

**Senate Committee
on Commonwealth Funding and Administration
of Mental Health Services**

SUBMISSION

**Some Empirical Evidence about
Economic Problems in Australia's Mental Health Services***

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RELEVANCE TO THE TERMS OF REFERENCE

There are several long-standing economic problems in Australia's mental health services. Apart from the resource shortages that this sector experiences, a problem which attracts much media attention, there are several problems which are not solved by 'throwing dollars' at mental health services.

For example, there is now some evidence of a specific misallocation of resources to which this sector is prone, and which may contribute to the persistent reluctance by governments to provide adequate budgets for people with a mental illness. The term that can be applied to the problem is 'structural imbalance' (our term). We provide evidence of this problem in this submission, and discuss it at some length. Our analysis of relevant data-sets provides some quantification of resource shortage, unmet need and met non-need. Structural imbalance in mental health services can be mistaken for resource shortages as both problems result in some people who need services not being served adequately by the system. Thus, resource shortage, unmet need and met non-need should be regarded as separate issues.

As well, we present empirical evidence about a workforce issue in our submission, along with some evidence about various economic problems with respect to equity of access to services under Medicare. This is based on an empirical study of prices for services under Medicare and some empirical studies of utilisation rates. We have also undertaken some empirical work on measuring mental health inequality. Those results are relevant in view of the fact that equity in access to services is said to be a 'pillar' of Medicare (Blewett, 1988). We finish this submission with a point relating to how to fix two fix-able problems in the economics of Australia's mental health services.

Our submission incorporates our empirical articles. The Terms of Reference relevant to these papers are (b), (c), (d), (e) and (f). The articles are attached/uploaded for the Senate Committee, and we provide some broad summary statements of those articles here.

All our work involves applied economics. It has been undertaken on the basis of our particular backgrounds and experience, which is in Industrial Economics, Welfare Economics, Public Finance and Health Economics. However, for the past 12 years or so (at least since the work associated with our 2001 book, *The Economics of Mental Health Care: Industry, Government and Community Issues*), our work has been concentrated on the mental health sector, rather than the general health sector. Although we currently undertake work on suicide, we have not included our suicide studies, except two empirical studies of mental health inequality: we analysed data on suicides rates for the purposes of determining Gini coefficients and other inequality measures to determine mental health inequality. Those results are included in this submission.

We discuss several policy implications throughout our submission and, in a final section herein, we also offer a discussion of policy gaps and make two policy recommendations. The fact that many of the economic problems in Australia's mental health services are long-standing suggests that the problems are **not self-correcting**. Developing an evidence-base for policy formation is very important. The Senate Committee's concern with the funding and administration of Australia's mental health services is salutary.

We now provide some commentary on our attached empirical articles on mental health services.

UNMET NEED AND MET NON-NEED: TWO SIDES OF A SINGLE PROBLEM

1. Doessel, D.P., Williams, Ruth F.G. and Whiteford, H. (2010), 'Structural Imbalance and Resource Shortage in Mental Health: Australian Results', *Journal of Mental Health Policy and Economics*, Vol. 13, No. 1, pp. 3-12.
2. Doessel, D.P. and Williams, Ruth F.G. (2011a), 'Resource Misallocation in Australia's Mental Health Sector under Medicare: Evidence from Time-series Data', *Economic Papers*, Vol. 30, No.2, June, pp. 253-264.

The first of these papers (Doessel, Williams and Whiteford, 2010) provides empirical evidence of the resource misallocation or 'mismatching' tendency between service utilisation and 'need' for services. This paper is based on the community epidemiological study undertaken by the ABS in 1997. The services examined in Doessel and Williams (2011a) are psychiatric services, GP mental health plans and allied mental health services. Time-series data are examined in that paper; the evidence of the problem in Doessel, Williams and Whiteford (2010) is based on cross-sectional data.

The problem involves 'unmet need' (people with a mental disorder not consuming mental health resources), which is well-known; it exists alongside 'met non-need' (some consumers of mental health resources having no mental

disorder), which is anecdotally discussed but seldom analysed in the literatures of service providers. These are co-existing sides of the same problem, a problem that we call 'structural imbalance'. The sources of the problem are discussed in our papers. Let us first focus on the evidence.

This problem of 'structural imbalance' in the funding and administration of Australian mental health services is not fixed by 'throwing money' at mental illness. Mental health services under Medicare insurance are subject to this specific type of resource misallocation, which involves the mismatching of 'need' and 'service utilisation'. The mismatching problem has also been noted internationally, including in the United States, Ontario (Canada) and New Zealand (cited herein) as well as in our Australian studies. The empirical evidence in our two Australian studies will now be introduced.

We found evidence of this problem first in a study of the available Australian cross-sectional data (Doessel, Williams and Whiteford, 2010); we then undertook a study of time-series data (Doessel and Williams, 2011a), and found further evidence of unmet need and met non-need. Despite this evidence, it must be emphasised that doing work on this problem is **not** to suggest that the correspondence between current illness and service use is completely misaligned.

The data on both need and utilisation in Doessel, Williams and Whiteford (2010) is cross-sectional data from the 1997 Australian Bureau of Statistics epidemiological survey *Mental Health and Wellbeing...*, which was the only available data at the time of the study. This study finds 1,477,500 mentally ill people in the 'unmet need' category. This group (receiving no mental health services) represents 62 per cent of all mentally ill people, and 11 per cent of the Australian population. On the other hand, there is a group of 591,600 people who consume mental health services but do not meet the criteria of mental illness. This group represents 4.4 per cent of the adult population. In this study, we also present clear evidence of resource insufficiency.

In the Doessel and Williams (2011a) study which analyses time-series data for structural imbalance, evidence of extensive structural imbalance is found not just in psychiatric services but in GP mental health plans and the (post-2006) services of allied mental health services as well. Details of the mismatch are depicted in the Figures in Doessel and Williams (2011a). Note that our two studies measure service utilisation by 'people' counts. In the absence of expenditure data, we use 'people' as a proxy for the ideal concept of expenditure.

Jorm, who has made a submission to this Committee, also presents evidence of this problem. It is contained in his submission 'Australia's Better Access Initiative: Do the Evaluation Data Support the Critics?':

... the data reported by Pirkis and colleagues show that over 90% had a diagnosis of an anxiety or depressive disorder and that over 80% had high or very high psychological distress on the K10. Furthermore, the greatest symptom improvement was seen in those with the greatest pre-treatment distress. Similarly, an analysis of data from the 2007 National Survey of Mental Health and Wellbeing [4] found that only 7% did not have an ICD-10 mental disorder or other indicator of need for treatment. Indeed, around half were assessed as having a severe disorder. It is clear that the "worried well" comprise only a very small minority of Better Access Users (Jorm, 2011, p. 6).

Note that the K10 (mentioned in this quoted passage) is an instrument that measures **psychological distress**. The above paragraph indicates that people with psychological distress are receiving treatment under Medicare. But psychological distress is **not** a mental illness. The DSM-IV is very clear: psychological 'distress' is **not** a mental illness; diagnoses of psychological distress are to be classified under the V-codes as they are not mental illnesses. Moreover, the K10 (as applied by Pirkis and colleagues) 'show that over 90% had a diagnosis of an anxiety or depressive disorder and that over 80% had high or very high psychological distress on the K10'. Jorm's paragraph then continues: 'Furthermore, the greatest symptom improvement was seen in those with the greatest pre-treatment distress.' We note Jorm's view that the number is 'only 7%' and 'a very small minority' (Jorm's words). Given the extent of 'unmet need' and resource shortage in Australian mental health services, we do not think that seven per cent is a trivial number of services users with 'met non-need'. These service users ought not to be receiving services under Medicare.

Thus, there is a problem in Australian mental health services with diagnostic efficacy and it must be emphasised that diagnostic efficacy is not just relevant to treatment; it is relevant also to improving resource allocation in the mental health sector. Where there is any diagnostic **inefficacy** (a problem which has, in mental health services, become exacerbated) (as discussed in our articles) then, under insurance, there will be some people with no mental disorder accessing government-subsidised mental health services.

In this content, we mention two papers which elaborate on one of the aspects of this **shift in attitudes** to mental health services, as these papers may also be helpful to the Committee:

Williams, Ruth F.G. and Doessel, D.P. (2010), 'Psychiatry Interacts with Contemporary Western Views: the *DSM-III* Innovation and its Adverse Effects', *Prometheus*, Vol 28, No. 3, pp. 245-266.

Williams, Ruth F.G. (2009), 'Review Article: "Everyday Sorrows are not Mental Disorders": The Clash between Psychiatry and Western Cultural Habits', *Prometheus*, Vol. 27, No. 1, pp. 47-70.

We conclude this Section by emphasising that **no public policy issue** would exist if these service users fund from their own incomes the services that they consume; but if those mental health services are funded either by pooled private health insurance contributions or by partially, or fully, subsidised taxpayer-funded schemes like Medicare, **then there is a policy issue**. This economic problem has become like 'the elephant in the room' that is being side-stepped.

We discuss the policy implications in our articles. This problem can be addressed by a requirement that a firm diagnosis of mental disorder is established (by valid psychological instruments) with a further requirement that the (positive) diagnosis so obtained is the pre-condition for receiving treatment via subsidised mental health services. However, in the US, where that approach is applied, a problem has developed in that some everyday conditions are now being defined 'in' as a mental illness. For example, (complicated) grief may soon be defined as a mental illness by the forthcoming edition of the DSM (*DSM-V*). Kay Redfield Jamison in her book, *Nothing was the Same*, eloquently makes the following distinction between grief and depression: 'Grief conspires to ensure that it will in time wear itself out. Unlike depression, it acts to preserve the self. Depression is malignant, indiscriminately destructive. Grief may bear resemblance to depression but it is a distant kinship' (Jamison, 2009).

Decisions about the stance that will be taken under Australia's Medicare as to what is to be funded are thus very important. If decisions are not made, structural imbalance will continue and may become exacerbated.

THE BROAD ECONOMIC STRUCTURE OF AUSTRALIAN MENTAL HEALTH SERVICES

We believe the Senate Committee could also be usefully informed by the material in the following three broad overviews of Australia's mental health services:

3. Doessel, D.P., Tonmukayakul, Utsana and Williams, Ruth F.G. (2011), 'Quantifying the Economic Structure of the Australian Mental Health Sector since 1992-93', *International Journal of Mental Health*, Summer, In press.
4. Williams, Ruth F.G., Doessel, D.P., Scheurer, R.W. and Whiteford, H. (2006), 'Some Economic Dimensions of the Mental Health Jigsaw in Australia', *International Journal of Social Economics*, Vol. 33, No.12, pp. 808-31.
5. Doessel, D.P. (2009), 'A Historical Perspective on Mental Health Services in Australia: 1883-84 to 2003-04', *Australian Economic History Review*, Vol. 49, No. 2, pp. 173-197.

In Doessel, Tonmukayakul and Williams (2011) the Committee will find an empirical overview which quantifies and describes some key dimensions of the mental health sector in Australia since 1992-93. In Williams, Doessel, Scheurer and Whiteford (2006), the first of our empirical overviews, data on private FFS psychiatric services were studied in some detail. This study sheds some light on the operations of Medicare in the context of private fee-for-service (FFS) psychiatry.

Doessel (2009) is an historical overview of Australia's mental health services under deinstitutionalisation. It is concerned with 'quantifying temporal changes in the output produced within those institutions providing dedicated services for the long-term mentally ill. The objective is to measure the effect of explicit (or implicit) social policy on that part of the hospital industry dealing with chronic mental illness' (Doessel, 2009, p. 173).

We make further mention here of Doessel, Tonmukayakul and Williams (2011). This article provides three broad perspectives on the economic structure of the sector. First we describe the sector's size by measuring expenditures and sources of funding in absolute and relative terms. Second, we examine expenditures since 1992-93 on specialized mental health services including stand-alone and co-located hospital services, community mental health services, residential services, non-government organizations, and so on. Finally, we undertake a regional perspective on population-adjusted measures of service provision data and measure regional dispersion. We determine whether

there has been convergence or divergence in the provision of specialized mental health services across Australia's main regions since 1992-93. This study, which is an important overview, is possible because of the data having been collected on mental health services in Australia since the advent of the National Mental Health Strategy.

Another article is Doessel, D.P., Williams, Ruth F.G. and Whiteford, H. (2009), 'Deinstitutionalisation and Managerialism in Queensland's Public Psychiatric Institutions: Challenging "Rhetoric" with Empirical Results', *Australian Journal of Public Administration*, vol. 68, no. 4, pp. 459-483. We have not uploaded this article, but mention it so that the Committee is aware that there are some empirical results on one aspect of the management of public psychiatric hospitals. This paper looks beyond the rhetoric of a health bureaucracy, not simply at what the bureaucrats **say they do** but also at what **they do**. There is a difference!

A WORKFORCE ISSUE

In Doessel and Williams (2011b), as follows, we provide an empirical account of the relative temporal decline of an important segment of the medical labour force, *viz.* psychiatry, and the rise of the paramedical mental health professions.

6. Doessel, D.P. and Williams, Ruth F.G. (2011b), 'The "Rise and Rise" of New Professional Groups: Mental Health Professions under Medicare', *Australian Bulletin of Labour*, Vol. 37, No. 1, pp. 97-126.

This ascendancy became more marked after 2006, the year in which the paramedical professions were brought under the umbrella of Medicare. Through a series of graphs, the article shows a modest growth in the number of psychiatrists per 100,000 population but an average decline in hours worked. This is also reflected in the declining number of services provided per psychiatrist (since the mid-1990s) by the psychiatry labour force: a maximum of 1,400 annual services in 1995-96 and in 2004-05 it had fallen to 1,065. There have also been falling average numbers of patients seen per psychiatrist. Thus, on average, relatively fewer patients are being treated by the psychiatry labour force since the 1990s. We also find that government subsidies for specialist psychiatry services have fallen relative to all medical services provided under the Medicare system. At the start of Medicare (February, 1984) subsidies for psychiatry services were 3.01 per cent of all Medicare subsidies, and by 2006-07 the share had fallen to 1.97 per cent. Some empirical evidence also indicates that net prices (out-of-pocket prices to consumers/patients) have risen since the advent of Medicare. The article then provides evidence of the marked rise in subsidies paid for the new paramedical services in population-adjusted terms.

Arguably more mental health services are needed for those people subject to mental illness having 'unmet need'. If so, then these trends in psychiatry clearly indicate little hope of obtaining those increased services from the psychiatry labour force. Encompassing allied mental health services under the umbrella of Medicare since 2006 can be viewed as 'an historic change' from this perspective, and has several implications for addressing serious mental illness.

PRICES AND QUANTITIES OF SERVICES UNDER MEDICARE

We would also like to provide the Senate Committee with the results of several studies that determined the gross and net prices for mental health services, *i.e.* the prices before and after the Medicare rebate/subsidy. These studies quantify the trends through time across the main regions of Australia since the start of Medicare. Utilisation rates for the services have also been quantified spatially, and through time and we have measured the inequality in the spatial distribution of utilisation. Although this work was undertaken prior to the Medicare items for allied mental health services, the results can usefully inform the Senate Committee.

7. Williams, Ruth F.G. and Doessel, D.P. (2007), 'The Gross Prices of Private Fee-for-Service Psychiatric Services under Medicare in Six Australian Regions 1984-2001', *Economic Papers*, Vol. 26, No. 1, pp. 86-101.
8. Williams, Ruth F.G. and Doessel, D.P. (2004), 'Equality of Spatial Access and Medicare: An Empirical Study of the Numbers of Private Fee-for-Service Psychiatric Services in the Australian States/Territories 1984-2001', *Australasian Journal of Regional Studies*, Vol. 10, No. 2, pp. 225-53.
9. Williams, Ruth F.G. and Doessel, D.P. (2009), 'Private psychiatry and Medicare: Regional Equality of Access in Australia?', *Journal of Mental Health*, Vol. 18, No. 3, pp. 242-252.

The following paper is a conceptual study. It applies geometry to show conceptually how the price structure of Medicare 'works' for mental health services, using two-dimensional price-quantity space. This article is for a more technically-inclined reader, but we wish to inform the Senate Committee of its 'relevance'.

10. Doessel, D.P. and Williams, Ruth F.G. (2004), "Prices and Subsidies for Australian Psychiatric Services: A Positive Analysis", *International Journal of Social Economics*, Vol. 31, Nos 5-6, pp. 544-60.

It should also be mentioned, in view of the fact that 'need' is an oft-heard word with respect to mental health services, that the following paper may also be useful to the Committee. It is another conceptual paper (though not too technical) and provides an economic classification of (health) 'need'. It may provide some useful (conceptual) clarification with respect to need, which is a word applied to many quite disparate (economic) concepts.

11. Williams, Ruth F.G. and Doessel, D.P. (2011), 'An Economic Classification of "Health Need" ', *International Journal of Social Economics*, Vol. 38, No. 3, pp. 291-309.

EQUALITY AND EQUITY

Further to the concern with equity of access under Medicare, mentioned above, we can provide the Senate Committee with a study of mental health inequality. The data that we examine are suicide data. With those data we have found that no improvement has occurred in mental health inequality in the study period. This result suggests that access to mental health services for the seriously mentally ill remains a neglected and long-standing problem in Australia. However, the problem is fixable: policies that improve access to services for seriously mental ill people and that addresses the unmet need will help to ameliorate this trend.

12. Doessel, D.P., Williams, Ruth F.G. and Robertson, J.R. (2010), 'Changes in the Inequality of Mental Health: Suicide in Australia, 1907-2003', *Journal of Health Economics, Policy and Law*, Vol. 6, No. 1, pp. 23-42.
13. Williams, R.F.G. and Doessel, D.P. (2009), 'Is Mental Health Improving? Some Initial Evidence from Australia', *Applied Economics Letters*, Vol. 16, No. 2, pp. 131-136.

A FINAL POLICY MATTER

There is a final problem to mention which, at a quick glance, may seem to be outside the Committee's Terms of Reference but is implicit right across the entire Terms of Reference.

The starting point for discussing this problem is the observation that Australia's federal structure of government is reflected in the supply of mental health services. The Commonwealth of Australia does not 'control' the provision of **hospital-based** health services in Australia: the governments of the states/territories do that. Hospital-based mental health services (it may be said) are beyond the 'control' of the Commonwealth of Australia and hence are not relevant to the Committee's Terms of Reference. (We note the heading for the Senate Inquiry is 'Commonwealth Funding and Administration of Mental Health Services'.) But this argument is a 'cop-out' (to use a colloquialism). We highlight a case below (people who attempt suicide) who are often at the interface of hospital-based care and ambulatory care.

The design of Medibank/Medicare by Richard Scotton and John Deeble (two economists located at The University of Melbourne) in the late 1960s-early 1970s, was designed not simply to pursue an equity objective (as eloquently expressed by Dr Neal Blewett, the then Minister for Health in the mid-1980s)(Blewett, 1988). The concern was also to address 'market failures' in the health sector. In other words, the various economic characteristics of health, emphasised by Kenneth Arrow (1963) in his famous paper, led to the failure of market mechanisms to produce all the relevant health service outputs. However, we now know that there is another problem, i.e. **government failure**. This concept is used to describe a problem that may be equally important as the problem of market failure. This issue can be illustrated by reference to the Life Promotion Clinic, which is located at Griffith University in Brisbane.

In 2004, the Australian Institute of Suicide Research and Prevention (AISRAP) at Griffith University established (and has continued to operate) the first outpatient clinic in Australia to provide specialised treatment for people with a history of suicidal behaviour. The primary goal of this Life Promotion Clinic is to reduce morbidity and mortality associated with suicidal behaviours. Referrals are accepted from Queensland public mental health services, e.g. Community Mental Health Services, public hospitals etc.

In the period 2004-07, the Life Promotion Clinic was funded by donations from members of the Community Action for the Prevention of Suicide, and other private donors. The Clinic has no dedicated recurrent funding from the Queensland Government or the Australian Government, and accommodation is provided by Griffith University. Community donations are needed for the Clinic to address adequately the increasing demand for relevant and specialised suicide prevention services.

The background information is noteworthy here because, in a sense, the Life Promotion Clinic highlights a 'gap'.

Gaps in Australia's Health System

In Australia's system of health funding and the provision of health services, a 'gap' requiring efficacious policy exists. The gap relates to the fact that, in large part, the **hospital** Medicare system provides 'cure' for acute illness, whilst any stay over the '35-day limit' has to 'go away' as the illness/condition is no longer 'acute'. Similarly, the provision of primary and specialist care under fee-for-service Medicare is largely concerned with acute, or episodic, illness. Specialised low-care and high-care services are provided for chronic conditions. They are provided under the general term 'aged care'. **The implication is that the Australian Government has had to address chronic medical conditions in a special fashion.**

People with a history of suicide attempts can be described as having chronic 'psychache', to use Schneidman's term (Schneidman, 1996). 'Psychache' is Schneidman's general term for the condition of mental, psychological or emotional **pain** brought on by various factors, including mental disorders: it is that which is believed will 'go away' by applying the act of suicide to one's life.

The provision of services under the Medicare system does not 'fit' with such people, in terms of aligning with their needs. How does one comprehend the gaps when they arise? There is an extensive literature in economics on 'market failure' (Bator, 1958); market failure explains much of government regulation and the provision of public goods. Essentially, the private sector does not produce all the goods and services that people desire, e.g. national defence, law and order etc. An example of market failure in the health sector is the case of inoculations for infectious diseases.

People (and firms) make decisions about such products on the basis of their own interests, and take no account of the benefits that accrue to other people, i.e. the social benefits. The market fails in the sense that too few inoculations are produced and consumed. However, the problem of government failure is another problem (Wolf, 1979; Le Grand, 1991; Tullock, Seldon and Brady, 2002). It is less often discussed.

Charitable behaviour by private agencies (religious hospitals etc.) has often been described as a manifestation of market failure (Arrow, 1963). However, the illustration here is about the Life Promotion Clinic. This is a non-government, non-Medicare organisation providing medical services that are **not** produced under the Medicare system. **This can be described as a 'government failure' or a 'Medicare failure'.**

Government failure was first described by members of the public choice school in economics. It refers to cases where government actions do not provide the goods and services that people want. In the public choice formulation, government failure arises from politicians and bureaucrats 'pursuing their own agenda', notwithstanding their rhetoric about acting 'in the public interest'. Generally, governments can

- i. **produce** goods and services, and
- ii. **raise taxation** revenue and **subsidise** some goods and services, and
- iii. engage in **regulations** to ensure the quality of the goods and services produced by the private sector.

In any, or all, of these three activities, governments can also 'make mistakes' or allow 'gaps' to exist. However, before discussing 'mistakes' and 'gaps', let us consider these three general mechanisms at work in the Australian health system. These three mechanisms in a health system can be regarded in the following terms:

- i. Australia's state/territory governments own and operate public hospitals that **produce** hospital-based services, which are provided to Australian citizens (and permanent residents) at zero prices under the hospital part of the Medicare system.

- ii. Australian government taxes and the **taxation revenue** of the states and territories are used to produce these hospital-based services **and** are used also **to reduce the prices** (often to zero under Medicare's bulk-billing arrangements) of privately-provided services produced by GPs and medical specialists.
- iii. Engage in **regulation**, such as in the regulation of the qualifications of medical personnel, the quality of pharmaceutical devices etc.

But these three arrangements can be subject to 'gaps'. For example, dental services may be excluded from insurance coverage. In such a case, oral health is neglected. There is the prospect of **government failure** if the coverage of **all relevant health conditions** is incomplete. In other words, the funding and provision of health services, or the 'architecture' of a health system, is flawed when there is government failure because it is due to the government's inadequate design of the system.

The design flaw in Australia's health system that is central to assisting where people attempt to take their own lives is that such people 'fall between the cracks' of a system that makes a sharp distinction between 'acute' medical conditions and 'chronic' medical conditions. This design flaw has existed in Medicare's architecture since its inception in February, 1984, as well as in its predecessor, the 1975 Medibank system. The flaw arose only because the focus of the architects of Medicare, Richard Scotton and John Deeble, was on the framework or 'big picture'.) On the one hand, the hospital-based Medicare system and the subsidised fee-for-service Medicare system, are designed to address acute medical conditions. On the other hand, chronic conditions requiring institutional care, in large part, are handled by Australia's system of (high care) nursing homes.

Belated recognition of how the individualistic, and isolated, environment of fee-for-service general practice was not conducive to co-operative or community medical care, which could improve integration with other elements of the health system, led to the formulation of the nation-wide system of Divisions of General Practice announced in the 1992-93 Australian Government Budget. This development, following on from the Register of General Practice, was a major innovation in Australia's medical landscape.

Structures such as the GP Divisions, with the emphasis on the health of the community, have had the effect of 'breaking up' the fixed fee-for-service structure, to some extent. We refer here to the advent of 'blended payments' being incorporated into the medical system. 'Blended payments' are in addition to fee-for-service payments to GPs: they are made when GPs achieve specific targets for child immunisation, screening for early detection of disease etc.

However, chronic medical conditions are not confined to those that require institutional care, i.e. nursing homes. Some common examples of chronic medical conditions include asthma, cancer, cardiovascular disease, diabetes mellitus, musculoskeletal conditions, strokes etc. These conditions do not lend themselves to a one-off, un-coordinated approach to therapy or management.

One development was the adoption of the *National Chronic Disease Strategy* for the Australian Health Ministers Conference in 2005 (National Health Priority Action Council, 2005). This was a nationally-agreed plan to encourage a co-ordinated approach to the increasingly important effects of chronic disease on Australians' health. The *Strategy* identified a number of National Health Priority Areas: arthritis and musculoskeletal conditions; cardiovascular health, injury prevention and control etc. (Mental health was not included.) But more importantly was the institutional response of the Department of Health and Ageing by introducing new 'Chronic Disease Management' Items into the *Medicare Benefits Schedule*. There are now six Items that financially remunerate GPs to manage chronic (or terminal) medical conditions by preparing, co-ordinating, reviewing or contributing to a Chronic Disease Management Plan. In addition, eligible patients are entitled to claim for allied health services as well as monitoring and supporting the work of Practice Nurses.

Another example of how the existing structure of the health system does not serve well a particular group of the population relates to intellectual disability. The general health needs of this small sub-set (about one per cent of the population) has not been well-served by the general structure of the health system which is currently prevailing. However, two new items (Item 718 and Item 719) were recently introduced into the *Schedule* for GPs to undertake the Comprehensive Health Assessment Program (CHAP) for people with intellectual disability. This is a clear example of how the health system can be changed to address a 'gap', or a 'government failure' in the design of the health system.

Another is the supply of health services to rural areas. Rural communities generally have low utilisation rates for health services. There are approximately 66 specific Australian Government rural health programs, largely because mainstream programs do not adequately address the needs of rural and remote communities (quoted in McGrail and Humphreys, 2009).

These are but a few examples of how the health sector has been changed by government policy to address specific health issues. It is now relevant to ask the following question: why should a research institute (AISRAP at Griffith University) operate an organisation such as the Life Promotion Clinic? Is it a university's role to 'fix' an imperfect health system? The short answer is 'no'. The function of a university is to teach, and to do research.

However, some relevant research for AISRAP cannot be done because there is a gap in the structure of health services in Australia. The Life Promotion Clinic is a manifestation of a university filling a **gap** in the health system. AISRAP fills this gap because of its objective to undertake evidence-based research. Moreover, the ethos of the Life Promotion Clinic with its non-judgemental approach is quite unlike a large multi-purpose hospital.

It is useful now to ask **how** these changes or reforms to health systems 'come about'. There is, on the one hand, the approach that achieved the decision to create the Register of General Practice and subsequently Divisions of General Practice in the early 1990s. Those reforms can be interpreted to be the result of the **pressure-group activities over many years** of the Royal Australian College of General Practitioners, which is the peak body concerned with professional issues and standards for the practice of medicine at the level of primary care in Australia. For some details, see the papers in Doessel (1990). On the other hand, the addition of two Items (Item 718 and Item 719) to the *Medicare Benefits Schedule* for people subject to intellectual disability can be explained by the traditional **research** activity of a university. Professor Nick Lennox (Director of the Queensland Centre for Intellectual and Development Disability at The University of Queensland), *inter alia*, advocated for this reform as a result of an empirical evaluation of the CHAP in a randomised setting (Lennox *et al.*, 2007).

TWO 'BOTTOM LINES'

A good outcome from this Senate Inquiry would be that the Committee make the following two recommendations:

1. That mental health services are for people with mental disorders, not stress or distress from every-day living. Before Medicare funding of any mental health services is approved, diagnostic tests must be undertaken to prevent the met non-need problem continuing.

[It is relevant to note that there is a **precedent** for conditions associated with mental health services being specified in the Medicare Benefits Schedule: we refer the Committee to Item 319. See Doessel *et al.* (2007) for an evaluation of the efficacy of the changed financial incentive associated with Item 319.]

2. That the Department of Health and Aged Care amend the *Medicare Benefits Schedule* in such a way that eligible persons (people who have attempted suicide) be funded to access a 'package' of mental health services, the contents of that 'package' being determined on the advice of experts in the field, such as the staff of the Life Promotion Clinic at Griffith University.

[Eligibility criteria, the content of the 'package', different 'packages' for people with different levels of severity etc are variables on which expert advice needs to be sought.]

REFERENCES

- Arrow, K.J. (1963), 'Uncertainty and the Welfare Economics of Medical Care', *The American Economic Review*, Vol. 53, pp. 941-973.
- Bator, F.M. (1958), 'The Anatomy of Market Failure', *Quarterly Journal of Economics*, Vol. 72, pp. 351-379.
- Blewett, N. (1988), 'The Policy Context in Australia: Commonwealth Government Support for Improved Access to Health and Better Health', *Community Health Studies*, Vol. XII, pp. 106-111.
- Doessel, D.P. (1990)(ed.), *Evaluation in General Practice: A Workshop on Vocational Registration*, Department of Community Services and Health, Canberra.
- Doessel, D.P., Scheurer, R.W., Chant, D.C. and Whiteford, H. (2007), 'Financial Incentives and Psychiatric Services in Australia: an Empirical Analysis of Three Policy Changes', *Health Economics, Policy and Law*, Vol. 2, pp. 7-22.
- Jamison, Kay Redfield (2009), *Nothing was the Same*, Knopf Doubleday, New York.
- Le Grand, J. (1991), 'The Theory of Government Failure', *British Journal of Political Science*, Vol. 21, pp. 423-442.
- Lennox, N., Bain C., Rey-Conde, T., Purdie, D., Bush, R. and Pandeya, N. (2007), 'Effects of a Comprehensive Health Assessment Programme for Australian Adults with Intellectual Disability: A Cluster Randomised Trial', *International Journal of Epidemiology*, Vol. 3, pp. 139-146.
- McGrail, M.R. and Humphreys J.S. (2009), 'Geographical Classification to Guide Rural Health Policy in Australia', *Australian and New Zealand Health Policy*, Vol. 6, p. 28.
- National Health Priority Action Council (2005), *National Chronic Disease Strategy*, Department of Health and Ageing, Canberra.
- Schneidman, E.S. (1996), *The Suicidal Mind*, Oxford University Press, Oxford.
- Tullock, G., Seldon, A. And Brady, G.L. (2002), *Government Failure: A Primer in Public Choice*, Cato Institute, Washington DC.
- Wolf, C. (1979), 'A Theory of Non-Market Failure: Framework and Intervention', *Journal of Law and Economics*, Vol. 22, pp. 107-139.