3 Impact of Better Access on the Distribution of the Allied Mental Health Workforce

This chapter presents an analysis of the extent to which the Better Access initiative has impacted on the distribution of the allied mental health workforce – psychologists, social workers and occupational therapists in the early years following the introduction of the initiative. Better Access substantially expanded allied mental health professionals' access to MBS Items and, therefore, to the private (Medicare) sector. Prior to the implementation of Better Access, psychologists and occupational therapists had access to one MBS Item each (10968 and 10958 respectively), while social workers could not make claims on Medicare.

The increased access to Medicare warranted attention to the impact this might have on the patterns of distribution within the allied mental health workforce. Several issues were raised in the planning of the evaluation:

- Whether Better Access has had an impact on the distribution of each of the allied mental health occupations between the private (Better Access) and public sectors;
- The extent to which Better Access has had an impact on the numbers of Medicare Providers in each of the allied mental health occupations;
- Whether Better Access has had an impact on the underlying trend in the distribution of allied mental health occupations across the states/territories; and
- Whether Better Access has had an impact on the underlying trend in the distribution of allied mental health occupations outside of capital cities.

Measuring the workforce in the whole of the private sector for the allied mental health occupations was not possible with the available data. The private sector workforce is comprised of all health professionals working outside of the public sector. However, data for this report was only available for services provided through Medicare, with a particular focus on Better Access Items. The private Medicare workforce is therefore a sub-set of the broader private workforce, and the Better Access workforce is a sub-set of the private (Medicare) workforce.[22] In discussing the private sector in this chapter, we differentiate between the broad category, private sector, the private (Medicare) sector and the private (Better Access) sector.

The analysis in this chapter is in four sections. Section 3.1 focuses primarily on trends *since* the implementation of Better Access in 2006 and examines the distribution of allied mental health professionals between the public and private (Better Access) sectors. Sections 3.2, 3.3 and 3.4 provide a broader analysis and incorporate data from before Better Access, up to December 2008, to examine whether Better Access has had an impact on pre-existing trends within the workforce.

[22] Given that data from Chapter 2 indicated that only a relatively small proportion of hours are spent providing Better Access services, and that there is only limited access to other MBS Items for the allied mental health workforce, it is likely that the majority of services provided in the private sector are provided outside of Medicare.

As this evaluation was undertaken just 2 years and 2 months after the implementation of Better Access, the impact on trends discussed in this chapter is preliminary. The full extent of changes created by the introduction of Better Access is unlikely to be realised within this time as there will be a lag period due to the length of training required to be a mental health professional.[23]

3.1 Distribution of the Private (Better Access) and Public Allied Mental Health Workforce since Better Access, 2006-2008

From the descriptive analysis of the characteristics of the broader potential Better Access allied mental health workforce (Section 2.2), approximately two-thirds of psychologists and just over half of all mental health social workers and occupational therapists worked in the private sector in 2006 (Tables 2.3, 2.7 and 2.10 respectively). In addressing concerns related to the extent to which the implementation of Better Access has depleted the numbers of allied mental health professionals in the public allied mental health sector, this section focuses on comparing the deemed full-time equivalent (DFTE) allied mental health workforce using Better Access Items to the full-time equivalent (FTE) allied mental health workforce in the public sector.[24] Although the Better Access initiative was implemented in November 2006, the analysis of each of the Better Access allied mental health occupations in sections 3.1.1 – 3.1.3 uses an extended, 2001 – 2008, to provide contextual information about patterns in the public sector mental health workforce prior to and after Better Access.

As explained in the methodology section, some caution is required when comparisons are made across data sources: the MHE: NMDS uses FTE based on average hours worked per week for each occupational category; while for the MBS, a DFTE (deemed FTE) has been estimated based on the recommended consultation times for the MBS Items and the average number of Items billed per week per occupational category. Despite these restrictions the figures presented are nevertheless interesting for their capacity to illustrate *indicative* trends in the allied mental health workforce.

Firstly, the analysis of the overall trends of the allied mental health workforce across the public and private (Better Access) sectors is discussed. Secondly, the trends between the two sectors are examined at a more detailed level, with analysis of each occupational category by state/territory and capital city/not capital city subdivisions. Finally, the comparison of the trends across the entire workforce for Australia as a whole is summarised.

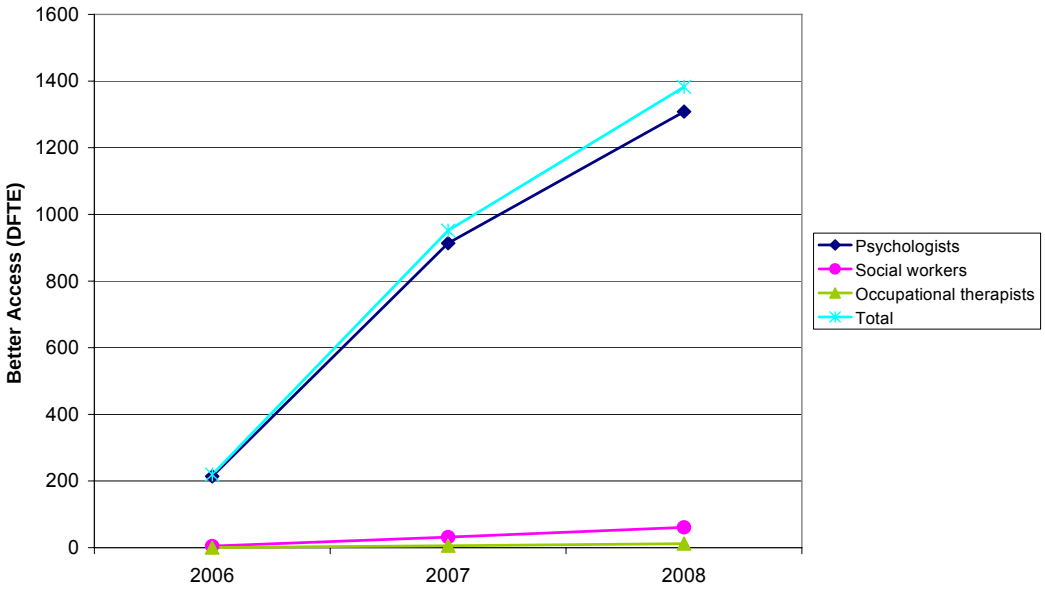
3.1.1 Overall trends in the allied mental health workforce

Trends in the DFTEs for the Better Access allied mental health workforce indicate that this workforce increased more quickly in the first 12 months of the initiative than it did for 2007-08 (Figure 3.1).

[23] Issues relating to the training of the future workforce are discussed in Chapter 4.

[24] For details on how the DFTE was calculated see Section 1.4.1

Figure 3.1 Private sector (DFTE) Better Access allied mental health workforce, for each occupational category, 2006-2008

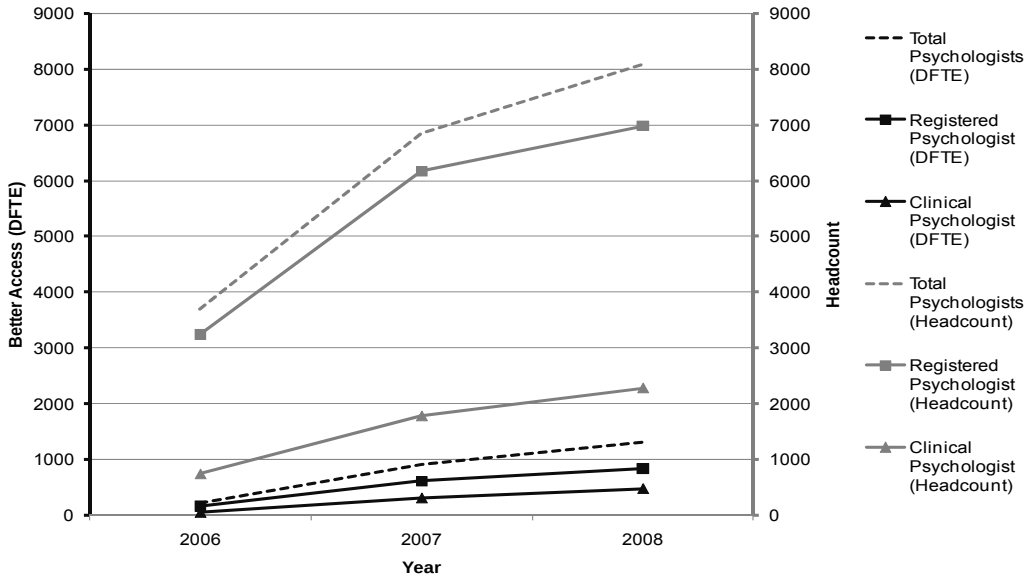


Source: Medicare Australia. 2006-08 Medicare Provider Data and Medicare Benefit Schedule (MBS) data

The strength of the increase is not surprising following the implementation of a new initiative. Overall, the total DFTE Better Access allied mental health workforce increased six-fold since November 2006. The number of DFTE psychologists utilising Better Access Items accounted for the largest majority of the total workforce in each year, and grew by approximately 511% over the two year period. The numbers of DFTE social workers and occupational therapists were small, relative to psychologists, although they experienced the highest rates of growth over the two year period, approximately 1,098% and 3,003% respectively (from a low base).

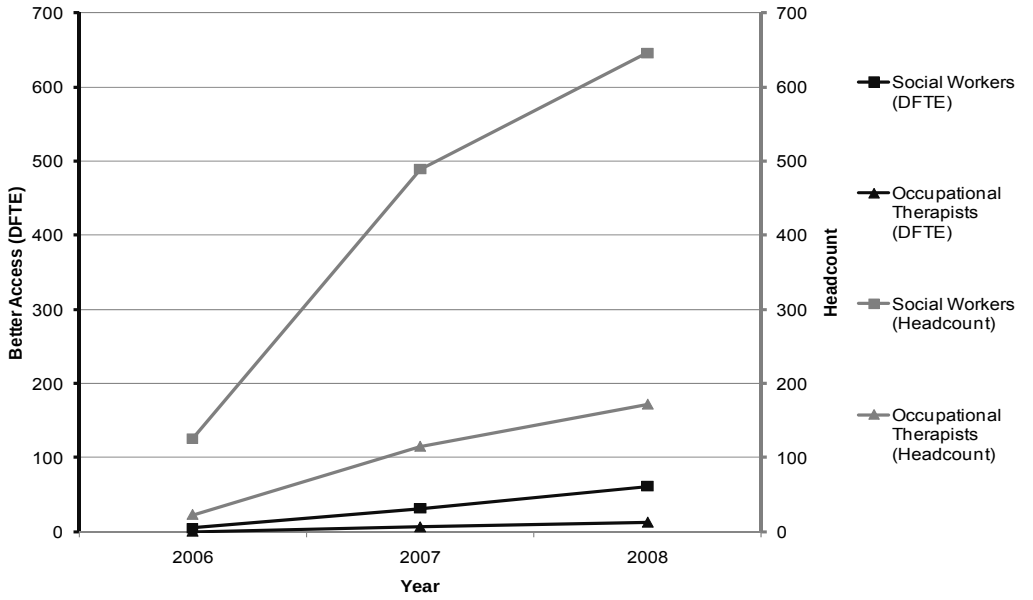
For each of the allied mental health occupations, the trends in the DFTE numbers were paralleled by the trends in the number of workers (headcount) providing Better Access services, over the two year period (see Figures 3.2 & 3.3). However, the increasing rate of growth in the headcount of each of the allied mental health occupations was slightly less than their respective DFTE numbers. This is reflected by the increase in average hours spent providing Better Access services (on a weekly basis per provider) for each occupation over the two year period (see Tables 2.3, 2.6 & 2.9); indicating that while the number of service providers was increasing each year, they were also delivering additional Better Access services.

Figure 3.2 Comparison of the Better Access psychology workforce (clinical, registered and total), DFTE and headcount, 2006-2008.



Source: Medicare Australia. 2006-08 Medicare Provider Data and Medicare Benefit Schedule (MBS) data: Servicing Provider Data

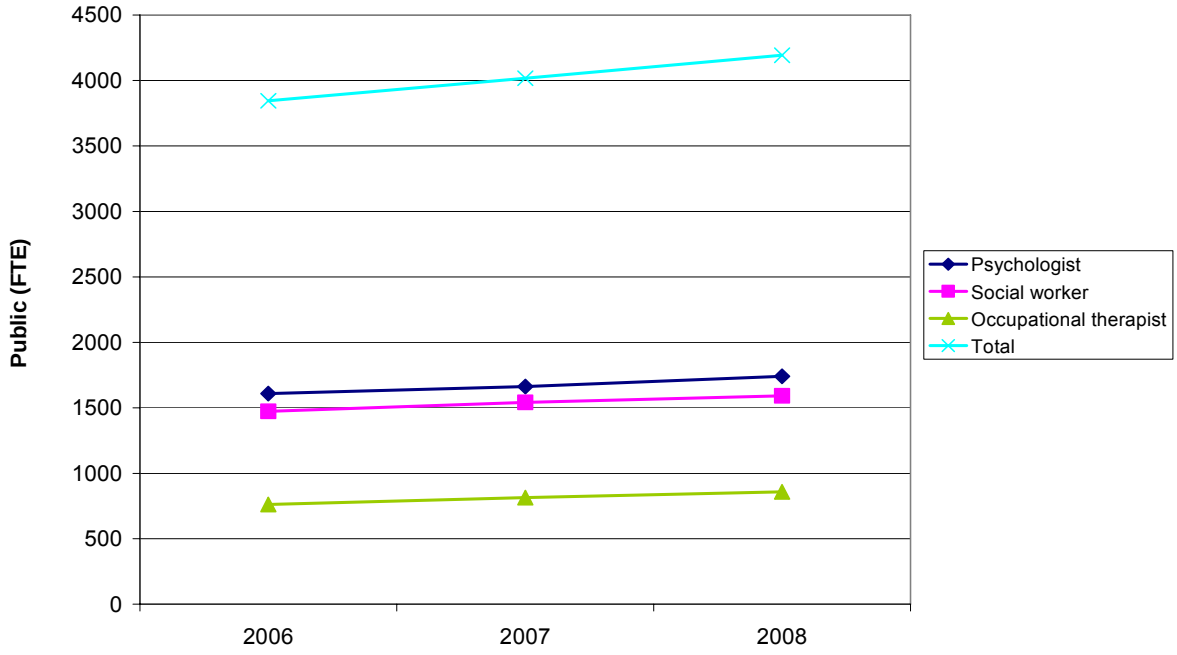
Figure 3.3 Comparison of the Better Access social work and occupational therapy workforces, DFTE and headcount, 2006-2008.



Source: Medicare Australia. 2006-08 Medicare Provider Data and Medicare Benefit Schedule (MBS) data: Servicing Provider Data

Unlike the private (Better Access) sector workforce, the FTE share of psychologists, social workers and occupational therapists in the public allied mental health workforce were fairly stable over the first years of Better Access (Figure 3.4). Over the period from 2006 to 2008 the number of FTE psychologists and social workers both experienced an approximate growth rate of 8%; while occupational therapists experienced approximately a 13% growth rate. During this period, neither the total public sector allied mental health workforce nor any of the three occupational categories experienced a decrease in the number of FTEs. At this broad level of analysis, there appears to be no evidence to suggest that the implementation of the Better Access initiative has had a negative impact on the FTE numbers of health professionals in the public allied mental health workforce.

Figure 3.4 Public sector (FTE) allied mental health workforce, for each occupational category, 2006-2008



Source: Mental Health Establishments: National Minimum Data Set, 2006-2008.

3.1.2 Psychology

The following analysis of trends in the psychology occupational category is discussed on a state by state basis, incorporating differences within each state of the distribution of psychologists between those working in capital cities and those located outside of capital cities.[25]

New South Wales

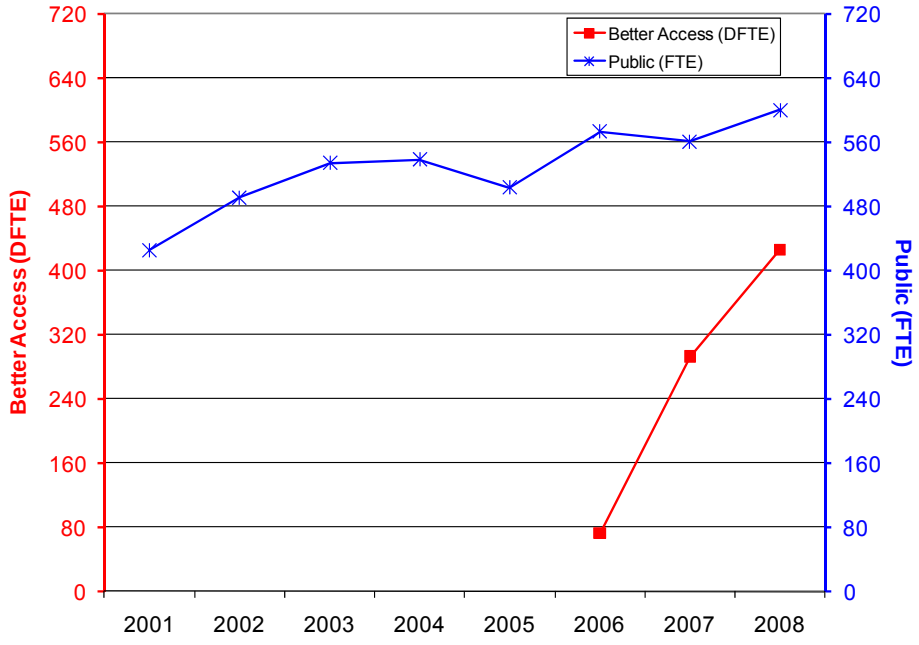
The number of DFTE psychologists that utilised Better Access Items in New South Wales (NSW) increased by 303% between 2006 and 2007, and 46% between 2007 and 2008; an increase of 486% over the entire period. In comparison, the number of FTE psychologists in

[25] For a comparison with the RRMA geographical categories, see Table 1.2

the public sector decreased by 2% between 2006 and 2007, increased by 7% between 2007 and 2008, an increase of 5% over the entire period (see Figure 3.5).

The overall trend of the psychology workforce in NSW indicates that in the first year of the Better Access initiative there was a significant increase in the size of the private (Better Access) sector workforce, and a small decrease in the size of the public sector workforce. However, in the second year of the Better Access initiative, the growth of public sector workforce reversed its downward trend and increased positively; while the private (Better Access) sector workforce also continued its increased growth, albeit at a slower pace relative to the previous year. Since the introduction of Better Access, the overall growth trend from 2001-2006 has continued in the public sector psychology workforce, albeit with fluctuations and at a slightly slower rate.

Figure 3.5 Comparison of the FTE/DFTE NSW psychology workforce, public and private (Better Access) sectors, 2001-2008

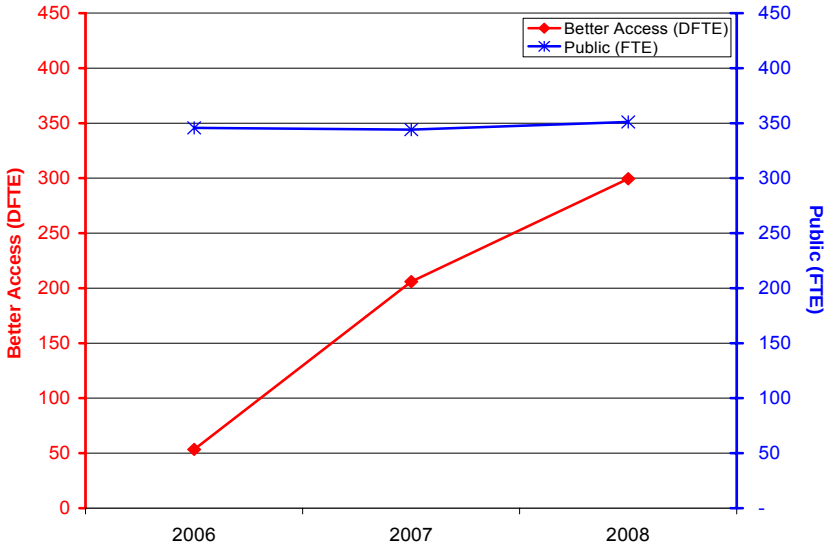


Sources: Medicare Australia. 2006-08 Medicare Provider Data and Medicare Benefit Schedule (MBS) data

Mental Health Establishments: National Minimum Data Set, 2006-2008,
National Survey of Mental Health Services 1996-2005

Within NSW, at the 'capital cities' level of geographic disaggregation, the number of DFTE psychologists that utilised Better Access items increased by 285% between 2006 and 2007, 45% between 2007 and 2008, and 459% over the entire period. In comparison, the number of FTE psychologists in the public sector decreased by 1% between 2006 and 2007, increased by 2% between 2007 and 2008, and increased by 1% over the entire period (Figure 3.6).

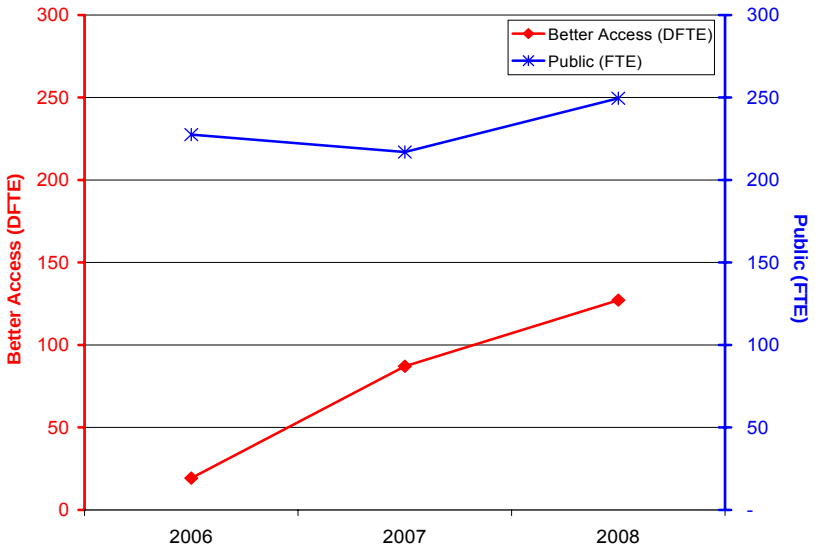
Figure 3.6 Comparison of the FTE/DFTE NSW psychology workforce, public and private (Better Access) sectors, by capital cities, 2006-2008



Sources: Medicare Australia. 2006-08 Medicare Provider Data and Medicare Benefit Schedule (MBS) data

Mental Health Establishments: National Minimum Data Set, 2006-2008

Figure 3.7 Comparison of the FTE/DFTE NSW psychology workforce, public and private (Better Access) sectors, by non-capital cities, 2006-2008



Sources: Medicare Australia. 2006-08 Medicare Provider Data and Medicare Benefit Schedule (MBS) data

Mental Health Establishments: National Minimum Data Set, 2006-2008

At the 'non-capital cities' level of geographic disaggregation, the number of DFTE psychologists that utilised Better Access items increased by 352% between 2006 and 2007, 46% between 2007 and 2008, and 561% over the entire period. In comparison, the number of

FTE psychologists in the public sector decreased by 5% between 2006 and 2007, increased by 15% between 2007 and 2008, and increased by 15% over the entire period (Figure 3.7).

The overall trend of the psychology workforce at the capital cities and non-capital cities level of disaggregation were both similar to the state as a whole, with the trend in the growth of both public and private (Medicare) workforces in the non-capital cities was greater than that in the capital cities over the two year period.

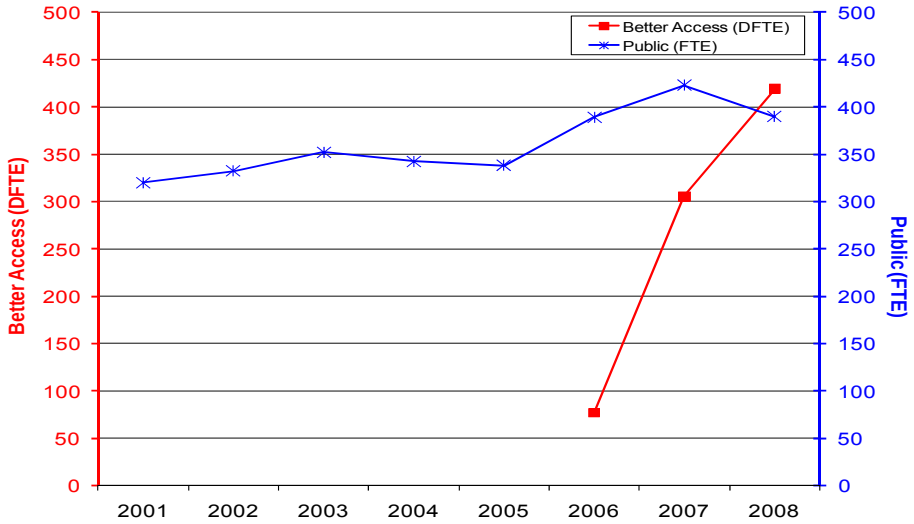
To summarise, since the implementation of Better Access in NSW both the public and the private (Better Access) psychology workforces have increased in size and this is reflected in increases in both workforces in capital cities and outside of capital cities.

Victoria

The number of DFTE psychologists that utilised Better Access Items in Victoria increased by 298% between 2006 and 2007, 37% between 2007 and 2008, and 446% over the entire period. In comparison, the number of FTE psychologists in the public sector increased by 9% between 2006 and 2007, then decreased by 8% between 2007 and 2008, and only increased by 0.1% over the entire period (Figure 3.8).

The overall trend of the psychology workforce in Victoria indicates that, in the first year of the Better Access initiative, there was a significant increase in the size of the private (Better Access) sector workforce coupled with relatively moderate growth in the public sector. However, in the second year of the Better Access initiative, the public sector workforce recorded negative growth almost negating the gains made in the previous year; while the private (Better Access) sector workforce continued its increased growth, albeit at a slower pace. Since the introduction of Better Access, the size of the public sector psychology workforce has remained stagnant, reflecting a short-term increase and subsequent decrease. However these fluctuations followed a period of strong growth in 2005-06 and 2006-07, and by 2008 numbers remained higher than they were for the period 2001-05.

Figure 3.8 Comparison of the FTE/DFTE Victorian psychology workforce, public and private (Better Access) sectors, 2001-2008

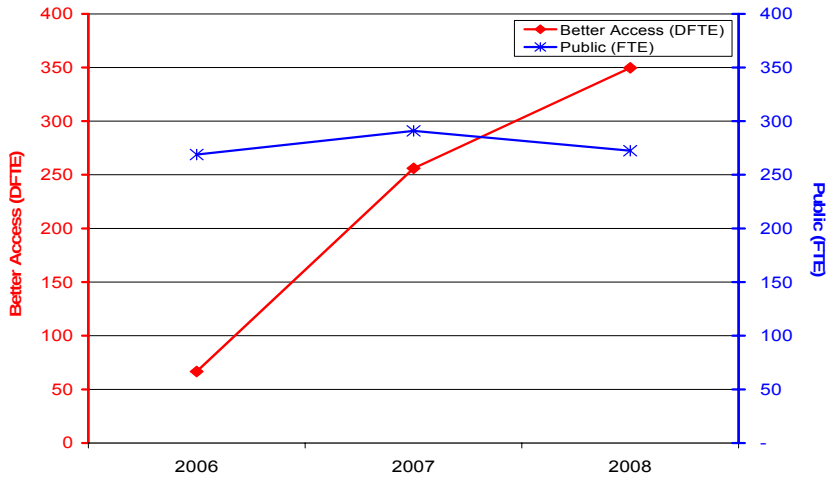


Sources: Medicare Australia. 2006-08 Medicare Provider Data and Medicare Benefit Schedule (MBS) data

Mental Health Establishments: National Minimum Data Set, 2006-2008,
National Survey of Mental Health Services 1996-2005

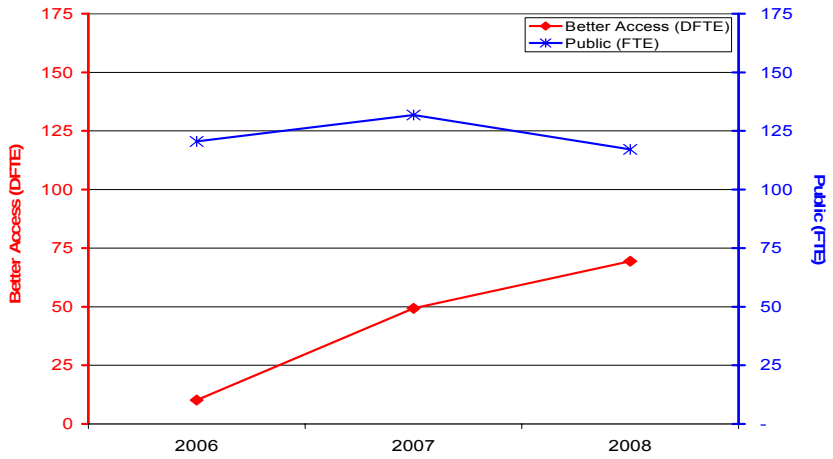
Within Victoria, at the 'capital cities' level of geographic disaggregation, the number of DFTE psychologists that utilised Better Access items increased by 284% between 2006 and 2007, and 37% between 2007 and 2008; an increase of 425% over the entire period. In comparison, the number of FTE psychologists in the public sector increased by 8% between 2006 and 2007, decreased by 6% between 2007 and 2008; an increase of 1% over the entire period (Figure 3.9).

Figure 3.9 Comparison of the FTE/DFTE Victorian psychology workforce, public and private (Better Access) sectors, by capital cities, 2006-2008



Sources: Medicare Australia. 2006-08 Medicare Provider Data and Medicare Benefit Schedule (MBS) data
Mental Health Establishments: National Minimum Data Set, 2006-2008

Figure 3.10 Comparison of the FTE/DFTE Victorian psychology workforce, public and private (Better Access) sectors, by non-capital cities, 2006-2008



Sources: Medicare Australia. 2006-08 Medicare Provider Data and Medicare Benefit Schedule (MBS) data
Mental Health Establishments: National Minimum Data Set, 2006-2008

At the 'non-capital cities' level of geographic disaggregation, the number of DFTE psychologists that utilised Better Access items increased by 386% between 2006 and 2007, 41% between 2007 and 2008, and 584% over the entire period. In comparison, the number of FTE psychologists in the public sector increased by 9% between 2006 and 2007, but decreased by 11% between 2007 and 2008; a decrease of 3% over the entire period (Figure 3.10).

The overall trend of the psychology workforce at the capital cities and non-capital cities level of disaggregation were both similar to the state as a whole. Over the two year period the growth of the private (Better Access) sector workforce in the non-capital cities was greater. Conversely, over the two year period, the size of the public sector psychology workforce stayed the same in the capital cities and experienced slight negative growth in the non-capital cities.

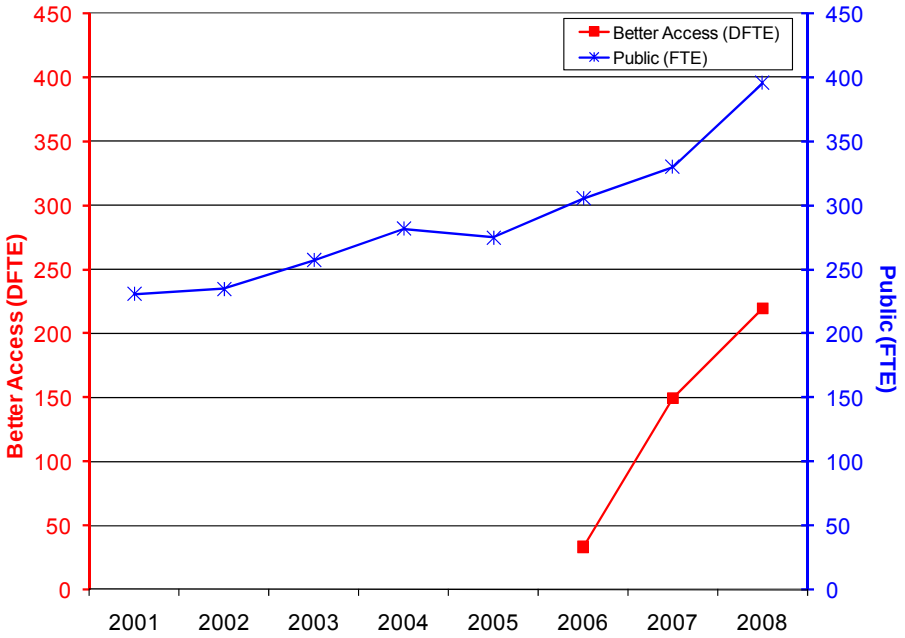
To summarise, since the implementation of Better Access in Victoria, the public sector workforce has fluctuated and by 2008, was at the same level as 2005-06. By 2008, DFTE numbers in the private (Better Access) psychology workforce exceeded that of FTE numbers in the public sector. Since the implementation of Better Access the size of the public sector workforce outside of capital cities decreased slightly more than it did in capital cities.

Queensland

The number of DFTE psychologists that utilised Better Access Items in Queensland (Qld) increased by 350% between 2006 and 2007, 47% between 2007 and 2008, and 561% over the entire period. In comparison, the number of FTE psychologists in the public sector increased by 8% between 2006 and 2007, 20% between 2007 and 2008, and 30% over the entire period (Figure 3.11).

The overall trend of the psychology workforce in Queensland indicates that, in the first year of the Better Access initiative, there was a significant increase in the size of the private (Better Access) sector workforce coupled with relatively moderate growth in the public sector. In the second year of the Better Access initiative, the size of both the public and private (Better Access) sector workforces continued to grow. However, while the growth rate of the public sector workforce increased substantially in the second year of Better Access, relative to the first year, the positive growth rate of the private (Better Access) sector moderated. Since the introduction of Better Access, the growth rate in the public sector psychology workforce was greater than that evident in the longer-term trend.

Figure 3.11 Comparison of the FTE/DFTE Queensland psychology workforce, public and private (Better Access) sectors, 2001-2008



Sources: Medicare Australia. 2006-08 Medicare Provider Data and Medicare Benefit Schedule (MBS) data

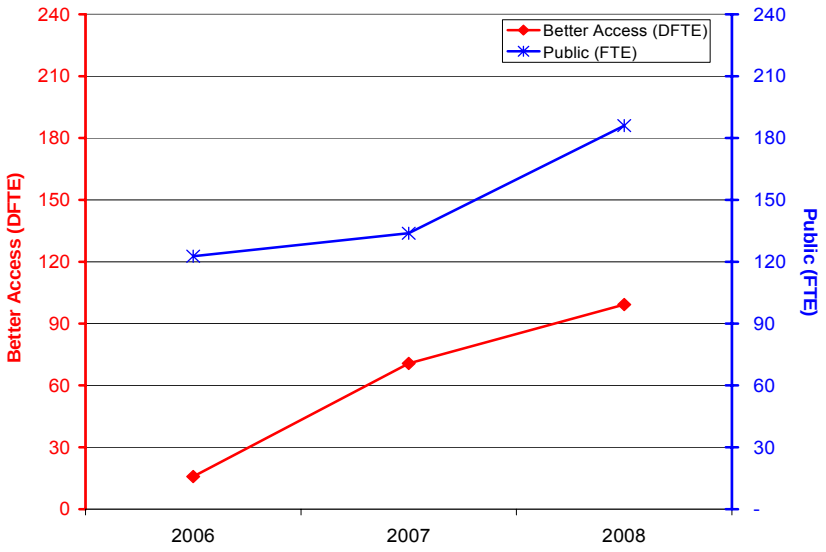
Mental Health Establishments: National Minimum Data Set, 2006-2008,
National Survey of Mental Health Services 1996-2005

Within Queensland, at the 'capital cities' level of geographic disaggregation the number of DFTE psychologists that utilised Better Access items increased by 349% between 2006 and 2007, and 40% between 2007 and 2008; an increase of 530% over the entire period. In comparison, the number of FTE psychologists in the public sector increased by 9% between 2006 and 2007, 39% between 2007 and 2008; and 51% over the entire period (Figure 3.12).

At the 'non-capital cities' level of geographic disaggregation, the number of DFTE psychologists that utilised Better Access items increased by 350% between 2006 and 2007, and 53% between 2007 and 2008; an increase of 590% over the entire period. In comparison, the number of FTE psychologists in the public sector increased by 7% between 2006 and 2007, 7% between 2007 and 2008, and 15% over the entire period (Figure 3.13).

The overall trend of the psychology workforce at the capital cities level of disaggregation was similar to the state as a whole. Over the two year period, both the public and private (Better Access) psychology workforces grew, with the growth rate of the public sector workforce increasing in the second year while the growth rate of the private (Better Access) sector slowed. At the non-capital cities level of disaggregation, over the two year period, the growth of the private (Better Access) sector workforce was consistently higher, compared with the capital cities; whereas, the growth of the public sector workforce was consistently slightly less, compared with the capital cities. Regardless, the size of both the public and private (Better Access) psychology workforces at the non-capital cities level was consistently larger to that at the capital cities level, over the two year period.

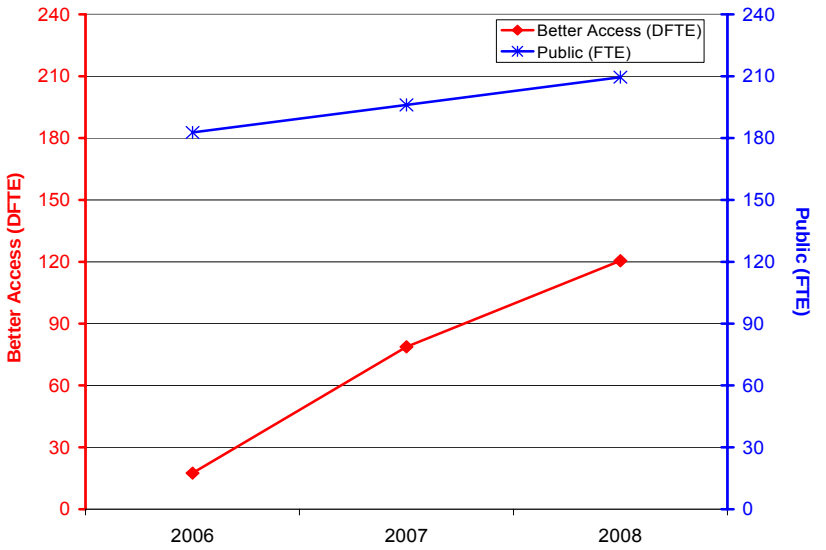
Figure 3.12 Comparison of FTE/DFTE Queensland psychology workforce, public and private (Better Access) sectors, by capital cities, 2006-2008



Sources: Medicare Australia. 2006-08 Medicare Provider Data and Medicare Benefit Schedule (MBS) data

Mental Health Establishments: National Minimum Data Set, 2006-2008

Figure 3.13 Comparison of the FTE/DFTE Queensland psychology workforce, public and private (Better Access) sectors, by non-capital cities, 2006-2008



Sources: Medicare Australia. 2006-08 Medicare Provider Data and Medicare Benefit Schedule (MBS) data

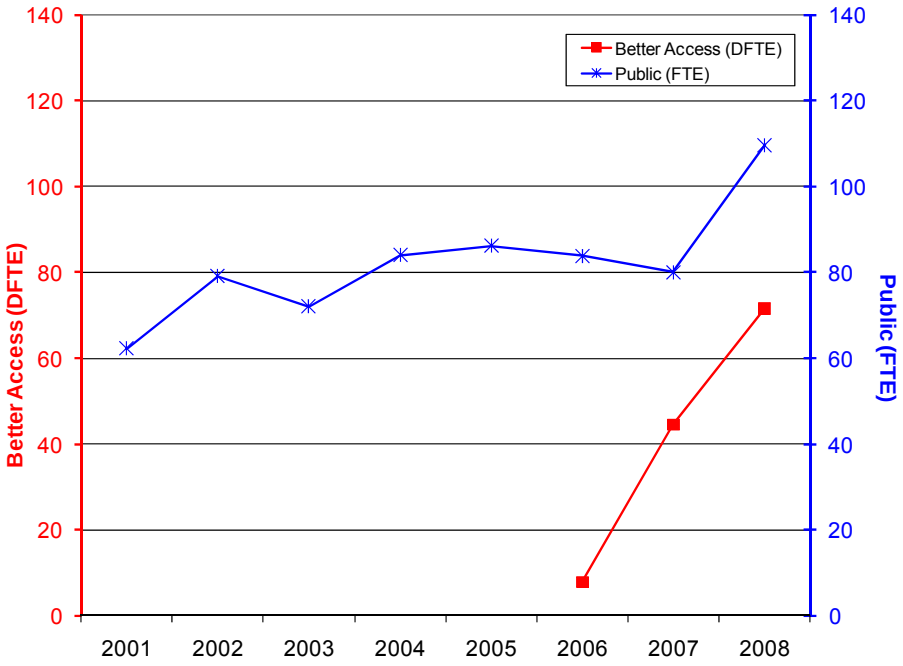
Mental Health Establishments: National Minimum Data Set, 2006-2008

To summarise, since the implementation of Better Access in Queensland, growth in the public sector has been greater than that of the longer term trend. This growth was reflected in both capital cities and outside of capital cities. During this period, growth was stronger outside of capital cities for both public and private (Better Access) sectors.

South Australia

The number of DFTE psychologists that utilised Better Access Items in South Australia (SA) increased by 470% between 2006 and 2007, 61% between 2007 and 2008, and 815% over the entire period. In comparison, the number of FTE psychologists in the public sector decreased by 5% between 2006 and 2007, increased by 37% between 2007 and 2008, and increased by 31% over the entire period (Figure 3.14).

Figure 3.14 Time trend comparison of the FTE/DFTE South Australian psychology workforce, public and private (Better Access) sectors, 2001-2008



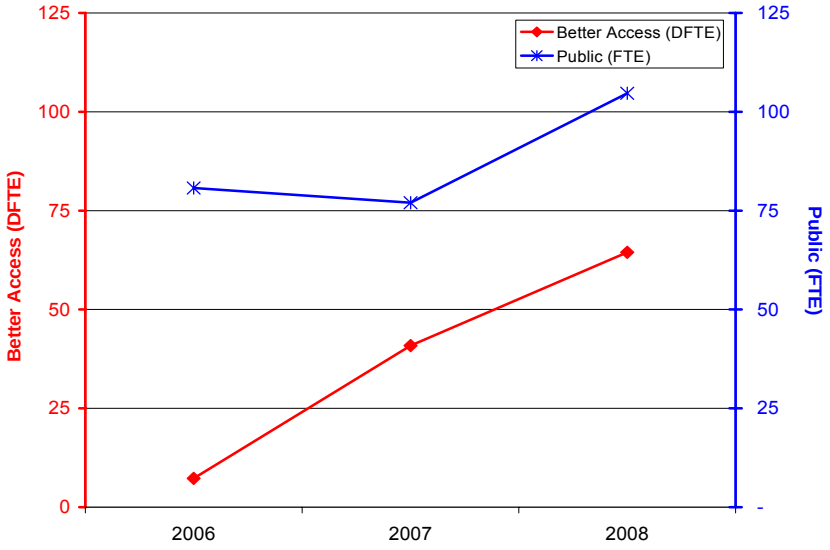
Sources: Medicare Australia. 2006-08 Medicare Provider Data and Medicare Benefit Schedule (MBS) data

Mental Health Establishments: National Minimum Data Set, 2006-2008,
National Survey of Mental Health Services 1996-2005

The overall trend of the psychology workforce in SA indicates that in the first year of the Better Access initiative there was a significant increase in the size of the private (Better Access) sector workforce, but a small decrease in the size of the public sector workforce. However, in the second year of the Better Access initiative, the growth of public sector workforce reversed its downward trend and increased positively; while the private (Better Access) sector workforce also continued its increased growth, albeit at a slower pace relative to the previous year. Since the introduction of Better Access, the growth rate in the public sector psychology workforce has been considerably greater than the long-run trend which was relatively stagnant betweem2002-03 and 2006-07.

Within SA, at the 'capital cities' level of geographic disaggregation, the number of DFTE psychologists that utilised Better Access items increased by 464% between 2006 and 2007, 58% between 2007 and 2008, and 789% over the entire period. In comparison, the number of FTE psychologists in the public sector decreased by 5% between 2006 and 2007, then increased by 36% between 2007 and 2008; an increase of 30% over the entire period (Figure 3.15).

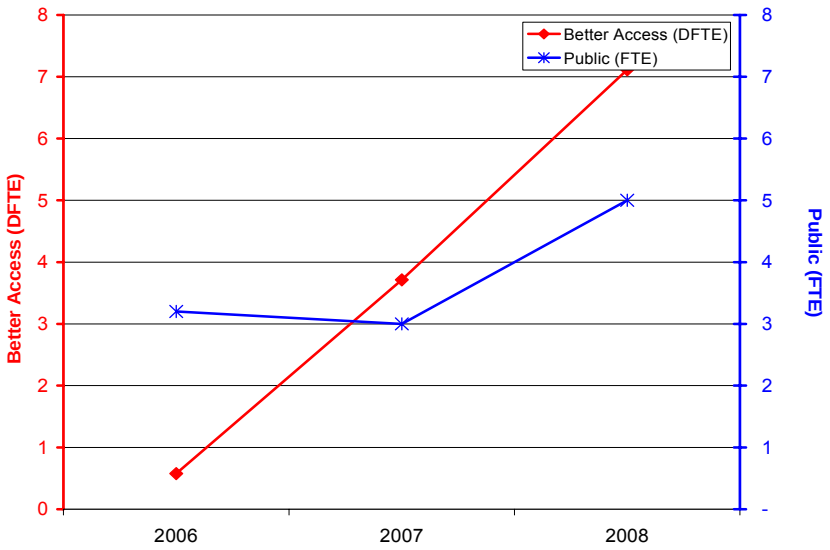
Figure 3.15 Comparison of the FTE/DFTE South Australian psychology workforce, public and private (Better Access) sectors, by capital cities, 2006-2008



Sources: Medicare Australia. 2006-08 Medicare Provider Data and Medicare Benefit Schedule (MBS) data

Mental Health Establishments: National Minimum Data Set, 2006-2008

Figure 3.16 Comparison of the FTE/DFTE South Australian psychology workforce, public and private (Better Access) sectors, by non-capital cities, 2006-2008



Sources: Medicare Australia. 2006-08 Medicare Provider Data and Medicare Benefit Schedule (MBS) data

Mental Health Establishments: National Minimum Data Set, 2006-2008

At the 'non-capital cities' level of geographic disaggregation, the numbers of DFTE psychologists in the private (Better Access) sector and FTE psychologists in the public sector workforces are both very small (Figure 3.16). Using these numbers to discuss proportional changes over time may be misleading; therefore the trend comparison of the two workforces at this level of disaggregation is not further discussed. The overall trend of the psychology

workforce at the capital cities and non-capital cities level of disaggregation were both similar to the state as a whole.

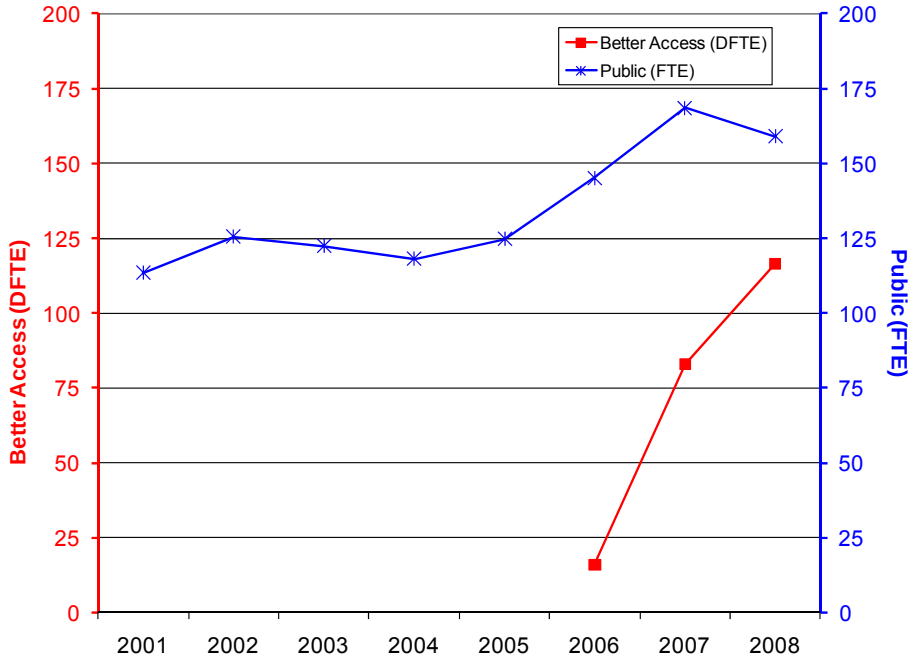
To summarise, since the implementation of Better Access in South Australia, growth in the public sector was greater than that of the longer term trend. The growth is reflected in both capital cities and outside of capital cities.

Western Australia

The number of DFTE psychologists that utilised Better Access Items in Western Australia (WA) increased by 418% between 2006 and 2007, 40% between 2007 and 2008, and 627% over the entire period. In comparison, the number of FTE psychologists in the public sector increased by 16% between 2006 and 2007, decreased by 6% between 2007 and 2008, and increased by 10% over the entire period (Figure 3.17).

The overall trend of the psychology workforce in WA indicates that in the first year of the Better Access initiative there was a significant increase in the size of the private (Better Access) sector workforce coupled with relatively moderate growth in the public sector. However, in the second year of the Better Access initiative, the public sector workforce suffered slight negative growth; while the private (Better Access) sector workforce continued its increased growth, albeit at a slower pace. Since the introduction of Better Access the growth rate in the public sector psychology workforce has maintained its overall rate of growth since 2001.

Figure 3.17 Comparison of the FTE/DFTE Western Australian psychology workforce, public and private (Better Access) sectors, 2001-2008

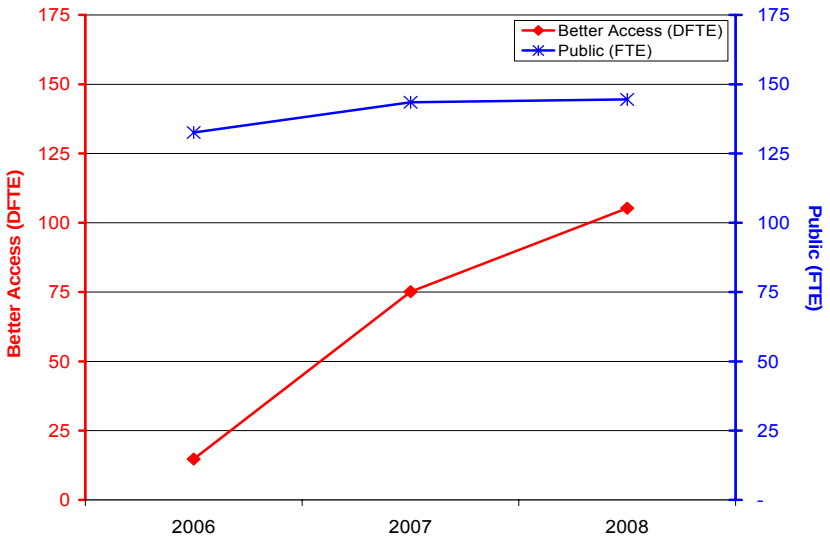


Sources: Medicare Australia. 2006-08 Medicare Provider Data and Medicare Benefit Schedule (MBS) data

Mental Health Establishments: National Minimum Data Set, 2006-2008,
National Survey of Mental Health Services 1996-2005

Within WA, at the 'capital cities' level of geographic disaggregation, the number of DFTE psychologists that utilised Better Access items increased by 409% between 2006 and 2007, 40% between 2007 and 2008, and 613% over the entire period. In comparison, the number of FTE psychologists in the public sector increased by 8% between 2006 and 2007, 1% between 2007 and 2008, and 9% over the entire period (Figure 3.18).

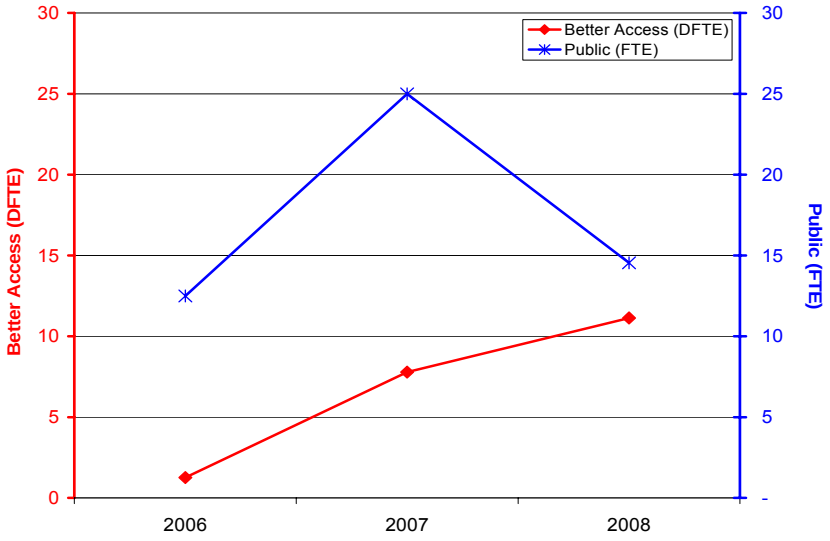
Figure 3.18 Comparison of the FTE/DFTE Western Australian psychology workforce, public and private (Better Access) sectors, by capital cities, 2006-2008



Sources: Medicare Australia. 2006-08 Medicare Provider Data and Medicare Benefit Schedule (MBS) data

Mental Health Establishments: National Minimum Data Set, 2006-2008

Figure 3.19 Comparison of the FTE/DFTE Western Australian psychology workforce, public and private (Better Access) sectors, by non-capital cities, 2006-2008



Sources: Medicare Australia. 2006-08 Medicare Provider Data and Medicare Benefit Schedule (MBS) data

Mental Health Establishments: National Minimum Data Set, 2006-2008

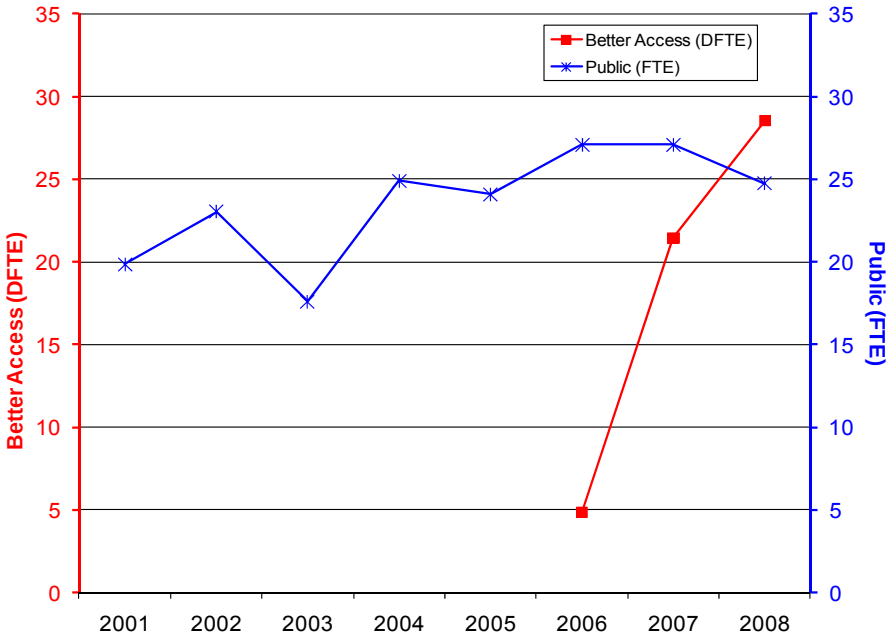
At the 'non-capital cities' level of geographic disaggregation, the numbers of DFTE psychologists in the private (Better Access) sector and FTE psychologists in the public sector workforces are both very small (Figure 3.19). As the use of proportional changes over time may be misleading, the trend comparison of the two workforces at this level of disaggregation is not further discussed. The overall trend of the psychology workforce at the capital cities level of disaggregation was similar to the state as a whole.

To summarise, since the implementation of Better Access in Western Australia there has been fluctuation in the public sector psychology workforce; this resulted in it maintaining its longer term rate of growth (since 2001). The decrease in numbers in the public sector in 2007-08 was mainly related to the workforce outside of capital cities.

Tasmania

The number of DFTE psychologists that utilised Better Access items increased by 344% between 2006 and 2007, 33% between 2007 and 2008, and 491% over the entire period. In comparison, the number of FTE psychologists in the public sector remained the same between 2006 and 2007, decreased by 9% between 2007 and 2008, and decreased by 9% over the entire period (Figure 3.20).

Figure 3.20 Comparison of the FTE/DFTE Tasmanian psychology workforce, public and private (Better Access) sectors, 2001-2008



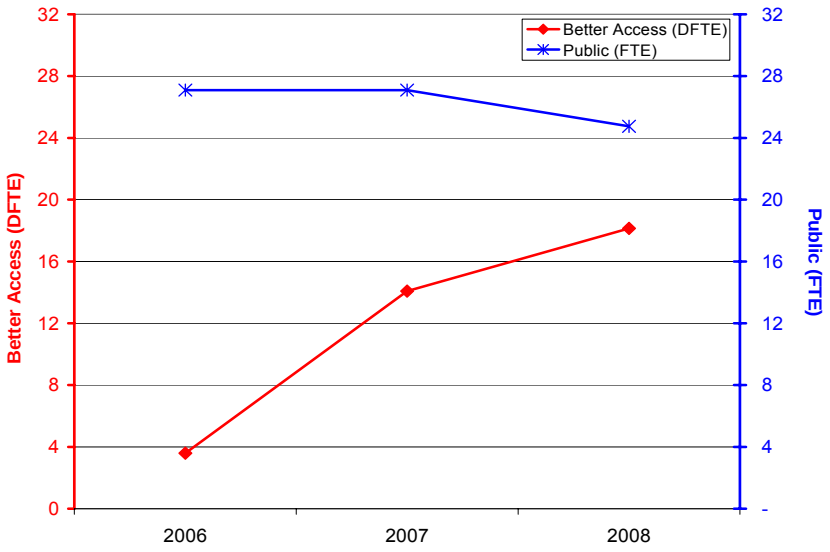
Sources: Medicare Australia. 2006-08 Medicare Provider Data and Medicare Benefit Schedule (MBS) data
Mental Health Establishments: National Minimum Data Set, 2006-2008,
National Survey of Mental Health Services 1996-2005

The overall trend of the psychology workforce in Tasmania indicates that in the first year of the Better Access initiative there was a significant increase in the size of the private (Better Access) sector workforce, but no change in the size of the public sector workforce. In the second year of the Better Access initiative, the public sector workforce experienced negative

growth, while the private (Better Access) sector workforce continued its increased growth, albeit at a much slower pace. Since the introduction of Better Access, the negative growth rate of the public sector psychology workforce has brought the size of the workforce back to the 2004 level.

Within Tasmania at the 'capital cities' level of geographic disaggregation, the number of DFTE psychologists that utilised Better Access items increased by 292% between 2006 and 2007, 29% between 2007 and 2008, and 405% over the entire period. In comparison, the number of FTE psychologists in the public sector remained the same between 2006 and 2007, and decreased by 7% between 2007 and 2008; a decrease of 7% over the entire period (Figure 3.21).

Figure 3.21 Comparison of the FTE/DFTE Tasmanian psychology workforce, public and private (Better Access) sectors, by capital cities, 2006-2008



Sources: Medicare Australia. 2006-08 Medicare Provider Data and Medicare Benefit Schedule (MBS) data

Mental Health Establishments: National Minimum Data Set, 2006-2008

At the 'non-capital cities' level of geographic disaggregation, the numbers of DFTE psychologists in the private (Better Access) sector workforce are small and the numbers of FTE psychologists in the public sector workforce are not available. The trend comparison of the two workforces at this level of disaggregation is therefore not presented or further discussed. The overall trend of the psychology workforce at the capital cities level of disaggregation was similar to the state as a whole.

To summarise, since the implementation of Better Access the size of the public sector psychology workforce in Tasmania has decreased slightly to its 2004 level. By 2008, the size of the private (Better Access) workforce was larger than that of the public sector workforce.

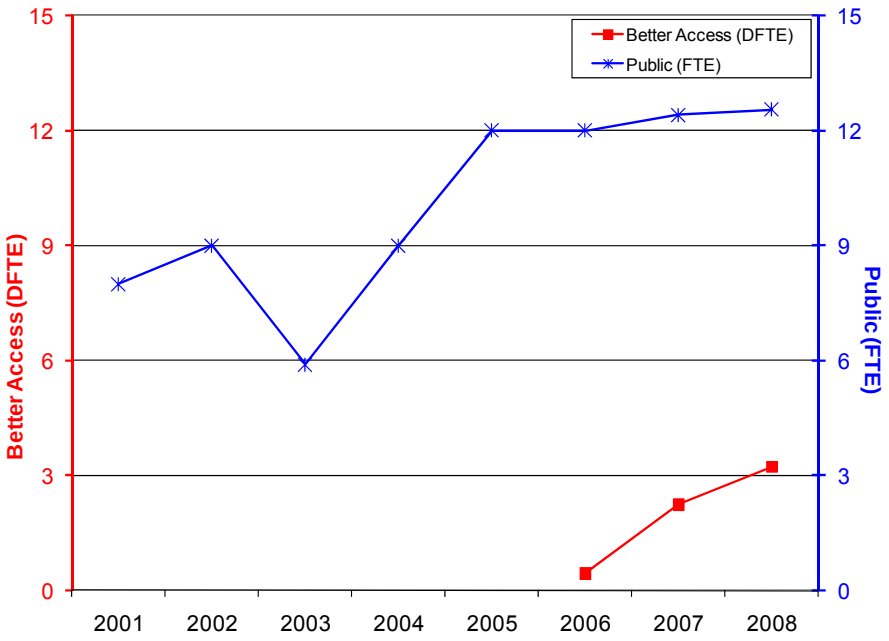
Northern Territory

The number of DFTE psychologists that utilised Better Access Items in the Northern Territory (NT) increased by 406% between 2006 and 2007, 44% between 2007 and 2008, and 627% over the entire period. In comparison, the number of FTE psychologists in the public

sector only slightly increased by 3% between 2006 and 2007, 1% between 2007 and 2008, and 4% over the entire period (Figure 3.22). It should be noted that, in this instance, the use of proportional changes over time may be misleading as the private (Better Access) sector workforce was starting from DFTE base of 0.4 in 2006, the smallest of all the states/territories.

The overall trend of the psychology workforce the NT indicates that in the first year of the Better Access initiative the size of the both the public and private (Better Access) workforces grew slightly. In the second year of the Better Access initiative, the size of both the public and private (Better Access) sector workforces continued to grow. However, while it appears that the private (Better Access) sector may have grown at a faster rate relative to the public sector, the absolute size of both workforces are considerably smaller than all the other states/territories. Since the introduction of the Better Access initiative, it appears that the short-run growth rate of the public sector workforce was considerably slower than the long-run trend, but both remained positive.

Figure 3.22 Comparison of the FTE/DFTE Northern Territory psychology workforce, public and private (Better Access) sectors, 2001-2008



Sources: Medicare Australia. 2006-08 Medicare Provider Data and Medicare Benefit Schedule (MBS) data

Mental Health Establishments: National Minimum Data Set, 2006-2008,
National Survey of Mental Health Services 1996-2005

Within the NT, at both the capital cities and non-capital cities level of geographic disaggregation, the numbers of DFTE psychologists in the private (Better Access) sector and FTE psychologists in the public sector workforces are very small. The trend comparison of the two workforces at this level of disaggregation is therefore not presented or further discussed.

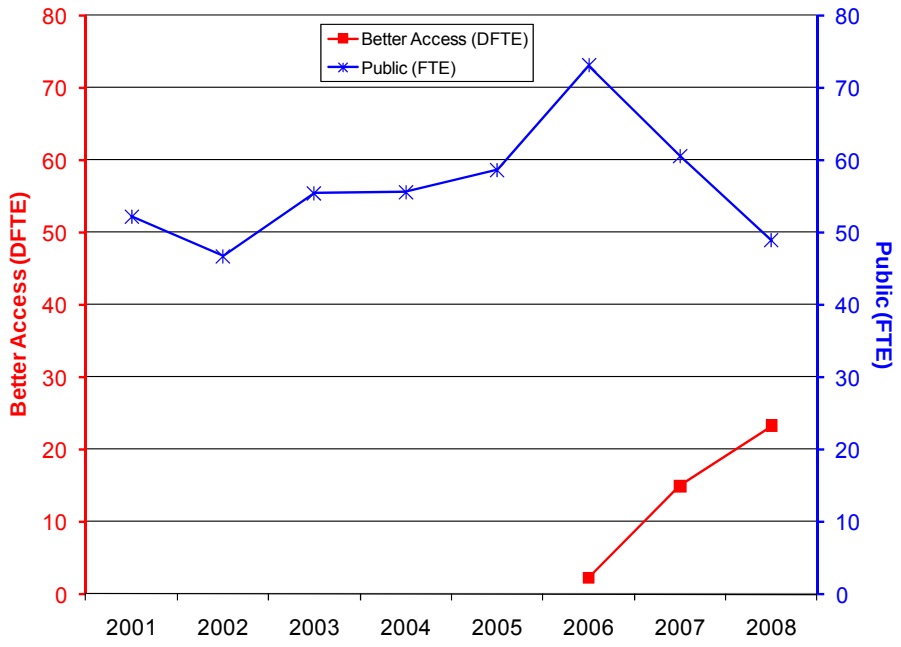
To summarise, since the implementation of Better Access, the public sector psychology workforce in the NT has increased slightly, but the rate of growth was weaker than in the years 2001-2005.

Australian Capital Territory

The number of DFTE psychologists that utilised Better Access Items in the Australian Capital Territory (ACT) increased by 548% between 2006 and 2007, 56% between 2007 and 2008, and 910% over the entire period. In comparison, the number of FTE psychologists in the public sector deceased by 17% between 2006 and 2007, and 19% between 2007 and 2008: a decrease of 33% over the entire period (Figure 3.23).

The overall trend of the psychology workforce in the ACT indicates that in the first year of the Better Access initiative the size of the private (Better Access) sector workforce increased, while there was a decrease in the size of public sector workforce. In the second year of the Better Access initiative the public sector workforce continued to shrink at approximately the same rate of growth, as the previous period; while the private (Better Access) sector workforce continued its positive growth, but at a moderated pace. Since the introduction of Better Access, there has been a reversal of the longer term growth trend in the public sector psychology workforce with the size of the workforce in 2008 being only marginally larger than it was in 2002.

Figure 3.23 Comparison of the FTE/DFTE ACT psychology workforce, public and private (Better Access) sectors, 2001-2008



Sources: Medicare Australia. 2006-08 Medicare Provider Data and Medicare Benefit Schedule (MBS) data

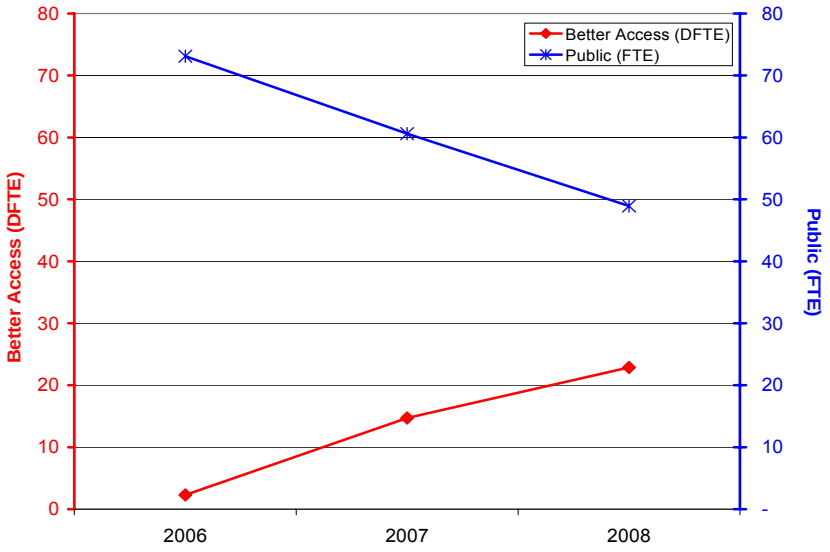
Mental Health Establishments: National Minimum Data Set, 2006-2008,
National Survey of Mental Health Services 1996-2005

Within the ACT, at the 'capital cities' level of geographic disaggregation, the number of DFTE psychologists that utilised Better Access items increased by 544% between 2006 and

2007, 56% between 2007 and 2008, and 902% over the entire period. In comparison, the number of FTE psychologists in the public sector decreased by 16% between 2006 and 2007, decreased by 20% between 2007 and 2008, and decreased by 33% over the entire period (Figure 3.24).

At the non-capital cities level of geographic disaggregation, the numbers of DFTE psychologists in the private (Better Access) sector workforce are small and the numbers of FTE psychologists in the public sector workforce are not available. As such, the trend comparison of the two workforces at this level of disaggregation are not presented or further discussed. The overall trend of the psychology workforce at the capital cities level of disaggregation was almost representative of the territory as a whole.

Figure 3.24 Comparison of the FTE/DFTE ACT psychology workforce, public and private (Better Access) sectors, by capital cities, 2006-2008



Sources: Medicare Australia. 2006-08 Medicare Provider Data and Medicare Benefit Schedule (MBS) data

Mental Health Establishments: National Minimum Data Set, 2006-2008

To summarise, since the implementation of Better Access, there has been a decrease in the size of the public sector psychology workforce in the ACT to the extent that it has reversed all gains since 2002.

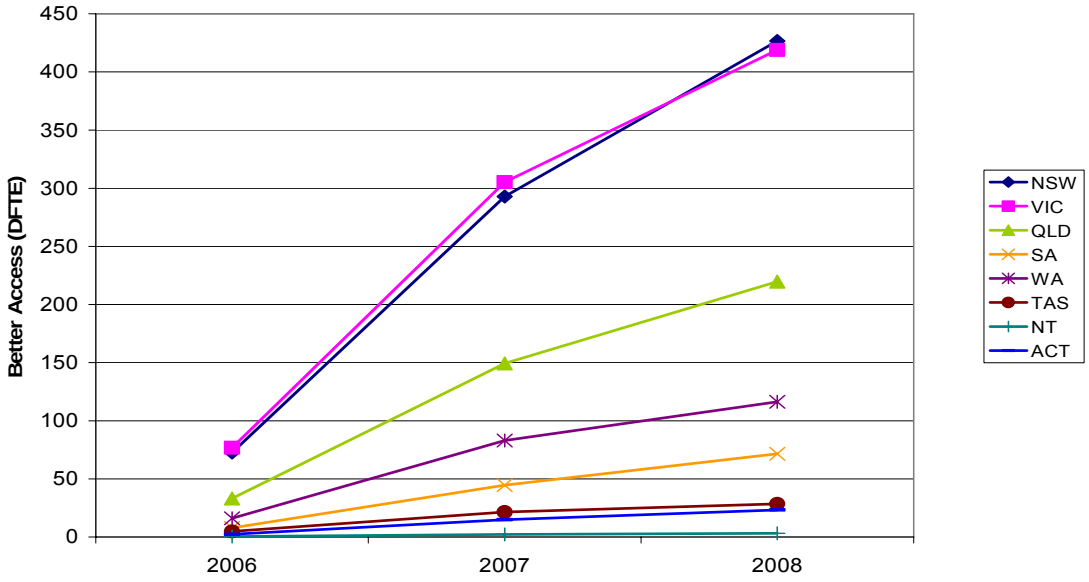
State and Territory summary

Not surprisingly, the overall trends in the DFTE of the Better Access psychology workforce indicate an increase in every state and territory. Over the period from 2006 to 2008, the largest Better Access DFTE psychology workforces were located in NSW, Victoria and Queensland (Figure 3.25), with the highest growth being in SA (815%), the ACT (910%) and WA (627%).

To a lesser extent the overall trends in the public FTE psychology workforce by state and territory reveal that there was an increase over the two year period in every state and territory except for Tasmania and the ACT, with Victoria remaining virtually unchanged (Figure 3.26). Again, the largest public sector psychology workforces (by FTE) were located

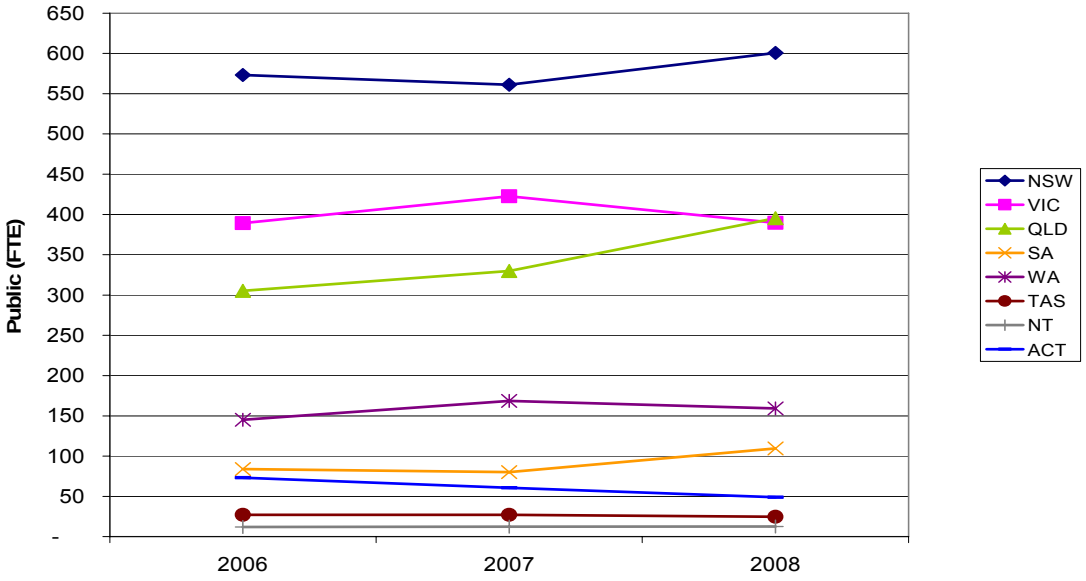
in NSW, Victoria and Queensland, with the highest growth public being in SA (31%), Queensland (30%) and WA (10%).

Figure 3.25 Private sector (DFTE) Better Access psychology workforce, by state/territory, 2006-2008



Source: Medicare Australia. 2006-08 Medicare Provider Data and Medicare Benefit Schedule (MBS) data

Figure 3.26 Public sector (FTE) psychology workforces, by state/territory, 2006-2008



Source: Mental Health Establishments: National Minimum Data Set, 2006-2008

It is evident from the data that the implementation of Better Access has had a positive impact on the growth of the private (Better Access) psychology workforce. However, it is difficult from the current data to attribute the changes in the public sector psychology workforces to

the introduction of the Better Access initiative, as there are an insufficient number of time periods. Further monitoring of the MBS and MHE: NMDS data over subsequent years will provide a clearer indication of whether the changes in the size of the workforces are due to a period of adjustment, state-level policies in the public mental health sector, or to more underlying trends in supply in those states/territories.

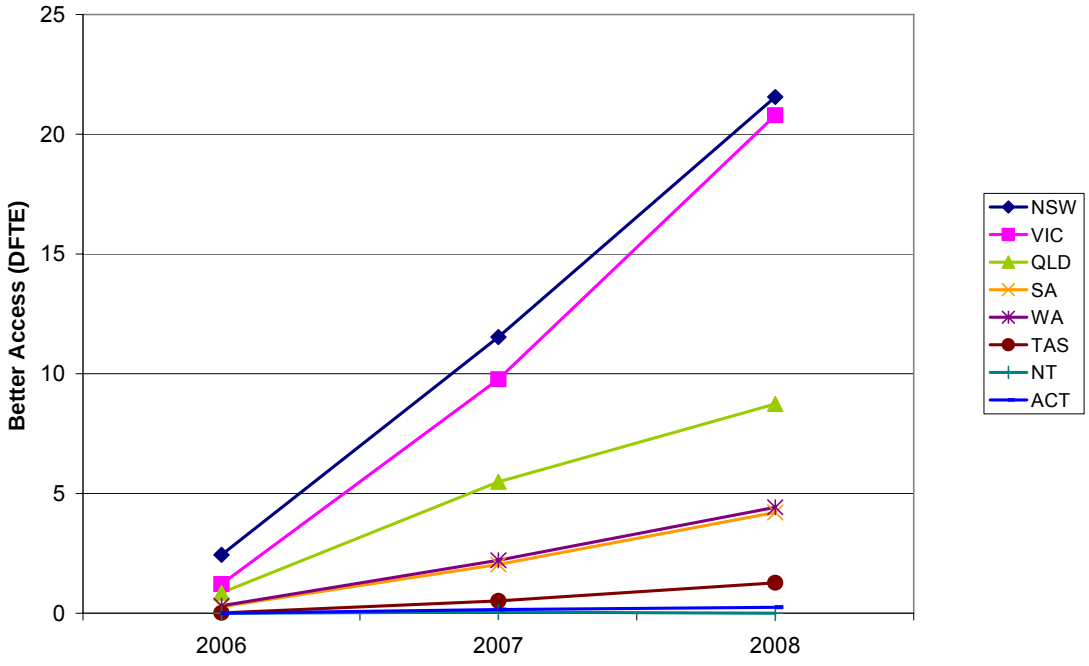
3.1.3 Social Work

State and Territory

Trends for the Better Access social work workforce indicate that the DFTE number of social workers in the private (Better Access) sector increased in all states/territories. Overall, the private (Better Access) sector workforce for Australia increased from a DFTE of 5.1 in 2006 to 61.2 in 2008, representing a rate of growth of 1,098%. The largest Better Access social work workforces were located in NSW, Victoria and Queensland (Figure 3.27). However, over the two year period, the private (Better Access) sector workforces with the highest growth rates were located in Victoria, SA and Tasmania.

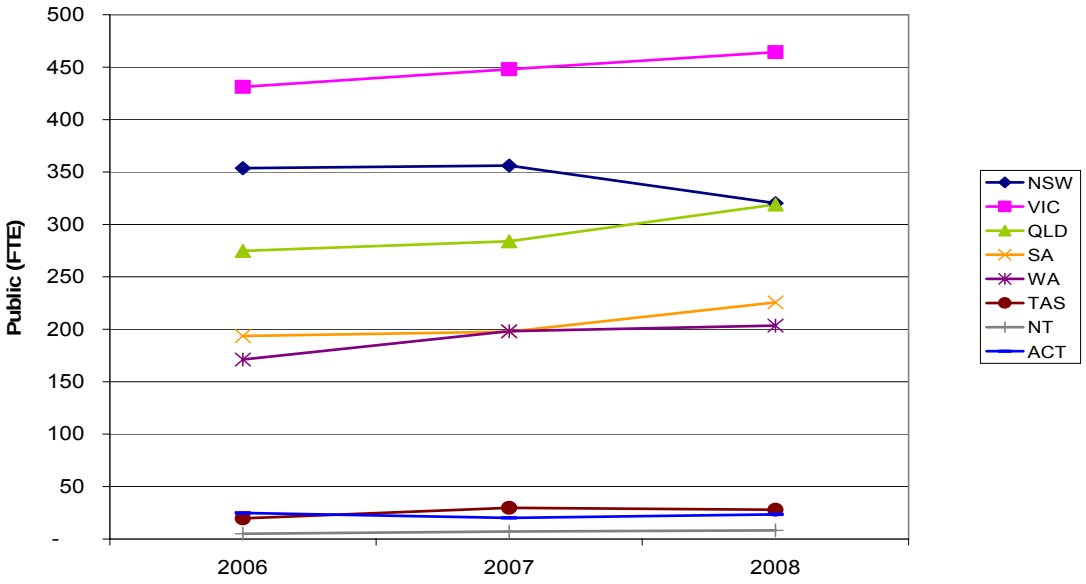
The number of FTE social workers in the public sector workforce for Australia continually increased from a FTE of 1,474 in 2006 to 1,592 in 2008, representing an 8% rate of growth. Although Victoria, NSW and Queensland had the largest numbers of FTE social workers (Figure 3.28), it was the NT, Tasmania and WA that had the highest growth rates over the two year period. Both NSW and the ACT were the only two jurisdictions that had negative rates of growth over the two year period and smaller workforces in 2008 than in 2006.

Figure 3.27 Private sector (DFTE) Better Access social work workforce, by state/territory, 2006-2008



Source: Medicare Australia. 2006-08 Medicare Provider Data and Medicare Benefit Schedule (MBS) data

Figure 3.28 Public sector (FTE) social work workforce, by state/territory, 2006-2008



Source: Mental Health Establishments: National Minimum Data Set, 2006-2008

The overall trend of both the public and private (Better Access) sector social work workforces grew in most states/territories, between 2006 and 2008. While further monitoring of the MBS and MHE: NMDS data would be recommended to provide a clearer indication of the workforce trends, the current trend indicates that there was strong positive growth in both the public and private (Better Access) sectors.

Capital cities/Non-Capital cities

As the FTE and DFTE numbers for the social work workforce were small, the analysis of the geographic distribution between capital cities and non-capital cities has been conducted using totals for the whole of Australia.

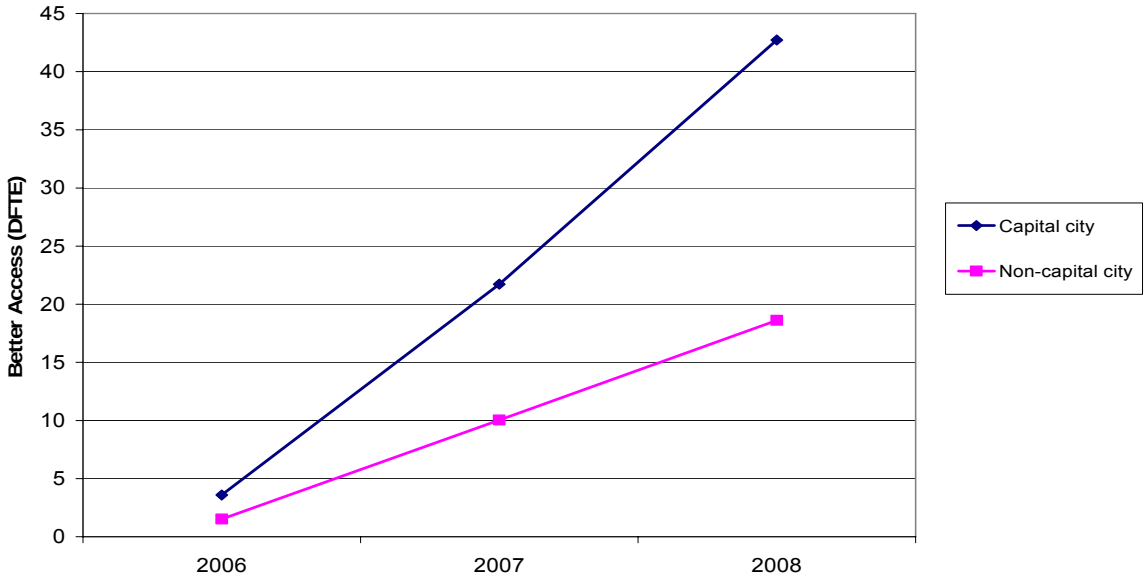
Trends for the Better Access social work workforce indicate that the DFTE number of social workers in the private (Better Access) sector increased at both the capital city and non-capital city levels of geographical disaggregation. At the capital city level, the private (Better Access) sector workforce for Australia increased from a DFTE of 3.6 in 2006 to 42.7 in 2008, representing a 1,090% rate of growth; whereas, at the non-capital city level, the private (Better Access) sector workforce increased from a DFTE of 1.5 in 2006 to 18.6 in 2008, representing a 1,125% rate of growth (Figures 3.29 & 3.30).

The number of FTE social workers in the public sector workforce also increased at both the capital city and non-capital city level. At the capital city level, the public sector social work workforce for Australia increased from a FTE of 1,083 in 2006 to 1,162 in 2008, representing a 7% rate of growth; whereas, at the non-capital city level, the public sector workforce increased from a FTE of 391 in 2006 to 430 in 2008, representing a 10% rate of growth (Figures 3.29 & 3.30).

During the first year of Better Access, both the public and private (Better Access) social work workforces increased at a higher rate in non-capital city areas than capital city areas. This

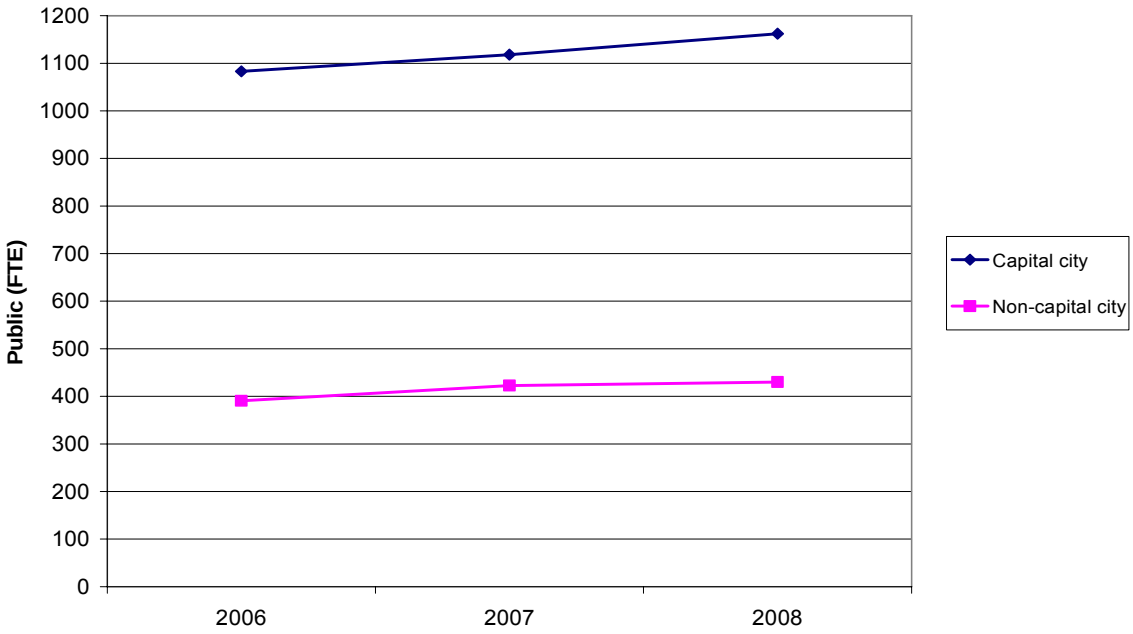
positive trend slowed somewhat during the second year of Better Access, however the growth rate in non-capital city areas was greater over the two year period.

Figure 3.29 Private sector (DFTE) Better Access social work workforce, by capital city/non-capital city, 2006-2008



Source: Medicare Australia. 2006-08 Medicare Provider Data and Medicare Benefit Schedule (MBS) data

Figure 3.30 Public sector (FTE) social work workforce, by capital city/non-capital city, 2006-2008



Source: Mental Health Establishments: National Minimum Data Set, 2006-2008

To summarise, since the implementation of Better Access the public sector social work workforce has grown in all jurisdictions except for NSW and the ACT. In both the public and

private (Better Access) sectors, growth was stronger in capital cities compared to outside of capital cities.

3.1.4 Occupational Therapy

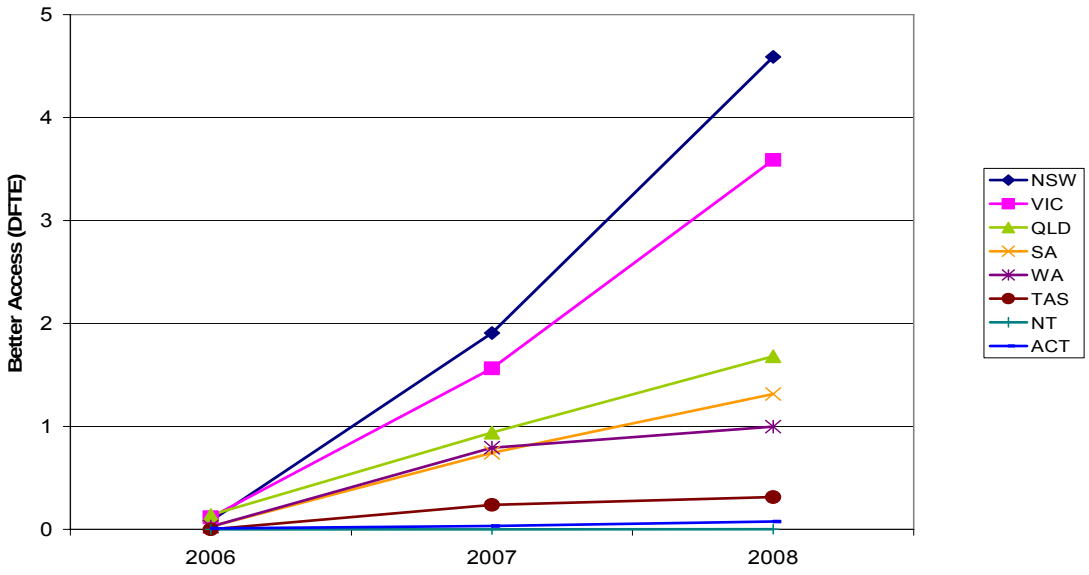
State and Territory

Trends for the Better Access occupational therapy workforce indicate that the DFTE number of occupational therapists in the private (Better Access) sector increased in all states/territories. Overall, the private (Better Access) sector workforce for Australia increased from a DFTE of 0.4 in 2006 to 12.6 in 2008. Of that, the largest Better Access occupational therapy workforces were located in NSW, and Victoria (Figure 3.31).

The number of FTE occupation therapists in the public sector workforce for Australia increased from a FTE of 762 in 2006 to 859 in 2008, representing a 13% rate of growth. Queensland, NSW and Victoria had the largest numbers of FTE occupational therapists (Figure 3.32). None of the states/territories experienced a decline in their occupational therapy workforces during this year period. However, during the first year of Better Access, the Queensland and ACT public sector workforces had a negative growth rate, while the Victorian and Tasmanian public sector workforces had negative rates of growth during the second year of Better Access.

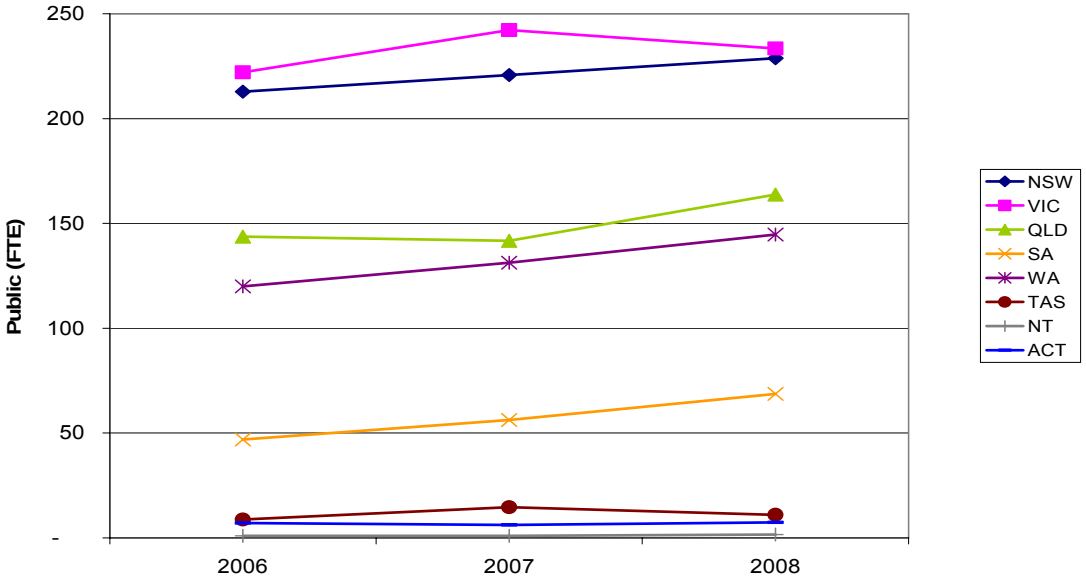
The overall trend of both the public and private (Better Access) sector occupational therapy workforces grew in all states/territories, between 2006 and 2008, with strong positive growth in the private (Better Access) sector (albeit from a small base) and moderately continuous growth in the public sector for most of the states/territories.

Figure 3.31 Private sector (DFTE) Better Access occupational therapy workforce, by state/territory, 2006-2008



Source: Medicare Australia. 2006-08 Medicare Provider Data and Medicare Benefit Schedule (MBS) data

Figure 3.32 Public sector (FTE) occupational therapy workforce, by state/territory, 2006-2008



Source: Mental Health Establishments: National Minimum Data Set, 2006-2008

Capital cities/Non-Capital cities

As the FTE and DFTE numbers for the occupational therapy workforce were small, the analysis of the geographic distribution between capital cities and non-capital cities has been conducted using totals for the whole of Australia.

Trends for the Better Access occupational therapy workforce indicate that the DFTE number of occupational therapists in the private (Better Access) sector increased at both the capital city and non-capital city levels of geographical disaggregation. At the capital city level, the private (Better Access) sector workforce for Australia increased from a DFTE of 0.3 in 2006 to 9.0 in 2008; whereas, at the non-capital city level, the private (Better Access) sector workforce increased from a DFTE of 0.1 in 2006 to 3.5 in 2008 (Figures 3.33 & 3.34).

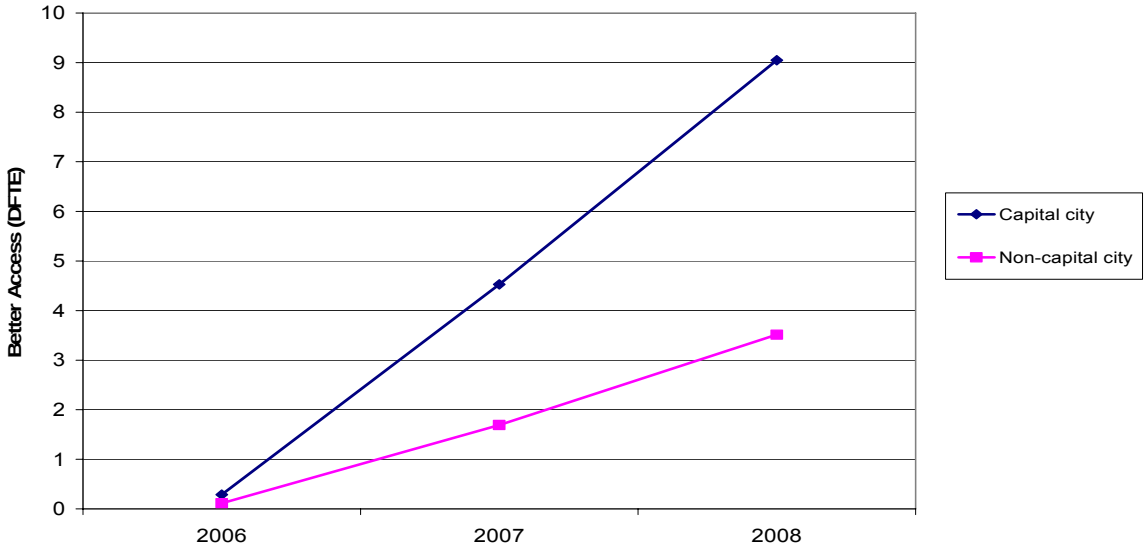
The number of FTE occupational therapists in the public sector workforce increased at both the capital city and non-capital city level. At the capital city level, the public sector workforce for Australia increased from a FTE of 554 in 2006 to 636 in 2008; at the non-capital city level, the public sector workforce increased from a FTE of 208 in 2006 to 223 in 2008 (Figures 3.33 & 3.34).

Over the two year period, the growth rate of both the public and private (Better Access) sector occupational therapy workforces at the capital city level were similar to changes at the national level, indicating that most of the occupational therapy workforces were located in the highly populated areas. Furthermore, both the public and private (Better Access) occupational therapy workforces grew at a faster rate in capital city areas compared to non-capital areas over the two year period.

To summarise, since the implementation of Better Access, the public sector occupational therapy workforce has either grown slightly or remained stable. The rate of growth in capital

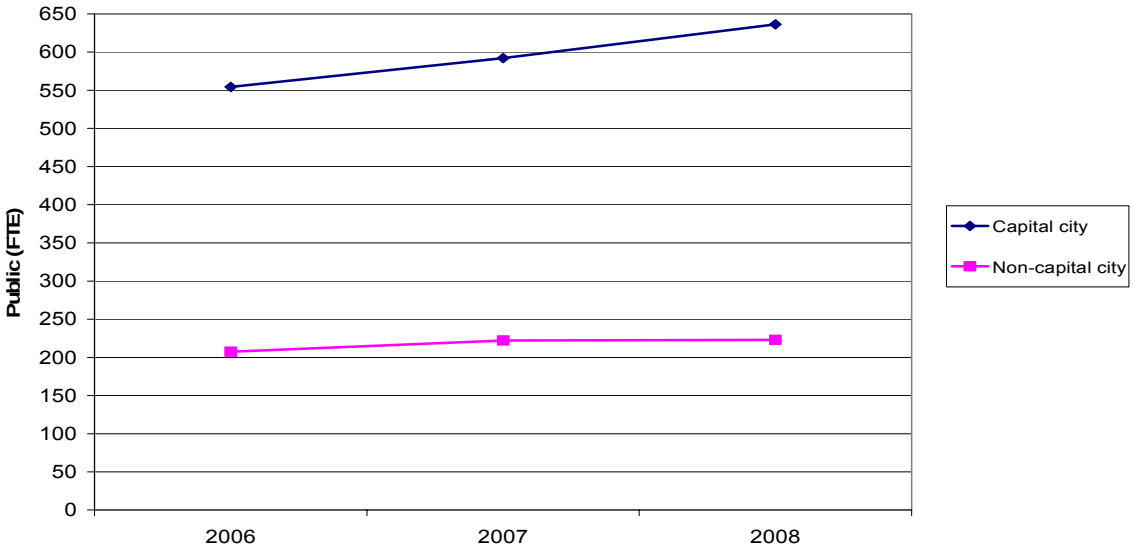
cities for both the public and private (Better Access) workforces was higher than that outside of capital cities.

Figure 3.33 Private sector (DFTE) Better Access occupational therapy workforce, by capital city/non-capital city, 2006-2008



Source: Medicare Australia. 2006-08 Medicare Provider Data and Medicare Benefit Schedule (MBS) data

Figure 3.34 Public sector (FTE) occupational therapy workforce, by state/territory, 2006-2008



Source: Mental Health Establishments: National Minimum Data Set, 2006-2008

3.2 Distribution of the Allied Mental Health Workforce Registered with Medicare, 2004-2008

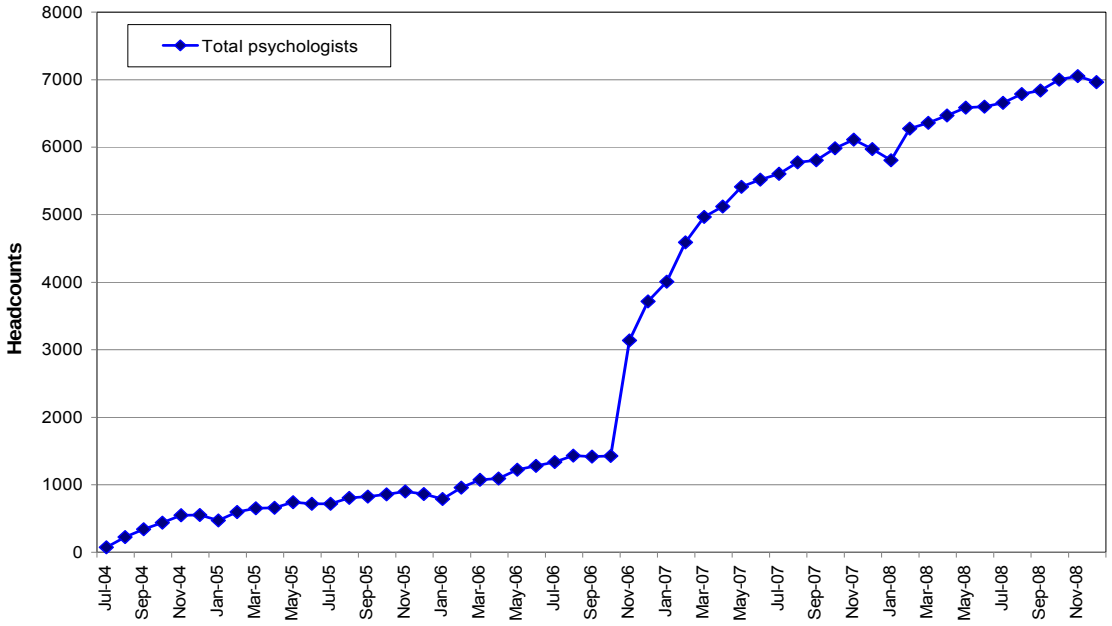
This section examines the trends or breaks in supply of each category in the private (Medicare)[26] allied mental health workforce before and after the implementation of the Better Access in November 2006. It analyses the geographic distributions of psychologists, social workers and occupational therapists in the Medicare sector, distinguishing by state, and by region (urban, rural).

3.2.1 Psychology

The psychology workforce is the largest component of the Better Access allied mental health workforce in the private (Medicare) sector. Before the implementation of Better Access, psychology mental health services were reported under MBS Item 10968. Better Access added another 10 MBS Items for which psychologists could provide services.

As indicated in previous sections of this report, the implementation of Better Access resulted in a significant increase in the number of psychologists registered with Medicare. The historical use of Medicare Items by psychologists is shown in Figure 3.33 for the period July 2004 to December 2008. This gives a graphic illustration of the spike in the numbers of psychologists upon the introduction of Better Access: increasing from 1,429 persons in October 2006 to 3,132 persons in November 2006.

Figure 3.33 Change in total numbers of psychologists in the private (Medicare) workforce, 2004-2008



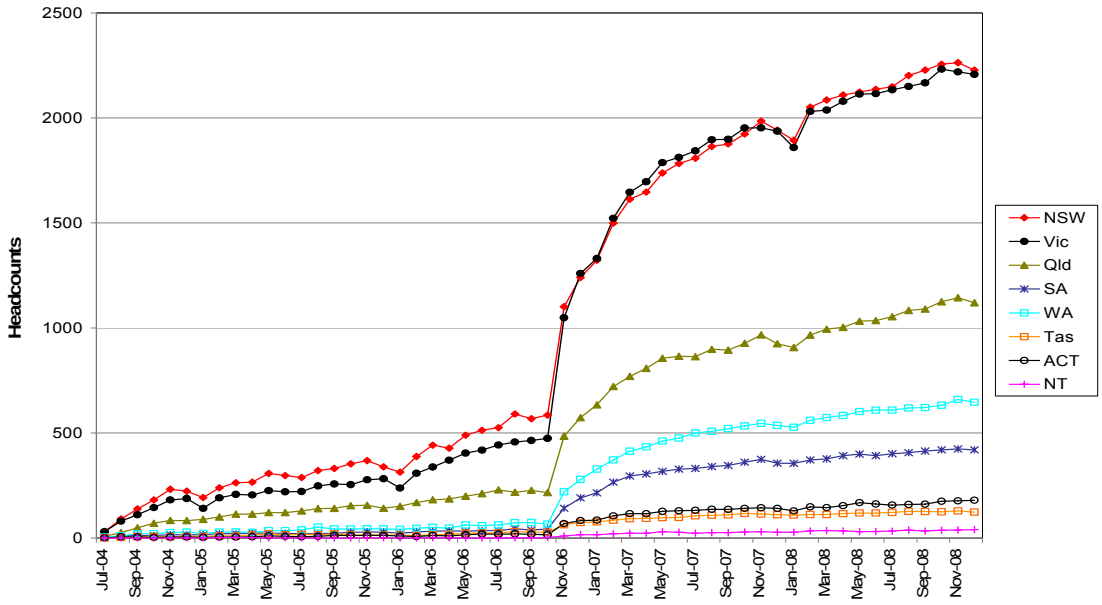
Source: Medicare Australia. 2004-08 Medicare Provider Data and Medicare Benefit Schedule (MBS) data

[26] The term private (Medicare) workforce refers to service providers who have used MBS Items which include, but go beyond those associated with Better Access.

The extent to which Better Access has impacted on the supply of psychologists into the private (Medicare) sector is also reflected by the changing average growth rate of the number of psychologists per month. During period October 2004 to October 2006 (i.e. prior to the Better Access) the average monthly growth rate of the actual numbers of psychologists was 2.4%, and the growth was on a small base. Since the implementation of Better Access in November 2006 the average monthly growth rate of this workforce was 3.4%, and the growth was on a relatively large base.

The increase in the supply of psychologists into the private (Medicare) sector is evident across all states and territories (Figure 3.34). The biggest impact of Better Access on the psychology workforce occurred in four states – NT, ACT, SA, and WA – each of which grew 8-12 times by December 2008 from the October 2006 levels. NSW has had the largest segment of the psychology workforce both before and after the implementation of the Better Access, however, its share slid by about 8 percentage points, dropping from 40% prior to the Better Access to 35.1% in November 2006 and further to 32.1% in November 2008 (Table 3.2). In contrast, WA almost doubled its share from 5% prior to the Better Access to 9.4% in November 2008. Similarly, SA doubled its share from 3% to 6% on the same time horizon.

Figure 3.34 Change in total numbers of psychologists in the private (Medicare) workforce: 2004-2008, by state/territory



Source: Medicare Australia. 2004-08 Medicare Provider Data and Medicare Benefit Schedule (MBS) data

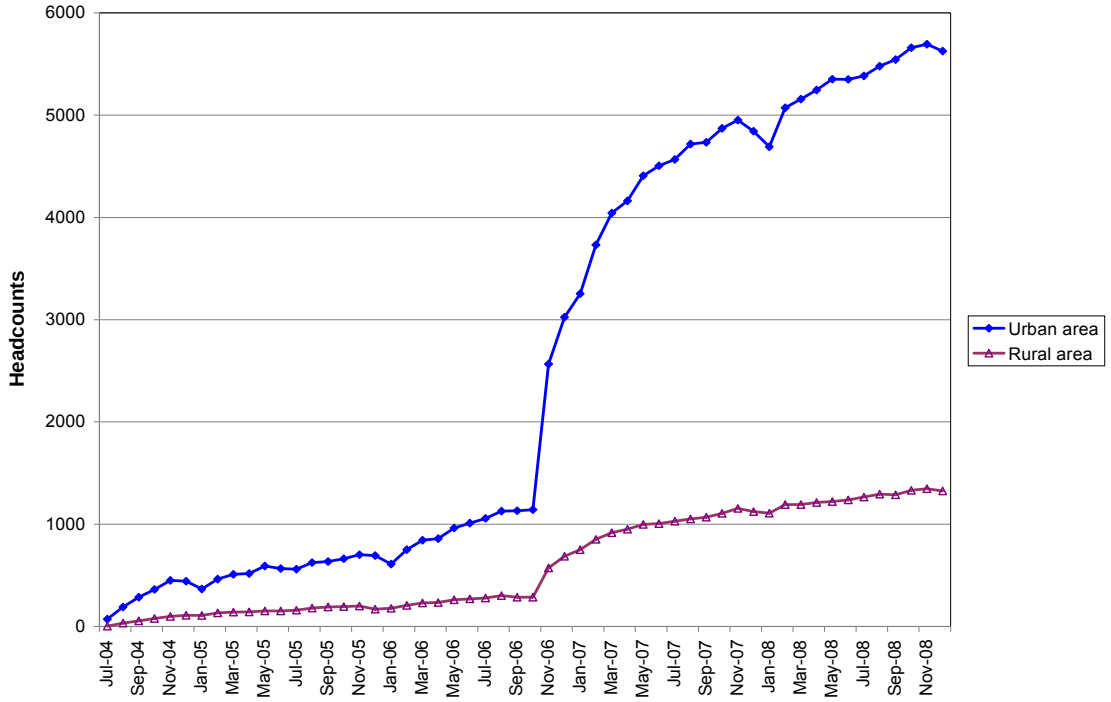
Better Access increased the supply of psychologists providing mental health services using MBS Items in both urban and rural areas (Figure 3.35). In the urban areas (capital cities and metropolitan areas), the psychology workforce increased by about four fold in a short period following the implementation of Better Access; in the rural areas in this workforce increased by 3.6 times during the same period. The psychology workforce is disproportionately distributed between the urban areas and rural areas (Table 3.1). Psychologists in the urban areas have consistently accounted for about 80% of this workforce. There was a slight reduction of the share of this workforce that provided Better Access services to people residing in rural centres after the implementation of the Better Access.

Table 3.1 Change in proportion (%) of psychology workforce in the private (Medicare) sector 2004-2008, by state/territory, by region

	State/Territory									Region	
	Total headcounts	NSW (%)	Vic (%)	Qld (%)	SA (%)	WA (%)	Tas (%)	ACT (%)	NT (%)	Urban (%)	Rural (%)
Oct-04	440	41.1	33.0	15.9	2.7	4.8	1.8	0.7	0.0	82.3	17.7
Oct-05	858	41.1	29.6	17.9	3.1	5.0	1.7	1.4	0.0	77.3	22.6
Oct-06	1429	40.9	33.2	15.1	3.0	4.6	1.9	1.0	0.2	79.9	20.1
Nov-06	3138	35.1	33.4	15.5	4.5	7.0	2.0	2.2	0.3	81.8	18.2
Nov-07	6114	32.5	31.9	15.8	6.1	8.9	1.9	2.4	0.5	81.0	18.9
Nov-08	7054	32.1	31.5	16.2	6.0	9.4	1.8	2.5	0.5	80.7	19.1

Source: Medicare Australia. 2004-08 Medicare Provider Data and Medicare Benefit Schedule (MBS) data

Figure 3.35 Change in numbers of psychologists in the Medicare workforce 2004-2008, by region (urban, rural)



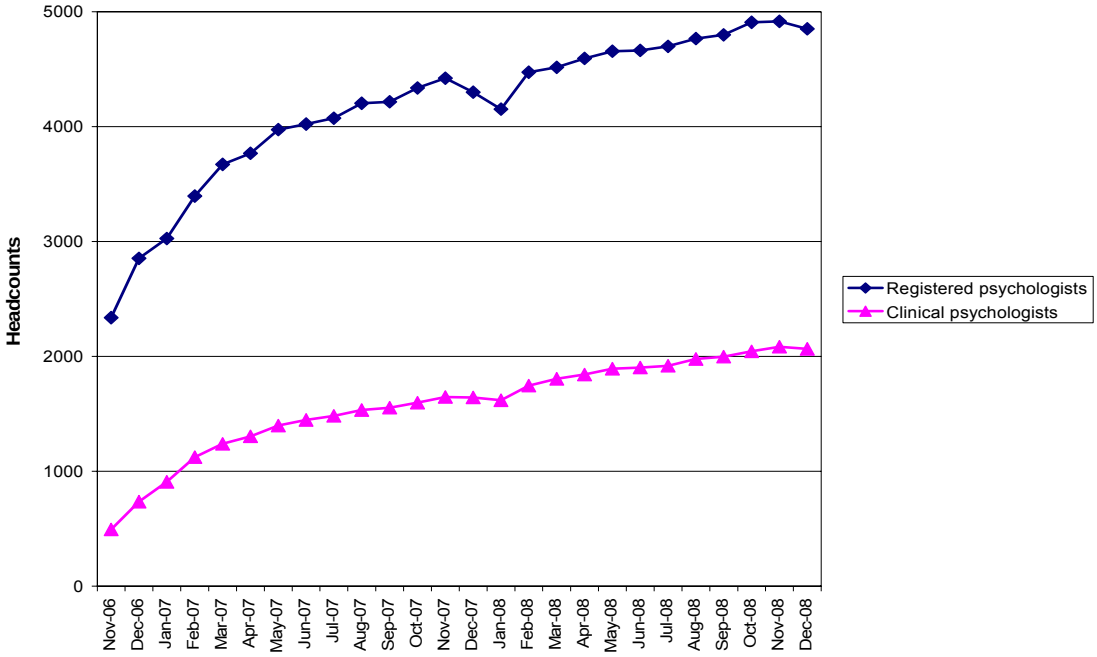
Source: Medicare Australia. 2004-08 Medicare Provider Data and Medicare Benefit Schedule (MBS) data

Registered and clinical psychology provider categories

This section provides a more detailed understanding of change in the supply of psychologists using MBS Items by differentiating between registered and clinical psychologists after the implementation of Better Access. As discussed in Section 2.1.1, some clinical psychologists provide both Focussed Psychological Strategies and Psychological Therapy Services, resulting in an exaggeration of the numbers of psychologists: that is, the number of clinical plus registered psychologists providing Better Access services is greater than the total number of Better Access psychologists. In the following analysis, MBS Item 10968 has been excluded from the estimation as it cannot be split between the two categories.

The supply of both clinical and registered psychologists into the Medicare sector has increased since the implementation of Better Access (Figure 3.36). The number of registered psychologists using MBS Items has doubled since the implementation of Better Access. Registered psychologists remain the dominant group in their use of MBS Items, accounting for between 82.5% of psychology service providers in November 2006 and 70.2% in November 2008. However, the dominance of registered psychologists has been reduced owing to the faster growing proportion of clinical psychologists using MBS Items, which went from 17.5% to about 30% over the same period. Although clinical psychology has been a smaller provider category than that of registered psychology, it has maintained a fast growing trend since November 2006, and increased by 3.2 times by November 2008.

Figure 3.36 Change in numbers of registered and clinical psychologists in the Better Access workforce since November 2006



Source: Medicare Australia. 2004-08 Medicare Provider Data and Medicare Benefit Schedule (MBS) data

The differential increase in these two provider categories is also well reflected in their average monthly growth rates, distinguishing by state, and by region (Table 3.2). The average growth rate of the total registered psychologists in the private sector was 3.1% per month over the 24-month period to December 2008. The average growth rate of clinical psychologists registered with Medicare grew to 6.2% per month over the 24-month period to November 2008. All states/territories except NT, Vic and WA experienced higher growth than the average over the same period. There is a different growth pattern between the urban and rural areas for these two psychology categories. For registered psychologists, their numbers increased at a slightly higher growth rate (3.4% per month), from a much smaller base, in rural areas than in urban areas (3.1%). In contrast, clinical psychologists increased in number at a higher rate (6.2% per month), and on a larger base, in the urban areas than in rural areas (5.9%).

The distribution of the clinical and registered psychology Medicare provider categories has been analysed using proportions. The distribution of registered psychologists across all states/territories is measured as the percentage of Medicare registered psychologists in a particular state relative to the total number (headcounts) of this workforce in the Medicare sector. As Table 3.3 illustrates, the share of registered psychologists has been relatively constant during the 25 months since implementing Better Access. Victoria and NSW together comprise two thirds of the registered psychology workforce. It is noted that the share of NSW declined by 4 percentage points from 35.9% in November 2006 to 31.5% in November 2008.

Table 3.2 Growth in numbers and average growth rates (%) of psychologists in the private (Better Access) workforce 2006-2008, by category, by State, by region

Registered psychologists											
	State/Territory									Region	
	Total	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	Urban	Rural
Nov-06	2,337	838	791	394	102	109	45	6	52	1,932	405
Nov-08	4,916	1548	1709	901	233	296	70	31	128	4,012	904
% average growth rate per month: Nov.2006-Nov.2008	3.1	2.6	3.3	3.5	3.5	4.3	1.9	7.1	3.8	3.1	3.4
Clinical psychologists											
	State/Territory									Region	
	Total	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	Urban	Rural
Nov-06	494	147	159	46	25	93	14	3	7	443	51
Nov-08	2,084	693	505	226	190	361	57	7	45	1881	203
% average growth rate per month: Nov.2006-Nov.2008	6.2	6.7	4.9	6.9	8.8	5.8	6.0	3.6	8.1	6.2	5.9

Source: Medicare Australia. 2004-08 Medicare Provider Data and Medicare Benefit Schedule (MBS) data

Table 3.3 Change in proportion of registered and clinical psychologists in the private (Better Access) workforce, by state, by region

Registered psychologists (%)										
	State/Territory								Region	
	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	Urban	Rural
Nov-06	35.9	33.8	16.9	4.4	4.7	1.9	0.3	2.2	82.7	17.3
Nov-07	32.0	34.5	18.0	5.3	5.7	1.6	0.5	2.4	82.0	18.0
Nov-08	31.5	34.8	18.3	4.7	6.0	1.4	0.6	2.6	81.6	18.4
Clinical psychologists (%)										
	State/Territory								Region	
	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	Urban	Rural
Nov-06	29.8	32.2	9.3	5.1	18.8	2.8	0.6	1.4	89.7	10.3
Nov-07	33.5	25.4	9.7	8.3	17.7	2.7	0.4	2.2	90.9	9.1
Nov-08	33.3	24.2	10.8	9.1	17.3	2.7	0.3	2.2	90.3	9.7

Source: Medicare Australia. 2004-08 Medicare Provider Data and Medicare Benefit Schedule (MBS) data

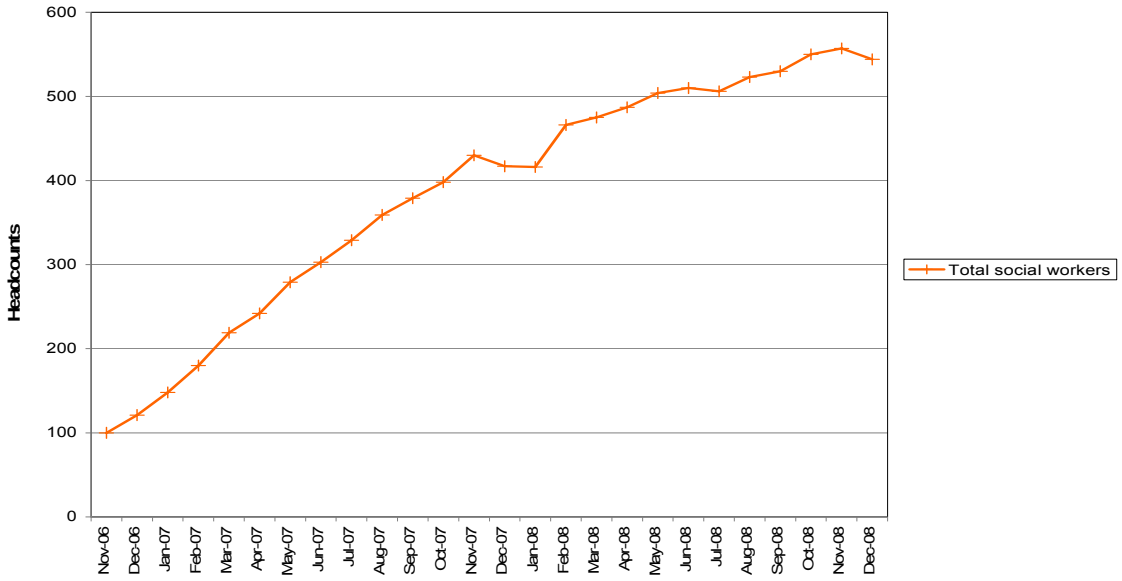
The pattern for the clinical psychology provider category has slightly more variation, especially in NSW and Victoria (Table 3.4). The proportion of clinical psychologists in NSW climbed from 30% in November 2006 to 33% by February 2007, overtaking Victoria. Since then, NSW has consistently had the largest proportion of this provider category. In contrast, the proportion in Victoria dropped by 8 percentage points over a 2-year period (from 32% in November 2006 to 24% in November 2008), with WA dropping moderately from 20% in December 2006 to 17.3% by February 2008. Surprisingly, the proportion of clinical psychologists in SA nearly doubled after one year following the implementation of Better Access, increasing from 5.1% in November 2006 to 9.1% in January 2008 where it has stayed. For the remaining states, their share of the clinical psychology provider category has remained virtually unchanged.

Both categories of psychologists are predominantly distributed in urban areas (Table 3.4). Of the registered psychologists providing Better Access services, about 82% work in the urban areas, while 18% work in rural areas. The concentration of clinical psychologists providing Better Access services is even greater than that of registered psychologists. About 90% of clinical psychologists work in the urban areas, with a small proportion (10%) of them providing services in rural areas.

3.2.2 Social Work

Social workers could only register with Medicare after the implementation of the Better Access initiative. As shown in Figure 3.37, this workforce has been steadily growing over the two year period, with the exception of a small reduction in January 2008.

Figure 3.37 Change in total numbers of social workers using Better Access, 2006-2008



Source: Medicare Australia. 2004-08 Medicare Provider Data and Medicare Benefit Schedule (MBS) data

Increases in numbers of social workers using Better Access are greater in NSW and Victoria and in the capital cities and other metropolitan areas, compared to other states or rural areas

Table 3.4 Change in proportion (%) of social workers in the private (Medicare) workforce 2006-2008, by state/territory, by region

	State/Territory									Region	
	Total headcounts	NSW (%)	VIC (%)	QLD (%)	SA (%)	WA (%)	TAS (%)	NT (%)	ACT (%)	Urban (%)	Rural (%)
Nov-06	100	45.0	28.0	14.0	6.0	7.0	0.0	0.0	0.0	78.0	22.0
Nov-07	430	30.2	35.8	16.7	6.3	7.7	2.3	0.5	0.5	78.6	21.4
Nov-08	557	29.1	38.4	15.3	6.5	7.4	2.3	0.4	0.9	78.3	21.3

Source: Medicare Australia. 2004-08 Medicare Provider Data and Medicare Benefit Schedule (MBS) data

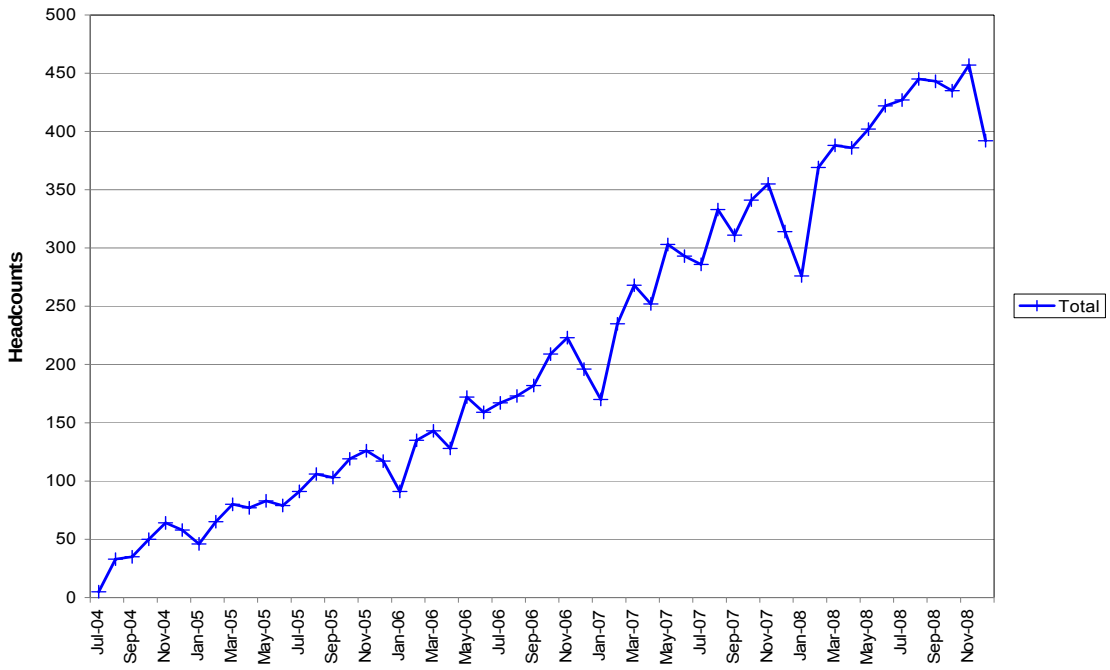
(Table 3.4). Major changes in the proportional distribution of the social work workforce occurred in two states (NSW, Victoria). The proportion of the social work workforce in Victoria increased from 28% (in November 2006) to 38.4% (in November 2008). In contrast, the proportion in NSW decreased from 45% to 29.1% over the same period. The proportions in the states of Qld, SA and WA remained almost unchanged.

More than three quarters of the social workers in the private sector are distributed in the urban areas, while the remaining services in rural areas (Table 3.4). The pattern of distribution of social workers registered with Medicare between the urban and rural areas were quite stable over the two-year period of implementing the Better Access initiative.

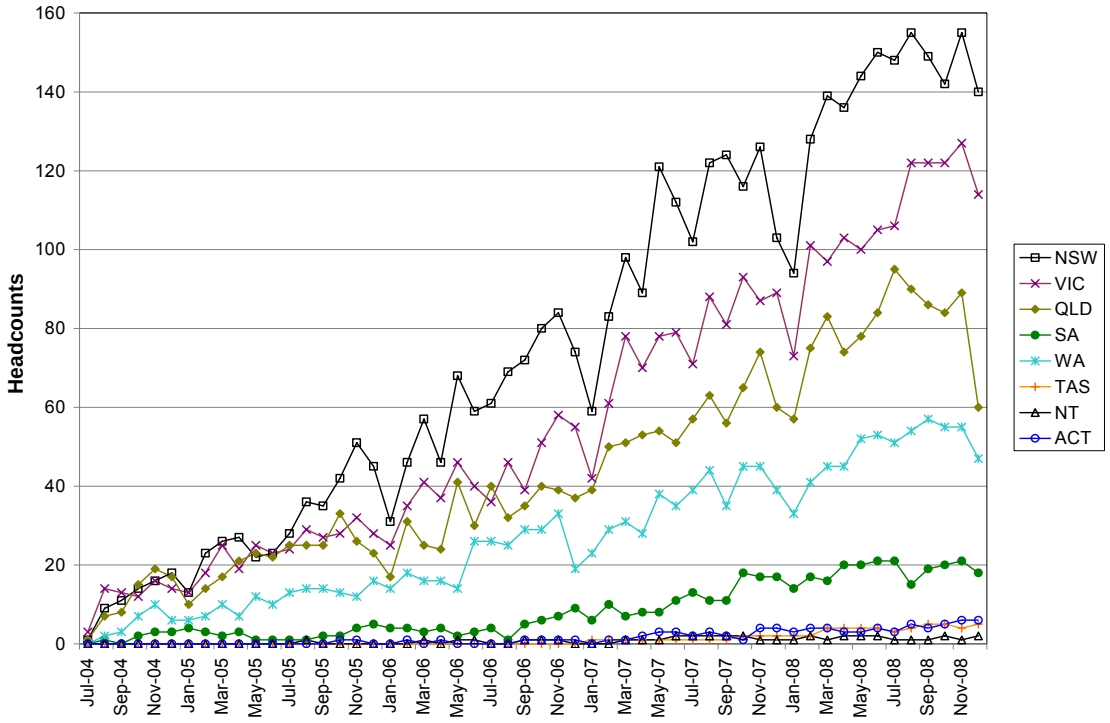
3.2.3 Occupational Therapy

Before November 2006, Medicare services provided by occupational therapists (OTs) were reported under Item 10958, which was still in use as at December 2008. Since November 2006, five new MBS Items have been introduced as part of Better Access. The OT workforce registered with Medicare is fairly small: having just five persons in July 2004. This number increased to 209 persons by October 2006, just prior to the commencement of Better Access (Figure 3.38a). By November 2008 this workforce totalled 457 persons - this includes OTs providing Better Access services and those providing services under MBS Item 10958. There is considerable variation in the supply of OTs providing MBS services across states/territories and between regions (Figure 3.38b, Figure 3.38c). In December 2008, for example, there was a difference of 174.7% between the state with the lowest and the state with the highest numbers in the private (Medicare) OT workforce.

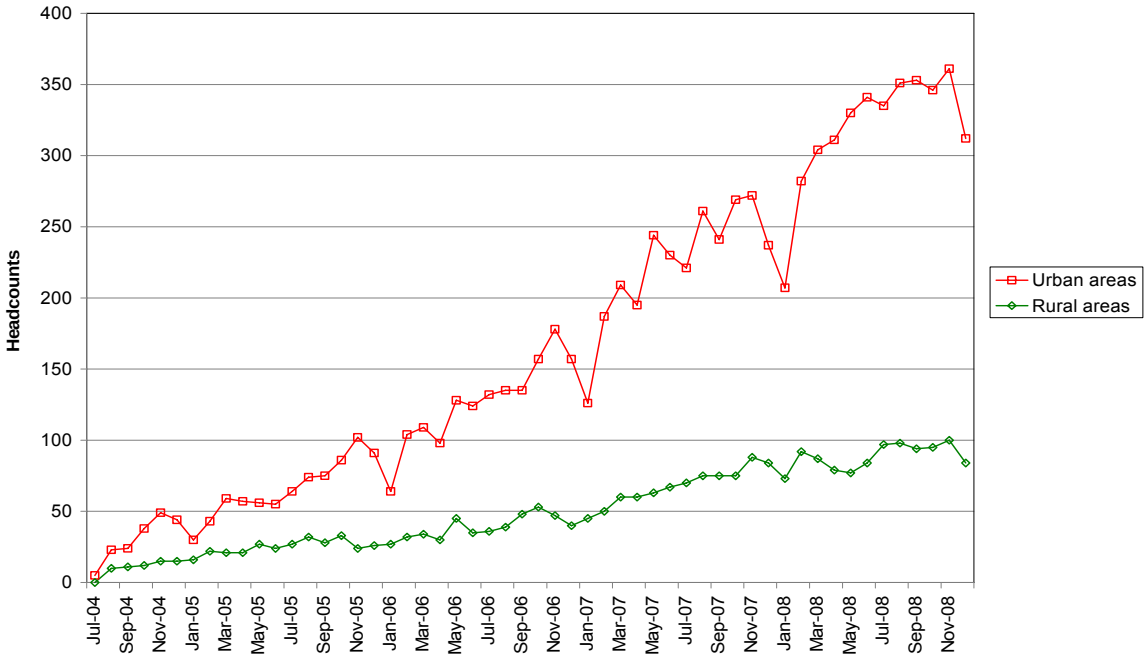
Figure 3.38 Change in total numbers of occupational therapists 2004-2008, (a) total, by (b) state/territory, and by (c) region



a. Total



b. By state/territory



c. By region

Source: Medicare Australia. 2004-08 Medicare Provider Data and Medicare Benefit Schedule (MBS) data

The extent to which Better Access has impacted on the supply of OTs into Medicare sector was indicated by change in the proportion of this workforce among states/territories and between regions (Table 3.5). OTs have disproportionately provided Better Access mental health services to people in the four large states: NSW, Victoria, Queensland and WA.

Table 3.5 Change in proportion of occupational therapists in the private (Medicare) workforce, 2004-2008, by state/territory, by region

	State/Territory									Region	
	Total headcounts	NSW (%)	VIC (%)	QLD (%)	SA (%)	WA (%)	TAS (%)	NT (%)	ACT (%)	Urban (%)	Rural (%)
Nov-04	64	25.0	25.0	29.7	4.7	15.6	0.0	0.0	0.0	76.6	23.4
Nov-05	126	40.5	25.4	20.6	3.2	9.5	0.0	0.0	0.8	81.0	19.0
Nov-06	223	37.7	26.0	17.5	3.1	14.8	0.0	0.4	0.4	79.8	21.1
Nov-07	355	35.5	24.5	20.8	4.8	12.7	0.6	0.3	1.1	76.6	24.8
Nov-08	457	33.9	27.8	19.5	4.6	12.0	0.9	0.2	1.3	79.0	21.9

Source: Medicare Australia. 2004-08 Medicare Provider Data and Medicare Benefit Schedule (MBS) data

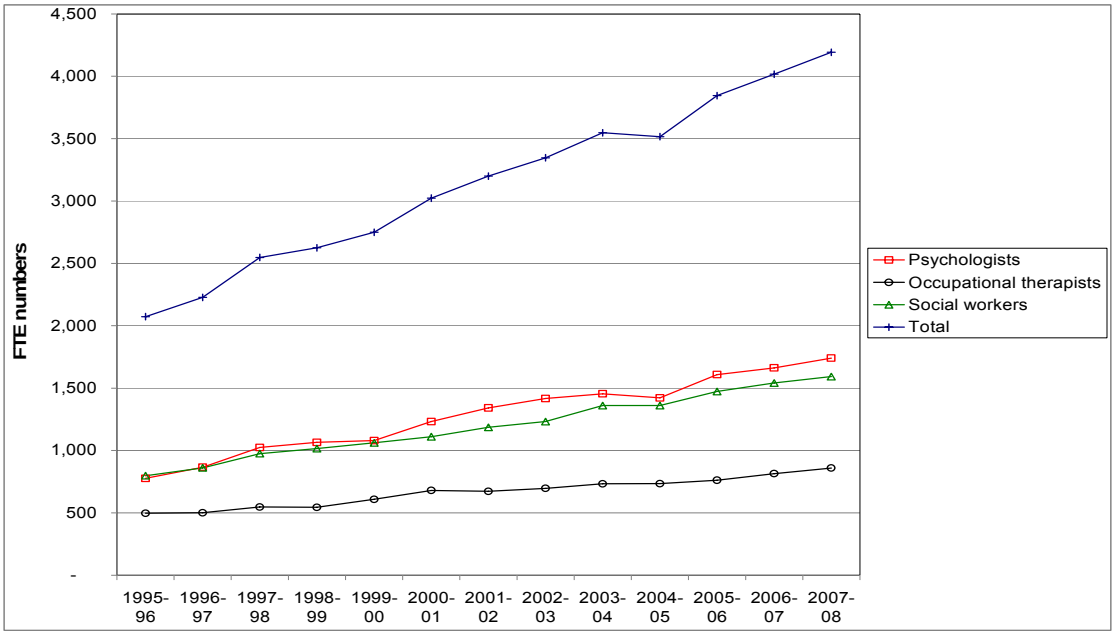
Yet the degree of concentration of this workforce decreased slightly from an overall proportion 96% prior to implementing the Better Access initiative to 93% right after implementing the Better Access. There was variation in the OT workforce among these four states. For instance, the proportions for NSW and WA presented a downward trend, while they did not vary much in Victoria and Queensland.

Approximately 80% of the OT workforce registered with Medicare provided MBS services to people residing in capital cities and other metropolitan areas. This distributional concentration of OTs in the urban areas is consistent with the national population distribution. The Better Access initiative has significantly stimulated the supply of this workforce in both urban and regional areas, but there has been no apparent trend of change in the workforce distribution between the two broad geographical regions.

3.3 Distribution of the Allied Mental Health Workforce in the Public Sector, 1995-2008

The overall picture of change since the mid 1990s in total FTE numbers in the public sector allied mental health workforce, distinguishing between psychologists, OTs and social workers is presented in Figure 3.39. Overall, the FTE allied mental health workforce doubled over the 13-year period to 2007-08, amounting to 4,192 FTE persons in 2007-08. The biggest component of and the largest growth in the allied mental health workforce is the psychology category. There was an overall net growth of 2,120 FTE persons of the allied mental health workforce into the public sector during this period. The increased psychology workforce comprises nearly half (45.5%) of the total net growth in the allied mental health workforce in the public sector, while the social work category accounted for over one third (37.5%) of the total net growth.

Figure 3.39 Change in total FTE numbers of Psychologists, Occupational Therapists, Social Workers in the public sector, 1995-96 to 2007-08



Sources: Mental Health Establishments: National Minimum Data Set, 2006-2008,

National Survey of Mental Health Services 1996-2005

Table 3.6 Change in growth rates (%) of allied mental health workforce in public sector, by state, 1995-96 to 2007-08

	FTE psychologists		FTE occupational therapists		FTE social workers	
	Average growth rate (%): 1995-96 to 2005-06	Growth rate per annum (%): 2006-07 to 2007-08	Average growth rate (%): 1995-96 to 2005-06	Growth rate per annum (%): 2006-07 to 2007-08	Average growth rate (%): 1995-96 to 2005-06	Growth rate per annum (%): 2006-07 to 2007-08
NSW	7.6	6.6	3.3	3.6	6.0	-10.1
VIC	7.7	-8.5	5.5	-3.6	8.0	3.6
QLD	9.0	16.6	7.6	15.6	7.4	12.3
SA	3.9	27.0	1.7	22.3	4.6	14.1
WA	6.8	-5.9	2.4	10.2	6.7	2.7
TAS	1.4	-9.5	3.3	-24.6	-3.5	-6.8
NT	2.9	1.1	0.0	64.0	0.0	16.5
ACT	12.6	-23.9	9.8	20.0	2.4	16.6
Total	7.6	4.5	4.4	5.6	6.3	3.3

Sources: Mental Health Establishments: National Minimum Data Set, 2006-2008,

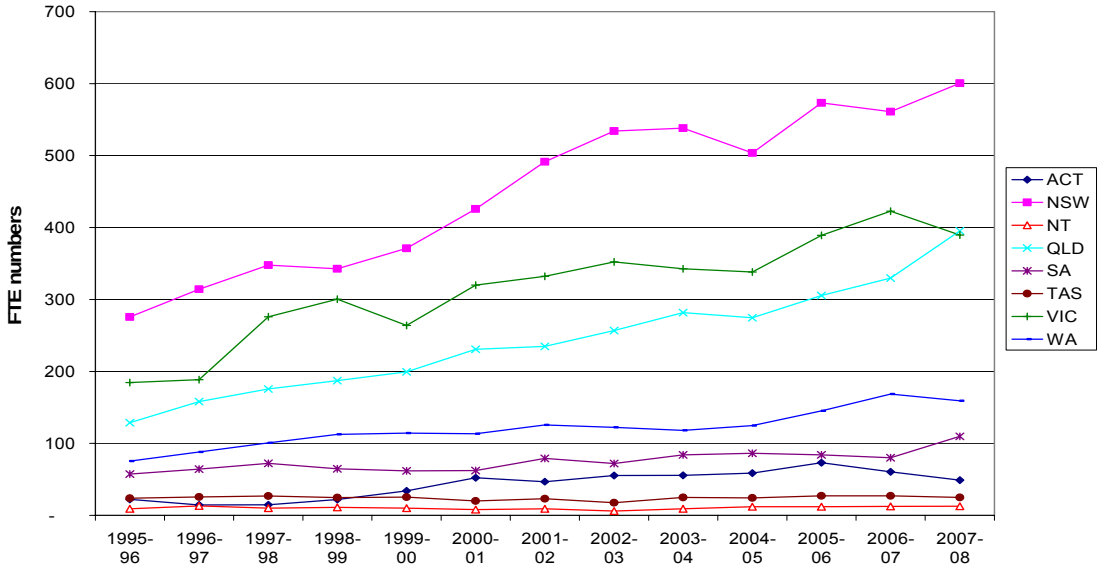
National Survey of Mental Health Services 1996-2005

Differences in the changes in the three occupational categories, before and after Better Access, are reflected in the change in the average growth rates per annum (Table 3.6). For example, during the decade prior to Better Access, the biggest average growth rate was in the psychology category, at 7.6% per annum, followed by social workers, at an average rate 6.3% per annum. Since the implementation of Better Access, growth (by 5.6%) has occurred in the OT category.

3.3.1 Psychology

An analysis of trends in the public FTE psychology workforce by state and territory shows that NSW, Victoria and Queensland have maintained an overall growing trend in psychologists in the public sector over time (Figure 3.40). In the remaining states/territories, the increase in the sizes or FTE numbers of this workforce has been minimal, or virtually non-existent. Since 2005-06, there has been very little change in the number of public FTE psychologists for Victoria and WA, while NSW, Queensland and SA continued an upward trend.

Figure 3.40 Trends in the distribution of FTE psychologists in the public allied mental health workforce, by state, 1995-96 to 2007-08



Sources: Mental Health Establishments: National Minimum Data Set, 2006-2008,

National Survey of Mental Health Services 1996-2005

The psychology workforce in the public sector has been consistently concentrated in three major states – NSW, Victoria and Queensland – since the mid-1990s. Almost 80% of psychologists work in these states. The impact of Better Access appeared to be greater for the states of Victoria, Queensland and SA than for the remaining states/territories (Table 3.7). For example, the proportion of psychologists working in Victoria declined by 3 percentage points to 22.4% within a year of implementing Better Access. In contrast, the proportion of FTE psychology numbers in Queensland increased by 3 percentage points to 22.7% in 2007-08. SA also increased its share of psychologists by 1.5 percentage points to 6.3% in 2007-08, but this growth was from a small base.

Table 3.7 Change in proportion (%) of psychology workforce in the public sector before and after implementing Better Access, by state/territory

	NSW (%)	VIC (%)	QLD (%)	SA (%)	WA (%)	TAS (%)	NT (%)	ACT (%)	Total (%)	Total (FTE persons)
1995-96	35.5	23.8	16.6	7.4	9.7	3.0	1.2	2.9	100.0	777
1996-97	36.3	21.8	18.2	7.4	10.2	3.0	1.5	1.7	100.0	866
1997-98	34.0	26.9	17.2	7.1	9.8	2.6	1.0	1.4	100.0	1024
1998-99	32.2	28.2	17.6	6.1	10.6	2.3	1.0	2.1	100.0	1065
1999-00	34.4	24.4	18.5	5.7	10.6	2.3	0.9	3.1	100.0	1080
2000-01	34.5	26.0	18.7	5.0	9.2	1.6	0.6	4.2	100.0	1232
2001-02	36.6	24.8	17.5	5.9	9.4	1.7	0.7	3.5	100.0	1342
2002-03	37.7	24.9	18.1	5.1	8.6	1.2	0.4	3.9	100.0	1417
2003-04	37.0	23.6	19.4	5.8	8.1	1.7	0.6	3.8	100.0	1454
2004-05	35.4	23.8	19.3	6.1	8.8	1.7	0.8	4.1	100.0	1422
2005-06	35.6	24.2	19.0	5.2	9.0	1.7	0.7	4.5	100.0	1609
2006-07	33.8	25.4	19.8	4.8	10.1	1.6	0.7	3.6	100.0	1662
2007-08	34.5	22.4	22.7	6.3	9.1	1.4	0.7	2.8	100.0	1741

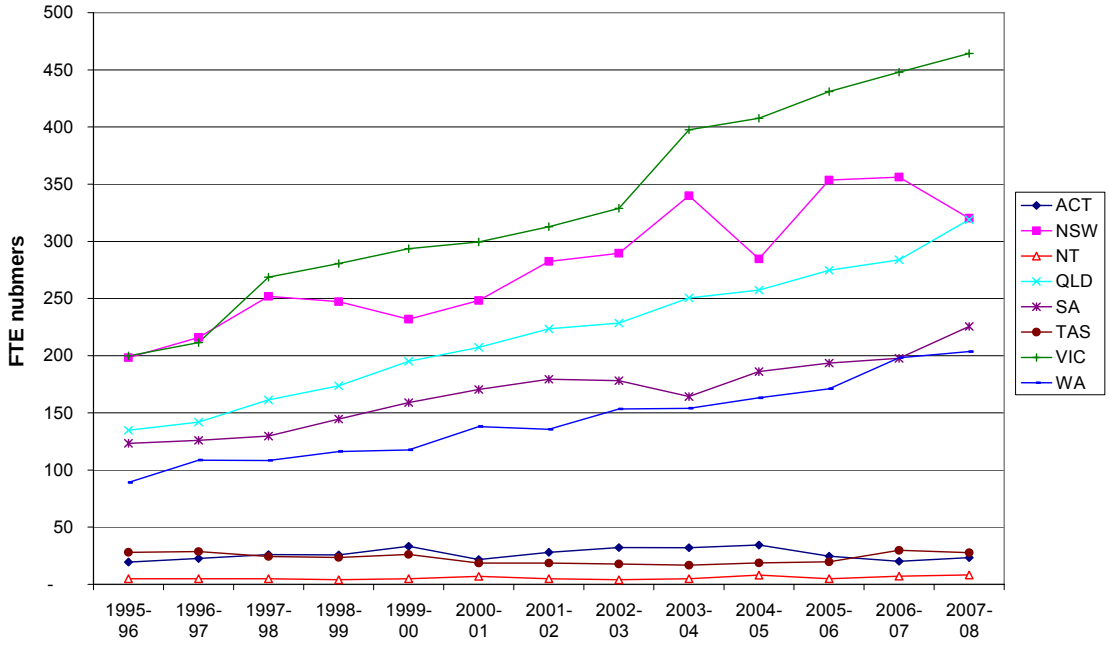
Sources: Mental Health Establishments: National Minimum Data Set, 2006-2008,

National Survey of Mental Health Services 1996-2005

3.3.2 Social Work

In the public allied mental health workforce, the FTE numbers of social workers in all mainland states have increased since 1995-96 (Figure 3.41). Numbers in the ACT, NT and Tasmania have remained relatively static. Victoria and NSW have the majority of public sector social workers however, the trend in NSW has fluctuated more with there being virtually no overall increase since 2003-04. By 2007-08 the FTE social work workforce in Queensland had more than doubled (since 1995-96) and was the same size as that in NSW. Both SA and WA have experienced a growth period since 2003-04.

Figure 3.41 Trends in the distribution of FTE social workers in the public allied mental health workforce, by state/territory, 1995-96 to 2007-08



Sources: Mental Health Establishments: National Minimum Data Set, 2006-2008,

National Survey of Mental Health Services 1996-2005

Major changes in the proportional distribution of the social work workforce among all states/territories occurred in three large states of NSW, Vic and Qld. Before the implementation of the Better Access initiative in November 2006, nearly one quarter of allied mental health social workers were employed by the public sector in NSW (Table 3.8). However in NSW the share dropped by 3 percentage points to 20% in 2007-08 within 2 years of implementing Better Access. In contrast, Victoria steadily increased its share of this workforce over the decade prior to the implementation of the Better Access, and since then its share has stayed at 29%. Similarly, the share of this category of allied mental health workforce in Qld persistently increased during the 10-year period before the Better Access. This growing trend has been sustained since the Better Access initiative, with a share standing at 20% in 2007-08. Note that the declining trend in the share of the social work workforce in SA was halted due to the Better Access initiative.

Table 3.8 Change in proportion (%) of social work workforce in the public sector before and after implementing Better Access, by state/territory, 1995-96 to 2007-08

	NSW (%)	VIC (%)	QLD (%)	SA (%)	WA (%)	TAS (%)	NT (%)	ACT (%)	Total (%)	Total (FTE persons)
1995-96	24.8	25.1	16.9	15.5	11.2	3.5	0.6	2.4	100.0	798
1996-97	25.1	24.6	16.5	14.6	12.6	3.3	0.6	2.6	100.0	860
1997-98	25.8	27.5	16.5	13.3	11.1	2.5	0.5	2.7	100.0	975
1998-99	24.3	27.6	17.1	14.2	11.4	2.3	0.4	2.5	100.0	1016
1999-00	21.8	27.7	18.4	15.0	11.1	2.5	0.5	3.1	100.0	1062
2000-01	22.3	27.0	18.7	15.3	12.4	1.7	0.6	2.0	100.0	1111
2001-02	23.8	26.4	18.9	15.1	11.4	1.6	0.4	2.4	100.0	1185
2002-03	23.5	26.7	18.5	14.5	12.4	1.4	0.3	2.6	100.0	1233
2003-04	25.0	29.2	18.4	12.1	11.3	1.2	0.4	2.4	100.0	1360
2004-05	20.9	30.0	18.9	13.7	12.0	1.4	0.6	2.5	100.0	1360
2005-06	24.0	29.3	18.6	13.1	11.6	1.3	0.3	1.7	100.0	1474
2006-07	23.1	29.1	18.4	12.8	12.9	1.9	0.5	1.3	100.0	1541
2007-08	20.1	29.2	20.0	14.2	12.8	1.7	0.5	1.5	100.0	1592

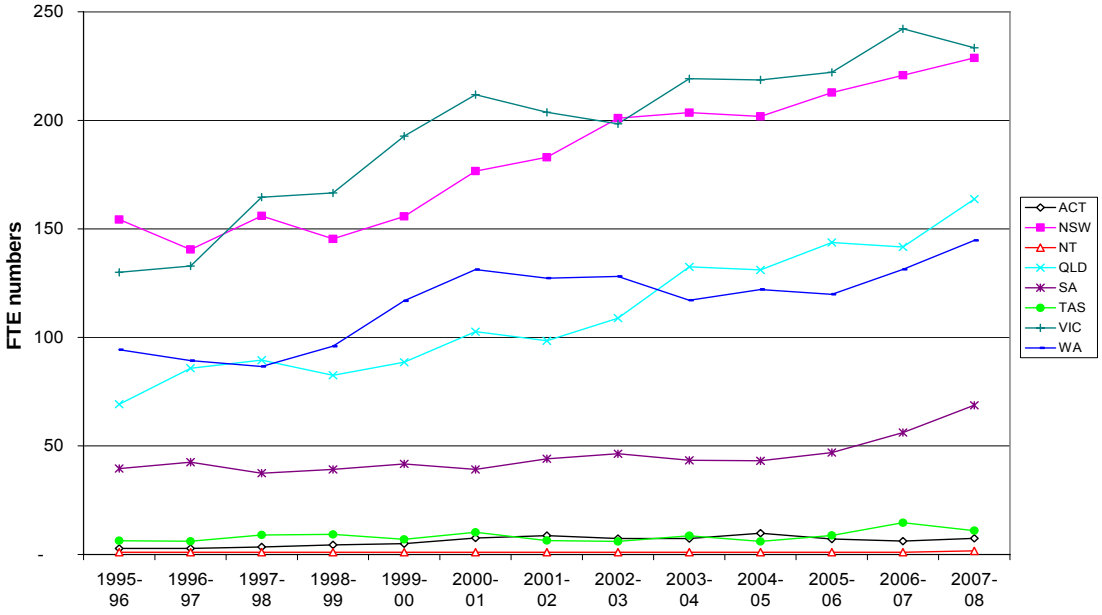
Sources: Mental Health Establishments: National Minimum Data Set, 2006-2008,

National Survey of Mental Health Services 1996-2005

3.3.3 Occupational Therapy

At the national level the supply in FTE numbers of OTs in the public sector has gradually increased since the mid-1990s from 498 FTE persons in 1994-95 to its highest level (859 FTE persons) in 2007-08. As illustrated in Figure 3.42, at the state/territory level there are fluctuations in the numbers of OTs in the public sector allied mental health workforce. In general, the four large states of Victoria, NSW, Queensland and WA have maintained a growing momentum in the supply of this workforce since the mid-1990s. The implementation of Better Access has sustained the growing numbers of OTs in the states of NSW, Queensland, WA and SA, while the stock numbers in Victoria decreased. The implementation of Better Access has not changed the numbers of occupational therapists in the public sector in the small states/territories including Tasmania, ACT and NT.

Figure 3.42 Trends in the distribution of FTE occupational therapists in the public allied mental health workforce, by state/territory, 1995-96 to 2007-08



Sources: Mental Health Establishments: National Minimum Data Set, 2006-2008,

National Survey of Mental Health Services 1996-2005

NSW and Victoria have more than half of the FTE number of occupational therapists, while Queensland has had a period of strong growth (Table 3.9). Since the implementation of Better Access, SA, WA and NSW have maintained their shares of the public sector occupational therapy workforce. Queensland has strengthened their rate of increase, while both the numbers and shares of FTE occupational therapists in Victoria and Tasmania have decreased.

Table 3.9 Change in proportion (%) of occupational therapy workforce in the public sector 1995-96 to 2007-08, by state/territory

	NSW (%)	VIC (%)	QLD (%)	SA (%)	WA (%)	TAS (%)	NT (%)	ACT (%)	Total (%)	Total (FTE persons)
1995-96	31.0	26.1	13.9	7.9	19.0	1.3	0.2	0.6	100.0	498
1996-97	28.0	26.5	17.1	8.5	17.8	1.2	0.2	0.6	100.0	501
1997-98	28.5	30.1	16.3	6.8	15.8	1.6	0.2	0.6	100.0	548
1998-99	26.7	30.6	15.2	7.2	17.6	1.7	0.2	0.8	100.0	544
1999-00	25.6	31.7	14.6	6.9	19.2	1.1	0.2	0.8	100.0	608
2000-01	26.0	31.1	15.1	5.8	19.3	1.5	0.1	1.1	100.0	680
2001-02	27.2	30.3	14.6	6.6	18.9	1.0	0.1	1.3	100.0	673
2002-03	28.8	28.5	15.6	6.7	18.4	0.9	0.1	1.1	100.0	697
2003-04	27.8	29.9	18.1	5.9	16.0	1.2	0.1	1.0	100.0	733
2004-05	27.5	29.8	17.9	5.9	16.6	0.8	0.1	1.3	100.0	734
2005-06	27.9	29.1	18.9	6.2	15.7	1.2	0.1	0.9	100.0	762
2006-07	27.1	29.8	17.4	6.9	16.1	1.8	0.1	0.8	100.0	814
2007-08	26.6	27.2	19.1	8.0	16.8	1.3	0.2	0.9	100.0	859

Sources: Mental Health Establishments: National Minimum Data Set, 2006-2008,

National Survey of Mental Health Services 1996-2005

3.4 Proportion of the private (Medicare) allied mental health workforce relative to the total potential allied mental health workforce in Australia

Since the commencement of Better Access there has clearly been an upward trend in the proportions of the total numbers (headcounts) of psychologists providing MBS services relative to the total potential psychology workforce in Australia, based on registration board data[27] (Table 3.11, next page). There are a couple of interesting features when comparing these workforces across time. Firstly, numbers in the potential Better Access psychology workforce have been increasing over time as indicated in the change in the proportions across three points of time. Secondly, the relative proportions of the psychology workforce in the private (Medicare) sector have increased substantially and rapidly over a short period since the implementation of Better Access. Specifically, one third of the potential Better Access psychology workforce in Victoria and SA were registered with Medicare (and using MBS Items) by June 2008. In WA and ACT, one in five psychologists were registered with Medicare. The proportions rise to between 20% and 35% by June 2008.

For social workers, the proportion providing Medicare services relative to the maximum potential supply of social workers in the country increased significantly, climbing to 9.5% by December 2008 (Table 3.12, next page).[28] By December 2008 the proportion of this workforce in Vic and NSW were greater than the national average, at 13.6% and 10.7% respectively. In contrast, the proportions of this workforce in the other states/territories were much smaller than the national average.

Data on the potential OT workforce were available for three states: Queensland, SA and WA. Despite data constraints, information about the OT workforce from these three states helps us to understand the extent to which OTs register with Medicare and use MBS Items. The maximum supply of the potential workforce has increased in all of these states since the implementation of Better Access (Table 3.10). A prominent feature of this workforce is that the proportion of OTs that are registered with Medicare against the potential workforce is very small, being less than 4% of the total potential workforce in each state (June 2008).

Table 3.10 Proportion of OTs registered with Medicare against the potential OT workforce (headcounts), 2006-2008

	QLD		SA		WA	
	Headcounts	%	Headcounts	%	Headcounts	%
Jun-06	1997	1.5	788	0.4	1463	0.8
Jun-07	2143	2.4	728	1.5	1542	2.3
Jun-08	2172	3.9	783	2.7	1575	3.4

Sources: Medicare Australia. 2006-08 Medicare Provider Data and Medicare Benefit Schedule (MBS) data

State/territory Occupational Therapy Registration Boards data, 2006-2008

[27] The same categories of registration board data were used for calculations in this section, as was used in Section 2.2.1. See Table 1.5 for categories and Table 2.3 for numbers.

[28] Note that the numbers used to calculate the potential Better Access social work workforce are the numbers registered with AASW, not those with mental health accreditation. The AASW membership numbers were the only ones provided that could be disaggregated by state/territory.

Table 3.11 Proportion of psychologists registered with Medicare against the potential psychology workforce (headcounts), 2006-2008

	Total potential psychology workforce		NSW		Vic		Qld		SA		WA		Tas		ACT	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Jun-06	21716	5.9	7716	6.6	5731	7.3	3154	6.7	1070	3.4	2878	2.1	448	5.4	719	2.6
Jun-07	22912	24.1	8140	21.9	5988	30.3	3416	25.3	1136	28.9	3002	15.9	457	21.4	773	16.8
Jun-08	23708	27.8	8513	25.1	6215	34.0	3484	29.7	1192	32.9	3061	19.9	468	25.4	775	20.9

Sources: Medicare Australia. 2006-08 Medicare Provider Data and Medicare Benefit Schedule (MBS) data

State/territory Psychology Registration Boards data, 2006-2008

Table 3.12 Proportion of social workers registered with Medicare against the potential social worker workforce (headcounts), 2006-2008

	Total potential social work workforce		NSW		Vic		Qld		SA		WA		Tas		ACT		NT	
	No.	%	No.	%	No	%	No	%	No	%	No	%	No	%	No	%	No	%
Dec-06	5791	2.1	1606	2.9	1659	2.0	1173	1.9	521	1.0	751	1.6	81	0.5	203	0.0	81	0.0
Dec-07	5862	7.1	1558	8.1	1639	9.3	1205	5.7	515	5.2	660	4.1	84	5.9	203	1.5	94	2.4
Dec-08	5714	9.5	1481	10.7	1546	13.6	1144	7.1	469	7.5	626	6.4	79	6.2	196	2.6	79	3.8

Source: Medicare Australia. 2006-08 Medicare Provider Data and Medicare Benefit Schedule (MBS) data: Servicing Provider Data.

Unpublished data, Australian Association of Social Workers, 2006-2008

3.5 Summary

This chapter examined the impact of Better Access on the distribution of the allied mental health workforce (psychologists, social workers and occupational therapists). Three aspects of the distribution of this workforce were examined: across the public – private sectors; across states / territories; and the distribution between capital cities and outside of capital city areas.

The analysis of the distribution of the allied mental health workforce was limited by the available data in two ways. Firstly, comprehensive data for the private allied mental health sector was not available for analysis. In the absence of this data, we were only able to comment on the distribution of allied mental health professionals in the private (Medicare) and private (Better Access) sectors. It is recognized that there are allied mental health professionals that work outside of the Medicare sector. Secondly, the analysis did not allow for causal relationships to be established. That is, we cannot say that changes in the distribution of the allied mental health workforce in the public sector or geographically were *caused* by the implementation of Better Access. Consequently, while changes since the implementation of Better Access are reported, no causal relationship is inferred.

Overall, since the implementation of Better Access there have been increases in the numbers of allied mental health professionals (headcount and FTE/DFTE) in each of the occupational groups in both the private (Medicare) and public sectors. In summarising the distribution in each of the allied mental health occupations, we have placed changes since the implementation of Better Access in the context of longer term trends.

Psychologists

Psychologists formed the largest component of the public allied mental health workforce, and accounted for the highest rate of growth in this workforce over the 13 year period to 2007-08. During this period, the public sector psychology workforce more than doubled from 777 to 1741 FTE persons, which was 45.5% of total growth in the public sector allied mental health workforce. Most of the growth in the public sector psychology workforce was in NSW, Victoria and Queensland, with there being minimal or no change in the remaining states/territories. The average rate of growth in the public sector psychology workforce prior to Better Access was 7.6% p.a., which fell to 4.5% p.a. after the implementation.

Approximately 65% of all psychologists worked in the private sector in 2006, just prior to the implementation of Better Access (ABS Census 2006). Psychologists have had access to Medicare since July 2004, and there were already 1,429 psychologists registered in the private (Medicare) workforce before the implementation of Better Access. The growth rate in the numbers of psychologists registering for Medicare increased from a monthly average of 2.4% prior to Better Access to 3.4% thereafter. There were differences between the two psychology provider categories. While there were more registered psychologists, the proportion of psychology services they provided fell from 82.5% in November 2006 to 70.2% by November 2008. Clinical psychologists in the private (Medicare) workforce grew at a rate of 6.2% per month over this period, compared to 3.1% for registered psychologists. By June 2008, 27.8% of the psychology workforce (based on registration board data) was in the private (Medicare) workforce.

Since the implementation of Better Access the number (headcount) of psychologists providing Better Access services increased from 3688 (December 2006) to 8088 (December 2008). This equated to an increase from 214 to 1,308 DFTE psychologists. There was an increase in the private (Better Access) psychology workforce in every state and territory, with the highest rates of growth being in SA, ACT and WA.

There has also been an increase in the public sector psychology workforce since the implementation of Better Access. However there were differences across states/territories with Victoria remaining virtually unchanged and decreases recorded in Tasmania and the ACT. The highest rates of growth in this workforce were in SA, Queensland and WA. Notably, by December 2008 Victoria and Tasmania had more DFTE psychologists in the private (Better Access) workforce than in the public sector workforce.

Changes in the geographic distribution of the public and private (Better Access) psychology workforce working in capital cities and non-capital city areas varied across states. Since the implementation of Better Access, the public sector psychology workforce decreased outside of capital city areas in Victoria and WA; and increased outside of capital city areas in Queensland. Changes in NSW and SA were relatively evenly distributed across geographical categories, while the workforce in Tasmania, ACT and NT was too small to comment.

Social Workers

Over the 13 year period to 2007-08, the public sector social work workforce doubled, increasing from 798 to 1592 FTE persons. This accounted for 37.5% of the total net growth in the public sector allied mental health workforce, 1995-96 to 2007-08. The increase in the public sector social work workforce occurred in all mainland states, with Tasmania, ACT and NT remaining relatively static. The average rate of growth prior to the implementation of Better Access was 6.3% p.a., which fell to 3.3% p.a. after the implementation.

Approximately 53% of the social work workforce was in the private sector prior in 2006, just before the implementation of Better Access (ABS Census 2006). In contrast to psychologists and OTs, social workers could not register with Medicare until the Better Access initiative. The private (Medicare) workforce is therefore the same as the private (Better Access) workforce. The proportion of social workers (based on professional association data) registered with Medicare rose from 2.1% in December 2006 to 9.5% in December 2008.

Since the implementation of Better Access the number of social workers in the private (Better Access) workforce has increased from 126 (Dec 2006) to 646 (Dec 2008). This equated to an increase from 5 to 61 DFTE social workers. Increases were recorded in every state and territory, with the highest rates of growth being in Victoria, SA and Tasmania.

The overall trend in the public sector social work workforce has also been one of growth since the implementation of Better Access. There were, however, state differences. Tasmania, WA and NT recorded the highest growth rates, while NSW and ACT experienced an overall decline in the number of FTE social workers in the public sector.

Changes in the geographic distribution of the public and private (Better Access) social work workforce indicated that it increased at a higher rate in non-capital city areas than it did in capital cities.

Occupational Therapists

Over the 13 year period to 2007-08, the public sector OT workforce has gradually increased from 498 to 859 FTE persons. Growth in this workforce was strongest in Queensland, NSW and Victoria. The average rate of growth prior to the implementation of Better Access was 4.4% p.a., which rose to 5.6% p.a. thereafter. The OT workforce was the only allied mental health occupation in the public sector to increase its rate of growth following the implementation of Better Access.

Approximately 54% of the OT workforce was in the private sector in 2006, just prior to the implementation of Better Access. Occupational therapists have had access to Medicare since July 2004, with there being 209 persons registered in the month prior to the implementation of Better Access, growing to 457 persons by December 2008. During this time NSW and Victoria increased their proportion of OTs in the private (Medicare) workforce. In contrast to the psychology workforce, the OT workforce registered with Medicare fluctuated markedly from month to month, with the fluctuations reflected across the states. By 2008 the proportion of OTs (based on available registration board data) registered with Medicare ranged from 2.7% in SA to 3.9% in Queensland.

Since the implementation of Better Access the number of OTs in the private (Better Access) workforce increased from 23 in December 2006, to 172 in December 2008. This equated to an increase from 0.4 to 12.6 DFTE occupational therapists. The increase was recorded across all states and territories.

The overall trend in the public sector OT workforce has been one of growth since the implementation of Better Access. The increase in FTE persons did, however, fluctuate over the two years with Queensland and ACT having negative growth in the first year and Victoria and Tasmania having negative growth in the second year.

Changes in the geographic distribution of the public and private (Better Access) OT workforce indicated that it grew at a faster rate in capital cities compared to non-capital city areas over the two year period.