

Do older people receive equitable private psychiatric service provision under Medicare?

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Objective: The objective of this study is to determine the 1998 rates, types, regional variation and Medicare expenditure of private psychiatry services for older people in Australia, as compared with younger adults and with 1985–1986 data.

Method: Medicare Benefits Schedule Item Statistics for the psychiatric item numbers 300–352 and item 14224 were obtained from the Health Insurance Commission for each State and Territory. The items were examined in the age groups 15–64 years, 65 years and over and 75 years and over. Main outcome measures were per capita service provision by age group, State and Territory and Medicare expenditure by age group.

Results: During 1998, 6.4% (5765.6 per 100 000) of private psychiatric services were to patients aged > 64 years. Patients aged 15–64 received 2.7 times the number of psychiatric services per capita than patients > 64 and 3.6 times that of patients aged > 74 years. Patients aged > 64 received more hospital and nursing home consultations, home visits and electroconvulsive therapy per capita, while younger adults used more office-based consultations, longer consultations, and group therapy. Victoria had the highest per capita rate (7659.2 per 100 000) and the Northern Territory the lowest (540.4 per 100 000), although the highest proportion of services to older patients was in Western Australia. Per capita the proportion of Medicare expenditure allocated to adults aged less than 65 years was 4.1 times that for adults over 64 years.

Conclusions: Private psychiatric service provision to older people is inequitable when compared with younger adults. The proportion of Medicare private psychiatry expenditure on older adults has declined since 1985–1986.

Key words: aged, geriatric psychiatry, mental disorders, mental health services, psychiatric services.

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There has long been a perception that private psychiatrists underservice older people. An analysis of Medicare data for the 1985–1986 financial year found that younger adults received 2.7 times per capita as many private

psychiatric services than older adults did. This was particularly noted with standard consultations (46–75 min duration) where young adults received 7.59 times the number of services per capita than older people [1]. Similar concerns have been expressed in the USA. Although the proportion of office visits to psychiatrists by patients aged 65 years and over increased from 6.5% to 10.6% between 1985 and 1995, this still significantly underrepresented the increase in the proportion of older people in the community [2,3].

There have been a number of developments in Australia over the last 15 years that may have changed service provision. The Australian population is progressively ageing with approximately 12% aged 65 years and

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over in 1998 [4]. The Aged Care Reform Strategy has seen a change in emphasis from institutional to community care for disabled older people [5]. Specialist public mental health services for older people are now available in most urban and regional areas of Australia and, in particular, provide a focus for the acute treatment of serious mental disorders. Long-term care for dementia, however, has been largely transferred from long-stay psychogeriatric wards into aged care facilities [6]. Within the Royal Australian and New Zealand College of Psychiatrists, a Section in Psychiatry of Old Age was established in 1988. In 1999 it became a Faculty of the College with responsibility for subspecialty training in old age psychiatry [7].

The main aim of this study is to determine the rates, types, regional variation, and Medicare expenditure of private psychiatry services for older people as compared with younger adults in Australia in 1998. A further aim is to determine whether these have changed since 1985–1986.

Method

Medicare Benefits Schedule Item Statistics for 1998 the psychiatric item numbers 300–352 were obtained from the Health Insurance Commission for each State and Territory [8]. These were grouped in the following categories with five or six items in each category based upon the duration of the consultation: office-based consultations (items 300–308); office-based consultations over 50 sessions per year (items 310–319); hospital and nursing home consultations (items 320–328) and home visits (items 330–338). In addition, group therapy (items 342–346); relative/carer interviews (items 348–352); and electroconvulsive therapy (ECT) (item 14224) were recorded. The items were examined in the age groups 15–64 years, 65 years and over and 75 years and over.

Medicare enrolments by age groups and State/Territory were obtained for 30 June 1998 and this was used to calculate the per capita

rates of service provision per 100 000 population for 1998. The data do not include services provided by hospital doctors to public patients in public hospitals or services that qualify for a benefit under the Department of Veteran's Affairs.

The Statistical Package for the Social Sciences [9] was used to compare rates of service provision per 100 000 population in three different age groups (15–64 years, 65 years and over, 75 years and over) and reported as odds ratios with 95% confidence intervals (ORs; 95% CI).

Results

During 1998, there were 2 172 416 private psychiatric services provided, of which 139 877 (6.4%) were to patients aged 65 years and over, with their modal service being item 304, office-based consultations of 30–45 min duration ($n = 31\ 512$). However, for patients aged 75 years and over the modal service was item 322, hospital or nursing home consultation of 15–30 min duration ($n = 9509$).

In Table 1, the per capita service provision by Medicare item categories for patients aged 65 years and over is presented for each State/Territory and Australia overall for the calendar year 1998. Service provision in Australia for patients aged 15 years and over was 13 958.3 private psychiatric services per 100 000 population, which drops to 5765.6 per 100 000 for those aged 65 years and over, and 4348.3 per 100 000 for those aged 75 years and over.

In Table 2, comparisons (ORs) of the per capita psychiatric service provision for patients aged 15–64 versus aged 65 and over, and 15–64 versus aged 75 and over are presented. The analysis of Medicare data found that patients aged 15–64 years received 2.7 times the number of psychiatric services per capita than patients over 64 years ($OR = 0.33$) and 3.6 times as many than patients aged 75 years and over ($OR = 0.25$). Overall, adults aged 65 years and over received more hospital and nursing home consultations, home visits and ECT per capita, while younger adults used more office-based consultations, office-based consultations over 50 sessions per year (psychotherapy), group therapy and relative/carer interviews.

Consultations over 45 min duration occurred 5.6 times as often in patients aged 15–64 years than in patients 65 years and over ($OR = 0.18$), and 10 times more frequently than in patients 75 years and over

Table 1. Rates of private psychiatric service provision (per 100 000) by State/Territory for people aged 65 years and over (Medicare Items, 1998)

MBS items	NSW	VIC	QLD	SA	WA	TAS	ACT	NT	Australia
300–319*	3551.7	5056.0	3566.4	4393.7	2454.5	2835.1	3104.7	512.7	3875.4
320–328†	906.3	2007.5	1892.1	2802.3	1045.6	713.3	963.3	27.7	1521.0
330–338‡	152.0	286.9	28.5	157.7	123.1	159.1	25.9	0	159.9
342–346§	46.8	74.5	52.7	8.4	6.0	145.9	18.5	0	50.0
348–352¶	12.8	33.4	14.8	15.0	19.0	14.8	11.1	0	18.9
14224**	89.0	200.9	172.2	216.7	73.5	111.5	0.0	0	140.4
Total	4758.7	7659.2	5726.7	7593.9	3721.7	3979.6	4123.6	540.4	5765.6

*Office-based consultations and office-based consultations over 50 sessions per year, †hospital and nursing home consultations, ‡home visits, §group therapy, ¶relative/carer interviews, **electroconvulsive therapy. MBS, Medicare Benefits Schedule.

Table 2. Psychiatric service provision (number of consultations per 100 000 population) in 1998: a comparison (odds ratios, 95% CI) for age groups ≥ 65 versus 15–64 years and ≥ 75 versus 15–64 years

Medicare item category	NSW	VIC	QLD	SA	WA	TAS	ACT	NT	Australia	Australia 75 +
300–319 [†]	0.23*	0.25*	0.27*	0.22*	0.33*	0.26*	0.31*	0.19*	0.25*	0.15*
320–328 [†]	0.22–0.24	0.24–0.26	0.26–0.28	0.21–0.23	0.31–0.34	0.25–0.27	0.30–0.33	0.17–0.20	0.24–0.26	0.14–0.16
330–338 [§]	1.26*	1.68*	1.14*	1.91*	0.88*	0.73*	1.80*	0.07*	1.36*	1.49*
342–346	1.14–1.39	1.56–1.80	1.07–1.22	1.74–1.98	0.81–0.96	0.66–0.80	1.62–2.00	0.05–0.11	1.26–1.47	1.38–1.61
348–352**	2.03*	3.34*	4.83*	1.05	3.85*	3.53*	2.17*	ND	2.50*	2.96*
14224 ^{††}	1.54–2.68	2.63–4.26	2.01–11.65	0.84–1.31	2.61–5.68	2.54–4.92	1.10–4.30	ND	1.87–3.34	2.23–3.93
All	0.14*	0.07*	0.24*	0.03*	0.03*	0.71*	0.23*	ND	0.10*	0.06*
> 45 min	0.11–0.19	0.05–0.08	0.18–0.33	0.02–0.06	0.01–0.07	0.58–0.88	0.14–0.38	ND	0.08–0.14	0.04–0.08
	0.65	1.57	0.42*	0.58	0.63	0.52*	0.34*	ND	0.76	0.68
	0.92–1.31	0.91–2.72	0.23–0.76	0.31–1.09	0.36–1.13	0.28–0.97	0.17–0.68	ND	0.42–1.38	0.37–1.26
	1.94*	2.16*	1.67*	1.57*	1.72*	1.54*	ND	ND	1.87*	1.88*
	1.36–2.67	1.69–2.77	1.31–2.13	1.18–2.51	1.18–2.51	1.14–2.06	0.39*	0.17*	1.41–2.47	1.42–2.49
	0.29*	0.33*	0.37*	0.34*	0.41*	0.32*	0.37–0.40	0.15–0.18	0.33*	0.25*
	0.28–0.30	0.32–0.34	0.36–0.38	0.34–0.35	0.39–0.42	0.31–0.33	0.20*	0.04*	0.32–0.34	0.24–0.26
	0.18*	0.14*	0.15*	0.14*	0.22*	0.24*	0.19–0.22	0.03–0.06	0.18*	0.10*
	0.17–0.19	0.14–0.15	0.14–0.16	0.14–0.15	0.20–0.23	0.22–0.26			0.16–0.18	0.10–0.11

ND, no data; OR could not be calculated since no patient was seen in the age group ≥ 65 years. *Significant odds ratios (ORs, $p < 0.05$). ORs below 1.0 indicate that less patient were seen in the age group ≥ 65 . [†]Office-based consultations and office-based consultations over 50 sessions per year, [‡]hospital and nursing home consultations, [§]home visits, ^{||}group therapy, ^{††}relative/carer interviews, ^{†††}electroconvulsive therapy.

(OR = 0.10). In contrast, ECT use increased with age, older adults receiving it 1.9 times the per capita rate for younger adults (OR = 1.87).

The overall service provision per capita varied substantially between States and Territories, with Victoria having the highest rate (18 213.3 per 100 000) and the Northern Territory (NT) the lowest (3016.6 per 100 000). There was a substantial variation of overall service provision per capita for older adults between States and Territories, with Victoria having the highest per capita rate (7659.2 per 100 000) and NT the lowest (540.4 per 100 000). For older adults, office-based consultations, home visits and relative/carer interviews per capita were most frequently provided in Victoria, hospital/nursing home visits and ECT in South Australia (SA) and group psychotherapy in Tasmania, with NT having the lowest per capita rates for all services.

In Australia as a whole, patients aged 65 years and over had one-third the chance (OR = 0.33) of receiving treatment from a psychiatrist in comparison with younger adults (15–64 years). There were regional variations with the likelihood of being treated being above the Australian average in Western Australia (WA; 0.41), the Australian Capital Territory (ACT; 0.39) and Queensland (0.37), approximately equal in Victoria (0.33), SA (0.34) and Tasmania (0.32) and below the Australian average for the NT (0.17) and New South Wales (NSW) (0.29).

Health service expenditure

Table 3 provides an overview of health service expenditure (Medicare Benefit Schedule: \$ per 100 000 population) for the calendar year 1998. Analysis of these data showed that per capita the proportion of total resources for psychiatric service provision allocated to adults aged less than 65 years was 4.1 times the resources allocated to adults over 64 years.

Allocation of health service expenditure varied per Medicare item category. Expenditure for office-based consultations, group therapy and relative/carer interviews was an average 5.4 higher for younger adults (5.4, 13.1 and 5.7 times, respectively) and expenditure for hospital and nursing home consultations, home visits and ECT was an average 1.2 times higher for people aged 65 years and more (1.1, 2.0 and 1.5 times, respectively).

Discussion

The rate of private psychiatric service provision to older people in 1998 was significantly lower than in younger adults and adolescents (15–64 years) who received 2.7 times more Medicare services than persons aged over 64 years and 3.6 times those over 74 years. This has not changed much since 1985–1986 when younger adults (20–64 years) received 2.7 times the number of private psychiatric services per capita than older adults [1]. There has, however, been a change in health-care resources with younger adults now receiving 4.1 times the Medicare expenditure than older adults compared with about 2.7 times the expenditure in 1985–1986. Does this mean that older people are being underserved?

There is no definite answer. The 1997 Australian Mental Health Survey found that the prevalence of

Table 3. Medicare Benefits Schedule (MBS): \$ benefit per 100 000 population in 1998

MBS benefit	Medicare item category							All
	300–308*	310–319†	320–328‡	330–338§	342–346¶	348–352**	14224††	
Age < 65	1 167 343	82 756	72 681	7788	20 316	4244	3132	1 351 995
Age 65 +	232 170	1242	79 953	15 593	1550	743	4854	331 251

*Office-based consultations, †office-based consultations over 50 sessions per year, ‡hospital and nursing home consultations, §home visits, ¶group therapy, **relative/carer interviews, ††electroconvulsive therapy.

anxiety disorders, depressive disorders, substance-use disorders and personality disorders in community settings all declined with age [10]. Two to threefold difference in rates were found between younger and older adults, which may suggest that the level of private psychiatric consultation matches the level of need.

This may be oversimplifying the situation. General practitioners have difficulties in the identification of mental disorders in old age and are less likely to refer older depressed patients to psychiatrists, possibly influenced by negative attitudes held by some older people about psychiatry [11]. Also, there are doubts about the accuracy of epidemiological survey data on depression in old age, due to the underreporting of depressive symptoms, and the misattribution of psychological symptoms to physical illnesses [12]. Further, the highest rates of mental disorders in older people occur in aged care facilities and hospitals, which were excluded from the surveys. In addition, the prevalence of cognitive impairment with its associated psychiatric syndromes rises exponentially with age [13]. For these reasons, we believe that the considerably lower rates of private psychiatric service provision to older people is not a reflection of lower need, but a reflection of unmet need.

The analysis of Medicare data did not include psychiatric service use by the veteran community. The Commonwealth Department of Veterans' Affairs (DVA) reported that for the financial year 1997–1998, there were a total of 77 415 consultations for psychiatric services in the DVA treatment population [14]. In this cohort 84% were older than 64 years and used an estimated 21.4% of the total number of services. If these data are incorporated in the overall per capita calculation for Australia, the ratio of service use between older and younger adults (less than 65 years) increases slightly from 2.7 to approximately 2.8 in younger people's favour.

Intriguingly the 1999 Australian Medical Workforce Advisory Committee (AMWAC) survey of the specialist psychiatry workforce reports that psychiatrists spend

15.1% of their clinical time with the elderly [15]. Yet, in private psychiatry less than 7% of Medicare services are provided to the elderly and these are of shorter average duration than those provided to younger adults. This would suggest that their clinical time with the elderly was closer to 6%. Although the AMWAC survey included public psychiatrists and work with veterans, it is unlikely that the inclusion of their work would increase clinical time with the elderly from around 6% up to 15%. The AMWAC survey was based on psychiatrists' self-report rather than objective data, which suggests that the self-reports are inaccurate and should be used cautiously in workforce planning.

The pattern of service delivery to older people is similar to 1985–1986 with lower rates of consultations with duration of 45 min and over, higher rates of home visits and use of ECT [1]. Few are in receipt of more than 50 consultations per year, suggesting that psychotherapy is infrequently used. It is not possible to determine from the data whether this is a reflection of referral bias of younger people for psychotherapy or a reluctance of psychotherapists to treat older people. Older people appeared to be receiving slightly longer consultations in 1998, although they continue to have shorter consultations than younger adults. For those aged 75 years and over, the modal location of service delivery is in a nursing home or hospital – the only age group where this is the case. As the per capita rates of service provision are even lower in this age group, it suggests that only the more severe mentally ill, possibly with comorbid physical disorders, are being seen.

There are significant differences between the States/Territories in the per capita rates of overall service delivery to older people and for different types of services. This is not simply a function of the psychiatry workforce as there is no linear relationship between the risk of not being treated as an adult over 65 years of age and the overall psychiatrist population ratio per State/Territory [16]. Home visits, a characteristic feature of old age psychiatry service delivery, are particularly common in

Victoria where they occur at over 10 times the per capita rates of Queensland, ACT and NT. The high use of home visits in Victoria possibly reflects the style of public old age psychiatry service delivery that private psychiatrists were exposed to in their training. Old age psychiatry services in Victoria, relative to other States, more closely resemble those in the UK where home visits are the norm. Consultations in nursing homes and hospitals are common in SA where they occur at over three times the rates in NSW, Tasmania and NT. Overall, there is little service provision to older people in the NT, both on a per capita basis and as a proportion of total services. As there are no public old age psychiatry services in NT, this means that older people with mental disorders are very unlikely to see a psychiatrist. Whether these different patterns of service delivery are associated with different outcomes should be explored.

Of great concern is our finding that in 1998 there was a much lower proportion of Medicare expenditure on older people than in 1985–1986, despite the higher proportion of older people in the community in 1998. In other words the relative cost of service provision to younger adults compared with older adults is increasing. The reason for this is unclear from the data but requires investigation.

In conclusion, we have found that private psychiatric service provision to older people remains at per capita rates significantly below younger adults and with considerably less Medicare expenditure. There is inequitable private psychiatric service delivery to older people Australia-wide with marked regional variations. A more detailed investigation is required of the pathways to private psychiatric care in Australia to determine the causes of the inequity so that appropriate efforts can be made to rectify it.

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