

The Case for Mental Health Reform in Australia: a Review of Expenditure and System Design

Executive Summary



© 2013 Medibank Private Limited and Nous Group.
Medibank Private Limited ABN 47 080 890 259

About Medibank

Medibank is Australia's largest provider of private health insurance and health solutions. Medibank has insured the health of Australians since our inception in 1976 and, under our Medibank and ahm brands, we provide cover to over 3.7 million people. Each year we purchase billions of dollars worth of hospital and allied health services and deliver almost 600,000 clinical care episodes, helping millions of Australians live healthier, fuller lives. At Medibank, we stand For Better Health.

Contents

Key findings	2
Overview of report	4
1. Governments have given substantially more policy attention and funding to mental health since the early 1990s	5
2. The critical issue in mental health is system design	7
3. Total direct expenditure on supporting people with a mental illness in Australia far exceeds that previously estimated	9
4. Mental health outcomes in Australia are sub-optimal	12
5. Selected reform models in Australia and internationally suggest key elements of a successful overall service system	14
6. Australia has an unprecedented opportunity to lead the world in end-to-end mental health system redesign to deliver better outcomes at the same or lower cost	18
References	19

The full report and companion documents can be downloaded at www.medibankhealth.com.au/Mental_Health_Reform

Key findings

Total direct expenditure on supporting people with a mental illness in Australia far exceeds that previously estimated

- Australia spends at least \$28.6 billion per year supporting people with mental illness (excluding capital expenditure).
- Direct health expenditure is at least \$13.8 billion.
- Direct non-health expenditure is at least \$14.8 billion.
- The total expenditure of \$28.6 billion is equivalent to 2.2% of Australia's Gross Domestic Product. This excludes indirect costs, such as lost productivity.

Governments have given substantially more policy attention and funding to mental health since the early 1990s

- Australian governments have made significant policy and funding commitments to improve mental health.
- The majority of expenditure on mental health is funded by governments, with the balance funded by insurers, consumers, employers, non-government organisations and other private payers.
- There has been a range of reforms in mental health. The system is also affected by broader health reforms.

The critical issue in mental health is system design

- The nature of mental illness increases the likelihood that consumers will interact frequently with multiple parts of the healthcare and broader social services (including employment services) and support payments systems. Yet the mental health, social services and support payments systems are characterised by fragmentation and insufficient coordination.
- Mental health services, and broader non-health services and supports, are comprised of a complex network of care settings and service providers, with mixed and overlapping responsibility for service delivery, funding and expenditure.
- Poor system design compounds Australia's mental health challenges:
 - new initiatives can add complexity to an already fragmented system and fail to address the critical issue of system design
 - it is impossible to tell if Australia is spending the right amount of money to support people with mental illness and if money is being spent in the right areas (especially the appropriate mix of health and non-health support)
 - mental health outcomes are likely to be sub-optimal, leading to additional health and non-health costs, especially as mental health is the fastest growing cause of disability in Australia.

Mental health outcomes in Australia are sub-optimal

- Despite the significant expenditure and focus:
 - the prevalence of mental illness is both high and stable
 - significant numbers of mentally ill people do not seek or receive appropriate treatment
 - for those that do seek and receive treatment their needs are not consistently met and they are less satisfied with mental health services than consumers of other health services.

Selected reform models in Australia and internationally suggest key elements of a successful overall service system

- Successful whole-of-system reform is rare. Whole-of-system approaches require key enablers including integrated funding, IT and care pathways. Some of the changes are achievable in Australia; others may not be.
- For people with severe and very severe mental illness, there is evidence to support comprehensive service coordination.
- Evidence from the United States, applicable to Australia, indicates people with moderate mental illness can be successfully treated in primary care settings.
- There are promising models to improve treatment and treatment rates of people with mild mental illness, with applicability for Australia.

Australia has an unprecedented opportunity to lead the world in end-to-end mental health system redesign to deliver better outcomes at the same or lower cost

- Major system-level changes are needed to improve outcomes covering prevention to detection to diagnosis to treatment to ongoing recovery. The system needs to integrate health and non-health support and funding.
- With effective mental health service provision a continuing challenge, there is an opportunity for Australia to lead the world.
- Subsequent work from Medibank will focus on identifying and testing system-wide reforms to improve outcomes and value for money.

Overview of report

Mental illness is a significant and growing challenge for Australia.

Research consistently confirms the high prevalence of mental illness in our community and its impact on the lives of people with mental illness, their families and carers. Since the early 1990s, governments have recognised the issue and devoted increasingly focused policy efforts to address it. Major funding injections have accompanied this policy attention, to the point where it is generally recognised that governments and other funders are spending significant sums on supporting mental health in Australia, through both health and non-health expenditure. However, until now there has been no comprehensive picture of just how much is really being spent.

The accompanying full report, *The Case for Mental Health Reform in Australia: a Review of Expenditure and System Design* (henceforth “the report”), develops that comprehensive picture. It calculates total direct expenditure, both health and non-health, on supporting people with mental illness in Australia and examines the limited available knowledge of system wide outcomes that this funding supports.

The report notes that, despite the significant policy attention and substantial additional funding to mental health over the past two decades, the mental health and social services systems remain fragmented. Funding, spending and service delivery comprise a complex network with overlapping responsibilities. Recent initiatives, which are not designed from a whole-of-system perspective and often lack substantive evidence, can add greater complexity.

The report then investigates reform models, both in Australia and internationally, which may help address those systemic issues and therefore achieve better outcomes for those with mental illness, their families and carers, for the same or lower expenditure. It identifies key elements of a reformed mental health service system.

The data analysis in this report was finalised on May 2012.

The full report and companion documents can be downloaded at www.medibankhealth.com.au/Mental_Health_Reform

1. Governments have given substantially more policy attention and funding to mental health since the early 1990s

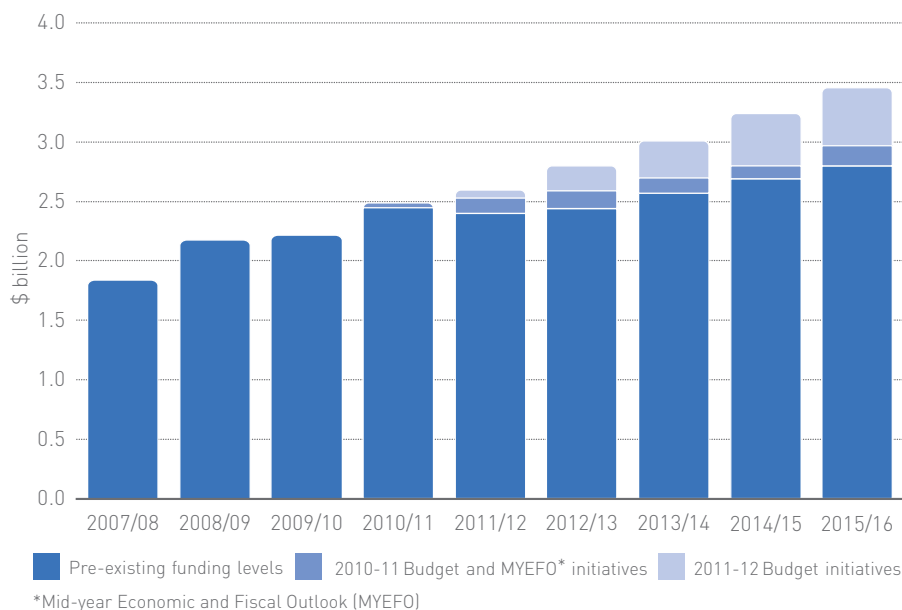
Australia spends at least \$28.6 billion per year supporting people with mental illness. The majority of expenditure is funded by governments, with the balance funded by insurers, consumers, employers, non-government organisations and other private payers. The key components of this expenditure are detailed below.

Since the early 1990s, governments have committed to a range of progressively wider mental health policy and planning initiatives, including:

- National Mental Health Strategy (1992), including the first five year National Mental Health Plan (and three further Plans in 1997, 2003 and 2009)
- Council of Australian Governments (COAG) National Action Plan (2006)
- National Partnership Agreement (2012)
- Development of COAG's 10 year Roadmap for National Mental Health Reform (2012)
- Establishment of the National Mental Health Commission [2012] and a number of state level commissions.

The major policy and planning announcements have in many cases been accompanied by significant increases to mental health expenditure. Figure 1 indicates the increase in Australian Government expenditure over the period from 2007/08 to 2011/12. It includes \$2.2 billion in funding for mental health for the five years from 2011-12 that is additional to the funding committed under the National Partnership Agreement.

Figure 1: Federal funding has increased significantly in recent years



Source: Commonwealth Government Budget 2011-12. Available at http://www.budget.gov.au/2011-12/content/glossy/health/html/health_overview_04.htm

A range of reforms have occurred in mental health, but the system is also affected by broader health reforms

Over the two decades that mental health has been the subject of national approaches, a number of reforms have been undertaken. These include the following changes:¹

- Significant growth has occurred in the number of mental health professionals working directly with consumers.
- Given the limitations on psychiatric beds in the hospital system, care is now delivered primarily in community settings.
- Access to mental health care in primary care settings has been substantially increased, following changes to the Medicare Benefits Schedule in 2006.
- Community mental health literacy has improved.
- Integrated approaches and stronger partnerships have begun to emerge.

These themes are likely to continue to underpin future reforms.

A number of non-government organisations also play a key role in mental health reforms

In recent years a number of mental health-specific organisations have been established at both the national and local level across Australia. These include government, academic and community organisations. Some of the key organisations are *beyondblue*, the Mental Health Council of Australia, Black Dog Institute and a number of university centres.

1. Department of Health and Ageing (2009), *Fourth National Mental Health Plan: An agenda for collaborative government action in mental health 2009-2014*, Commonwealth of Australia, Canberra.

2. The critical issue in mental health is system design

Mental health services encompass a complex network of care settings and service providers

Australia's mental health system lacks a clear end-to-end system design. The nature of mental illness increases the likelihood that consumers will interact frequently with multiple parts of the healthcare system. Yet the system is characterised by fragmentation and insufficient coordination. This is compounded by similar problems with social services (including employment services) and the support payment system.

The number of service providers illustrates the complexity of the system. In 2008-09, there were 156 public hospitals providing mental health care, 150 residential facilities, 990 community services, and 50 private psychiatric hospitals.² There are hundreds of mental health NGOs (with estimates ranging from 400 (in 2008)³ to 798 (in 2011)⁴) and there are currently 36 private health insurers. This is in addition to the numerous other service providers who deliver mental health services.

There are mixed and overlapping responsibilities for mental health funding and expenditure

A number of bodies – the Australian Government, state/territory governments, private health insurers, the corporate sector and consumers – are responsible for both health expenditure (i.e. spending the money) and health funding (i.e. providing the funds that are used to pay for health expenditure).⁵ NGOs, funded by governments, donations and other sources, also contribute to health expenditure.⁶

Of the \$28.6 billion in total direct expenditure in 2010-11, the funding sources for \$22.6 billion are able to be determined: approximately 90% is funded by government with the balance funded by insurers, consumers (out-of-pocket), employers, NGOs and other private payers. The funding split is unable to be determined for the remaining \$6 billion which comprises drug and alcohol services, and health and non-health payments by insurers – both government and private sector.

Fragmentation of funders and services is exacerbated by the lack of coordination within the healthcare system and between the healthcare and social services systems

The fragmentation that arises from diverse funding and expenditure arrangements is exacerbated by the lack of coordination within the healthcare system. Individuals with more severe mental illness face a further level of fragmentation. In addition to healthcare services, they may also receive a range of government transfer payments and social services, as well as insurance and income protection payments.

2. AIHW (2011), *Mental health services – in brief 2011*, AIHW Cat. No. HSE 113, Canberra, p. 25.

3. DoHA (2010), *National mental health report 2010: Summary of 15 years of reform in Australia's mental health services under the National Mental Health Strategy 1993-2008*, Commonwealth of Australia, Canberra, p. 5.

4. National Health Workforce Planning and Research Collaboration (2011), *Mental Health Non-Government Organisation Workforce Project: final report*. Available at: <http://www.ahwo.gov.au/documents/Publications/2011/Mental%20Health%20NGO%20Workforce%20Project%20Final%20Report.pdf>

5. These definitions follow AIHW (2011), *Health expenditure Australia 2009-10*, AIHW Cat. No. HWE 55, Canberra, Box 1.1, p. 1.

6. NGO services that are funded by government are a component of the estimates of government expenditure in this report.

The absence of coordinated, collaborative and consistently reliable recovery-based services for people with a mental illness has meant that the mental health system has become heavily reliant on the goodwill and ongoing care provided by carers to fund and resource recovery-based care. This was highlighted in a 2010 survey of mental health carers conducted by the Mental Health Council of Australia (MHCA) which found that the majority of mental health carers are responsible for organising the bulk of care for the person they care for. Medical workers, social workers or case managers organised approximately 10% of care, with community workers arranging a slightly higher amount.⁷

Fragmentation of the mental health service system also leads to frustration, confusion and distress for service users – people with mental illness and also family and carers. As the 2011 Australian Government Budget Paper on national mental health reform stated, people with severe mental illness have to “deal with fragmented and uncoordinated systems”.⁸ It continued: “despite previous attempts at reform and investment by governments, too many people with severe and debilitating mental illness are still not getting the support they need, don’t know where to find it, and are falling through the cracks in the system. The families and people who care for them struggle with a system which often causes them frustration and even despair”.⁹

Poor system design compounds Australia’s mental health challenges

There is a strong case that poor mental health system design exacerbates Australia’s mental health challenges. Three key challenges are:

- 1. New initiatives can add complexity to an already fragmented system and fail to address the critical issue of system design** – As noted above, the Australian and state/territory governments have introduced a number of initiatives in recent years to improve health and non-health services for people with mental illness. Yet, in a fragmented service system, without clear pathways for people with mental illness, new initiatives can add greater complexity. The introduction of new initiatives also diverts attention from what remains the key challenge – designing a mental health service system that improves the health of people with a mental illness in a cost-effective way.
- 2. It is impossible to tell if Australia is spending the right amount of money to support people with mental illness and if money is being spent in the right areas** – Expenditure to support people with mental illness is substantial, and far exceeds the amounts previously estimated (see Section 3). Without a clear system design, it is not possible to assess if total expenditure is appropriate

to meet Australia’s mental health challenges. It is also not possible to assess if:

- Health expenditure is appropriately focussed across different degrees of severity of mental illness and between prevention, early intervention, management and treatment
 - Non-health expenditure is appropriately balanced between income and non-income supports and social services (such as housing or employment)
 - The balance is appropriate between health expenditure and non-health expenditure.
- 3. Mental health outcomes are likely to be sub-optimal, leading to additional health and non-health costs** – Fragmentation and insufficient coordination contribute to Australia’s sub-optimal mental health outcomes. With mental health the fastest growing cause of disability in Australia, it is evident that poor outcomes, in turn, lead to additional health expenditure and also non-health expenditure, such as income support and other non-health services.

7. Mental Health Council of Australia (2010), *Mental Health Carers Report*, p. 20.

8. Australian Government (2011), *Budget: National mental health reform*, Canberra, p. 5.

9. Australian Government (2011), *Budget: National mental health reform*, Canberra, p. 12.

3. Total direct expenditure on supporting people with a mental illness in Australia far exceeds that previously estimated

In 2010-11, Australia's total direct expenditure to support people with mental illness was at least \$28.6 billion, equivalent to 2.2% of Australia's GDP. Total expenditure includes direct health expenditure of at least \$13.8 billion and direct non-health expenditure of at least \$14.8 billion. Of the \$28.6 billion, the funding sources for around 80% are able to be determined while the remainder cannot be determined.

The cost of supporting people with mental illness can be divided into direct and indirect costs; the report deals with direct costs only. *Direct cost is defined as the expenditure incurred to provide health and non-health support to people with mental illness, and expenditure on the promotion of, and research into, mental health.* (This report excludes capital expenditure.) Indirect cost is defined as the broader individual, social and economic costs of mental illness. These costs include indirect and non-financial costs such as lost productivity and the debilitating impact on the lives of those with a mental illness, their families and carers.

It is difficult to estimate the true cost of mental illness

Although the significance of mental illness is now increasingly understood, it is extremely difficult to develop a comprehensive and accurate picture of the costs involved. No comprehensive estimate presently exists, though a number of partial estimates have been developed. The range of costs to be considered is diverse, and the fragmentation of the mental health system (in funding, expenditure and service delivery) makes data gathering problematic. In addition, there are specific challenges to estimate direct health and non-health expenditure:

- **Direct health expenditure:** data is often unavailable; available data is not fully disaggregated; and Medicare only partially maps services to mental illness.
- **Direct non-health expenditure:** for many government transfer payments and social services, mental illness is one reason, typically of many, why people may receive assistance. Available data is not typically disaggregated to show expenditure attributable to various 'reasons' for the person needing the support, such as mental illness.

The report provides a more comprehensive estimate of expenditure than previous studies, yet the true expenditure to support people with mental illness is much greater than the \$28.6 billion estimate provided here. The conservative approach used to estimate expenditure means a number of figures are likely to underestimate true expenditure. (An asterisk is used to indicate such instances.) While there are also a few instances of possible double counting due to non-availability of disaggregated data, the amounts are relatively small. All such instances are noted in the report.

The available data often does not easily enable a breakdown of where money is being spent. So, despite total expenditure of at least \$28.6 billion it is difficult to assess if the current approach to mental health service provision is best directed to achieving better health outcomes for people with a mental illness.

Direct health expenditure is at least \$13.8 billion per annum

Total direct health expenditure on mental health services was at least \$13.8 billion in 2010-11. This includes expenditure by the Australian Government, state/territory governments, NGOs, private health insurers, consumers and the broader corporate sector.

Key insights into direct health expenditure are:

- Total estimated direct expenditure in 2010-11 was \$13.8 billion. This compares to \$130.3 billion of total healthcare expenditure in Australia in 2010-11.¹⁰
- Expenditure on drug and alcohol services was the largest element of the known expenditure on mental health services (\$4,628 million, and the true figure is probably larger).
- There was substantial expenditure on health care services for treating chronic physical conditions where the patient had a comorbid mental illness (\$1,964 million, and the true figure is probably larger).
- Expenditure on specialised public hospital mental health services was over four times larger than expenditure on mental health inpatient services covered by private health insurers (\$1,778 million compared to \$402 million).

- Available expenditure data indicates spending on psychology services was the largest share of expenditure on 'Other mental health services provided by health professionals' (\$336 million). Expenditure on mental health services provided by GPs is likely to be significantly larger, but robust data is not available.
- Of the mental health funding provided by the Australian and state/territory governments and private health insurers, 36.0% was from the Australian Government, 60.5% was from state/territory governments and 3.5% was from the private health insurers.^{11,12} Of the Australian Government funding, 4.2% is provided as grants to the states and territories.¹³

A summary of direct health expenditure is provided in Table 1.

The estimate of \$13.8 billion is likely to significantly underestimate true expenditure. For a number of services, expenditure is only available by some groups (for example, governments) and not available for other groups (such as consumers). For other areas of health services (such as out of pocket expenditure on private psychiatry services and private psychology services), no estimate of expenditure is possible as data is not available. (The report does not consider expenditure across specific population groups in any detail, though a brief discussion about expenditure on mental health services for Indigenous and non-Indigenous Australians is presented.)

Table 1: Summary of direct health expenditure to support people with mental illness

Direct health expenditure	Estimated expenditure (\$m)
Public mental health services	\$3,580
Private mental health services*	\$402
Other mental health services provided by health professionals*	\$924
Medication*	\$1,235
Drug and alcohol services*	\$4,628
Comorbid physical conditions*	\$1,964
Other mental health services*	\$293
Australian Government expenditure on selected national programs and initiatives	\$570
Mental health-related payments by injury compensation insurers*	\$106
Corporate expenditure on mental health services*	\$120
Mental health services in the criminal system*	\$7
Total	\$13,829

* An asterisk indicates the expenditure estimate provided is an underestimate of the true value.

10. AIHW (2011), *Health expenditure Australia 2010-11*, Health and welfare expenditure series No. 47., Cat. No. HWE 56. Canberra.

11. DoHA (2010), *National mental health report 2010: Summary of 15 years of reform in Australia's mental health services under the National Mental Health Strategy 1993-2008*, Canberra.

12. Funding by consumers, NGOs and the broader corporate sector is not considered here.

13. DoHA (2010), *National mental health report 2010: Summary of 15 years of reform in Australia's mental health services under the National Mental Health Strategy 1993-2008*, Canberra.

Direct non-health expenditure is at least \$14.8 billion per annum

Total direct non-health expenditure to support people with mental illness was at least \$14.8 billion in 2010-11. This includes expenditure by the Australian, state/territory governments and private insurers. Non-health expenditure can be broken down into:

- **Support payments:** income support payments; insurance payments; non-income support; and carer payments
- **Services provided to people suffering from mental illness:** aged care; services for people with a disability; housing and homelessness; employment services; education and training; and justice.

Key insights into direct non-health expenditure include:

- Total non-health expenditure was estimated to be \$14.8 billion. This compares to:
 - total Australian Government social security and welfare spend of \$116.9 billion in 2010-11
 - total state/territory government expenditure on social security and welfare of \$14.4 billion in 2010-11.

- Expenditure was split fairly evenly between support payments (\$7,236 million) and service provision (\$7,521 million).
- Two specific payments – Disability Support Pension (\$3,913 million) and insurance payments for total and permanent disability and income protection (\$1,045 million) – accounted for over two-thirds of total support payments.
- Expenditure on justice services – police, courts, specialised mental health courts/tribunals, prisons and community corrections, and juvenile justice – accounted for almost 40% of expenditure on service provision (\$2,918 million).
- The largest element of expenditure on service provision was expenditure on social housing (\$1,506 million).

A summary of direct non-health expenditure is provided in Table 2.

Table 2: Summary of direct non-health expenditure to support people with mental illness

Direct health expenditure	Estimated expenditure (\$m)
Support payments*	
Income support*	\$4,661
Insurance payments	\$1,293
Non-income support	\$591
Carers*	\$691
Total support payments*	\$7,236
Services provided*	
Housing and homelessness	\$1,650
Aged care*	\$390
Education and training	\$720
Services for those with a disability	\$1,843
Justice*	\$2,918
Total services provided*	\$7,521
Total	\$14,757

* An asterisk indicates the expenditure estimate provided is an underestimate of the true value.

4. Mental health outcomes in Australia are sub-optimal

Mental illness is highly prevalent

The Department of Health and Ageing (DoHA), based on results from the 2007 National Survey of Mental Health and Wellbeing (NSMH&W), has estimated that every year one in five Australians experience a mental illness and almost half the Australian population will experience a mental illness at some point in their lifetime.¹⁴ According to these figures, the prevalence of mental illness is slightly less than obesity (experienced by one in four adults), but significantly exceeds diabetes (4% of adults) and cancer (2.5% of adults).

The true rate of mental illness in Australia will be higher than these estimates because dementia and less common mental disorders (e.g. schizophrenia and other psychotic disorders) are excluded from the NSMH&W survey. For example, dementia affected 1.1% (or 245,400) Australians in 2009.

Of all Australians aged 16-85 years, 11.9% utilised health services for mental health problems in the preceding 12 months.¹⁵

Overall prevalence levels remain static but the types of disorders are changing

The proportion of Australians experiencing high or very high levels of mental distress has remained relatively stable over the past three National Health Surveys, at around 9%.

Data from the 1997 and 2007 National Survey of Mental Health and Wellbeing surveys indicates that, while the overall prevalence of mental illness has remained relatively stable, the prevalence of particular categories of disorders has changed. Anxiety disorders have increased in prevalence, while substance use disorders have decreased.

Long-term data related to Disability Support Pension (DSP) recipients suggests the proportion of people with more debilitating mental illness may have increased.

The focus of mental health services is changing

The proportion of people with mental health issues who are accessing different mental health services have stayed relatively static according to a high level comparison between the results of the 1997 and 2007 National Surveys of Mental Health and Wellbeing. The key exception is the proportion of people who used a psychologist, which has almost doubled. A similar

increase is reported in the Productivity Commission's National Agreement Performance Report covering the three years from 2007-08.¹⁶

Longitudinal data from the People Living with Psychotic Illness 1997-98 and 2010 surveys paint a different and more nuanced picture of how service demand is changing for a particular sub-population living with more severe mental health issues.^{17,18} The results show that:

- **General practitioners remain key providers** of healthcare to people with psychotic illness.
- **Hospital admissions for mental health reasons decreased markedly** with a 35.9% decrease in admissions.
- **Community services increased markedly** with 92.8% of the sample in 2010 having contact with an outpatient or community clinic (against 75.3% reported in 1997-98) and 36.8% undertaking community rehabilitation or day programs (60.7% higher than the 22.9% in 1997-98).
- **NGO provided services increased** with one quarter of the sample (26.5%) receiving mental health services through non-government organisations compared with 18.9% in 1997-98.

14. Slade T, et al. (2009), *The Mental Health of Australians 2, Report on the 2007 National Survey of Mental Health and Wellbeing*, Department of Health and Ageing, Canberra, p. xii.

15. Slade T, et al. (2009), *The Mental Health of Australians 2, Report on the 2007 National Survey of Mental Health and Wellbeing*, Department of Health and Ageing, Canberra, p. xii.

16. Productivity Commission (2008-2011), *National Agreement Performance Reporting-National Healthcare Agreement*, Indicator 21.

17. Australian Government (1999), *People living with psychotic illness: an Australian study 1997-98*, Canberra.

18. Australian Government (2011), *People living with psychotic illness 2010: Report on the second Australian national survey*, Canberra.

Treatment rates for mental illness are low

People with a mental illness often have low rates of service use. This can be due to them choosing not to access services, unavailability of appropriate services, lack of awareness that services are available or negative experiences associated with the previous use of services.

The 2007 NSMH&W revealed most people with mental illness do not receive any treatment for their condition. According to the survey, 65.1% of people who experienced mental disorders in the previous 12 months received no treatment at all. Mental health service use was more common among people with more severe disorders.

Even when people do access mental health services, their needs are often not being met

The 2007 NSMH&W found that, of the people who had symptoms of a mental disorder and a need for a service, the need was fully met by mental health services in only: 31% of cases for social intervention; 44% for skills training; and 57% for information. Counselling met the needs of 68% of respondents and medication 87%.¹⁹

Satisfaction levels with mental health services are low relative to other health services. In the 2012 Menzies-Nous Australian Health Survey, only 58% of those receiving health care services from a mental health provider were happy with the treatment.²⁰ This is significantly lower than for specialist doctors, general practitioners, nurses and community care.

Evidence to support improved mental health outcomes is limited

Relative to other health outcomes, there is limited longitudinal data related to mental health outcomes that can be aggregated at a national level.

Longitudinal outcomes data for Australians with a psychotic illness show positive changes over the past 15 years. However, mental health outcomes overall remain mixed. Longitudinal data from the most consistently applied mental health outcomes measurement tool in Australia – the Health of the Nation Outcome Scales (HoNOS)²¹ – does not indicate any notable trends.

Key insights gleaned from the available data, noted in the National Mental Health Report 2010, paint a mixed picture for mental health outcomes in Australia.

19. ABS (2007), *National Survey of Mental Health and Wellbeing: Summary of results*, October 2008, Cat No. 4326.0, Canberra.

20. Menzies Centre for Health Policy and Nous Group (2012), *The Menzies-Nous Australian Health Survey 2012*, Sydney.

21. HoNOS is a clinician completed measure which assesses a client's health status and the severity of their mental disorder over the previous two weeks. It is used as a standard outcome measure for specialist mental health services across Australia, as well as internationally.

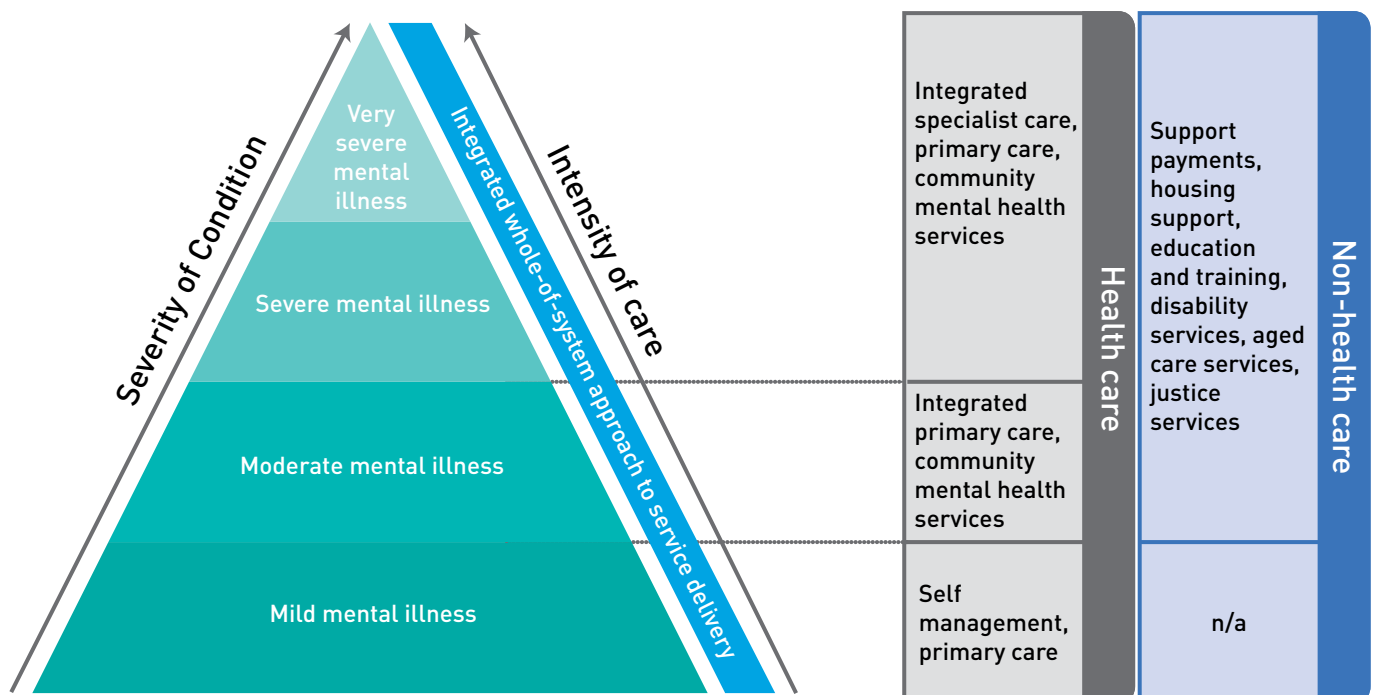
5. Selected reform models in Australia and internationally suggest key elements of a successful overall service system

Mental health problems and mental illness, as well as the mental health system, are complex. They include a very diverse set of conditions, each with its own prevalence rate, approach to management and level of impact on individuals, their families and carers. In the report, mental illnesses are categorised by severity into those that are very severe, severe, moderate and mild.

The intensity of health care services required to manage mental illness varies in accordance with the level of severity of the illness. Non-health care services are typically received by people who experience moderate, severe or very severe mental illness. These relationships are illustrated in Figure 2. This model has been developed specifically for use within the report.

Reform approaches in this report are broken down between whole-of-system reforms, and those targeted at specific levels of severity of illness.

Figure 2: Conceptual model to differentiate systemic approaches to supporting those with mental illness



Successful whole-of-system reform is rare internationally, with mixed relevance to Australian circumstances

The fragmentation of Australia's mental health system is replicated globally; there are few international examples of whole-of-system reform. In those instances where major reform has occurred, there have been varying degrees of success. The prime examples are:

- The US Veterans Health Administration Mental Health Program which is trying to provide uniform, evidence-based services to its geographically dispersed population, with greater transparency over what services are being provided (or not) across its network.
- Trieste in Italy, which provides evidence that deinstitutionalisation of mental health services can be achieved, provided the gap is filled by strong community mental health organisations.

The experiences of these two reforms reveal **some key enablers for successful system-level reform:**

- Stratification of populations according to risk, with an evidence-based approach to each population sub-group that applies funding and service commensurate with need.
- A single funding/payment model.
- Sophisticated and integrated information technology systems (e.g. electronic health records and provider payment systems) to underpin the coordination of services.
- Integrated care pathways within the health care system.
- Integration between the health care and broader social services system, including employment services.
- Clear clinical guidelines and benchmarks.

Self-contained care systems, with a single stream of funding, mean the jurisdictions are in a unique position to improve quality and efficiency in mental health care. To apply this kind of whole-of-system reform in Australia would require payment and structural reform beyond that outlined in any previous mental health plans or the Roadmap for Mental Health Reform. Other aspects of the reforms, while still requiring significant change, would require less transformation to the existing mental health service system. For example, the development of a national framework to ensure consistency and access to mental health services, as seen in the US Veterans example, is not beyond the realm of the existing Australian system. The use of community-based Mental Health Centres operating around the clock, which were fundamental to the success in Trieste, would require some transformation of existing community-based mental health services in Australia.

There is some evidence for very intensive person-centred case management of comprehensive community-based services to support people with very severe mental illness

Patients with very severe mental illness are a key challenge for most mental health systems, as they account for a disproportionately large share of service utilisation and cost. Such patients typically spend a significant amount of time moving in and out of the hospital system.

There are a range of initiatives that use a very intensive, person-centred, coordinated case management approach to effectively assist people with very severe mental illness through comprehensive ongoing support in all key aspects of their lives including health, housing, social connection and safety. Intensive Case Management models such as Assertive Community Treatment can decrease rates and length of hospital stays and produce cost savings.

People with severe mental illness require similar services to those with very severe mental illness but with less intensive case coordination

People with severe mental illness less frequently require inpatient care than those with very severe mental illness. However, the literature supports the widely held view that gaps in care result in a high level of hospitalisations and readmissions for people with severe mental illness.

There is evidence that effective support requires the clear integration of a comprehensive range of hospital based care, community clinical treatments, primary care and non-health services such as housing and employment programs. At the core of most successful models, and supported by a growing evidence base, is a somewhat intensive case management / care coordination function that helps patients to navigate their way through clinical and community services, thereby avoiding hospitalisation. In that context, a number of models have shown promise.

Evidence from the United States, applicable to Australia, indicates people with moderate mental illness can be successfully treated in primary care settings

A number of US initiatives provide evidence that people with moderate mental illness can be successfully treated in primary care settings. The improvements build on systematic changes in the delivery of care and show that General Practice is able to implement and sustain improvements when offered a standardised care management program and adequate support. There is also evidence that other chronic conditions (comorbid or not) that would benefit from such programmes include chronic heart failure, diabetes, and asthma.

The successful models incorporate three key features:

- Standardised programs, with implementation customised to each setting (to accommodate large or small health care organisations).
- A care manager (a centralised resource not necessarily located in the primary care practice) to manage patients in collaboration with the clinician, who retains overall responsibility for patient care.
- Psychiatrist supervision of the care manager, providing guidance to the clinician through the care manager, and advising the clinician directly as needed.

These initiatives could be translated to the Australian context.

There are promising models to improve treatment and treatment rates of people with mild mental illness, with applicability for Australia

According to *beyondblue*, only 35-40% of Australians with high prevalence and mild severity mental illness adequately access appropriate services. This low treatment rate is reflected internationally. A number of cost-effective, evidence-based models to reach these patients are being explored.

In the UK, increasing access to “talking therapies” using a stepped care approach, as with the Improving Access to Psychological Therapies program, is showing promise. In Australia, evidence is emerging that online Cognitive Behavioural Therapy (CBT) models increase the rate of treatment and quality of life. Another approach has been to explore primary care based models that integrate/co-locate mental health services. The Hamilton Family Health Team in Ontario, Canada, has shown this model can increase the rate of treatment of mental illness, and can be a crucial part of providing prevention and detection in early stages. Intermountain Health in the US has made mental health screening as routine as screening for physical conditions.

Stepped type services such as Improving Access to Psychological Therapies could be easily adapted in the Australian environment. Experience delivering evidence-based online psychological therapies (such as CBT), and existing primary care mental health initiatives, suggest that only limited system or payment changes would be necessary.

In 2009, *beyondblue* commissioned a feasibility study to investigate whether a similar model would work in Australia and has presented a business case to the Australian Government. In October 2012, the Australian Government announced Access Macquarie, developed by Macquarie University, would provide confidential mental health assistance, available to all Australians, via the internet, phone or email.

Mental health and wellbeing have been integrated into primary care (through the Access to Allied Psychological Services program and the Better Access Initiative). International initiatives suggest some key lessons. Services need to be seen as a partnership between mental health and primary care, rather than a traditional referral process, and embedded in the primary care system with each contributing to the program design.

Key elements can be identified for a reformed mental health service system

The review of successful reforms in Australia and internationally does suggest some key elements of a reformed mental health system. At a system-wide level, international experience suggests a number of key enablers of reform, noted above. Some of these enablers, such as a single funding/payment model, would require substantial change to the existing mental health service system; other elements, such as the development of clear clinical guidelines and benchmarks, would require less transformation in the current Australian context.

For mental illness at different levels of severity, the review suggests a tailored service approach with services commensurate with the severity of the condition.

- **Very severe and severe mental illness** – successful treatment requires a very intensive, person-centred, coordinated case management approach, with clear integration of a comprehensive range of hospital-based care, community clinical treatments, primary care and non-health services such as housing and employment programs.
- **Moderate mental illness** – successful treatment is possible in primary care settings, with the right balance between a standardised care management program and a collaborative, interdisciplinary approach between the clinician, care manager and psychiatrist.
- **Mild mental illness** – a variety of approaches offer promise such as “talking therapies”, online CBT models and primary care based models that integrate/co-locate mental health services. Further analysis is needed to assess which approach, or combination of approaches, is most appropriate for Australian circumstances.

6. Australia has an unprecedented opportunity to lead the world in end-to-end mental health system redesign to deliver better outcomes at the same or lower cost

As identified in the report, at least \$28.6 billion is spent annually to support people with mental illness, an amount likely to grow with the increased policy focus on mental health. Despite this, overall levels of mental illness are static, many of those with mental illness do not access services and, when they do, their needs are often not met.

The current system is extremely fragmented – across the supply of services, expenditure and funding. Health services are supplied in and out of hospitals (public and private), by psychiatrists and general practitioners and other doctors, psychologists, counsellors and other allied health professionals. Non health support is provided by governments (at the Australian and state/territory level), not-for-profit organisations and others. Funding, across health and non-health services, comes from the Australian and state/territory governments, insurers, non-insurance businesses and not for profits (and donors). Individuals with mental illness and their families also shoulder much of the burden.

Major system-level changes are required. There is a need for an end-to-end redesigned system, covering detection to diagnosis to treatment to ongoing recovery. The system needs to integrate health and non-health support and funding. This includes better integration across government departments (at the federal and state/territories levels) of the assistance they provide and/or fund. The review of reforms in Australia and internationally suggests some elements to inform an improved mental health service system. There is an opportunity for Australia to lead the world in designing and implementing a whole-of-system approach to support those with mental illness.

Pursuant to the report, Medibank Health Solutions will be working with other key stakeholders to detail options for systemic reform of mental health – to ensure the needs of people with mental illness are better met, and to deliver better outcomes and greater efficiency.

References

- Australian Bureau of Statistics (2007), *National Survey of Mental Health and Wellbeing: Summary of Results, 2007*, Cat. No. 4326.0, Canberra
- Australian Government (2011), *Budget: National mental health reform*, Canberra
- Australian Government (2011), *People living with psychotic illness 2010: Report on the second Australian national survey*, Canberra
- Australian Government (1999), *People living with psychotic illness: an Australian study 1997-98*, Canberra
- Australian Institute of Health and Welfare (2011), *Health expenditure Australia 2009-10*, Health and Welfare Expenditure Series, 46, Cat. No. HWE 55, Table 3.7, Canberra
- Australian Institute of Health and Welfare (2011), *Health expenditure Australia 2010-11*, Health and welfare expenditure series No. 47., Cat. No. HWE 56. Canberra
- Australian Institute of Health and Welfare (2011), *Mental Health Services – in Brief, 2011*, HSE 113, Canberra
- Commonwealth Government Budget 2011-12, available online at: http://www.budget.gov.au/2011-12/content/glossy/health/html/health_overview_04.htm
- Department of Health and Ageing (2010), *National mental health report 2010: Summary of 15 years of reform in Australia's mental health services under the National Mental Health Strategy 1993-2008*, Commonwealth of Australia, Canberra
- Department of Health and Ageing (2009), *Fourth National Mental Health Plan: An agenda for collaborative government action in mental health 2009-2014*, Commonwealth of Australia, Canberra
- Mental Health Council of Australia (2010), *Mental Health Carers Report*, MHCA, Canberra
- Menzies Centre for Health Policy and Nous Group (2012), *The Menzies-Nous Australian Health Survey 2012*, Sydney
- National Health Workforce Planning and Research Collaboration (2011), *Mental Health Non-Government Organisation Workforce Project: Final Report*, May 2011, Adelaide
- Productivity Commission (2008-2011), *National Agreement Performance Reporting-National Healthcare Agreement*, Indicator 21
- Slade T., et al. (2009), *The Mental Health of Australians 2, Report on the 2007 National Survey of Mental, Health and Wellbeing*, Department of Health and Ageing, Canberra

For more information

The full report and companion documents can be downloaded at www.medibankhealth.com.au/Mental_Health_Reform

Contact Medibank Corporate Affairs at Medibank.CorporateAffairs@medibank.com.au

medibank.com.au
medibankhealth.com.au

About Nous Group

Nous Group (Nous) is a leading Australian management consulting and leadership development firm. Nous works with public and private sector organisations in demanding and complex sectors to build success through bold ideas, engaging people and influential, enduring solutions. Nous has been involved in providing solutions for some of the country's most pressing problems and is highly regarded for its work on projects of national significance across mental health, health, ageing, disability and education reform. www.nousgroup.com.au.

nous group