Objective: To argue for the direct election of RANZCP officials as a means of ensuring that College statements and political activities correspond as closely as possible to the opinions and interests of the average psychiatrist.

Conclusions: The case to abolish item 319 and restore 5 day-per-week sessions is out of touch with political reality. It wastes limited political capital by the College, or other psychiatric organizations, that would be better used for other purposes.

Key words: personality disorder, psychotherapy, RANZCP.

In a recent post to the ‘auspsych’ email list, supporting the democratic election of the College president, I argued, provocatively, that I should like to be able to vote against certain factions, including the lobby for ‘the extravagant public funding for the treatment of Iatrogenic Dependency Disorder’.

My prime point was that:

The present system leaves the College administration wide open and vulnerable to being hijacked by factions and special interests that have little to do with the interests of the general common-or-garden Australasian psychiatrists who make up the majority of the fellowship.

Inevitably, this offended some people.

I believe it is very much against our interests to have the issue of intensive multisession-per-week Medicare item numbers feature prominently in our public statements, or in our negotiations with the Government.

Back in 1996, the Medicare item number most used by psychiatrists was item 140, equating to 45–75 min with a consultant psychiatrist, any number of sessions being permitted in a year.

On 1 November 1996, item 140 was replaced with 306 (which was the same, except that a 50 session-per-year limit was imposed). Item 316 cuts in after 50 sessions, but pays only half as much benefit. Item 319 pays the same as 306 for between 50 and 160 sessions, but subject to certain conditions, including the diagnosis and a Global Assessment of Functioning Scale score of 1–50.¹ ²

The purpose of the reform was to curtail the number of patients who were being seen several times a week. In particular, it was an attempt to clip the wings of the psychoanalysts, many of whom were advocating daily sessions of a 50 min hour.

Apparently, some psychiatrists were seeing patients more often than that. The then Federal Minister for Health, Michael Wooldridge, cited one psychiatrist who claimed for 747 sessions of more than 75 min (item 142) for a single patient for one year. Another psychiatrist in Adelaide apparently claimed for 900 visits for one patient in a single year and claimed $115 000 for this one patient.³

The effect of the reforms has been to limit benefits to a mere 160 visits a year, under conditions that are sufficiently rubbery that any number of people can be helped to wriggle through the net. When a series of criteria

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are linked by the word ‘OR’, the only one that really matters is the easiest criterion to satisfy. ‘Dysthymic disorder’ and ‘serious impairment in social functioning’ can be made to fit most people.

A measure of the flexibility of the limits is item 316, which is the lower paying item for people with more than 50 sessions a year, who do not meet the exclusionary criteria. There were a total of 18 954 such services in the calendar year 2002 for the whole country. By comparison, there were 90 529 who ‘fitted’ the 319 criteria.

Yes, I know that this might mean that intensive psychotherapy is going only to those that are seriously impaired. Might.

It might also be true that everyone taking two tablets of a selective serotonin re-uptake inhibitor (SSRI) really does have a ‘major depression; other treatment inappropriate’.

The effects of the changes can be seen in the table of Health Insurance Commission statistics.

It shows how item 140 was replaced by a mix of the three items 306, 316 and 319.

For number of services (in round numbers),

1995  Item 140  1 000 000

was replaced by

2002  Item 306  800 000
Item 316  20 000
Item 319  90 000
Total  910 000

A graph of these changes can be seen in reference 5. The financial changes can be seen on the table in reference 6.

Again, in round numbers:

1995  Item 140  $120 000 000

was replaced by

2002  Item 306  $100 000 000
Item 316  $1 300 000
Item 319  $12 000 000
Total  $113 300 000

So much for the main facts, as I understand them. Now for the politics.

The bottom line is that the ‘pollies’ attempted to restrain what they saw as a wasteful rort. Wild horses will not persuade them to reverse their decision. If we all go in to bat for the IDD squad, we will be seen as rotter-supporters and our credibility will be diminished.

The IDD lobby has been protesting loudly about the changes, and demanding that the restrictive criteria for 319 be relaxed. If I understand them correctly, they want a return to the old days in which it was possible to see patients in psychoanalysis, or psychoanalytic psychotherapy, more than 3 days a week (the 160 times a year permitted under item 319), presumably as much as five times a week. Much is claimed, of dubious credibility, about the severe need of the patients who will receive, and the great benefit that will occur as a result of, this ‘intensive’ therapy.

Note that the 75 percentile of psychiatrists use item 319 only about 10 times a year. That could be a single patient who had 60 sessions. In other words, the vast majority of us cope with all our patients inside the range of 50 visits a year.

Let’s look at the implications of the treatment delivery model that is being advocated.

We, the taxpayer, contribute to the cost of training psychiatrists: 12 years minimum, possibly more. The psychiatrists then work in the proposed way, seeing eight patients each for a 50 min hour, 5 days a week and billing Medicare at the 85% rate for $123.65 per visit (item 306 or 319). Let’s say they work 50 weeks a year. That means eight patients are treated for a year. Cost to Medicare: $247 300.00, per psychiatrist, per year.

And how long is the average treatment with this sort of approach. Do I hear 8 years? That means our expensively trained and subsidized specialist can take on, on average, one new patient a year. OK, let’s say 4 years; that amounts to two new patients a year.

Or look at the situation with the present 319 limits of 160 visits a year. Does our psychiatrist see eight patients for 3 days and eight patients for 2 days each? Or work Saturdays as well. That’s still only 16 patients. The average 8 years treatment means two new patients a year. With a 4 years average, four new patients each year.

The Medicare Statistical Feedback sheet says the 25th percentile psychiatrist sees 67–70 distinct Medicare patients a year. The 75th percentile one sees 260–270.

And our IDD lobby proposes eight, and complains about 16. This is dotty. This is politically unsustainable. This sort of treatment delivery model makes us a laughing stock in the eyes of the rest of the medical profession, politicians and public alike.

This baby is never going to fly. Never. Ever.

Now I have no particular axe to grind about item 319. I really don’t care if it continues as it is, and whether psychiatrists who want to work in that sort of way continue to do so. What makes my blood boil, and what makes me itch to have a direct vote for President with which I can express some sort of response, is when highly unrepresentative people get their hands on the College spokes-process and then claim to speak for the rest of us, when they are way out of touch with what other Fellows of the College think, with political reality, and with plain common sense.
That covers the ‘whining wet shrink faction’ who dabble in political issues such as the asylum seekers and the Governor General, as well as the IDD lobby. Apart from anything else, it is just bad politics for the rest of us. There are plenty of really important mental health matters that need effective lobbying. We should engage with the political process in areas where we are strong, where our arguments are sustainable, and where public sympathy with our position will enhance our influence.

This IDD issue is not it. It is the quaint little old aunt of the College, not the Lleyton Hewitt. We should keep her hidden away, as a memento of psychiatric history, like insulin treatment, schizophrenogenic mothers, bulk electroconvulsive therapy, and patient-run farms in rural mental asylums. She could be wheeled out and shown to new generations of psychiatric registrars, as another of the 20th century dreams that failed, like Communism, or mind expansion with psychedelic drugs. But she should not be sent out to fight for us in the tough world of contemporary health politics.

Imagine this. On TV is a debate between the new Minister for Health, Tony Abbott, and the newly appointed (not elected) spokesperson for the RANZCP. Tony Abbott has new figures to show that the expenditure on health in Australia has just reached an all-time high as a proportion of GDP. The spokesperson is arguing that item 319 should be changed from 160 sessions maximum to 245 sessions. Tony Abbott: ‘I understand, doctor, that some psychiatrists want Medicare to pay them more than $240 000 per year for the work of seeing one new patient a year.’ ‘Do other psychiatrists support you in this claim?’

Could anyone bear to watch? The tension would be excruciating. It would be like anticipating Mr Bean heading for a humiliating disaster. Basil Fawlty having to front Sybil. Eddie the Eagle at the top of a huge Olympic ski-jump. You’d better keep your hand on the remote in case you have to flick the channel over to Kath and Kim. It would be less embarrassing.

REFERENCES