# Expenditure on mental health services

This section reviews the available information on recurrent expenditure (running costs) for mental health-related services in Australia. Health expenditure (what was spent) and health funding (funding provided and who provided the funds) are distinct but related concepts essential to understanding the financial resources used by the health system. Data on expenditure and funding, calculated in both current and constant prices, are derived from a variety of sources, as outlined in the data source section.

As most data presented is for the 2017–18 period, constant prices are adjusted to 2017–18 levels, including more recent 2018–19 Australian Government Medicare expenditure and mental health-related medications subsidised under the PBS and RPBS expenditure data, where data is presented in time series. Further information on health expenditure is also available in Health expenditure Australia 2017–18 (AIHW 2019).

### Data downloads

<xls data download>

<pdf data download>

Data coverage includes the time period 1992–93 to 2017–18. Data in this section were last updated in January 2020.

## Key points

**$9.9 billion**, or $400 per person, was spent on mental health-related services in Australia during 2017–18, a real increase from $382 per person in 2013–14.

**1.1%** annual average increase in the real per capita spending on mental health-related services from 2013–14 to 2017–18.

**7.6%** of government health expenditure was spent on mental health-related services in 2017–18.

**$6.0 billion** was spent on state/territory mental health services in 2017–18; $2.6b on public hospital services; $2.3b on community services.

**$1.3 billion,** or $51 per person, was spent by the Australian Government on benefits for Medicare-subsidised mental health-specific services in 2018–19.

**$541 million,** or $21 per person, was spent by the Australian Government on subsidised mental health-related prescriptions under the PBS/RPBS during 2018–19.

# Overview

The national recurrent expenditure on mental health-related services was estimated to be around $9.9 billion in 2017–18. Overall, national expenditure on mental health-related services increased from $382 per person in 2013–14 to $400 per person during 2017–18, adjusted for inflation; an average annual increase of 1.1%.

Of the $9.9 billion spent nationally in 2017–18, state and territory governments funded 60.6% ($6.0 billion), the Australian Government 33.9% ($3.4 billion), and private health insurance funds and other third party insurers 5.5% ($544 million). These proportions have remained relatively stable over time, with 59.1% of national spending coming from state and territory governments, 36.4% from the Australian Government, and 4.5% from private health insurance funds and other third party insurers in 2013–14.

Government expenditure on mental health-related services in 2017–18 was estimated to be around 7.6% of total government health expenditure, which is a small decrease from 7.8% in 2013–14.

Funding from the Australian Government for mental health-related services (adjusted for inflation) has increased by an average annual rate of 1.0% over the period 2013–14 to 2017–18, while funding from state and territory governments increased by an average annual rate of 3.2%.

The National Mental Health Commission's 2014 Review of Mental Health Programmes and Services (NMHC 2014) used a broader methodology to estimate Australian Government expenditure on mental health. The methodology included broader mental health-related costs, such as the Disability Support Pension and Carer Payment and allowances. The Australian Government mental health-related expenditure in 2012–13 was estimated to be $9.6 billion, compared to $2.8 billion using the methodology employed in this publication, as outlined in the data source section.

# Specialised mental health services expenditure

## Recurrent expenditure

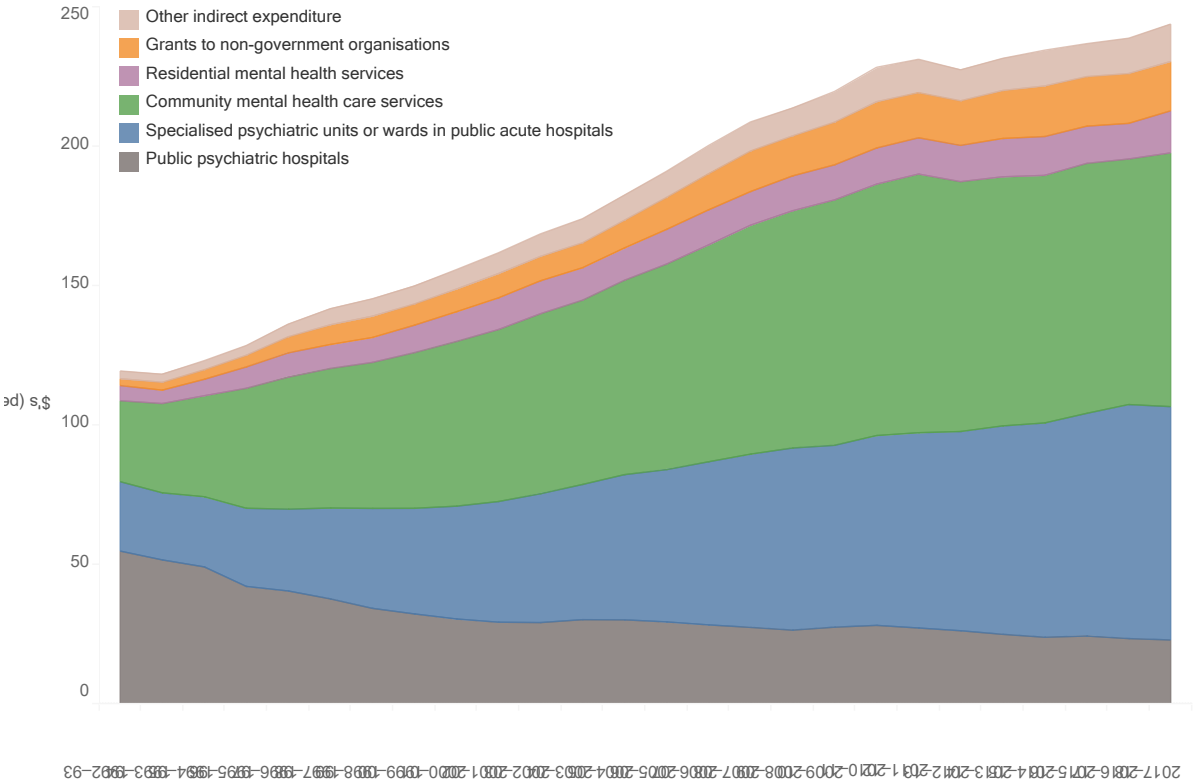
Around $6.0 billion was spent on state and territory specialised mental health services in 2017–18. The largest proportion of this recurrent expenditure was spent on public hospital services for admitted patients ($2.6 billion), comprising of public acute hospitals with a specialist psychiatric unit or ward (almost $2.1 billion) and public psychiatric hospitals (almost $0.6 billion). This was closely followed by expenditure on community mental health care services totalling $2.3 billion.

Per person expenditure on specialised mental health services ranged from $228 per person in Victoria to $315 per person in Western Australia, compared to a national average of $244 per person during 2017–18.

Expenditure on state and territory specialised mental health services, adjusted for inflation, increased by an average annual rate of 2.9% between 2013–14 and 2017–18. This equates to an increase of about $12 per person, from about $231 in 2013–14 to about $244 in 2017–18.

Detailed expenditure data are available covering 25 years to 2017–18. Figure EXP.1 shows the changes in state and territory spending patterns, for example, increased investment in community mental health care services, reflecting changes to the state and territory specialised mental health service profile mix over this time. Further information can be found in the Specialised mental health care facilities section.

Figure EXP.1: Recurrent expenditure ($) per capita on state and territory specialised mental health services, constant prices, 1992-93 to 2017-18




Sources: Australian Government Department of Health, National Survey of Mental Health Services Database (1992-93 to 2004-05); National Mental Health Establishments Database (2005-06 onwards); Table EXP.4

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# Funding

The majority (96.9% or $5.9 billion of the $6.0 billion total cost) of funding for state and territory specialised mental health services was provided by state or territory governments in 2017–18. However, this estimate does not take into account the Australian Government payments to states/territories for the running of public hospital services which includes the community-based clinical services managed by public hospitals. Refer to the data source section for technical information regarding Australian Government expenditure.

# Public sector specialised mental health hospital services

The $2.6 billion of recurrent expenditure for public sector specialised mental health hospital services during 2017–18 equates to an average cost per patient day of $1,178. The Northern Territory ($1,816) had the highest average cost per patient day, while the average cost in Queensland ($1,031) was the lowest.

Recurrent expenditure on public sector specialised mental health hospital services can be further described using target population (*General*, *Child and adolescent*, *Youth*, *Older person* and *Forensic* target groups), program type (acute and non-acute), or a combination of these.

## Target population and program type

Mental health services classified as having a *General* target population ($1.9 billion or 72.5%) accounted for the majority of recurrent expenditure for public sector specialised mental health hospital services during 2017–18. *Child and adolescent* services ($2,106 per patient day) had the highest costs per patient day, continuing a long term trend of these services costing more to run than services with *General* target population ($1,162 per patient day), *Older person* ($1,029 per patient day) and *Forensic* ($1,208 per patient day) services.

There was an average annual increase in expenditure per patient day for *General* (1.9%), *Child and adolescent* (3.5%), *Older person* services (3.7%), and *Forensic* services (0.8%) between 2013–14 and 2017–18, adjusted for inflation.

Average patient day costs for acute public sector specialised mental health hospital services at the national level were higher than those for non-acute services for all target population categories in 2017–18.

## Community mental health care services

Community mental health care services accounted for $2.3 billion of recurrent expenditure on mental health services during 2017–18, representing 37.3% of total state/territory expenditure in 2017–18.

## Residential mental health services

Of the $374 million spent on residential mental health services during 2017–18, the majority was spent on 24-hour staffed services ($331 million or 88.6%). *General* services ($262 million) accounted for more than two thirds (70.1%) of the total residential expenditure.

The average national cost per patient day for residential mental health services was $480 per day in 2017–18. Average costs varied between states and territories, ranging from $328 per patient day in Western Australia to $742 per patient day in the Australian Capital Territory.

## Expenditure by target population

Recurrent expenditure for public sector specialised mental health hospital, community and residential services can be combined and presented by target population. Expenditure on *General* services ($239 per person) was the highest of the 5 target populations during 2017–18, reflecting that many jurisdictions do not have the other specialised target population hospital services which contribute substantial costs to the overall expenditure profile. Adjusted for inflation, per capita expenditure between 2013–14 and 2017–18 has increased slightly for *General*, *Child and adolescent* and *Forensic* services while per capita expenditure on *Youth* services increased by an average of 16.3% per year. Over this time period, per capita expenditure on *Older person* services decreased by an average of 1.8% per year. This average annual decrease is likely because expenditure on *Older persons* services has not increased to the same extent as the increases in the *Older persons* population. For example, while the adjusted expenditure on *Older person* services increased 5.8% to $580 million between 2013–14 and 2017–18, the *Older person* population (65 years and over) increased by 13.8% to 4.0 million people over the same period.

## Private hospital specialised mental health services

Total revenue for specialised mental health private hospital services was $735 million in 2017–18, and the non-Commonwealth sourced component of this revenue was $544 million. Adjusted for inflation, these represent annual average increases from 2013–14 of 7.1% and 8.2% per year respectively. Expenditure on specialised mental health services in private hospitals was not available for 2017–18 due to changes in how the data is collected (see below), however historically this has been about 80% of revenue (averaged over 25 years), and was about 78% in 2016–17.

In previous years, estimates of expenditure on specialised mental health services in private hospitals were derived from the annual Private Health Establishment Collection (PHEC) undertaken annually by the Australian Bureau of Statistics. PHEC was discontinued after 2016-17. Commencing 2017-18, estimates of private psychiatric hospital care are based on the Private Psychiatric Hospitals Data Reporting and Analysis Service (PPHDRAS), a collection jointly funded by the Australian Private Hospitals Association and the Australian Government Department of Health. See the Data Source section further information.

# Australian Government expenditure

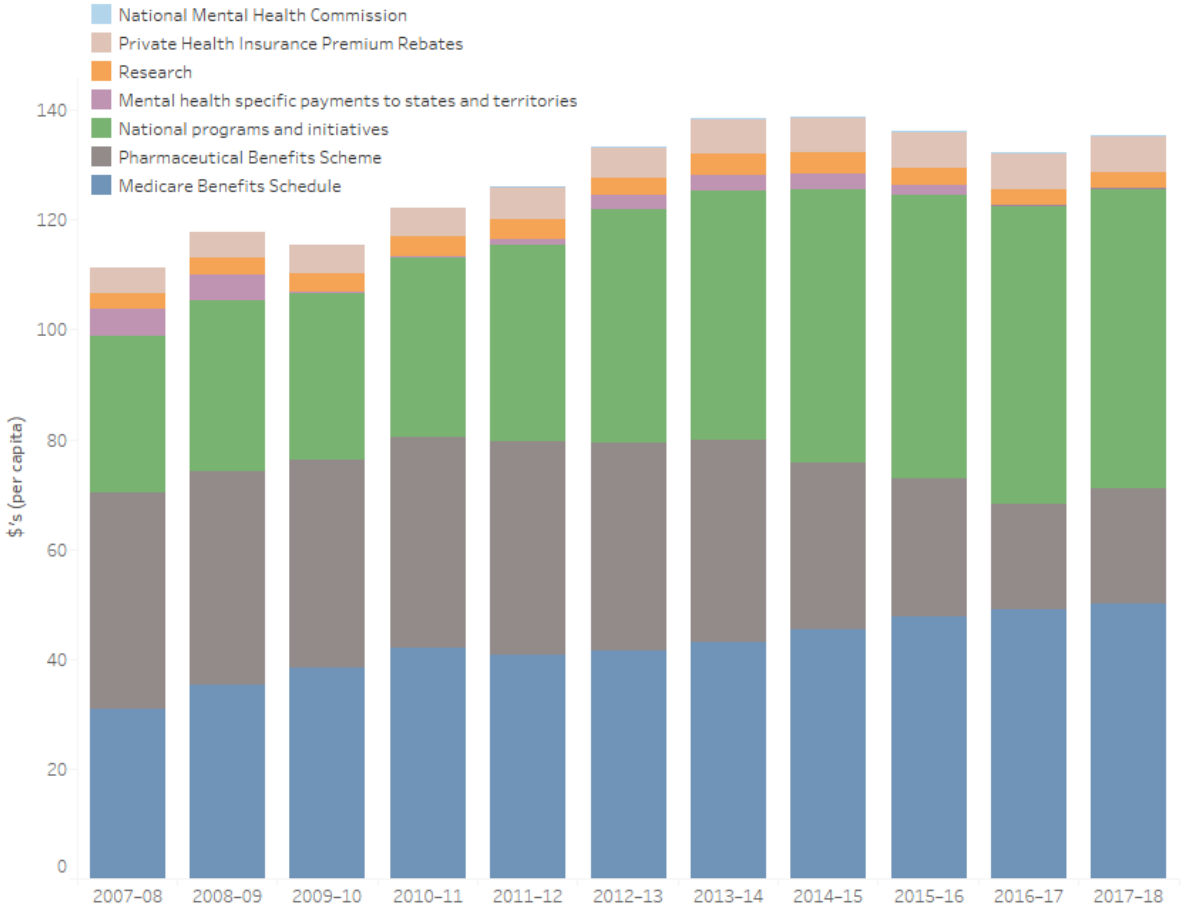
## Australian Government expenditure on mental health-related services

Australian Government expenditure on mental health-related services was estimated to be $3.4 billion in 2017–18. However, as noted previously and detailed in the data source section of this report, there are other known Australian government outlays attributable to supporting mental health issues which are not included in this estimate, for example, disability support pensions and the Australian Government's contribution to public hospital costs. Note that expenditure previously reported by DSS for 2016–17 excluded NDIS transitioning program expenditure but this has been amended in the current reporting.

Australian Government expenditure on mental health-related services, adjusted for inflation, increased by an average annual rate of 1.0% between 2013–14 and 2017–18. This equates to a small decrease, adjusted for inflation, from almost $139 per person in 2013–14 to $135 in 2017–18. Changes in PBS/RPBS expenditure substantially impacted the overall change, declining by almost $16 per person over this time frame, specifically due to expenditure on antipsychotics and antidepressants declining by about $11 and $6 per person respectively. This was likely the result of a decrease in the subsidised cost of some medications, partly due to some medications no longer being under patent.

Expenditure on MBS-subsidised mental health-specific services and mental health-related medications provided through the PBS accounted for 52.5% of the total in 2017–18 (Figure EXP.2). The next largest component was spending on National programs and initiatives managed by the Department of Health (22.5%), the Department of Social Services (7.0%), the Department of Veterans' Affairs (6.2%), and Private Health Insurance Premium Rebates (4.9%). Since 2007–08, there has been a decrease in the Government cost of PBS mental health-related prescriptions and an increase in MBS-subsidised services and programs and National programs and initiatives. Medication prices can reduce for a variety of factors (for example, Price Disclosure or statutory price reductions due to patent changes - legislation mandated by the Government to reduce the PBS listed price of drugs), refer to the Mental health-related prescriptions section and PBS.gov.au for more information on the Pharmaceutical Benefits Scheme (PBS) or Repatriation Pharmaceutical Benefits Scheme (RPBS). Technical information regarding the calculation of these figures can be found in the data source section.

Figure EXP.2: Australian Government expenditure ($) per capita, on mental health-related services, constant prices, 2007–08 to 2017–18




National programs and initiatives includes: programs managed by Department of Health, programs managed by DSS, programs managed by DVA, Department of Defence funded programs, Indigenous social and emotional wellbeing programs, National Suicide Prevention Program.

*Source:* Australian Government Department of Health (unpublished); Table EXP.31 www.aihw.gov.au/mhsa

Australian Government expenditure on Department of Defence funded programs has increased by an average of 7.6% per year for the period 2013–14 ($39.0 million) to 2017–18 ($52.3 million), adjusted for inflation. The expenditure covers a range of mental health programs and services delivered to Australian Defence Force (ADF) personnel. When the number of permanent ADF personnel is taken into consideration (58,363 people; Department of Defence, 2018) this equates to $897 per permanent ADF member in 2017–18.

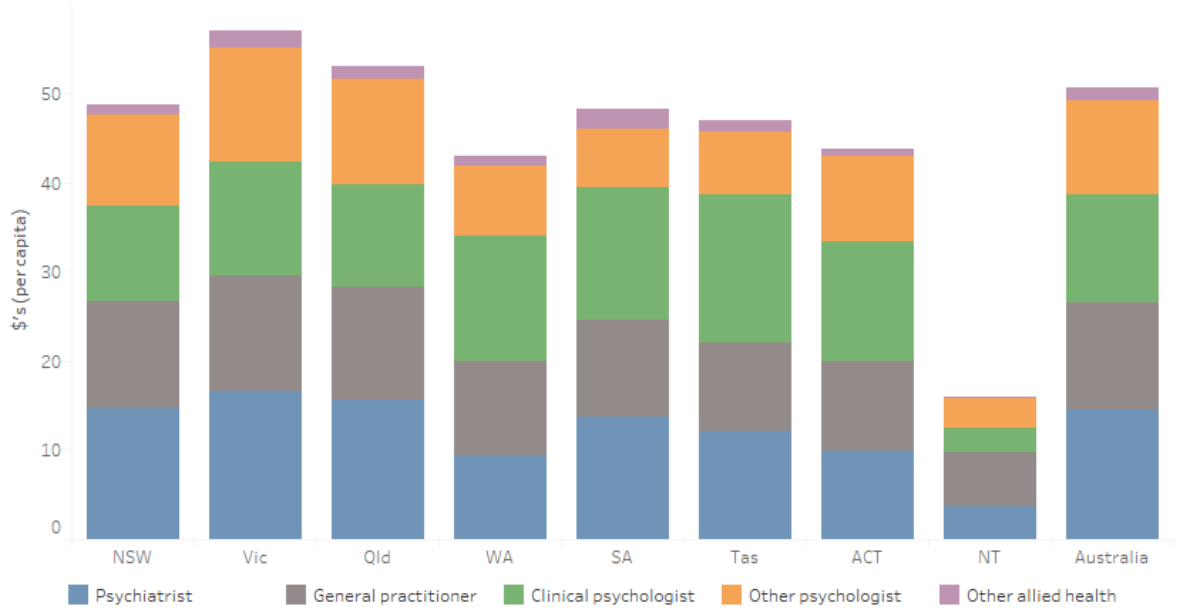
# Australian Government expenditure on Medicare-subsidised mental health-specific services

More recent expenditure data for 2018–19 Medicare-subsidised mental health-specific services is presented in this section. Throughout this section, Medicare-subsidised mental health-specific services refers to the mental health-specific services subsidised by the Australian Government through the Medicare Benefits Schedule (MBS). These services include mental health-specific services provided by psychiatrists, general practitioners (GPs), psychologists (both clinical and other), and other allied health professionals and are defined in the MBS. Refer to the data source section for further information on the estimation of GP expenditure prior to 2007–08.

In 2018–19, $1.3 billion was paid in benefits for Medicare-subsidised mental health-specific services, equating to 5.3% of total MBS expenditure ($24.3 billion - including Dental Benefits Schedule and the Child Dental Benefits Schedule) (DHS 2019). Expenditure for services provided by psychologists ($580 million or 44.8%) made up the largest proportion, comprising mostly Psychological Therapy Services (clinical psychologists; $310 million) and Focussed Psychological Strategies (other psychologists; $264 million). Expenditure on services provided by psychiatrists was the next largest expenditure group ($372 million or 28.7%). GP expenditure comprised $307 million (23.7%) of total Medicare subsidised mental health-related benefits.

Nationally, benefits paid for Medicare-subsidised mental health-related services averaged $51 per person in 2018–19, adjusted for inflation to 2017–18 prices (Figure EXP.3). The average benefits paid per person was highest in Victoria ($57 per person), and lowest in the Northern Territory ($16 per person).

Figure EXP.3: Australian Government expenditure ($) per capita Medicare-subsidised mental health-specific services, constant prices, by provider type, 2018–19




Note: *'Clinical psychologist'* refers to psychological therapy services provided by a clinical psychologist, and *'Other psychologist'* includes other psychology services involving clinical psychologists and other psychologists.

*Source:* Medicare Benefits Schedule data; Table EXP.20

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There was an average annual increase of 4.4% in the total expenditure on Medicare-subsidised mental health-related services (adjusted for inflation) between 2014–15 and 2018–19. This change equates to an average annual increase (per person) in spending of 2.8%, adjusted for inflation, from $45 in 2014–15 to $51 in 2018–19.

## Australian Government expenditure on mental health related subsidised prescriptions

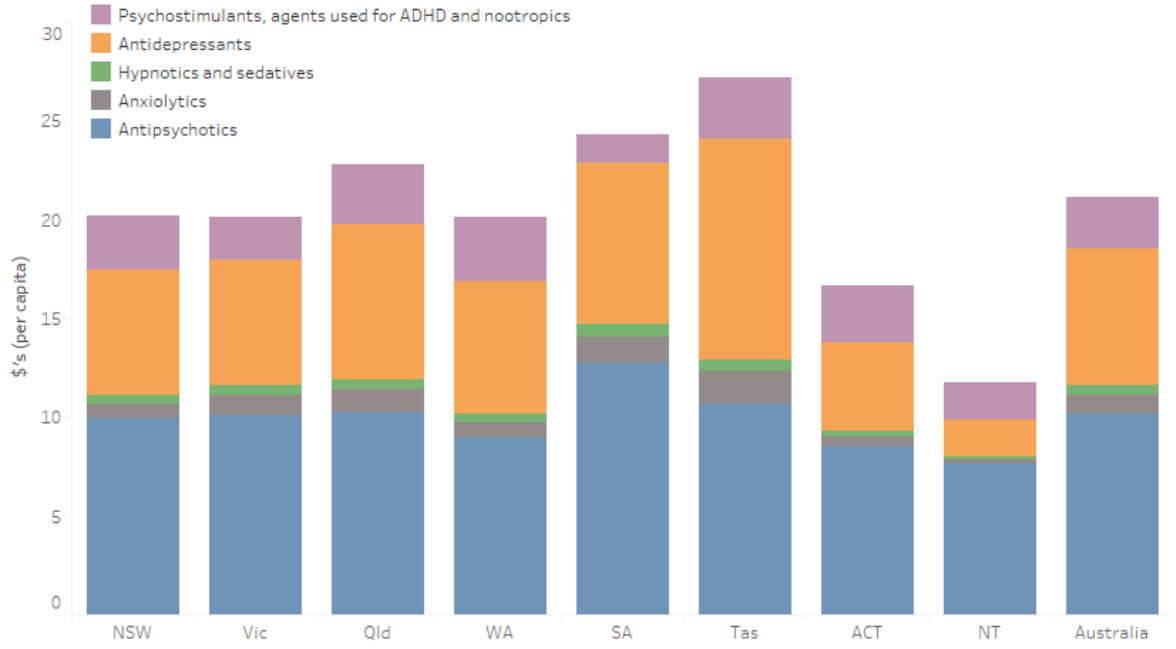
More recent expenditure data for 2018–19 PBS/RPBS mental health-related subsidised prescriptions are presented in this section. For information on data quality, coverage and other aspects of the PBS and RPBS refer to the data source section. The related Prescriptions section has information about the PBS and RPBS system and data on the number of prescriptions.

Australian Government expenditure on mental health-related subsidised prescriptions under the PBS and RPBS was $541 million, or $21.50 per person in the Australian population, in 2018–19. This was equivalent to 4.5% of all PBS and RPBS subsidies ($12.2

billion) (DHS 2019). Prescriptions for antipsychotics (48.2%) and antidepressants (32.5%) accounted for the majority of mental health-related PBS and RPBS expenditure in 2018–19, followed by prescriptions for psychostimulants, agents used for Attention-deficit hyperactivity disorder (ADHD) and nootropics (12.4%), anxiolytics (4.5%) and hypnotics and sedatives (2.4%).

Tasmania ($27.61 per person) had the highest per capita cost of PBS/RPBS medications, and the Northern Territory ($11.95) the lowest, compared with the national per capita cost of $21.50 (Figure EXP.4). For most states and territories, the cost of antipsychotics was the largest proportion of PBS/RPBS costs, followed by antidepressants, except for Tasmania where the cost of antidepressants was more than antipsychotics.

Figure EXP.4: Australian Government expenditure ($) per capita, mental health-related medications subsidised under the PBS/RPBS, constant prices, by type of medication prescribed (ATC group), states and territories, 2018–19




*Source:* Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme data; Table EXP.28. www.aihw.gov.au/mhsa

Over two-thirds (69.3% or $375 million) of the expenditure on mental health-related subsidised prescriptions was for prescriptions issued by GPs. This was followed by prescriptions written by psychiatrists (16.3% or $88 million), with non-psychiatrist specialists' prescriptions accounting for 9.2% ($50 million).

Real expenditure (constant prices) for mental health-related prescriptions declined between 2014–15 and 2018–19, from $729 million to $532 million. This was the result of a decrease in the subsided cost of some medications rather than a reduction in prescribing. The subsidised and total number of mental health-related prescriptions

grew at annual average rates of 0.4% and 3.2% per year respectively over this period (see table PBS.7). Medication prices can reduce for a variety of reasons (for example, Price Disclosure); refer to the Mental health-related prescriptions section for more information.

# Data source

## National Mental Health Establishments Database

Collection of data for the Mental Health Establishments (MHE) National Minimum Data Set (NMDS) began on 1 July 2005, replacing the Community Mental Health Establishments NMDS and the National Survey of Mental Health Services. The main aim of the development of the MHE NMDS was to expand on the Community Mental Health Establishments NMDS and replicate the data previously collected by the National Survey of Mental Health Services. The National Mental Health Establishments Database is compiled as specified by the MHE NMDS.

The scope of the MHE NMDS includes all specialised mental health services managed or funded, partially or fully, by state or territory health authorities. Specialised mental health services are those with the primary function of providing treatment, rehabilitation or community health support targeted towards people with a mental disorder or psychiatric disability. These activities are delivered from a service or facility that is readily identifiable as both specialised and serving a mental health care function.

The MHE NMDS data are reported at a number of levels: state, regional, organisational and individual mental health service unit. The data elements at each level in the NMDS collect information appropriate to that level. The state, regional and organisational levels include data elements for revenue, grants to non-government-organisations and indirect expenditure. The organisational level also includes data elements for salary and non-salary expenditure, numbers of full-time-equivalent staff and mental health consumer and carer worker participation arrangements. The individual mental health service unit level comprises data elements that describe the function of the unit. Where applicable, these include target population, program type, number of beds, number of accrued patient days, number of separations, number of service contacts and episodes of residential care. In addition, the service unit level also includes salary and non-salary expenditure and depreciation.

Data Quality Statements for National Minimum Data Sets (NMDSs) are published annually on the Metadata Online Registry (METeOR). Statements provide information on the institutional environment, timelines, accessibility, interpretability, relevance, accuracy and coherence. Refer to the Mental health establishments NMDS 2017–18: National Mental Health Establishments Database, 2020; Quality Statement.

## Data validation

Data presented in this publication are the most current data for all years presented. The validation process rigorously scrutinises the data for consistency in the current collection and across historical data. The validation process applies hundreds of rules to

the data to test for potential issues. Jurisdictional representatives respond to each issue before the data are accepted as the most reliable current data collection. This process may highlight issues with historical data. In such cases, historical data may be adjusted to ensure data are more consistent. Therefore, comparisons made to previous versions of Mental health services in Australia publications should be approached with caution.

## New South Wales CADE and T–BASIS services

All New South Wales Confused and Disturbed Elderly (CADE) 24-hour staffed residential mental health services were reclassified as specialised mental health non-acute admitted patient hospital services, termed Transitional Behavioural Assessment and Intervention Service (T-BASIS), from 1 July 2007. All data relating to these services have been reclassified from 2007–08 onwards, including number of services, number of beds, staffing and expenditure. Comparison of data over time should therefore be approached with caution.

## New South Wales HASI Program

Since 2006, New South Wales has been developing the NSW Housing Accommodation Support Initiative (HASI) Program. This model of care is a partnership program between NSW Ministry of Health, Housing NSW and the non-government-organisation (NGO) sector that provides housing linked to clinical and psychosocial rehabilitation services for people with a range of levels of psychiatric disability. These services are out-of-scope as residential services according to the MHE NMDS, however, are reported as Supported housing places. Expenditure on the HASI program is reported as Grants to non-government-organisations. For further information see the NSW HASI program.

## Rate calculations

Calculations of rates for target populations are based on age-specific populations as defined by the MHE NMDS metadata and outlined below:

- *General* services: persons aged 18–64
- *Child and adolescent* services: persons aged 0–17
- *Youth* services: persons aged 16–24
- *Older persons*: persons aged 65 and over
- *Forensic* services: persons aged 18 and over.

As the ages included in the target population groups overlap, the rates for the target populations cannot be summed to generate the total rate.

Crude rates were calculated using the Australian Bureau of Statistics estimated resident population (ERP) at the midpoint of the data range (for example, rates for 2017–18 data were calculated using ERP at 31 December 2017). Historical rates have been recalculated using revised ERPs, as detailed in the online technical information.

# Private Health reporting

## Private Health Establishments Collection

From 1992–93 to 2016–17 (excluding 2007–08) the ABS conducted a census of all private hospitals licensed by state and territory health authorities and all freestanding day hospitals facilities approved by the Commonwealth Department of Health. As part of that census, data on the staffing, finances and activity of these establishments were collected and compiled in the Private Health Establishments Collection. Additional information on the Private Health Establishments Collection can be obtained from the ABS publication *Private hospitals, Australia* (ABS 2018).

The data definitions used in the Private Health Establishments Collection are largely based on definitions in the *National health data dictionary* (NHDD) published on the AIHW's Metadata Online Registry (METeOR) website (AIHW, 2015). The ABS defines private psychiatric hospitals as those licensed or approved by a state or territory health authority and which cater primarily for admitted patients with psychiatric, mental or behavioural disorders (ABS 2018). This is further defined as those hospitals providing 50% or more of the total patient days for psychiatric patients. This definition can be extended to include specialised units or wards in private hospitals, consistent with the approach in the public sector. For further technical information, see the Private psychiatric hospital data section of the *National mental health report 2013* (DoH 2013).

Caution is required when comparing the ABS data for 2011–12 onwards to earlier years because the survey was altered in 2010–11 such that psychiatric units could no longer be separately identified from alcohol/drug treatment units. Therefore, the data for beds, patient days, separations and staffing from 2011–12 onwards are estimates based on reported 2010–11 data and trends observed in previous years. Data from the Private Mental Health collection suggest that these data may be underestimates (PMHA 2013).

The Private Health Establishments Collection was discontinued in 2016-17.

## Private Psychiatric Hospitals Data Reporting and Analysis Service

The Australian Private Hospitals Association Private Psychiatric Hospitals Data Reporting and Analysis Service (PPHDRAS), previously known as the Private Mental Health Alliance Centralised Data Management Service (PMHA CDMS), was launched in Australia in 2001 to support private hospitals with psychiatric beds to routinely collect and report on a nationally agreed suite of clinical measures and related data for the purposes of monitoring, evaluating and improving the quality of and effectiveness of care. The PPHDRAS works closely with private hospitals, health insurers and other funders (e.g.

Department of Veterans' Affairs) to provide a detailed quarterly statistical reporting service on participating hospitals' service provision and patient outcomes.

The PPHDRAS fulfils two main objectives. Firstly, it assists participating private hospitals with implementation of their National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures. Secondly, the PPHDRAS provides hospitals and private health funds with a data management service that routinely prepares and distributes standard reports to assist them in the monitoring and evaluation of health care quality. The PPHDRAS also maintains training resources for hospitals and a database application which enables hospitals to submit de-identified data to the PPHDRAS. The PPHDRAS produces an annual statistical report. In 2017–18, the PPHDRAS accounted for 98% of all private psychiatric beds in Australia.

From 2017–18, all private hospital data is sourced from the Private Psychiatric Hospitals Data Reporting and Analysis Service (PPHDRAS). Data on expenditure and Staffing (FTE) are not collected in PPHADRAS.

# Australian Government expenditure on mental health-related services

The Australian Government Department of Health annually compiles the total Australian Government expenditure on mental health-related services. This practice was initiated in 1992–93 for publication in the National Mental Health Report which continued through to 2013 as the final publication year, and subsequently incorporated in related reports. Estimated Australian Government expenditure reported in table EXP.31 of this report covers only those areas of expenditure that have a clear and identifiable mental health purpose. A range of other expenditure, which may be either directly or indirectly related to the provision of support for people affected by mental illness, is not covered in this table. Broadly, this covers:

- programs and services principally targeted at providing assessment, treatment, support or other assistance to people affected by mental ill health
- population-level programmes that have as their primary aim the prevention of mental illness or the improvement of mental health and well-being
- research with a mental health focus.

Expenditure that can be directly linked to mental health service provision, but not counted in the Commonwealth spending estimates includes:

- An estimated mental health share of Commonwealth payments made to states for the running of public hospitals provided through the non-specific 'base grants' provided to states and territories under the former:
    - Medicare Agreements (1993–98)
    - Australian Health Care Agreements (1998–03, 2003–09)

- National Healthcare Agreements (2009–2012)

For the years indicated, because most state and territory mental health services were delivered through public hospitals, and made up about 10% of state-run health services, it is reasonable to assume they benefitted from Commonwealth funding contributions. However, estimates have not been included in reporting for historical reasons – principally because payments were not specifically tagged for mental health purposes and therefore fell outside the definition of 'mental health specific' services when decisions were made about how Commonwealth funding contributions would be attributed across the two levels of government.

- From 2012-13, Commonwealth contributions for state and territory public hospital services paid under the former Medicare Agreements, Australian Health Care Agreements and National Healthcare Agreements were replaced by new arrangements under the National Health Reform Agreement (NHRA). These arrangements include grants and activity-based payments specifically tied to the operation of specialist mental health services delivered by state and territory-managed public hospitals. While the quantum of funding made for mental health specific services under the NHRA is significant and identifiable, expenditure of those funds continues to be attributed to states and territories on the basis of their role as system managers of Australia's public hospital services. Current estimates available to the Department of Health, based on public reports of the National Health Funding Body (https://www.publichospitalfunding.gov.au/) indicate that mental health specific payments made by the Commonwealth under the NHRA in 2018-19 totalled $1.79 billion.
- From 2006–07, the costs of GP-provided mental health care delivered using MBS general consultation items rather than the mental health specific items introduced to the MBS in November 2006. See section 'Medicare Benefits Schedule—general practitioners' below for further details.
- An estimated mental health share of Commonwealth payments to states for sub-acute mental health services made under the National Partnership Agreement – Improving Public Hospital Services (2009–2014). Although mental health sub-acute beds represented 16% of the growth funded under the Agreement, programme specific expenditure was not tracked under the NPA reporting arrangements preventing mental health estimates being distinguished from payments for other categories of subacute beds. As a broad estimate however, the mental health component of the Agreement represented approximately $175 million over the period 2010–11 to 2013–14.
- Commonwealth subsidies paid to nursing homes and hostels provided for mental health-related care in nursing homes.
- All administrative overheads associated with administration of the mental health items within the MBS and PBS (Note: administrative costs associated with the

Department of Health's mental health policy and program management areas are included).

Costs of mental health related costs for support packages delivered under the National Disability Insurance Scheme are also currently excluded from estimates of Australian Government expenditure. A staged implementation of the National Disability Insurance Scheme (NDIS) began in July 2013. People with a psychiatric disability who have significant and permanent functional impairment are eligible to access funding through the NDIS. In addition, people with a disability other than a psychiatric disability, may also be eligible for funding for mental health-related services and support if required. These costs are expected to be significant at full NDIS scheme roll-out.

In addition, the Australian Government provides significant support to people affected by mental illness through income security provisions and other social and welfare programs. Consistent with the focus on mental health specific expenditure, these costs have been excluded from the analysis.

The following detailed notes on how estimates specific to Australian Government mental health specific expenditure have been revised in consultation with the Department of Health, building on those described in Appendix 11 of the National Mental Health Report 2010 (DoHA 2010).

## Mental health-specific payments to states and territories

For years up to 2008–09, this category covers specific payments made to states and territories by the Australian Government for mental health reform under the Medicare Agreements 1993–98, and Australian Health Care Agreements 1998–2003 and 2008–09. From July 2009 the Australian Government provided Specific Purpose Payments (SPP) to state and territory governments under the National Healthcare Agreement (NHA) that do not specify the amount to be spent on mental health or any other health area. Therefore, specific mental health funding cannot be identified under the NHA.

From 2008–09 onwards, the amounts include:

- National Partnership Agreement—National Perinatal Depression Plan—Payments to States, ending 30 June 2015;
- National Partnership Agreement—Supporting Mental Health Reform, commencing 2011–12; and
- National Partnership Agreement—Improving Health Services in Tasmania (Innovative flexible funding for mental health), commencing 2012–13.

Nil payments are shown from 2016-17 as all three National Partnerships were completed by 2015-16.

The expenditure reported here excludes payments to states and territories for the development of subacute mental health beds made under Schedule E of the National Partnership Agreement - Improving Public Hospital Services, which totalled $175 million

over the period 2010–11 to 2013–14. Mental-health specific payments cannot be separately identified from payments for other categories of subacute beds made to states and territories.

The data under this item do not include Department of Veterans' Affairs payments to states and territories for public hospital mental health services delivered to veterans and other eligible recipients. These costs are included under the item 'National programs and initiatives (DVA managed)'.

## National program and initiatives (Department of Health managed)

This category of expenditure includes the following programs and activities:

Initiatives funded through national mental health reform funding provided under special appropriations linked to the Australian Health Care Agreements (excluding amounts reported against Mental health specific payments to states and territories above).

- For years up to 2005–06, this covers the following categories of Commonwealth spending:
    - National Mental Health Program
    - National Depression Initiative (beyondblue)
    - More Options Better Outcomes (ATAPS)
    - Kids Helpline — one off grant 2003–04
    - Youth mental health (headspace)
    - Program of Assistance for Survivors of Torture and Trauma
    - OATSIH Social & Emotional Wellbeing Action Plan
    - Departmental costs.

- From 2006–07 onwards, programs include the above plus new Department of Health-administered measures funded by the Australian Government under the COAG Action Plan on Mental Health 2006 (excluding MBS expenditure through Better Access) and additional measures introduced in subsequent Federal Budgets. Programs added to the category are:
    - Alerting the Community to Links between Illicit Drugs and Mental Illness
    - New Early Intervention Services for Parents, Children and Young People
    - Better Access to Psychiatrists, Psychologists, GPs - Education and Training component
    - New Funding For Mental Health Nurses (Mental Health Nurse incentive program)

- Support for Day to Day Living program
- Mental Health Services in Rural and Remote Areas
- Improved Services for People with Drug and Alcohol Problems and Mental Illness
- Funding for Telephone Counselling, Self-help and Web based Support Programmes
- Mental Health Support for Drought Affected Communities Initiative
- Additional Education Places, Scholarships and Clinical Training in Mental Health - Scholarships and Clinical Training components only
- Mental Health in Tertiary Curricula
- National Perinatal Depression initiative (excluding mental health specific payments to states and territories include above)
- Expansion of Early Psychosis Prevention and Intervention Centres
- Partners In Recovery Program
- Leadership in Mental Health Reform.

Some of these programs were time limited and do not apply to all data presented in this section.

More recently, there has been a consolidation of Department of Health Mental Health Program funding into a reduced set of categories, arising largely from the Australian Government response to the 2014 National Mental Health Commission Review of Mental Health Programs and Services. Direct spending on mental health related programs is split into five broad program areas: national leadership; primary mental health care services; promotion, prevention and early intervention; psychosocial support; and suicide prevention (see below). Over half of the Mental Health Program funding is provided to Primary Health Networks to plan and commission mental health services at a regional level.

Note also that the category excludes expenditure on the National Suicide Prevention Program is reported separately in the relevant expenditure tables of Australian Government spending. While managed by the Department of Health this is reported separately.

Expenditure reported under the item 'Indigenous social and emotional wellbeing programmes' has previously been reported under 'National programs and initiatives (Department of Health managed)'. This expenditure is now separately reported following the transfer of the former OATSIH Social and Emotional Wellbeing program to the Department of Prime Minister and Cabinet. Adjustments have been made to all years.

## National program and initiatives (DSS managed)

Expenditure on DSS (previously FaHCSIA) managed programs commenced with three measures introduced in 2006-07 through the COAG Action Plan on Mental Health (Personal Helpers and Mentors, Mental Health Respite, Family Mental Health Support Services). Subsequently a number of additional new measures have been added from Federal Budgets that are managed through the DSS portfolio and are included in expenditure reporting ('A Better Life', 'Carers and Work', and 'Individual Placement and Support Trial'). DSS has advised that, from 2016–17, two programs (Personal Helpers and Mentors, Mental Health Respite Care) began transitioning to the NDIS, with full transition being completed by 2020. Expenditure reported for these programs in 2016–17 and 2017–18 is inclusive of funding transferred to the NDIS. Expenditure previously reported by DSS for 2016–17 excluded NDIS transitioning program expenditure but this has been amended in the current reporting.

## National programs and initiatives (DVA managed)

Reported expenditure includes Repatriation Pharmaceutical Benefits Scheme expenditure, Repatriation Medical Benefits expenditure on general practitioners, psychiatrists and allied health providing mental health care, payment for mental health care provided in public and private hospitals for veterans, grants to the Australian Centre for Posttraumatic Mental Health and expenditure on the Vietnam Veterans Counselling Service and related mental health programs. Note that estimated expenditure on mental health-related Pharmaceuticals includes the costs of anti-dementia drugs for years up to and including to 2009–10 but these have been removed for subsequent years.

DVA provided the following information in respect of its mental health related expenditure in 2017–18.

### Data Source EXP.1: Department of Veterans Affairs mental health expenditure, 2017–18

| | 2017–18 ($M)(a) |
|---|---|
| Private hospitals[(b)(c)(d)] | 54.8 |

| | |
|---|---|
| Public hospitals[(b)(e)] | 38.1 |
| Consultant psychiatrists | 26.2 |
| OpenArms (previously Veterans and Veterans' Families Counselling Service) | 40.9 |
| Pharmaceuticals[(f)] | 14.4 |
| Private psychologists and allied health | 11.0 |
| General practitioners | 20.1 |
| Phoenix Australia (previously Australian Centre for Posttraumatic Mental Health) | 1.5 |
| Veterans' mental health care—improving access for younger veterans | - |
| Other programs | 2.7 |
| **Total** | **209.7** |

(a) Expenditure is indicative as not all data sets are fully complete. Small variations may be expected over time.

(b) Based only on payments made for patients classified to Major Diagnostic Category (MDC) 19 (Mental Diseases and Disorders) under the Australian Refined Diagnosis Related Groups (AR-DRG) classification system. Excludes payments made for patients classified to MDC 20 (Alcohol/drug use and alcohol/drug induced organic mental disorders).

(c) Private hospital figure includes payments to the hospital only (i.e. any other payments during these episodes such as payments to doctors have been excluded).

(d) DVA depends on submitted Hospital Casemix Protocol data from private hospitals and Diagnostic Procedure Combinations to obtain correct MDC and diagnosis information. When this information is not available (e.g. provided by hospitals on a quarterly basis and most recent quarter's data not yet received) then an understatement can occur in reporting. For this report, and only in relation to private psychiatric facilities, billing item codes have been used to identify and include mental health data in this category.

(e) For 2017–18, non-admitted costs are included for all jurisdictions except ACT, Tasmania and Northern Territory.

(f) Excludes anti-dementia drugs.

## National Mental Health Commission

The Commission commenced operation in January 2012. Source data for 2017-18: NMHC Annual Report 2016-17, Pg. 35.

## Department of Defence-funded programs

Expenditure covers a range of mental health programs and services delivered to ADF personnel, as of 2009–10 onwards; data for prior years is unavailable. Increased expenditure over the period reflects, in part, increased accuracy of data capture. Details of the recently updated ADF Mental Health Strategy are available at Defence's website.

The Department provided the following information in respect of its mental health related expenditure in 2017–18 and 2018-19.

### Data Source EXP.1: Department of Veterans Affairs mental health expenditure, 2017–18

| | 2017–18 ($M) | 2018-19 ($M) |
|---|---|---|
| JHC Direct Mental Health Program and Implementation Costs [1] | 1.339 | 2.313 |
| Mental Health Personnel Costs [2] | 6.675 | 6.842 |
| FFS Garrison Psychology Services | 12.711 | 11.972 |
| FFS Garrison Psychiatrist Services [3] | 4.636 | 5.054 |
| Mental Health Treatment Programs | 8.928 | 8.999 |
| Contracted General Practitioner Costs [4] | 6.695 | 7.045 |
| Contracted Mental Health Professionals [5] | 11.022 | 13.662 |
| MIMS Dispensed Therapeutic Classification Drugs [6] | 0.335 | 0.275 |
| **Total** | **52.340** | **56.162** |

1| JHC Direct Mental Health Program and Implementation Costs includes ASL Services. The FY 2018-19 expense is higher than usual due to Research & Development Contract.

2| FY 18-19 personnel costs includes both APS and ADF MH personnel (incl. GPs) working in Garrison Health. This is calculated using the average FY17-18 MH personnel costs plus 2.5%.

3| Mental Health Treatment Programs data capture commenced with ADF Health Services contract implementation in FY 2012-13.

4| Represents the methodology whereby 10% of a Contracted General Practitioners consultations relate to mental health.

5| Contracted Mental Health Professionals for FY2009-10 to FY2011-12 was coded into a generic Health Contractor GL account and therefore no costs could be identified.

6| Data collection processed refined to include data from Pharmaceutical Integrated Logistic System (PILS) dispensing records from FY2018-19

## National Suicide Prevention Program

This program commenced in 1995–96 as the National Youth Suicide Prevention Strategy but was broadened in later years. Reported expenditure includes all Australian Government allocations made under the national program, including additional funding made available under the COAG Action Plan and subsequent Federal Government Budgets. Changes in administrative arrangements and financial reporting make the estimates from 2015–16 not directly comparable to previous years. Components of the National Suicide Prevention Program are based on estimated expenditure to as closely as possible match the former methodology.

## Indigenous social and emotional wellbeing programs

This expenditure refers to two programs:

- The OATSIH Social & Emotional Wellbeing Action Plan program that commenced in 1996–97 following the Bringing Them Home report on the stolen generation of Indigenous children. Up to 2012–13 this program was managed by the Department of Health and rolled into the reporting category 'National program and initiatives (Department of Health managed)'. As part of a realignment of responsibility for indigenous affairs, the program was transferred to the Department of Prime Minister and Cabinet in 2013–14.
- The measure titled 'Improving the Capacity of Health Workers in Indigenous Communities' funded under the COAG Action Plan in 2006–07. This measure ceased in 2010–11.

In previous years' reporting, expenditure on these programmes was included under 'National program and initiatives (Department of Health managed) '. From 2013–14, relevant expenditure is now reported separately, with appropriate adjustments to previous years.

## Medicare Benefits Schedule—psychiatrists

Reported expenditure refers to benefits paid for all services by consultant psychiatrists processed in each of the index years. Data exclude payments made by the Department of Veterans' Affairs under the Repatriation Medical Benefits Schedule which are reported in the item National programs and initiatives (DVA managed).

## Medicare Benefits Schedule—general practitioners

Reported expenditure includes data for the Medicare-subsidised Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS initiative described above and in the Medicare-subsidised specialised mental health services section. Expenditure on GP mental health care is based solely on benefits paid against

MBS mental health specific GP items, which are predominantly the Better Access GP mental health items plus a small number of other items that were created in the years preceding the introduction of the Better Access initiative. This estimate of mental health-related GP costs is conservative because it does not attempt to assign a cost to the range of GP mental health work that is not billed as a specific mental health item.

As the Better Access items were introduced in November 2006, the 2006–07 data do not represent a full financial year for these specific items. The data for this item before November 2006 were estimated to be 6.1% of total MBS benefits paid for GP attendances, based on data and assumptions as detailed in the National Mental Health report 2010 (DoHA 2010). To incorporate these changes, GP expenditure reported for 2006–07 was based on total MBS benefits paid against these new items specific to mental health, plus 6.1% of total GP benefits paid in the period preceding the introduction of the new items (July to November 2006). For future years, all expenditure on GP mental health care is based solely on benefits paid against MBS Better Access mental health items, plus a small number of other items that were created in the years preceding the introduction of the Better Access initiative. The latter group includes items that may be claimed by other medical practitioners. This provides a significantly lower expenditure figure than obtained using the 6.1% estimate of previous year because it does not attempt to assign a cost to the range of GP mental health work that is not billed as a specific Better Access item. Comparisons of GP mental health related expenditure reported in Table EXP.19 prior to 2007–08 with subsequent years are therefore not valid as the apparent decrease reflects the different approach to counting GP mental health services. Data exclude Repatriation Medical Benefits expenditure on general practitioner mental health care which is included in the item National programs and initiatives (DVA managed).

## Medicare Benefits Schedule—psychologists/allied health

Expenditure refers to MBS benefits paid for services provided by clinical psychologists, psychologists, social workers and occupational therapists approved by Medicare, for items introduced through the Better Access to Mental Health Care initiative on 1 November 2006. Note that these items commenced 1 November 2006 and were not available for the full 2006–07 period. MBS benefits paid in relation to a small number of allied health items introduced in 2004 under the Enhanced Primary Care program are also included, but these represent less than 1% of the overall expenditure reported.

## Pharmaceutical Benefits Scheme

Refers to all Australian Government benefits for psychiatric medication in each of the index years, defined as drugs included in the following classes of the Anatomical Therapeutic Chemical Drug Classification System: antipsychotics; anxiolytics; hypnotics and sedatives; psychostimulants; and antidepressants. In addition, payments include Clozapine dispensed in public hospitals under the Highly Specialised Drug program and

funded separately through special arrangements prior to December 2013.The amounts reported exclude payments made by the Department of Veterans' Affairs under the Repatriation Pharmaceutical Benefits Schedule which are included in the item National programs and initiatives (DVA managed).

## Private Health Insurance Premium Rebates

Estimates of the 'mental health share' of Australian Government Private Health Insurance Rebates are derived from a combination of sources and based on the assumption that a proportion of Australian Government outlays designed to increase public take up of private health insurance have subsidised private psychiatric care in hospitals and other services paid by private health insurers. For illustrative purposes, the methodology underpinning these estimates is described below, sourced from Appendix 11 of the National Mental Health Report 2010 (DoHA 2010).

In 1997, the Australian Government passed the Private Health Insurance Incentives Act 1997. This introduced the Private Health Insurance Incentives Scheme (PHIIS) effective from 1 July 1997. Under the PHIIS, fixed-rate rebates were provided to low and middle-income earners with hospital and/or ancillary cover with a private health insurance fund. Those rebates could be taken in the form of reduced premiums (with the health funds being reimbursed by the Australian Government out of appropriations) or as income tax rebates, claimable after the end of the income year. On 1 January 1999, the means-tested PHIIS was replaced with a 30% rebate on premiums, which is available to all persons with private health insurance cover. As with the PHISS, the 30% rebate could be taken either as a reduced premium (with the health funds being reimbursed by the Australian Government) or as an income tax rebate.

The combined Australian Government outlays under the two schemes, and the estimated amounts spent on private hospital care for 2017–18 are as follows (current prices):

### Data Source EXP.3: Estimated amounts spent on private hospital care, 2017–18

| | 2017–18 ($M) |
|---|---|
| (A) Total Australian Government outlays on private health insurance subsidies | 5,879 |
| (B) Estimated component of Australian Government private health insurance subsidies spent on hospital care | 3,332 |

Source: AIHW 2019.

Estimation of the 'mental health share' of the amounts shown at (B) is based on the proportion of total private hospital revenue accounted for by psychiatric care. This assumes that if psychiatric care provided by the private hospital sector accounts for x% of revenue, then x% of the component of the Australian Government private health insurance subsidies spent by health insurance funds in paying for private hospital care is directed to psychiatric care. The estimates provided by this approach are shown below (current prices):

A new element introduced from 2015–16 includes an estimate of the PHI Premium Rebates contribution to ancillary benefits paid by private health insurers for private psychologists. All years have been adjusted to include this component.

The previous method for estimating the private hospital activity and revenue relied on data provided by the Australian Bureau of Statistics through its Private Health Establishment Collection (PHEC) which was discontinued in 2016–17. Commencing 2017–18, the estimate is based on the Private Psychiatric Hospitals Data Reporting and Analysis Service (PPHDRAS), a collection jointly funded by the Australian Private Hospitals Association and the Australian Government Department of Health, complemented by data from the Department's Private Hospital Data Bureau.

### Data Source EXP.4: Estimated mental health share of amounts spent on private hospital care, 2017–18

| | 2017–18 ($M) |
|---|---|
| Estimated component of Australian Government private health insurance subsidies spent on hospital care | 3,332 |
| Per cent of total private hospital revenue earned through the provision of psychiatric care | 4.71% |
| Estimated 'mental health share' of Australian Government private health insurance subsidies spent on hospital care | 156.9 |
| Estimated private health insurance susbidies spent on mental health related ancillary benefits (Psychologists/Group Therapy) | 7.1 |
| Total PHI subsidies spent on mental health related care | 164.0 |

## Research

Research expenditure represents the value of mental health related grants administered by the National Health and Medical Research Council (NHMRC) during the relevant year. Data were provided by the NHMRC. Minor amendments have been made to years preceding 2017–18.Medicare Benefits Schedule data

Refer to the data source section of the Medicare services section for more information.

## Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme data

Refer to the data source section of the Mental health-related prescriptions section.

## Population data

Population estimates used to calculate population rates were sourced from the Australian Bureau of Statistics.

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NMHC (National Mental Health Commission) 2014. The national review of mental health programmes and services. Sydney: NMHC.

# Key concepts

## Expenditure on mental health services

| Key Concept | Description |
|---|---|
| **Average cost per patient day** | **Average cost per patient day** is determined by dividing the total recurrent expenditure of the specialised mental health service by the total number of patient days as presented in the Specialised mental health care facilities section. |
| **Constant price** | **Constant price** estimates are derived by adjusting the current prices to remove the effects of inflation. This allows for expenditures in different years to be compared and for changes in expenditure to reflect changes in the volume of health goods and services. Generally, the constant price estimates have been derived using annually re-weighted chain price indexes produced by the Australian Bureau of Statistics (ABS). In some cases, such indexes are not available, and ABS implicit price deflators have been used instead (AIHW 2018). |
| **Current price** | **Current price** refers to expenditures reported for a particular year, unadjusted for inflation. Changes in current price expenditure reflect changes in both price and volume (AIHW 2018). |
| **Health expenditure** | **Health expenditure** is reported in terms of who incurs the expenditure rather than who ultimately provides the funding. In the case of public hospital care, for example, all expenditures (that is, expenditure on medical and surgical supplies, drugs, salaries of doctors and nurses, and so forth) are incurred by the states and territories, but a proportion of those expenditures are funded by transfers from the Australian Government (AIHW 2018). |
| **Health funding** | **Health funding** is reported in terms of who provides the funds that are used to pay for health expenditure. In the case of public hospital care, for example, the Australian Government and the states and territories together provide over 90% of the funding; these funds are derived ultimately from taxation and other sources of government revenue. Some other funding comes from private health insurers and from individuals who choose to be treated as private patients and pay hospital fees out of their own pockets (AIHW 2018). The national recurrent expenditure on all mental health-related services can be estimated by combining funding from 3 sources: |

| | |
|---|---|
| | • state and territory contributions to specialised mental health services<br>• Australian government expenditure on mental health-related services and contributions to specialised mental health services<br>• private health insurance fund component estimated by the Department of Health. |
| **Patient days** | **Patient days** are days of admitted patient care provided to admitted patients in public psychiatric hospitals or specialised psychiatric units or wards in public acute hospitals and in residential mental health services. The total number of patient days is reported by specialised mental health service units. For consistency in data reporting, the following patient day data collection guidelines apply: admission and discharge on the same day equals 1 day; all days are counted during a period of admission except for the day of discharge; and leave days are excluded from the total. Note that the number of patient days reported to the National Mental Health Establishments Database is not directly comparable with the number of patient days reported either to the National Hospital Morbidity Database (Overnight admitted patient mental health-related care section) or the number of residential care days reported to the National Residential Mental Health Care Database (Residential mental health services section) |
| **Program type** | Public sector specialised mental health hospital services can be categorised based on **program type**, which describes the principal purpose(s) of the program rather than the classification of the individual patients. *Acute* care admitted patient programs involve short-term treatment for individuals with acute episodes of a mental disorder, characterised by recent onset of severe clinical symptoms that have the potential for prolonged dysfunction or risk to self and/or others. *Non-acute* care refers to all other admitted patient programs, including rehabilitation and extended care services (see METeOR identifier 288889). |
| **Recurrent expenditure** | **Recurrent expenditure** refers to expenditure that does not result in the acquisition or enhancement of an asset—for example, salaries and wages expenditure and non-salary expenditure such as payments to visiting medical officers (AIHW 2018). |

| | |
|---|---|
| **Target population** | Some specialised mental health services data are categorised using 5 **target population** groups (see METeOR identifier 682403):<br>• Child and adolescent services focus on those aged under 18 years.<br>• Youth services focus on those aged 16–24 years.<br>• Older person programs focus on those aged 65 years and over.<br>• Forensic health services provide services primarily for people whose health condition has led them to commit, or be suspected of, a criminal offence or make it likely that they will reoffend without adequate treatment or containment.<br>• General programs provide services to the adult population, aged 18 to 64, however, these services may also provide assistance to children, adolescents or older people.<br>Note that, in some states, specialised mental health beds for aged persons are jointly funded by the Australian and state and territory governments. However, not all states or territories report such jointly funded beds through the National Mental Health Establishments Database. |