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## 2.1 Introduction

Since its original publication, the *National Mental Health Report* has focused on building a long term picture of mental health reform in Australia. It has done this by presenting summary information on system-level indicators of reform that track changes in the mix of services along with the financial and human resources that underpin those services. Part 2 continues that tradition by adding the most recently available data in five key areas, namely:

- National spending on mental health;

- National workforce trends;
- Trends in public sector mental health services;
- Trends in private sector mental health services; and
- Consumer and carer participation in mental health care.

Data sources and explanatory notes for data presented in Part 2 are provided in Appendix 1.

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## 2.2 National spending on mental health

### KEY MESSAGES:

- The original commitment made by all governments to protect mental health resources under the National Mental Health Strategy has been met. Total government expenditure on mental health increased by 178% in real terms between 1992-93 and 2010-11. In 2010-11, Australia spent \$4.2 billion more of public funds on mental health services than it did at the commencement of the Strategy in 1992-93.
- Until recently, growth in mental health spending mirrored overall health expenditure trends for most of the 18 year period since the Strategy began. In the most recent year (2010-11), mental health increased its position in terms of relative spending within the broader health sector.
- Australian Government spending has increased by 245% compared to an increase of 151% by state and territory governments. This increased the Australian Government share of total national spending on mental health from 28% in 1992-93 to 35% in 2010-11. Most of the increase in Australian Government spending in the first ten years of the Strategy was driven by increased outlays on psychiatric medicines subsidised through the Pharmaceutical Benefits Scheme, but more recently other activities have taken over as the main drivers of increased mental health spending.

- The considerable variation in funding between the states and territories that existed at the beginning of the Strategy is still evident 18 years later, mid-way through the *Fourth National Mental Health Plan*. The gap between the highest spending and the lowest spending jurisdiction increased over the 1992-93 to 2010-11 period. The disparity between the states and territories points to wide variation in the level of mental health services available to their populations.
- Despite claims to the contrary, there are no reliable international benchmarks by which to judge Australia's relative investment in mental health. These await international collaboration on costing standards to ensure 'like with like' comparisons.

Public reporting on the level of spending on mental health services has been a central function of previous *National Mental Health Reports*. Under the *First National Mental Health Plan*, all governments agreed to maintain a level of expenditure on specialised mental health services at least equivalent to the level at the beginning of the National Mental Health Strategy, and to review annually whether this was occurring.

Regular monitoring of the relative contributions of the main funding authorities responsible

for mental health services also serves as a check against the possibility that the reform process may simply lead to shifts of financial responsibility from one funder to another, rather than overall growth in services. This was a concern expressed by advocacy groups at the outset of the Strategy.

This section of the report provides an overview of 2010-11 spending on mental health services within the context of information about spending patterns since the Strategy began.

## Total spending on mental health services, 2010-11

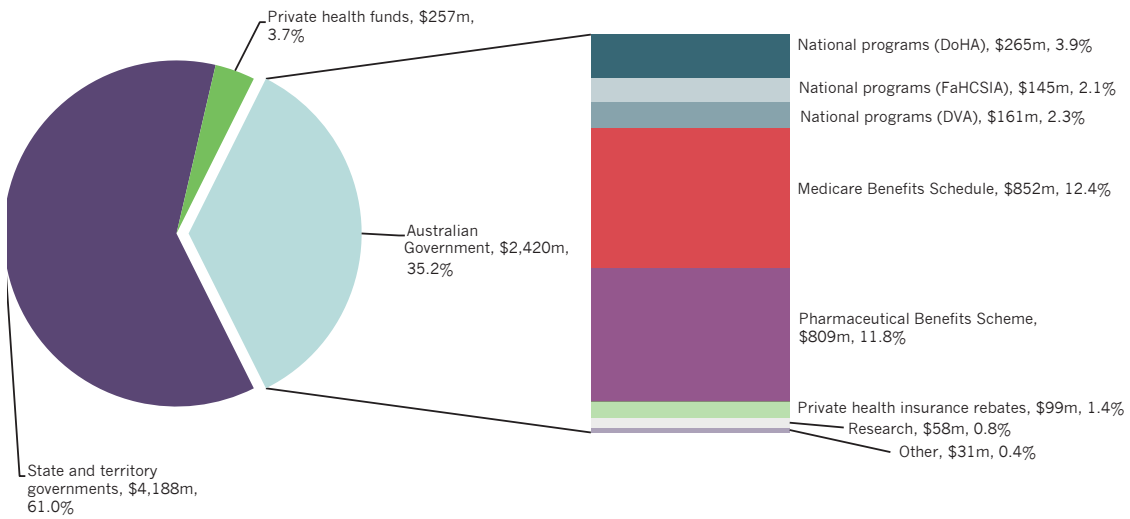
Total spending on mental health services by the major funders in Australia in 2010-11 was \$6.9 billion. This represents an increase of 6.7% in real terms from 2009-10. Spending on mental health services and related activity represented 7.7% of total government health spending in 2010-11, compared with 7.3% at the beginning of the National Mental Health Strategy.<sup>A</sup> This is the highest level of mental health spending as a share of overall health expenditure recorded since the *National Mental Health Report* series commenced in 1993.

<sup>A</sup> Based on Department of Health and Ageing analysis of health expenditure data prepared by the Australian Institute of Health and Welfare and extracted from the national database used for the publication *Health Expenditure Australia 2010-11* (Health and Welfare Expenditure Series No. 47, Cat. No. HWE 46). Canberra: Australian Institute of Health and Welfare, 2012. The calculation of the proportion of total health expenditure directed to mental health includes only government and private health insurance revenue sources.

The major funders are the Australian Government, state and territory governments and private health insurers. Their relative contributions are summarised in Figure 3. Collectively, state and territory governments continue to play the largest role in specialised mental health service delivery, as they are primarily responsible, either directly or indirectly, for the delivery and management of most services. They have been the main focus of previous *National Mental Health Reports*, and remain a major feature of the current report.

The Australian Government is the largest single funder and was responsible for more than one third (35%) of total spending in 2010-11. It provides funding for a range of services and programs but does not deliver these services directly.

**Figure 3**  
Distribution of recurrent spending on mental health, 2010-11 (\$millions)

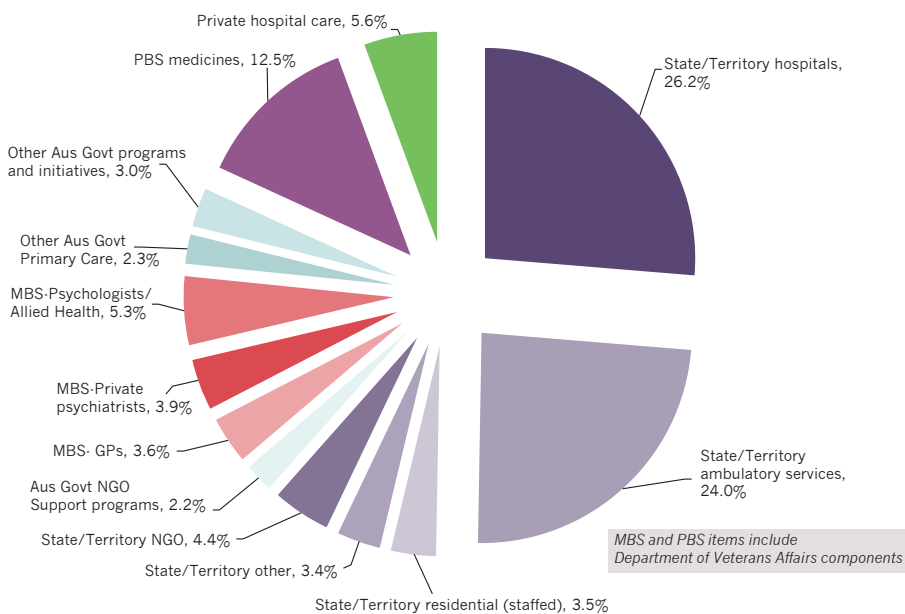


## How Australia's 2010-11 spending was invested

Figure 4 shows how Australia's \$6.9 billion investment in mental health in 2010-11 was spent. Hospital services administered by state and territory governments accounted for the largest share of total national spending (26%).

This was followed by state and territory ambulatory care services (24%) and psychiatric medicines subsidised through the Australian Government Pharmaceutical Benefits Scheme (13%).

**Figure 4**  
National spending on mental health, 2010-11



Total 2010-11 spending on mental health programs and services: \$6.9 billion

## National spending trends

Annual recurrent expenditure on mental health services by the major funding authorities increased by 171% from 1992-93 (the year before the National Mental Health Strategy began) to 2010-11 (the mid-point year of the *Fourth National Mental Health Plan*). Figure 5 shows that growth occurred to varying extents in all three major funding streams:

- Combined state and territory spending increased by 151% or \$2.5 billion;
- Australian Government expenditure increased by 245% or \$1.7 billion; and
- Spending by private health funds increased by 59% or \$95 million.

In per capita terms, national spending on mental health increased from \$144 in 1992-93 to \$309 in 2010-11.

To put this in context, it is worth considering how the combined expenditure on mental health by the Australian Government and state and territory governments compares with their overall expenditure on health. Looking at government spending only, recurrent

expenditure on mental health increased by 178% between 1992-93 and 2010-11, averaging 6% growth per year. This figure is difficult to compare with overall expenditure on health because it includes some expenditure from outside health departments, most notably by the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) in the more recent years. Removing funding administered by FaHCSIA from the equation, recurrent expenditure on mental health increased by 172% from 1992-93 to 2010-11, whereas recurrent expenditure on health increased by 157% (see Figure 6). In the first decade of the National Mental Health Strategy, the two figures tracked closer together, but commencing in the mid-2000s, mental health has incrementally increased its position in terms of relative spending within the overall health sector. The increased growth of mental health relative to general health is most pronounced in 2010-11.

Figure 5  
National expenditure on mental health by source of funds, 1992-93 to 2010-11 (\$millions)

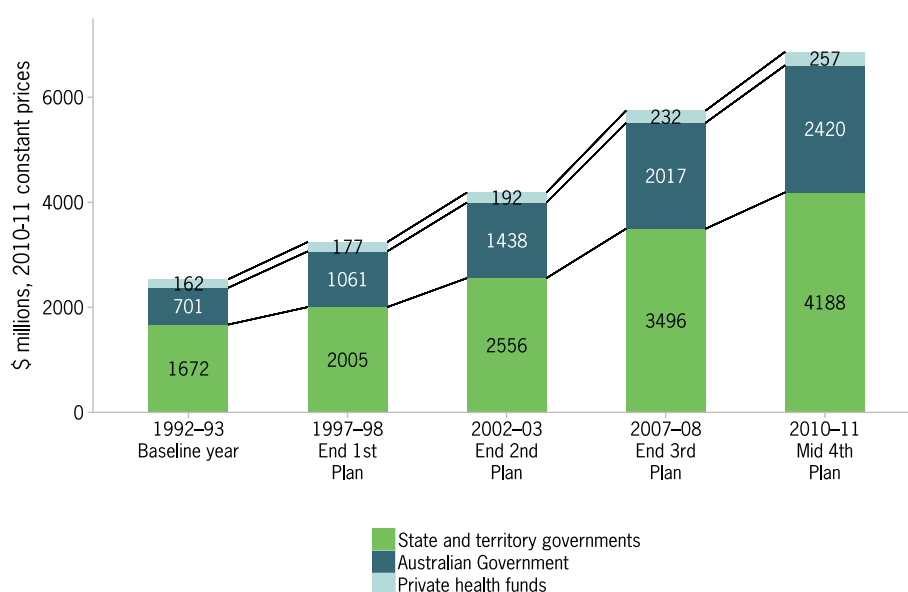
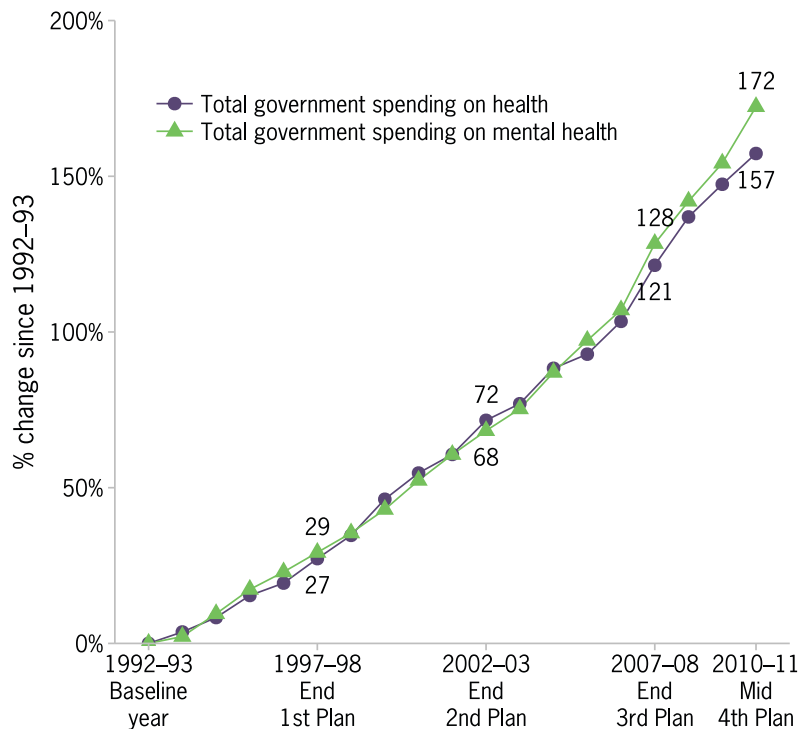


Figure 6  
Cumulative growth in government spending on health and mental health, 1992-93 to 2010-11



Further context would ideally be provided by comparisons to other countries from around the world. Unfortunately, there are no reliable benchmarks available to assess whether the 'right' level of funding is allocated for a given population's mental health needs. Significant differences exist between countries in how mental health is defined, how expenditure is reported, what is included as 'health expenditure', and what costing

methodologies are employed, making comparisons of available data unreliable and potentially misleading. Substantial collaboration between countries will be required for any future international comparisons of mental health spending to be valid.

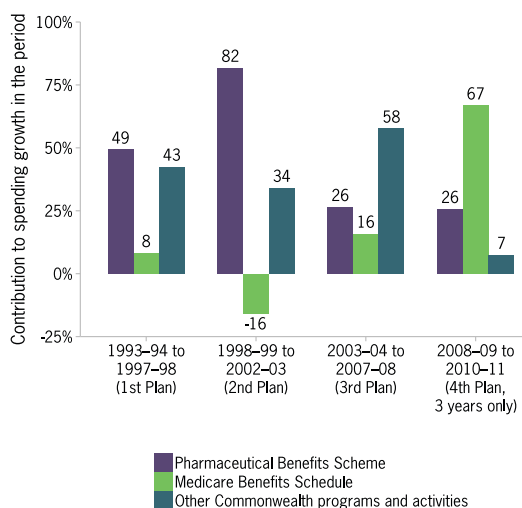
## Australian Government expenditure

The Australian Government's spending on mental health increased from \$701 million in 1992-93 (28% of national mental health spending) to \$2.4 billion in 2010-11 (35% of national spending). This increased share was due to a combination of growth in new activities and programs and increases in existing services. Figure 7 shows that in the early years of the National Mental Health Strategy, the main driver of growth was expenditure on psychiatric medicines subsidised through the Pharmaceutical Benefits Scheme (PBS). Increased spending on subsidised

pharmaceuticals accounted for 49% of the growth in Australian Government expenditure under the *First National Mental Health Plan* and 82% under the *Second National Mental Health Plan*. The impact of psychiatric medicines on Australian Government mental health spending reduced markedly under the *Third* and *Fourth National Mental Health Plans*, dropping to 26% in both of these periods. This was due to a combination of factors, including the fact that several commonly prescribed antidepressants came off patent during this time, allowing new generic products into the Australian

market. The costs of these products fell below the PBS subsidy threshold, or required significantly less Australian Government subsidisation than the patented products. Additionally new programs funded under the COAG *National Action Plan* began to be rolled out between 2006 and 2008, including the introduction of new Medicare-funded ‘talking therapies’ provided by psychologists and other allied health professionals. Each of these factors moderated the previous role of the PBS as the main driver of Australian Government mental health spending.

**Figure 7**  
Drivers of growth in expenditure on mental health by the Australian Government under the National Mental Health Plans, 1992-93 to 2010-11



## State and territory government expenditure

The commitment by state and territory governments to some form of budget protection was part of the original *National Mental Health Policy* and has since been reinforced at various points through the Strategy. The commitment was intended to serve three purposes. Firstly, the Australian Government required a guarantee that the benefits of additional funds provided under the National Mental Health Strategy would not be negated by a reduction in state and territory funding for mental health. Secondly, there was recognition that existing service levels in Australia were struggling to meet even the highest priority needs and could not be further reduced without serious consequences. Thirdly, the commitment safeguarded against erosion of resources that was believed to be occurring with the downsizing of state- and territory-managed psychiatric hospitals and the incorporation of mental health services into mainstream health care.

The original *National Mental Health Report*, released in 1994, established the baseline for measuring change in state and territory mental health resources and documented the gross recurrent expenditure by each jurisdiction in

1992-93. The current report compares ongoing expenditure against this baseline, using the same approach that has been taken in the intervening reports. This approach describes what was spent by a particular state or territory, as opposed to what was spent within it, by deducting specific Australian Government payments from the total spending reported by each state and territory. This reduces the impact of growth in state and territory expenditure caused by mental health specific grants made by the Australian Government under the former Health Care Agreements and more current mental health specific Commonwealth-State funding agreements and payments provided by the Department of Veterans’ Affairs for the mental health care of veterans by state and territory services. The intent of this approach is to focus on health funding that is under the discretionary control of state and territory governments – that is, funding that may or may not be spent on mental health.

Table 2 shows the summary picture of expenditure by state and territory governments, comparing baseline spending in 1992-93 with spending at the close of the first three *National Mental Health Plans* and the mid-point of the *Fourth National Mental Health Plan*.

All state and territory governments have met their commitment to maintaining mental health spending over the period 1992-93 to 2010-11. Spending growth increased by 145% overall, averaging 8% per year. With the exception of Victoria, all jurisdictions more than doubled their expenditure during the period.

**Table 2**  
Recurrent expenditure on mental health services by state and territory governments, 1992-93 to 2010-11 (\$millions)<sup>a</sup>

	1992-93 (Baseline year)	1997-98 (End 1st Plan)	2002-03 (End 2nd Plan)	2007-08 (End 3rd Plan)	2010-11 (Mid 4th Plan)	Change since 1992-93	Average annual growth
NSW	\$564	\$653	\$867	\$1,085	\$1,303	131%	7%
Vic	\$496	\$534	\$673	\$857	\$974	96%	5%
Qld	\$253	\$361	\$454	\$681	\$830	228%	13%
WA	\$164	\$244	\$305	\$434	\$523	219%	12%
SA	\$150	\$184	\$205	\$295	\$327	118%	7%
Tas	\$47	\$54	\$59	\$98	\$116	149%	8%
ACT	\$23	\$28	\$45	\$63	\$72	208%	12%
NT	\$14	\$20	\$22	\$36	\$43	211%	12%
Total	\$1,710	\$2,168	\$2,630	\$3,550	\$4,188	145%	8%

(a) Excludes Australian Government dedicated mental health funding to states and territories but includes revenue from other sources (including patient fees and reimbursement by third party compensation insurers) and non-specific Australian Government funding provided under the Australian Health Care Agreement base grants/National Healthcare Agreement specific purpose payments.

## Per capita spending by state and territory governments

Different population sizes and rates of growth need to be taken into account when reviewing trends in resourcing of mental health services. Higher population growth in some jurisdictions places greater demands upon the resources available for mental health care. Adjusting for this growth is necessary given that this report covers an 18 year period during which significant population shifts occurred.

When population growth is taken into account, growth in mental health spending becomes more conservative than the 145% suggested in Table 2.

Figure 8 shows that per capita adjusted growth over the 18 years was 94%, or an annual average of 5%. Figure 9 shows that the relative positions of the states and territories have shifted over time with, for example, Victoria investing the highest amount per capita in 1992-93 and the lowest amount in 2010-11. Additional detail on jurisdictions' growth is provided in Part 4.

Figure 8

Average per capita expenditure by state and territory governments, 1992-93 to 2010-11 (\$)

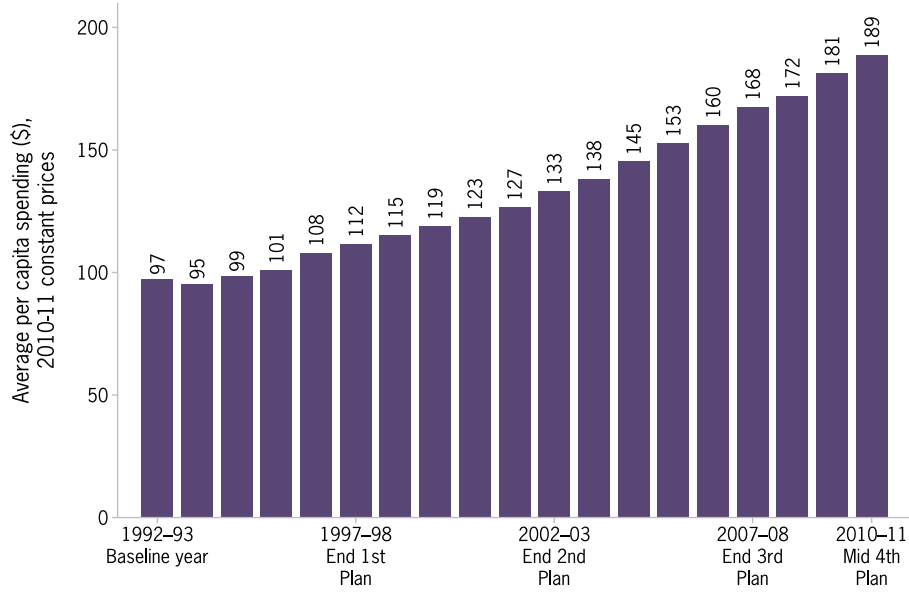
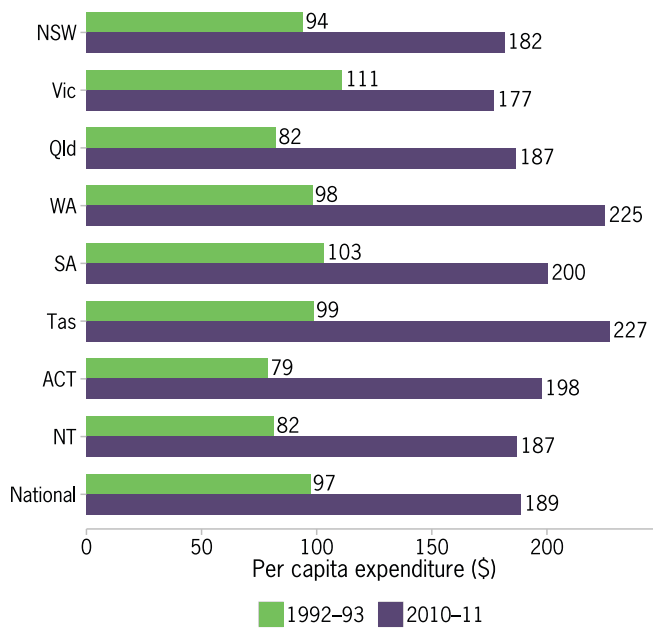


Figure 9

Per capita expenditure by state and territory governments, 1992-93 and 2010-11 (\$)





## State and territory investment in programs for age specific populations

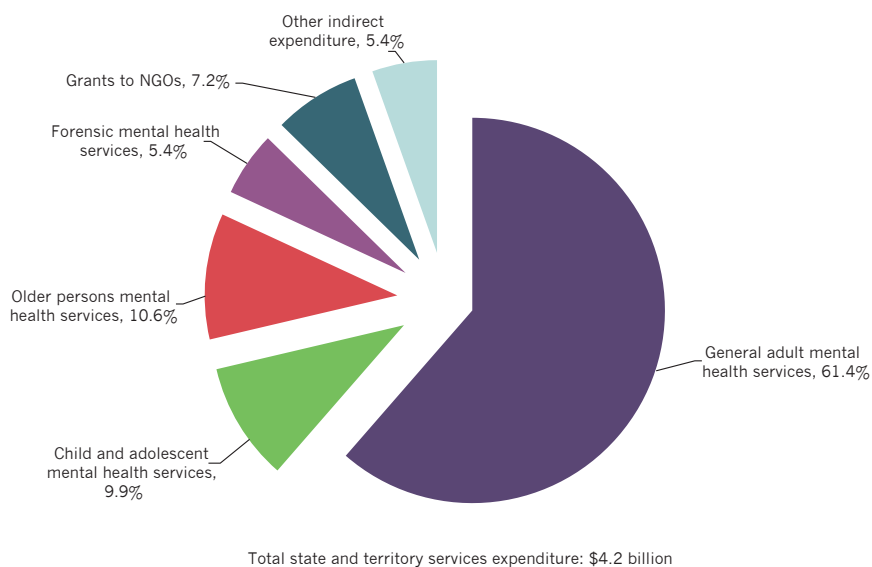
The above perspective provides an overall picture of the relative investments by each of the states and territories in providing mental health services, but does not shed light on how particular population groups are served. Data from the 2010-11 National Minimum Data Set – Mental Health Establishments collection provide the basis for such an analysis, although they do not permit the exclusion of mental health specific grants made by the Australian Government in the same way as the data reported in the overall state and territory analyses described above.

Distribution of funds in each state and territory is organised into general adult, older persons, child and adolescent and forensic programs and services. Figure 10 summarises how state and territory funding was distributed across these

program areas in 2010-11. It shows that just under two thirds of expenditure was directed to general adult services, which primarily serve those aged 18-64 years. The remainder was distributed across the other population groups, in grants to NGOs and in other indirect expenditure.

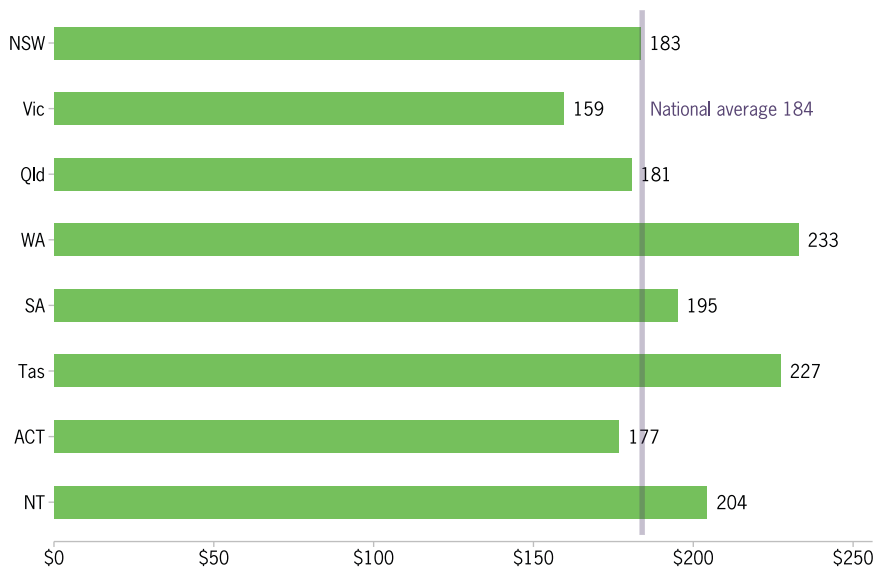
Substantial differences exist between jurisdictions in both the extent to which mental health services are differentiated according to age specific programs and the level at which these programs are funded. Figure 11 shows the per capita level of funding provided for general adult mental health services by each state and territory, and Figure 12 and Figure 13 provide the same information for child and adolescent services and older persons' services respectively.

Figure 10  
National summary of state and territory government mental health expenditure by program type, 2010-11<sup>a,b</sup>



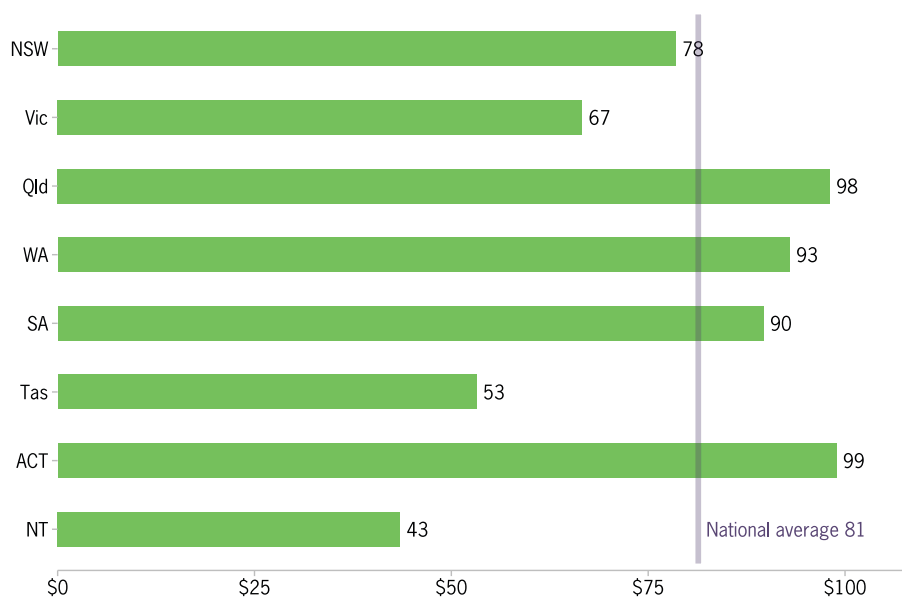
(a) Youth mental health services (0.2% of total state and territory mental health expenditure) have been included in child and adolescent mental health services; (b) NGO expenditure excludes residential services managed by the NGO sector. This expenditure is targeted mainly at the adult population.

**Figure 11**  
Per capita expenditure by states and territories on general adult mental health services (\$), 2010-11<sup>a,b,c</sup>



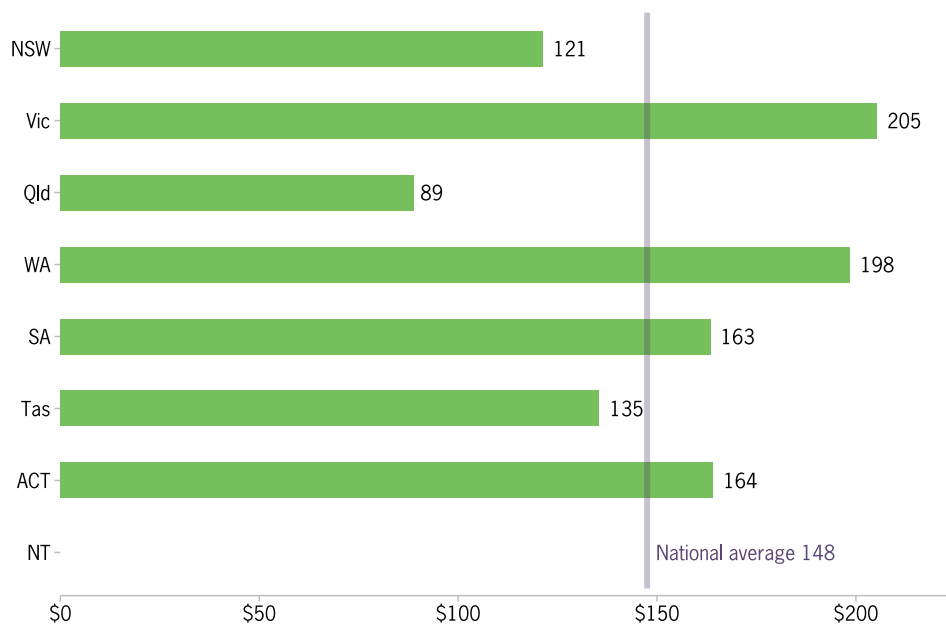
(a) Estimated expenditure for each age specific population is based on the classification of services reported to the Mental Health Establishments National Minimum Dataset, not the age of consumers treated; (b) Analysis excludes NGO grants (other than NGO managed staffed residential services) and expenditure on services classified as Forensic Psychiatry; (c) Per capita rates calculated using age specific population denominators.

**Figure 12**  
Per capita expenditure by states and territories on child and adolescent mental health services (\$), 2010-11<sup>a,b,c</sup>



(a) Estimated expenditure for each age specific population is based on the classification of services reported to the Mental Health Establishments National Minimum Dataset, not the age of consumers treated; (b) Analysis excludes NGO grants (other than NGO managed staffed residential services) and expenditure on services classified as Forensic Psychiatry; (c) Per capita rates calculated using age specific population denominators.

**Figure 13**  
Per capita expenditure by states and territories on older persons' mental health services (\$), 2010-11<sup>a,b,c</sup>



(a) Estimated expenditure for each age specific population is based on the classification of services reported to the Mental Health Establishments National Minimum Dataset, not the age of consumers treated; (b) Analysis excludes NGO grants (other than NGO managed staffed residential services) and expenditure on services classified as Forensic Psychiatry; (c) Per capita rates calculated using age specific population denominators.

Together, these figures show that the relative positions of the 'well resourced' and 'poorly resourced' jurisdictions differ depending on which age related program is considered. For example, although Queensland is one of the lower per capita spending jurisdictions, its expenditure on child and adolescent mental health services in 2010-11 was 21% above the national average. Tasmania, on the other hand, is the second top spending jurisdiction overall, but spends 35% less than the national average on child and adolescent mental health services.

The analysis highlights that, while mental health services are not provided uniformly across Australia, the greatest variation is in the availability of specialist child and adolescent and older persons' services, with a nearly two and a half fold difference between the highest and lowest spending jurisdictions.

It should also be noted that general adult mental health services provide care not only for the adult population but also for children and adolescents and older persons. Indeed, where such services do not exist or are less well developed (such as in the Northern Territory), general adult services substitute. The net impact is that in some jurisdictions, estimates of the total expenditure on adults are overstated because a proportion of the resources is necessarily used to provide services to younger or older people.

Differences between the jurisdictions may reflect different population needs, different ways of organising services, or a combination of both. At this stage, there is no national agreement on how mental health budgets should be split across age specific programs.

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## Caveats about mental health spending trends

The data presented in this report on mental health spending trends need to be interpreted in the context of two reminders about the limitations of an exclusive focus on health spending.

The first concerns the fact that spending patterns do not tell us about what is actually delivered in terms of the volume and quality of services and the outcomes they achieve. In the context of the National Mental Health Strategy, understanding how resources are allocated is necessary but not sufficient to judge whether policy directions are achieving the intended benefits for the community. Simply put, more dollars do not necessarily produce more or better services. The indicators reported in Part 3 go some way towards addressing this issue, offering a basis for monitoring 'value for money' in current mental health investment.

The second limitation concerns the relationship between resources and needs. Measuring growth over the past 18 years informs us about changes since the commencement of the Strategy. It does not tell us whether the original 1992-93 funding levels were adequate to meet community need, or whether the growth that has taken place has been sufficient to meet new demands that have emerged since the Strategy began. The 2007 National Survey of Mental Health and Wellbeing highlighted continuing and substantial levels of unmet need for mental health services.

The implication is that current funding levels may not be enough to meet priority needs of the Australian population. These concerns underpinned many of the new initiatives announced under the 2006 COAG *National Action Plan on Mental Health*, and, more recently, the 2010 and 2011 Federal Budget measures that allocated \$2.2 billion over five years for a broad range of mental health initiatives. The *Fourth National Mental Health Plan* includes a commitment by all governments to develop a National Mental Health Service Planning Framework that establishes targets for the optimal mix and level of the full range of mental health services that will provide a framework to guide future investment.