14 Expenditure on mental health services

This section reviews the available information on ***recurrent expenditure*** (running costs) for mental health-related services. ***Health expenditure*** (what was spent), and ***health funding*** (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. Further information on health expenditure is available in *Health expenditure Australia 2009–10* (AIHW 2011).

Key points

- Almost $6.4 billion, or $287 per person, was spent on mental health-related services in Australia during 2009–10, an increase from $241 per Australian in 2005–06 (an average annual increase of 4.5%).
- Expenditure on state and territory specialised mental health services increased by an average annual rate of 5.4% between 2005–06 and 2009–10, to $3.9 billion. Public hospital services for admitted patients ($1.7 billion) were the largest proportion of this spending, followed by community mental health care services ($1.5 billion).
- Expenditure on specialised mental health services in private hospitals was $282 million during 2009–10.
- The Australian Government paid $852 million in benefits for MBS-subsidised mental health-related services in 2010–11, equating to 5.2% of all MBS subsidies. Expenditure on psychologist services ($335 million) made up the majority of mental health-related MBS subsidies in 2010–11.
- The Australian Government spent $834 million, or $37 per Australian, on subsidised prescriptions under the PBS/RPBS during 2010–11, equating to 10.1% of all PBS/RPBS subsidies.

Overview

The national recurrent expenditure on all mental health-related services in 2009–10 was estimated to be almost $6.4 billion. Of this total, 61.0% ($3.9 billion) came from state and territory governments, 35.0% ($2.2 billion) from the Australian Government and 4.0% ($254 million) from private health insurance funds.

During the period 2005–06 to 2009–10, funding from state and territory governments for mental health-related services increased by an average annual rate of 6.3%, adjusted for inflation. During the same period funding by the Australian Government increased by an average annual rate of 7.0%, adjusted for inflation. Overall, expenditure on mental health-related services increased from $241 per Australian in 2005–06 to $287 per Australian during 2009–10, adjusted for inflation, which equates to an average annual increase of 4.5%.

Reference

AIHW 2011. Health expenditure Australia 2009–10. Health and welfare expenditure series no. 46. Cat. no. HWE 55. Canberra: AIHW.

Expenditure on specialised mental health services

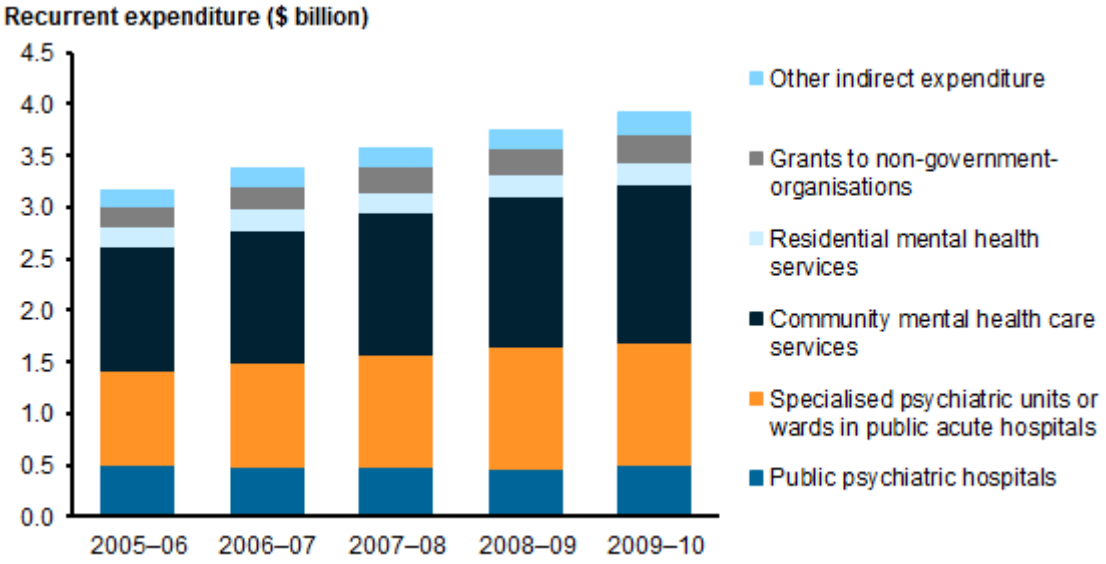
State and territory specialised mental health services

Recurrent expenditure

Over $3.9 billion was spent on state and territory specialised mental health services in 2009–10. The largest proportion of this recurrent expenditure was spent on public hospital services for admitted patients ($1.7 billion), comprising public acute hospitals with a specialist psychiatric unit or ward ($1.2 billion) and public psychiatric hospitals ($0.5 billion). This was closely followed by expenditure on community mental health care services totalling $1.5 billion during 2009–10.

Per capita expenditure on specialised mental health services ranged from $216 per person in Tasmania to $168 in Victoria, compared to the national average of $177 per Australian during 2009–10.

Expenditure on state and territory specialised mental health services, adjusted for inflation, increased by an average annual rate of 5.4% between 2005–06 and 2009–10 (Figure 14.1). This equates to an increase of $22 per Australian in 2009–10, from $154 in 2005–06 to $177 in 2009–10.



Sources: National Mental Health Establishments Database.

Figure 14.1: Recurrent expenditure ($ billion) on state and territory specialised mental health services, constant prices, 2005–06 to 2009–10

Funding

The majority (96.2% or $3.8 billion) of funding for state and territory specialised mental health services was from state or territory governments in 2009–10, with a further 2.1% ($81 million) provided by the Australian Government, and 1.7% ($66 million) from patients and other revenues and recoveries. (See the data source section for technical information regarding Australian Government expenditure.)

Public sector specialised mental health hospital services

The $1.7 billion of recurrent expenditure for public sector specialised mental health hospital services during 2009–10 is equivalent to an ***average cost per patient day*** of $802. The Northern Territory ($1,189) had the highest average cost per patient day, while the average cost in Queensland ($752) was the lowest.

Recurrent expenditure on public sector specialised mental health hospital services can be described using ***target population***, ***program type*** or a combination of both.

Target population

General services ($1.2 billion) accounted for the majority of recurrent expenditure for public sector specialised mental health hospital services during 2009–10, however, *Child and adolescent* services ($1,524 per patient day) were the most expensive.

Program type

Across all public sector specialised mental health hospital services average patient day costs for *Acute* services ($863) were more expensive than those for *Non-acute* services ($666). The average patient day cost for public psychiatric hospitals ($758 per day) was less that than for specialised units or wards in public acute hospitals, reflecting the greater proportion of non-acute services in public psychiatric hospitals (data not shown).

Community mental health care services

Community mental health care services accounted for $1.5 billion of recurrent expenditure on mental health services during 2009–10. Nationally, the majority of these funds were spent providing *General* community mental health care services ($1.1 billion or 70.3%). Expenditure on *Child and adolescent* community mental health care services ($283 million or 18.5%) was the next largest item.

Residential mental health services

Of the $220 million spent on residential mental health services during 2009–10, the majority was spent on 24-hour staffed services ($191 million or 86.5%). *General* services ($140 million) accounted for almost two-thirds of the total residential expenditure when target population was considered.

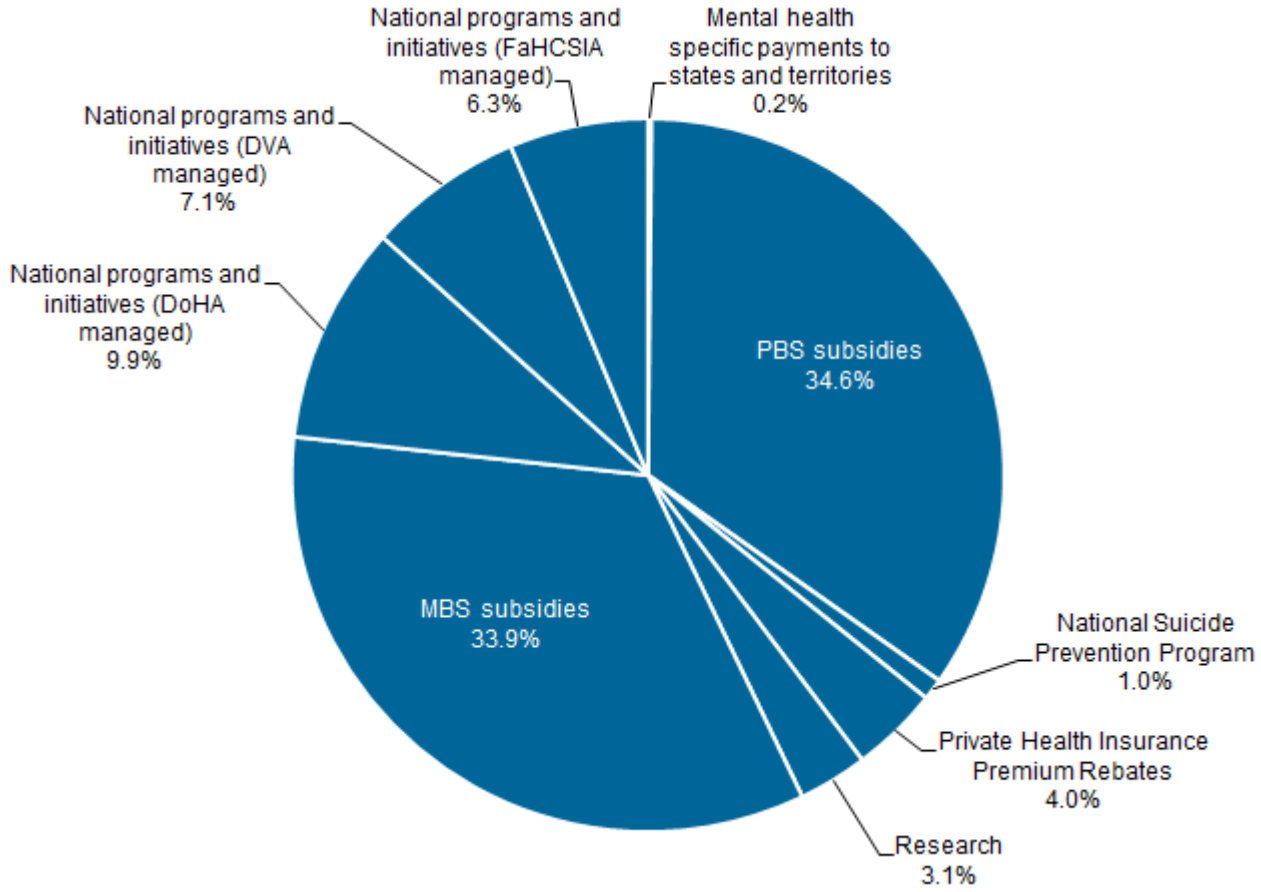
The average national cost per patient day for residential mental health services was $324 per day in 2009–10. Average costs varied between the jurisdictions, ranging from $227 per patient day in New South Wales to $403 per patient day in Tasmania; however, this reflects the greater reliance on 24-hour staffed services in Tasmania, which have higher costs than non-24-hour staffed services.

Private hospital specialised mental health services

Expenditure on specialised mental health services in private hospitals increased from $241 million to $281 million between 2005–06 and 2009–10, adjusted for inflation. This equates to an average annual increase of 2.1% in per capita expenditure from $12 per Australian in 2005–06 to $13 in 2009–10.

Australian Government expenditure on mental health-related services

The total Australian Government expenditure on mental health-related services was estimated as $2.2 billion in 2009–10. Expenditure on MBS-subsidised mental health services and medications provided through the PBS accounted for 68.5% of the total (Figure 14.2). (See the data source section for technical information regarding the calculation of these figures.)



Source: Department of Health and Ageing (unpublished data).

Figure 14.2: Australian Government expenditure ('$000) on mental health-related services, 2009–10

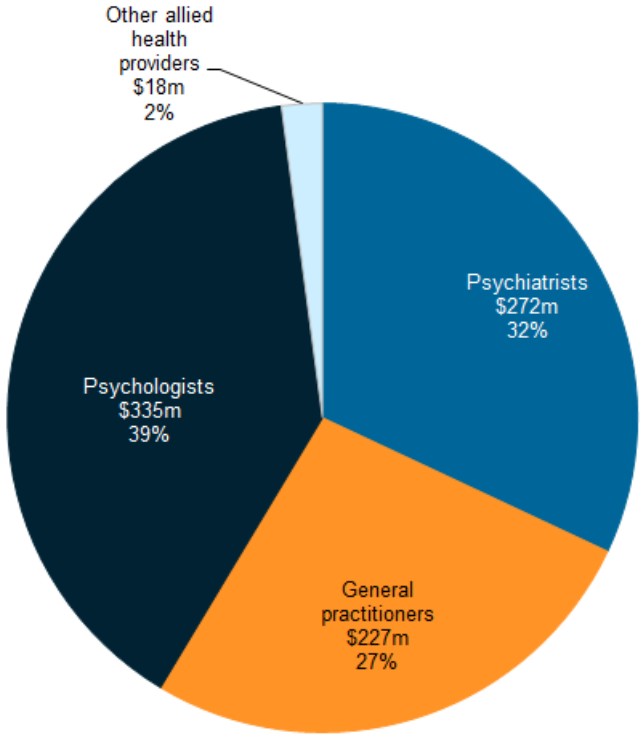
Australian Government expenditure on mental health-related services increased by an average annual rate of 7.0% during the period 2005–06 and 2009–10 when adjusted for inflation. This equates to an increase of $18 per Australian, from $83 in 2005–06 to $101 in 2009–10. Much of this increase was due to increases in expenditure on the national programs and initiatives managed by the Department of Health and Ageing (DoHA) and the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA).

Australian Government expenditure on MBS-subsidised mental health-related services

Australian Government expenditure for 2010–11 MBS-subsidised mental health-related services is presented in this section.

In 2010–11, $852 million was paid in benefits for MBS-subsidised mental health-related services, equating to 5.2% of total Medicare expenditure ($16.4 billion) for that year (Medicare 2012). This spending was for mental health-related services provided by psychiatrists, general practitioners (GPs), psychologists and other allied health professionals. See the data source section for further information on data quality, coverage and other aspects of the MBS data.

Expenditure for services provided by psychologists ($335 million or 39.3%) made up the largest proportion of MBS-subsidised mental health-related services expenditure (Figure 14.3), comprising mostly *Focussed Psychological Strategies—psychologist services* ($178 million) and *Psychological Therapy Services—clinical psychologist services* ($156 million). Expenditure on services provided by psychiatrists was the next largest expenditure group ($272 million or 32.0%). GP expenditure comprised $227 million (26.6%) of total MBS-subsidised mental health-related benefits.



Source: MBS data (DoHA).

Figure 14.3: Australian Government expenditure ($ million) on MBS-subsidised mental health-related services, 2010–11

Nationally, benefits paid for mental health-related Medicare services averaged $38 per Australian in 2010–11. The average benefits paid per person in Victoria ($46) and New South Wales ($39) were above the national average, while those in the Northern Territory were much lower ($11 per person).

There was an average annual increase of 21.0% in the total expenditure on MBS-subsidised mental health-related services, adjusted for inflation, between 2006–07 and 2010–11. This change equates to an

average annual increase (per Australian) in spending of 18.8%, in constant prices, from $18 in 2006–07 to $36 in 2010–11.

Reference

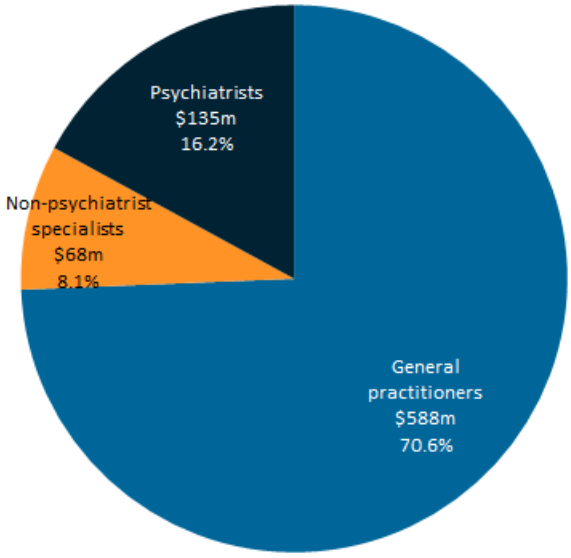
Medicare 2012. Medicare Australia monthly and quarterly standard reports. Canberra: Medicare. Viewed June 2012, https://www.medicareaustralia.gov.au/statistics/mth_qtr_std_report.shtml.

Australian Government expenditure on mental health-related subsidised prescriptions

Australian Government expenditure for 2010–11 is available for mental health-related subsidised prescriptions and presented in this section.

Australian Government expenditure on mental health-related subsidised prescriptions, under the Pharmaceutical Benefits Scheme (PBS) and Repatriation Pharmaceutical Benefits Scheme (RPBS), was $834 million, or $37 per Australian, in 2010–11. This was equivalent to 10.1% of all PBS and RPBS subsidies (Medicare 2012). For further information on data quality, coverage and other aspects of the PBS and RPBS database refer to the data source section.

Over 70% ($588 million) of the expenditure on mental health-related subsidised prescriptions was issued by general practitioners (GPs). This was followed by prescriptions written by psychiatrists ($135 million or 16.2%), with non-psychiatrist specialists' prescriptions accounting for the remaining 8.1% ($68 million) (Figure 14.4).



Sources: Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme data (DoHA)

Figure 14.4: Australian Government expenditure ($ million) on mental health-related subsidised prescriptions, by prescribing medical practitioner, 2010–11

Prescriptions for antipsychotics (53.9%) and antidepressants (40.1%) accounted for the majority of mental health-related PBS and RPBS expenditure in 2010–11, followed by prescriptions for psychostimulants and nootropics (3.1%), anxiolytics (1.8%) and hypnotics and sedatives (1.1%).

Real growth in expenditure (constant prices) for mental health-related prescriptions averaged 4.5% per year between 2006–07 and 2010–11. Per Australian, this represents an average growth rate of 2.6% per year from $33 in 2006–07 to $37 per Australian in 2010–11. These rises can be largely attributed to the increase in expenditure on antipsychotics.

Expenditure on psychostimulants and nootropics increased by an average annual rate of 49.1% over the 5-year period from 2006–07 to 2010–11. This appears to be the result of new listings on the PBS in 2007–08.

Reference

Medicare 2012. Medicare Australia monthly and quarterly standard reports. Canberra: Medicare. Viewed June 2012, https://www.medicareaustralia.gov.au/statistics/mth_qtr_std_report.shtml.

Data source

National Mental Health Establishments Database

Collection of data for the Mental Health Establishments (MHE) 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 consumer and carer consultant 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 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 to previous *Mental health services in Australia* publications should be approached with caution.

Consumer committee representation arrangements

Specialised mental health organisations report the extent to which consumer participation arrangements are in place to promote the inclusion of mental health consumers in the planning, delivery and evaluation of the service. Organisations report their consumer participation arrangements at various levels, as detailed below.

Levels of consumer participation arrangements

Level	Description
Level 1	Formal position(s) for consumers exist on the organisation's management committee for the appointment of person(s) to represent the interests of consumers. Alternatively, specific consumer advisory committee(s) exists to advise on all relevant mental health services managed by the organisation.
Level 2	Specific consumer advisory committee(s) exists to advise on some but not all relevant mental health services managed by the organisation.

Level	Description
Level 3	Consumers participate on a broadly based advisory committee that includes a mixture of organisations and groups representing a wide range of interests.
Level 4	Consumers are not represented on any advisory committee but are encouraged to meet with senior representatives of the organisation as required. Alternatively, no specific arrangements exist for consumer participation in planning and evaluation of services.

National standards for mental health services review status

There are eight levels used to describe the extent to which a service unit has implemented the national standards during 2009–10, as shown in the table below.

National standards for mental health services review status levels

Level	Description
1	The service unit had been reviewed by an external accreditation agency and was judged to have met the national standards.
2	The service unit had been reviewed by an external accreditation agency and was judged to have met some but not all of the national standards.
3	The service unit was in the process of being reviewed by an external accreditation agency but the outcomes were not known.
4	The service unit was booked for review by an external accreditation agency and was engaged in self-assessment preparation prior to the formal external review.
5	The service unit was engaged in self-assessment in relation to the national standards but did not have a contractual arrangement with an external accreditation agency for review.
6	The service unit had not commenced the preparations for review by an external accreditation agency but this was intended to be undertaken in the future.
7	It had not been resolved whether the service unit would undertake review by an external accreditation agency under the national standards.
8	The national standards are not applicable to this service unit.

Source: National Standards for Mental Health Services (DHFS 1996).

New South Wales CADE and T–BASIS services

All New South Wales Confused and Disturbed Elderly (CADE) residential mental health services were reclassified as specialised mental health 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.

Rates for target populations

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

- General services: Includes persons aged 18–64.

- Child and adolescent services: persons aged 0–17.
- Older person: persons aged 65 and over.
- Forensic services: persons aged 18 and over.

Reference

DHFS (Commonwealth Department of Health and Family Services) 1996. National Standards for Mental Health Services. Canberra: Commonwealth of Australia.

Private Health Establishments Collection

The ABS conducts a census of all private hospitals licensed by state and territory health authorities and all freestanding day hospitals facilities approved by DoHA. As part of that census, data on the staffing, finances and activity of these establishments are collected and compiled in the Private Health Establishments Collection.

The data definitions used in the Private Health Establishments Collection are largely based on definitions in the *National health data dictionary, Version 14* (HDSC 2008). 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 2011). 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. Data for 2009–10 includes private psychiatric hospitals and specialised psychiatric units or wards within other private hospitals. To allow for comparisons across time, historical data has been updated to include this broadened definition. For further technical information see the Private psychiatric hospital data section of the *National mental health report 2010* (DoHA 2010).

The most recent data was collected for the 2009–10 period. Additional information on the Private Health Establishments Collection can be obtained from the ABS publication *Private hospitals, Australia* (ABS 2011).

References

ABS 2011. Private hospitals, Australia, 2009–10. ABS cat. no. 4390.0. Canberra: ABS.

DoHA 2010. National mental health report 2010: summary of 15 years of reform in Australia's mental health services under the National Mental Health Strategy 1993–2008. Canberra: Commonwealth of Australia.

HDSC (Health Data Standards Committee) 2008. National health data dictionary. Version 14. AIHW cat. no. HWI 101. Canberra: AIHW.

Australian Government expenditure

The Commonwealth Department of Health and Ageing (DoHA) annually estimates the total Australian Government expenditure on mental health-related services. Estimated Australian Government expenditure reported in table 14.19 covers only those areas of expenditure that have a clear and identifiable mental health purpose. A range of other expenditure, both directly and indirectly related to the provision of support for people affected by mental illness, is not covered in the table. Detailed notes on how estimates specific to Australian Government mental health specific expenditure are derived are provided in Appendix 11 of the National Mental Health Report 2010 (DoHA 2010).

The reported expenditure does not include contributions to the running of state and territory specialised mental health hospital services provided through the non-specific 'base grants' of the Australian Health Care

Agreements. These are also excluded in the estimates of Australian government funding for state and territory specialised mental health services, as they cannot be specifically identified.

Expenditure on national programs and initiatives managed by the Department of Families, Housing, Community Services and Indigenous Affairs (the FaHCSIA managed row) refers to funding outlays on initiatives funded by the Australian Government under the COAG Action Plan on Mental Health. These programs are *Personal helpers and mentors*, *More respite care places to help families and carers* and *Community based programmes to help families coping with mental illness*.

The *Medicare Benefits Schedule—GPs* data in Table 14.19 include data for the Medicare-subsidised Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS initiative described above and in both the *Services provided by general practitioners* section and the *Medicare-subsidised specialised mental health services* section. However, as these new Medicare 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 was 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 all future years, expenditure on GP mental health care is fully based solely on benefits paid against MBS Better Access mental health items. This provides a significantly lower expenditure figure than obtained using the 6.1% estimate of previous year because it is conservative and 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 14.19 are therefore not valid as the apparent decrease reflects the different approach to counting GP mental health services. Data also excludes Repatriation Medical Benefits expenditure on general practitioner mental health care which is included in the item National programs and initiatives (DVA managed).

Expenditure reported as *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 (except prochloperazine); anxiolytics; hypnotics and sedatives; psychostimulants; and antidepressants. In addition, expenditure on Clozapine, funded under the Highly Specialised Drugs Program, has been included for all years, requiring adjustment to the historical data. 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).

Expenditure reported as *Private Health Insurance Premium Rebates* are 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.

Source of funding for specialised mental health services

Funding for health products and services is derived from both government and non-government sources, depending on the type of good or service provided. The Australian Government, for example, funds the majority of Medicare services. These services include those provided GPs, medical specialists and other professionals (in private practices), residential aged care and pharmaceuticals, for which benefits were paid under the PBS and the RPBS. As well as these direct forms of expenditure, the Australian Government provides subsidies for private health insurance and health-related Special Purpose Payments to the states and territories.

Responsibility for funding public hospitals and public health activities is shared by the Australian Government and the states and territories, while state and territory governments provide the main funding for other health services, including ambulance and community health services.

The main non-government funding sources are out-of-pocket payments by individuals, benefits paid by health insurance companies and payments by injury compensation insurers. These non-government sources provide the majority of funding for incidentals, including over-the-counter pharmaceuticals, dental and other professional services and private hospital services.

Private health insurance fund

DoHA calculates the private health insurance fund component by estimating the total mental health-related private hospital revenue and then deducting all payments made to these hospitals by the Department of Veterans Affairs (DVA) and estimates of the private hospital mental health component of the Australian Government Private Health Insurance Rebate. The remaining amount is then deemed to represent the payments made by private health insurers in respect of private hospital psychiatric care.

Reference

DOHA 2010. National mental health report 2010: summary of 15 years of reform in Australia's mental health services under the National Mental Health Strategy 1993–2008. Canberra: Commonwealth of Australia.

Medicare Benefits Schedule data

Medicare Australia collects data on the activity of all providers making claims through the Medicare Benefits Schedule (MBS) and provides this information to DoHA. Information collected includes the type of service provided (MBS item number) and the benefit paid by Medicare Australia for the service. The item numbers and benefits paid by Medicare Australia are based on the *Medicare Benefits Schedule Book* (DoHA 2011). Services that are not included in the MBS are not included in the data. The table below lists all MBS items that have been defined as mental health-related.

MBS mental health-related items

Provider	Item group	MBS Group & Subgroup	MBS item numbers
Psychiatrists	Initial consultation new patient —psychiatrist[(a)]	Group A8	296, 297, 299
	Patient attendances—consulting room	Group A8	291[(a)], 293[(a)], 300, 302, 304, 306, 308, 310, 312, 314, 316, 318, 319
	Patient attendances—hospital	Group A8	320, 322, 324, 326, 328
	Patient attendances—other locations	Group A8	330, 332, 334, 336, 338
	Group psychotherapy	Group A8	342, 344, 346
	Interview with non-patient	Group A8	348, 350,352
	Telepsychiatry	Group A8	353, 355, 356, 357, 358, 359[(b)], 361[(b)], 364, 366, 367, 369, 370
	Case conferencing—psychiatrist		855, 857, 858, 861, 864, 866

	Electroconvulsive therapy	Group T1 Subgroup 13 Group T10	14224 20104
	Referred consultation for assessment, diagnosis and development of a treatment and management plan for autism or any other pervasive developmental disorder (PDD)—psychiatrist[c]	Group A8	289
General practitioners	GP Mental Health Care[a]	Group A20 Subgroup 1	2702, 2710, 2712, 2713
	Focussed Psychological Strategies	Group A20 Subgroup 2	2721, 2723, 2725, 2727
	Family Group Therapy	Group A6	170, 171, 172
	3 Step Mental Health Process —GP[d]	Group A18 Subgroup 4	2574, 2575, 2577, 2578
	3 Step Mental Health Process —OMP[d]	Group A19 Subgroup 4	2704, 2705, 2707, 2708
Psychologists	Enhanced Primary Care —psychologist	Group M3	10968
	Focussed Psychological Strategies (Allied Mental Health)—psychologist[a]	Group M7	80100, 80105, 80110, 80115, 80120
	Psychological Therapy Services —clinical psychologist[a]	Group M6	80000, 80005, 80010, 80015, 80020
	Assessment and treatment of PDD —psychologist[c]	Group A10	82000, 82015
	Follow-up allied health service for Indigenous Australians—psychologist[e]	Group M11	81355
Other allied health providers	Enhanced Primary Care — mental health worker	Group M3	10956
	Focussed Psychological Strategies (Allied Mental Health)—occupational therapist[a]	Group M7	80125, 80130, 80135, 80140, 80145
	Focussed Psychological Strategies (Allied Mental Health)—social worker[a]	Group M	80150, 80155, 80160, 80165, 80170

	Follow-up allied health services for Indigenous Australians—mental health worker[e]	Group M11	81325

(a) These items introduced 1 November 2006 except for item 2702 which was introduced 1 January 2010.
(b) These items introduced 1 November 2007.
(c) These items introduced 1 July 2008.
(d) These items were discontinued after 30 April 2007.
(e) These items were introduced 1 November 2008.

The MBS data presented in this report relate to services provided on a fee-for-service basis for which MBS benefits were paid. The year is determined from the date the service was processed by Medicare Australia, rather than the date the service was provided. The state or territory is determined according to the postcode of the patient's mailing address at the time of making the claim. In some cases, this will not be the same as the postcode of the patient's residential address.

Reference

DoHA 2010. Medicare Benefits Schedule Book, effective 1 July 2010. Canberra: Commonwealth of Australia.

Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme data

Medicare Australia collects data on prescriptions funded through the Pharmaceutical Benefits Scheme (PBS) and Repatriation Pharmaceutical Benefits Scheme (RPBS) and provides the data to DoHA. Information collected includes the characteristics of the person who is provided with the prescription, the medication prescribed (for example, type and cost), the prescribing practitioner and the supplying pharmacy (for example, location). The figures reported in this publication relate to the number of mental health-related prescriptions processed by Medicare Australia in the reporting period, the number of people provided with the prescriptions and their characteristics, as well as the prescription costs funded by the PBS and RPBS.

Although the PBS and RPBS data capture most of the prescribed medicines dispensed in Australia, these data have the following limitations:

- They refer only to prescriptions scripted by registered medical practitioners who are approved to work within the PBS and RPBS and to paid services processed from claims presented by approved pharmacists who comply with certain conditions. They exclude adjustments made against pharmacists' claims, any manually paid claims or any benefits paid as a result of retrospective entitlement or refund of patient contributions.
- They exclude non-subsidised medications, such as private and below copayment prescriptions (where the patient copayment covers the total costs of the prescribed medication) and over-the-counter medications.
- The level of the copayment increases annually and drug prices can reduce for a variety of factors (for example, patent changes), which means that some medicines that were captured in previous years might fall below the copayment level and thus be excluded in following years.
- Programs funded by the PBS that do not use the Medicare Australia PBS processing system include
  - most Section 100 drugs funded through public hospitals (although the pharmaceutical reform measures for public hospitals under the Australian Health Care Agreements and the Chemotherapy Pharmaceutical Access Program are paid through Medicare Australia)
  - Aboriginal health services program
  - Opiate Dependence Treatment Program

- Special Authority Program
- Botox (including Dysport)
- in vitro fertilisation
- human growth hormones.

Only one of these has a significant bearing on the mental health-related prescriptions data published in the Mental health-related prescriptions section and the Expenditure on mental health services section of this publication: the Aboriginal health services program. Most affected are the data for *Remote* and *Very remote* areas and the data for the Northern Territory. Consequently, the mental health-related prescriptions data in these sections will not fully reflect Australian government expenditure on mental health-related medications.

The ATC classification version used is the primary classification as it appears in the PBS Schedule of Pharmaceutical Benefits. This can differ slightly from the WHO version. There are two differences between the WHO ATC classification and the PBS Schedule classification that have a bearing on mental health data. *Prochlorperazine* is regarded as an *other antiemetic* (A04AD) in the PBS Schedule while it is an *antipsychotic* according to the WHO classification. This means that information on *prochlorperazine* will not appear in the data provided as it is not classed as an N code in the PBS Schedule. *Lithium carbonate* on the other hand is classified as an *antidepressant* in the PBS Schedule while it is an *antipsychotic* according to the WHO classification. This means that *lithium carbonate* will appear in the data as an *antidepressant* rather than an *antipsychotic* (See following table).

Differences between the WHO ATC classification and the PBS Schedule of Pharmaceutical Benefits classification

Drug name	WHO ATC Code	PBS Schedule Code	Scripts dispensed in 2010–11[(a)]
Prochlorperazine	N05AB04	A04AD	600,908
Lithium carbonate	N05AN01	N06AX	109,421

(a) Prescriptions data using date of service basis.
Source: Drug Utilisation Sub Committee database (DoHA).

To avoid double counting in the demographic tabulations, patients are allocated to the last category in which they appear. The category most affected by this will be the age group data as the age is calculated at the time of supply, and patients' ages will be 1 year greater for prescriptions supplied after their birthday than before it.

State and territory are determined by DoHA according to the patient's residential address. If the patient's state or territory is unknown, then the state or territory of the pharmacy supplying the item is reported.

Unless otherwise indicated, the year was determined from the date the service was processed by Medicare Australia, rather than the date of prescribing or the date of supply by the pharmacy.

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 2011).
Current price	***Current price*** refers to expenditures reported for a particular year, unadjusted for inflation. Changes in current price expenditures reflect changes in both price and volume (AIHW 2011).
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 2011).
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 2011). The national recurrent expenditure on all mental health-related services can be estimated by combining funding from three sources: • state and territory contributions to specialised mental health services • Australian government expenditure on mental health-related services and contributions to specialised mental health services • private health insurance fund component estimated by the Department of Health and Ageing (DoHA).

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 to neither the National Hospital Morbidity Database (Admitted patient mental health-related care section) nor the number of residential care days reported to the National Residential Mental Health Care Database (Residential mental health services section)
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 2011).
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).
Target population	Some specialised mental health services data are categorised using four ***target population*** groups (see METeOR identifier 288957): • *Child and adolescent* services focus on those aged under 18 years. • *Older person* programs focus on those aged 65 years and over. • *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. • *General* provides services to the adult population, aged 18 to 64, however, these services may also provide assistance to children, adolescents or older people. 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.

Reference

AIHW 2011. Health expenditure Australia 2009–10. Health and welfare expenditure series no. 46. Cat. no. HWE 55. Canberra: AIHW.