ORCID iDs

Saxby Pridmore https://orcid.org/0000-0002-9170-1798
William Pridmore https://orcid.org/0000-0002-9604-1397

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Saxby Pridmore
Hobart, TAS

William Pridmore
Hobart, TAS

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Private health insurance, methodology and interpretation of 'Variation in outpatient consultation fees of psychiatrists in Australia by state and territory'

Dear Editor,

We highlight methodological and interpretational issues regarding a recent paper which investigates private outpatient psychiatric consultation fees and marshals arguments for allowing private health insurers to subsidise outpatient psychiatric consultations.[1] We discuss the central interpretational issues here and outline methodological concerns in Table 1.

The usual practice in interpretation and discussion of research studies is to begin from the findings of the study. As listed in Table 1, there are methodological issues that raise questions as to the completeness and accuracy of the data collection and analysis. However, these methodological issues, which constitute limitations of the paper, have not been acknowledged. Consequently, the validity of the findings remains questionable.

In this context, the arguments that are expressed in the discussion do not necessarily have a foundation in valid study findings. In addition, the usual practice is that explanation and discussion of the findings should, at least initially, be based on the data in that study, before exploration of proposed actions or further research. There appears to be a conflation between interpretations and proposed actions in this paper.

Specifically, the discussion of Private Health Insurance (PHI) extension to outpatient care is not based on the findings of the study and in this context is substantively *non sequitur*, for example, '*…Freed and Allen*

Table 1. Methodological issues in the Coulston and Leahy paper.[a]

- The study does not report the commonly used MBS Item Number 304 for 30–45 min consultation of a private psychiatrist, i.e., this is an incomplete data collection that does not reflect real-world clinical practice.[b] The quantification of out-of-pocket costs is inaccurate if commonly used consultations are not counted in the data being analysed. This is likely to result in significant underestimation of the amount of private practice consultations by private psychiatrists and accordingly have substantial effects on the accurate estimation of out-of-pocket costs.
- It is not acknowledged that 'private-billing' by salaried public sector specialists, in the form of bulk-billing, occurs as a form of state-to-federal cost-shifting.[c] Accordingly, this can overestimate the extent of bulk-billing in outpatient private practice, as, in many circumstances, salaried public sector specialists in private practice are prohibited from charging additional private fees that represent out-of-pocket costs.
- The AIHW data covers the period from 2014 to 2019, and therefore, psychiatrist FTE for a region may be averaged over that period.[d] However, not all psychiatrists may be in clinical practice, or billing. This can lead to an overestimate of the actual number of those billing, and accordingly, erroneous conclusions regarding private consultation accessibility within a given state.
- The national median wage should be estimated on a state-by-state basis to be a useful comparator for patient costs, since wages differ across states/territories. Median wages by state and calculated estimated cost percentages should be tabulated in the results to enable informed comparison of wages and out-of-pocket costs by state. The omission of state comparisons leads to the less suitable use of the national median wage as comparator, when state median salaries vary, and a relative under- or overestimate of the relative costs.
- The paper does not reference the relevant Australian federal government subsidies known as the Original Medicare Safety Net and the Extended Medicare Safety Net which partially offset high out-of-pocket costs for private patients.[e] This effectively overestimates the costs to patients that frequently need to access private psychiatric care with out-of-pocket costs. An accurate consideration of out-of-pocket costs should include subsidies that support private psychiatric consultation, as the Safety Nets are reimbursements that offset the costs to patients and thus are relevant in economic evaluations of costs.

[a]Coulston C and Leahey J. Variation in outpatient consultation fees of psychiatrists in Australia by state and territory. Australas Psychiatry 2023: 10398562231190783. 2023/07/29. DOI: 10.1177/10398562231190783.

[b]Looi JCL, Allison S, Bastiampillai T, et al. Telepsychiatry and face-to-face psychiatric consultations during the first year of the COVID-19 pandemic in Australia: patients being heard and seen. Australasian Psychiatry 2022; 30: 206–211. DOI: 10.1177/10398562211046301.

[c]Leeuwenburg T. Double-dipping Medicare funding pool, https://insightplus.mja.com.au/2018/19/double-dipping-medicare-funding-pool/ (2018, accessed 2 August 2023).

[d]AIHW. Mental health workforce, https://www.aihw.gov.au/getmedia/6975aa54-246d-426e-9e33-fec8ec7ce105/Mental-health-workforce-2019.pdf.aspx (2019, accessed 2 August 2023).

[e]Services_Australia. What are the Medicare safety nets thresholds, https://www.servicesaustralia.gov.au/what-are-medicare-safety-nets-thresholds?context=22001 (2023, accessed 2 August 2023).

suggested that the Australian Government's rule preventing health insurers from covering outpatient consultations had failed to prevent increases in fees…'[1] and '*Allowing health insurers to subsidize outpatient psychiatric consultations would improve access for the 45.2% of Australians who hold private health insurance*'.[1] These statements imply that the PHI market can address out-of-pocket costs and propose action which is not supported by the findings of the study, which does not involve research into why and how out-of-pocket costs are addressed to improve equitable access to care. Furthermore, US-style PHI managed care initiatives that encompass outpatient care have not demonstrated efficacy and have instead limited clinical and patient autonomy regarding choice of and access to care.[2]

A recent comprehensive health economic analysis of out-of-pocket healthcare costs for Australians observed that there was a linear relationship between costs and healthcare access by patients, that is, the higher the cost, the less patients accessed care.[3] However, this paper noted that there needs to be broader consideration of the healthcare ecological context to develop equitable accessibility, and this may include improving access to out-of-pocket cost subsidies such as the Medicare Safety Net and Pharmaceutical Benefits Schedule.[3]

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ORCID iDs

Jeffrey CL Looi https://orcid.org/0000-0003-3351-6911
Stephen Allison https://orcid.org/0000-0002-9264-5310
Tarun Bastiampillai https://orcid.org/0000-0002-6931-2913

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Jeffrey CL Looi
Canberra, ACT

Stephen Allison
Adelaide, SA

Tarun Bastiampillai
Adelaide, SA
Clayton, VIC

William Pring
Clayton, VIC
Glen Iris, VIC

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There ain't such a thing as a free lunch: Pharmaceutical company payments to Australian psychiatrists

Dear Editor,

The marketing of products to psychiatrists by pharmaceutical companies includes offers of money for consulting services and for conference registration, travel and accommodation. Since 2019, under changes in the Medicines Australia (MA) Code of Conduct, the names of all doctors receiving payments from MA member pharmaceutical companies have been published online at www.disclosureaustralia.com.au/.

Here, we present an analysis of the first 3 years of data from this repository. We recorded the names of psychiatrists who received any payment between November 2019 and October 2022 and cross-checked this information against their AHPRA public listing, with doctors matched by name and practice address. Matching was undertaken in R (version 4.3) using an efficient approximate entity matching algorithm. We used a Jaro-Winkler threshold of ≥0.8, with accuracy manually assessed by two authors using a 10% random sample. The total number of psychiatrists in Australia in 2020/21 was 4409 (Callie Kalimniou, personal communication, 26/04/2023).

In total, 103 psychiatrists received at least one payment, with a total of AUD$515,437 transferred. The range of payments was between AUD$100 and AUD$30,598 (median AUD$2984). The 10 highest paid psychiatrists were all prominent individuals, including university professors and past RANZCP office bearers.

There were substantial errors within the MA database, with misclassification of psychiatrists as other health professionals and some psychiatrists listed under several different names. There is a clear need for greater transparency given the poor quality of MA data.

In our sample, 2.3% of Australian psychiatrists received a payment from a pharmaceutical company. This relatively low number may reflect that MA, an industry body, do not include meal expenses in their database. In the USA, which has more robust legislative instruments to capture pharmaceutical payments, over half of practising psychiatrists receive some form of pharmaceutical payment, with most payments made to influential psychiatrists.[1] Additionally, this 2.3% figure is likely an underestimate given Servier (makers of Valdoxan and Latuda, who have made payments to psychiatrists in the past) are not a MA member company.

There is evidence that pharmaceutical payments influence prescribing patterns, including off-label prescribing.[2] This remains the case even when payments are indirect and of nominal value.[3] Pharmaceutical industry payments may be partly contributing to rising stimulant prescription rates.[4] In our study, over 80% of payments to psychiatrists were from Janssen-Cilag and Takeda, the makers of Concerta (methylphenidate) and Vyvanse (lisdexamfetamine), respectively.

Psychiatrists receiving payment or gratuity from pharmaceutical companies should consider whether they are free from real or perceived undue influence and whether their involvement with pharmaceutical