements

NAPP notes with some concern that no private psychiatrists who are currently engaged in clinical practice for the majority of their working week were consulted in this Review.

Consumers and Carers: Ways Forward

We agree that the enhanced role for consumers foreshadowed in this section is a positive suggestion, but care needs to be taken that consumer representatives do not become 'token members' on committees. Neither should 'consumerists' (government funded consumer representatives) be seen to overtake and over look the real concerns of patients. We understand from anecdotal reports that this sometimes is the case.

Partnership Development: Ways Forward

Although this section contains important initiatives (eg extending Beyond Blue) NAPP is concerned that this might be at the expense of specialist availability.

While there is a need for improved consultation and management advice to general practitioners (which Beyond Blue seeks to address) there is also a place for specialist treatment for some individuals. This sentiment was expressed in the findings of the RANZCP when they undertook detailed "Quality Assurance" projects. Although now rather dated, clinical reality has not changed, and the patients increasingly seen in psychiatric practice are the equivalent group to that treated by medical specialists in any discipline. For example, it is our experience (supported by research) that the population group targeted by Item 319 restrictions are the equivalent of a medical group often treated in Intensive Care units. The critical difference is that treatment is slow and difficult - the similarity is that treatment is highly specialised and ultimately rewarding.

Therefore, when this section of *The Review* section makes the following suggestion:

> *"placing the lead role in mental health promotion with mainstream, generic health promotion agencies."*[8]

NAPP is concerned that this will inevitably lead to increased dissatisfaction from patients caused by reduced access to quality care, and poor outcomes as those with decision-making responsibilities will be divorced from the core work as it is practiced. NAPP has made a separate Submission on the issue of generic mental health workers (See Appendix A).

The Mental Health Workforce: Ways Forward

NAPP is firmly of the view that there is insufficient acknowledgement that there exists a group of patients that only psychiatrists, with their broad training base, can treat. To put it differently, there is a need for the particular skills and knowledge required to deal with severe illness.

The patients we deal with are often severely ill, often have a history of previous failed treatments, previous significant personal trauma, and all have significant DSM-IV diagnoses (many with co-morbid problems). NAPP would remind the reader that psychiatric training provides the requisite flexibility and expertise to deal with these

[8] *ibid.* pg 5.

issues. Making this expertise less available, as suggested by enshrining a "*psychosocial model rather than a medical model*"[9] would constitute a dereliction of our duty of care and represent a breach of ethics.

Further, the proposal to "*provide to the Commonwealth details of the outcomes of their interventions*"[10] would appear to us to be a gross interference in clinical autonomy which can only lead to defacto managed care and adverse outcomes.

Quality, Effectiveness, and Accountability: Ways Forward

NAPP cannot agree at all with the statements below, contained in *The Review*:

> *"• Establish strong lines of accountability for the implementation of service standards and the routine use of outcome measures.*
> *• Fund service providers based on addressing population needs and using evidence-based practice and measurable outcomes for financial, system, and clinical accountability.*
> *• Establish co-ordinated centres and networks to teach and evaluate the routine use of clinical guidelines and protocols.*
> *• Establish a national network for mental health services research to evaluate cost-effective treatments and service models."*[11]

These suggestions, in our view, arguably represent attempts to introduce or facilitate managed care strategies that place the decision-making process in some arbitrary outcome measure, rather than the clinical need of the patient. This challenge to clinical autonomy cannot lead to better outcomes, and can only produce distressed and dissatisfied patients and carers.

Similarly, clinical guidelines have been the subject of extensive debate within the RANZCP due to their potential for misuse resulting in adverse effects on patient care.

In addition, these suggestions may well lead to a situation where only those who can afford co-payments can access adequate treatments (ie those not proscribed arbitrarily).

The Second Mental Health Plan in an International Perspective

The Review states;

> *"The World Health Organisation (WHO) released its report Mental Health: New Understanding; New Hope in October 2001. In that report, the WHO reported that 25% of the world's population will suffer from a mental illness sometime during their life, yet 40% of countries have no mental health policy and 67% spend less than 1% of their annual health budget on mental health*

[9] *ibid*. pg 6.
[10] *ibid*. pg 6.
[11] *ibid*. pg 7.

> *despite the enormous impact mental illness has on each nation's productivity and quality of life."*[12]

There can be no better argument for a re-investment of funds in providing comprehensive and adequate care across the board. Public outpatient clinics have been destroyed and this is an enormous loss. Every effort should be made to restore them. The huge loss of availability of psychiatric beds and inpatient psychiatric treatment has created an inequitable situation whereby those with private health insurance receive treatment not available to patients dependent on the taxpayer only. These clinics and inpatient units require urgent funding by government.

NAPP therefore strongly disagrees with recommendations 5.5 and 5.6 of *The Review* that urge partnerships to be developed under the auspices of generic mental health workers. For too long now, policy has been implemented which downgrades the effectiveness of psychiatric intervention and which promotes management strategies by those unfamiliar with the complexities involved.

This can only lead to the kinds of adverse outcomes that have now led to the Select Committee inquiry into the gross deficiencies in mental health services outlined in NSW. NAPP respectfully submits that it was entirely predictable that *The Review* found

> *"…staff exude energy and are eager both to learn and to share their successes and continuing concerns."*[13]

In its submission to the NSW inquiry, NAPP made clear references to the difficulty staff face if they were to reveal the true condition of services, and the threats to staff of potentially losing their jobs. (This submission can be found in Appendix 2).

Specialist Mental Health Services: Ways Forward

While NAPP supports and welcomes suggestions aimed at increasing services to children and the elderly, we feel some concern with the notion of "*Increase services to those with disorders of high prevalence*"[14]. It is not specified what disorders *The Review* has in mind, but if it refers to high prevalence anxiety and depressive disorders there is a danger that treatment will be prescribed in a rigid manner; this would ignore the clinical reality that these disorders need a range of treatments as they are often complicated by underlying personality disorders. These need specialised and complex management skills, which appear in *The Review* to be entirely overlooked.

Conclusions

The Review concludes with a clarion call for a Third National Mental Heath Strategy to consolidate gains and improve programmes already in existence. While NAPP can acknowledge that positive outcomes might emerge from this, we are mindful that

[12] *ibid*. pg 15.
[13] *ibid*. pg 13.
[14] *ibid*. pg 13.

these positive outcomes will only emerge if the Strategy is not used to entrench existing ineffective policy. The inclusion of private psychiatry groups can inform policy if it is to be effective, and if improved patient care and outcomes is the desired goal.

Remedial Policy Suggestions

NAPP is mindful of the concerns of the federal government that access and maldistribution issues need to be attended to in some meaningful way.

However, we note that an assumption which underpins this concern is that of 'unmet need'. It is unclear to NAPP what the true state of any unmet need really is, as we have noted elsewhere in other submissions that figures appear to have been modified to lead to results that are not necessarily accurate.

NAPP is of the view that this unmet need argument dates back to the mid-1990's when semi-governmental reports (Buckingham-Solomon-Epstein Report, MacKay Report) were published outlining a severe unmet need in the community. The methodology of these reports was heavily criticised, but the results have somehow become part of policy thinking regardless.

Nevertheless, NAPP acknowledges that GPs do complain of difficulty in accessing psychiatrists. This too, however, may not reflect 'unmet need' as often a referral comes about as busy GPs search for a psychiatrist to take over the patient even if they could manage with supervisory input. Further, increased public awareness programmes may have inadvertently added to access problems by increasing demand. We repeat that the private sector is overloaded and strained as a direct result of the downgrading of the public system especially given that patients with psychiatric disorders frequently require time-intensive treatment.

In NAPP's submission to the MBCC, several policy options were detailed which aimed at relieving this tension, providing access to effective services, and which detailed possible preventative strategies which might reduce overall need and expenditure.

These options are outlined again for consideration.

Some points necessarily require a medium to long term perspective or 'vision'. All however, point the way to potential cost saving initiatives that would also benefit the community at large:

- Allowing access to treatment by repeal (or modification) of Item 319 regulations does in fact save the community from more general medical and PBS costs, and would have an important preventative role in reducing future costs.

- GPs complain of lack of access to psychiatrists. Consideration could be given to funding trials of "Balint" type groups between psychiatrists with suitable interest/training and GPs as a part of professional development. Previous trials (abandoned for lack of funding) in Victoria produced GPs who were more sophisticated as to the emotional needs of their patients, and more sophisticated in whether referral was actually necessary (Prytula). This has the potential for (a) cost savings by reducing unnecessary referrals, (b) lessening the problems of access to specialist psychiatrists by reducing need in

the GP group and (c) supporting GPs in an increasingly complex medical environment. It would also serve as an adjunct to current initiatives aimed at training GPs in brief therapy.

- If it became policy to fund positions for Visiting Medical Officers (VMO) in the public sector then many of the psychiatry workforce issues would be partly resolved. At present the limited funding for psychiatry is used on cheaper professionals and it has become a circular argument that psychiatrists are not in the system. In fact most VMO's have been sacked from their positions and those wishing to have such positions do not find them readily available.

- Similarly, rural GPs are also faced with difficulty. Consideration could be given to the viability of funding interested Visiting Psychiatrists to accompany such initiatives as the "Royal Flying Doctor" service. This has the potential to effectively and efficiently bring psychiatric expertise in acute assessment situations to very remote areas at regular intervals to look at group as well as individual functioning. This would be in addition to current country Visiting arrangements as exist eg in South Australia

- Psychiatrists have become very much aware of the obvious and demonstrable deficiencies associated with the tyranny of distance in rural and remote Australia. They are also aware of the rapid rate of technological change. It could not have escaped the notice of the Department of Health and Aging (DHA) of the particular leadership already shown by psychiatrists in this area. Telepsychiatry, in the form of Video links and Email communication is now being widely used especially within the public sector.

- On a broader note, priority should be given to facilitating enquiry into issues of early childhood development (as is being reviewed by the Attorney-General's Department) and how that can best be helped. It is well known that early experiences and socio-economic factors play a significant part in morbidity. By attending to this, there is huge potential for cost savings by reducing the need for psychiatric care of future generations. Such initiatives would be in keeping with similar international trends eg: The Early Years Study (Canada), The Sure Start Programme White Paper (UK), and Health 21 (WHO).

- Similarly, savings in psychiatric expenditure are there to be achieved by attending to educational policies (understaffing, high class numbers, teacher stress, lack of support networks eg school counselling) that allow the behavioural problems often classed as "attention deficit hyperactivity disorder" to emerge. These latter problems are a cause of great concern to the community as well as a source of expenditure for DHA.

- Equally, work practices may well contribute to the psychiatric costs incurred by the DHA. For example, how much does the rigid application of competition policy encourage absenteeism, stress leave and poor productivity which then triggers referral to private psychiatrists? How much do lack of paid maternity leave, and shared job arrangements have similar outcomes? Addressing these

issues has the potential for large cost-offsets by reducing utilisation of medical services as well as by increasing productivity through job satisfaction.

In order to facilitate consideration of the policy matters raised above, an important initiative might well lie in the formation of an "overarching" committee whose task it would be to identify areas across diverse portfolios that have an economic impact by virtue of their leading to higher medical costs (as described in the above examples). Remedial policies could then be more easily identified and possibly implemented.

Clearly then, NAPP is of the view that a broader approach to the problems of service provision has the potential to reduce costs at source so that cruder managerial tools that rely on price signalling and inequity of access (in effect, crisis management) to achieve their aims need not be implemented.

In addition, NAPP puts forward the following possibilities and qualifications.

- NAPP wonders whether the time is ripe for the introduction of new Item numbers in the MBS that provide rebates for patients of private psychiatrists, for time spent providing liaison advice on management, providing reports, and contacting para-health professionals - this already happens for physicians in case conferencing. They might involve a log to detail work done, and rebate fees could be the subject of further negotiation. This could be based on savings in hand rather than from a reduction in services elsewhere, given NAPP's strong feeling that expenditure in psychiatry is grossly underfunded. Any such proposal would require careful consideration of costings etc by all stakeholders, including private psychiatrists.

- NAPP also wonders whether the concept of a "rural loading" might make rural psychiatry more attractive. This might operate in addition to the suggestions made above to ease the plight of rural patients and increase access.

- NAPP cannot agree with the suggestion put in *The Review* that curtailing the provision of Provider Numbers will do anything to enhance services. NAPP feels this would not further the aims detailed in the AMWAC Report that called for an increase in services and an increase in psychiatrists trained.

Conclusion

In conclusion, NAPP views the findings of *The Review* with grave concern. In particular the concept of differential weighting for consultation items can only increase consumer dissatisfaction, and increase the likelihood of adverse outcomes. The suggestions made above provide a more rational approach to the perceived problems.