Well meant or well spent? Accountability for $8 billion of mental health reform

Despite significant recent public investment in mental health, do we really know what Australia is getting for its money?

Sebastian P Rosenberg
MPubAdmin, Senior Lecturer[1]

John Mendoza
BEd, Adjunct Associate Professor[1]

Lesley Russell
PhD, Research Associate[2]

1 Brain and Mind Research Institute, University of Sydney, Sydney, NSW.
2 Menzies Centre for Health Policy, University of Sydney, Sydney, NSW.

sebastian.rosenberg@sydney.edu.au

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In response to repeated inquiries revealing a profound crisis in the provision of mental health care services,[1] Australia has committed to spending around $8 billion of new money on mental health since 2006. Few would argue that this investment was long overdue, given the significant gap between the funding mental health receives ($5.8 billion[2] out of $113 billion of total health expenditure in the 2008–09 financial year[3]) and the contribution of mental illness to the burden of disease (13%).[4]

However, proper accountability for this expenditure is crucial. Health care consumers, carers, service providers, funders and taxpayers all have a right to know that funding for mental health is being spent judiciously, is targeted at the areas of greatest need, and is delivering better outcomes for people with mental illness.

Establishing this accountability is not easy. The complexity of state and federal Budget announcements (and re-announcements) are the modus operandi of governments and perpetuate an environment characterised by opacity rather than transparency. After decades of underfunding for mental health services, new funding is often simply welcomed without query as to provenance or policy.

In this article, we review the recent wave of mental health funding decisions in Australia. While we want to see the level of funding increase, such increases must be evidence-based, effectively delivered and transparently monitored.

Recent mental health funding

The major contribution to recent funding for mental health has been through the Council of Australian Governments (COAG) National Action Plan (NAP) on Mental Health 2006–2011.[5] This provided $5.5 billion, comprising $2.2 billion from the Australian Government and $3.3 billion from the states and territories. However, analysis of Medicare Benefits Schedule (MBS) item reports shows that the uncapped growth in the Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS (Better Access) initiative alone accounted for $2.1 billion by September 2011. It is concerning that, for such a sizeable investment, there have only been two NAP progress reports published, the most recent being released in September 2009.[6]

A subsequent COAG agreement in 2010 included $1.6 billion to be spent on subacute care, with an unspecified proportion to be allocated to mental health.

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Lastly, there is the federal government's 2011 Budget announcement of a "record" $2.2 billion investment in mental health, partly funded through changes made to curb government payments under the Better Access initiative. A large proportion of this package was to enable continued funding of existing programs like Better Access, but the Budget also continued the government's extensive investment in largely untested semi- or non-professional coordination of services (the Personal Helpers and Mentors Program) and "flexible" packages of care. There are as yet no data to assess how this new funding is progressing.

In total, this new spending represents a significant public investment in mental health and, as such, deserves scrutiny.

COAG National Action Plan funding

The $5.5 billion committed in the 2006–2011 COAG NAP was allocated across four agreed action areas. However, there were no agreed definitions as to what activities could or should occur within each action area, and jurisdictions had complete autonomy over how money would be spent and reported. Consequently, there were significant variations in the funding allocations between jurisdictions (Box).[6]

Fully two-thirds of all NAP funding was allocated to Action Area 2 — "integrating and improving the care system" — while only 5% was allocated to Action Area 4 — "increasing workforce capacity".[6] The bulk of Action Area 2 funds went to the Better Access initiative.

Supported housing options, community participation and employment (Action Area 3) remained secondary elements of the NAP, accounting for 17% of total funding allocations. In New South Wales, more than half the spending in this area ($58 million) was on one program — the Housing and Accommodation Support Initiative. Victoria pledged to spend about $44 million on growing its psychosocial rehabilitation sector, but over a 5-year period (2006–2011) this would barely cover anticipated price pressures and wage increases, let alone service expansion.

Increasing access to mental health care was clearly a key goal of the NAP, but the evidence for progress is equivocal. The second NAP progress report certainly shows substantial service growth over the period 1997–2007, largely accounted for by the growth in Medicare-funded (Better Access) services.[7] It reported that the proportion of the Australian population receiving clinical care for mental illness under Medicare rose from 3.1% in 2006–07 to 4.8% in 2007–08.[6] However, the same progress report also shows that the proportion of the population accessing state-run mental health services dropped from 1.6% to 1.5%. Further, the National Survey of Mental Health and Wellbeing conducted by the Australian Bureau of Statistics

Council of Australian Governments (COAG) National Action Plan (NAP) on Mental Health 2006–2011 funding allocations, by action area and jurisdiction[6]

Jurisdiction	Action area*: 1: Promotion, prevention and early intervention	2: Integrating and improving the care system	3: Participation in the community and employment†	4: Increasing workforce capacity	Total NAP ($ million)
Australian Government	164.2 (8.2%)	1329.8 (66.7%)	369.5 (18.5%)	129.9 (6.5%)	1993.4
New South Wales	121.7 (12.4%)	721.6 (73.6%)	113.8 (11.6%)	23.3 (2.4%)	980.3
Victoria	97.7 (15.2%)	432.1 (67.0%)	110.6 (17.2%)	4.4 (0.7%)	644.8
Queensland	16.3 (1.7%)	717.5 (73.0%)	168.4 (17.1%)	76.9 (7.8%)	983.3
Western Australia	106.8 (22.1%)	216 (44.6%)	139.6 (28.9%)	21.5 (4.4%)	483.9
South Australia	47.1 (16.3%)	215.1 (74.6%)	22.1 (7.7%)	4.2 (1.5%)	288.5
Tasmania	2.2 (3.8%)	36.6 (62.4%)	11.3 (19.3%)	8.6 (14.7%)	58.7
Australian Capital Territory	5.1 (12.3%)	20.1 (48.3%)	8.1 (19.5%)	8.3 (20.0%)	41.6
Northern Territory	1.3 (8.6%)	13 (86.1%)	0.8 (5.3%)	0	15.1
Total	**562.3 (10.2%)**	**3701.8 (67.4%)**	**944.2 (17.2%)**	**277 (5.1%)**	**5490.1**

* Figures shown for each action area are $ million (percentage of total COAG commitment). Percentages may not sum to 100% because of rounding. † Including accommodation. ◆

in 2007 showed that treatment rates for people with a mental illness were unchanged since 1997.[8]

If the spending effort in Action Area 2 has not led to a discernible increase in treatment rates, then what substantive impact is this increased investment in traditional services having on mental health care in Australia? One explanation might be that new funds and new services are struggling to reach new clients. The data for state-run mental health services in the second NAP progress report indicate that this is the case for state and territory services.

The current debate regarding the effectiveness and reach of the Better Access initiative is significant in this regard.[9,10] There is evidence suggesting that groups who were missing out on care before Better Access are still missing out. In 2008, 68% of people using the Better Access program were using it for the first time. In 2009, this figure had dropped to 57%.[11]

The NAP progress report does not provide reasons for the variation in spending priorities between jurisdictions. There is no context to explain why Western Australia should allocate nearly a quarter of its funding to Action Area 1, while Queensland spent almost nothing (Box). Similarly, WA spent four times as much as South Australia on Action Area 3, and the Australian Capital Territory allocated 20% of its effort to workforce development, to which Victoria committed less than 1%. It is conceivable that these jurisdictional variations may be based on local service deficiencies and are therefore warranted. However, if this is the case, it is not clear how such deficiencies were identified.

The NAP progress report shows a patchwork of jurisdictional investments rather than a coordinated national effort to address the agreed priorities. In the absence of nationally consistent definitions and accounting processes, it is impossible to verify whether jurisdictions really did spend what they reported.

2010 COAG agreement funding for subacute care

The 2010 COAG agreement to spend $1.6 billion on creating 1300 subacute beds, some of which are to be allocated to mental health, is also without transparency and agreed guidelines. In making this commitment to subacute care, COAG echoed the 2009 final report of the National Health and Hospitals Reform Commission, which stated:

> We recommend that every hospital-based mental health service should be linked with a multi-disciplinary community-based sub-acute service that supports "stepped" prevention and recovery care.[12]

There has been no progress report on the implementation of the mental health aspect of this agreement, but from public announcements it is possible to once again discern major variations in jurisdictional approaches. Queensland is building community care units, while SA is opting for supported accommodation places with crisis respite support. NSW is allocating all its subacute funding to new beds on hospital campuses. This variation between jurisdictions is not surprising, as there is no agreement on what constitutes subacute mental care. The term "subacute" does not appear anywhere in the National Mental Health Policy 2008 and is mentioned only once in passing in the Fourth National Mental Health Plan.

> "new [mental health] funding is often simply welcomed without query as to provenance or policy"

Alternatives to hospital admission for mental health care in Australia are few. An unpublished national snapshot survey of acute psychiatric wards across Australia in 2006 indicated that 43% of all acute beds were occupied by people who could be cared for in other settings if suitable services were available. The investment in subacute care offers critical opportunities to build new services nationwide. However, competing priorities and a lack of consistent implementation may mean this opportunity could be lost.

Conclusion

Despite these increased investments, mental health's share of overall health spending is shrinking. For the period 2004–05 to 2008–09, total mental health spending in Australia increased by an average of 4.8% per annum,[2] while total health spending rose by more than 5%.[3]

There have been some 44 inquiries into mental health in Australia since the 1890s — about one every 2 and a half

years. Despite these inquiries, and dozens of plans and policies, spending between jurisdictions continues to be uncoordinated, lacking both accountability and a focus on patients' needs. There is little evidence to show that new mental health investments are driving improved health outcomes. For people with mental illness, the spectrum, capacity and quality of services available depends on where they live, and the quality of care goes largely unassessed.

For real accountability, the new National Mental Health Commission must begin with a robust plan to identify and close service gaps based on evidence-based models of care. This should be accompanied by a National Report Card that includes nationally validated data of the experience of care, quality of life, and rates of homelessness, education and employment for people with a mental illness.

Without this, no one will know if mental health funding is well targeted or just well meant.

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