

# 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. All constant prices figures are adjusted to 2012–13 levels. Further information on health expenditure is available in *Health expenditure Australia 2012–13* (AIHW 2014).

## Key points

- Over \$7.6 billion, or \$332 per person, was estimated to be spent on mental health-related services in Australia during 2012–13, an increase from \$302 per person (adjusted for inflation) in 2008–09.
- \$4.6 billion was spent on state and territory specialised mental health services, an average annual increase of 3.2% between 2008–09 and 2012–13. Of this, most was spent on public hospital services for admitted patients (\$2.0 billion), followed by community mental health care services (\$1.8 billion).
- Expenditure on specialised mental health services in private hospitals was \$330 million during 2012–13.
- The Australian Government paid \$906 million in benefits for Medicare-subsidised mental health-related services in 2012–13, equating to 4.9% of all Medicare subsidies. Expenditure on psychologist services (clinical and other) (\$391 million) made up the largest component of mental health-related Medicare subsidies in 2012–13.
- The Australian Government spent \$788 million, or \$34 per person, on subsidised prescriptions under the PBS/RPBS during 2012–13, equating to 8.3% of all PBS/RPBS subsidies.

## Overview

The national recurrent expenditure on mental health-related services in 2012–13 was estimated to be just over \$7.6 billion. Overall, national expenditure on mental health-related services increased from \$302 per person in 2008–09 to \$332 per person during 2012–13, adjusted for inflation, which equates to an average annual increase of 2.4%.

Of the \$7.6 billion spent nationally in 2012–13, 59.5% (\$4.5 billion) came from state and territory governments, 36.4% (\$2.8 billion) from the Australian Government and 4.1% (\$309 million) from private health insurance funds. This ratio has remained relatively stable over time, with 59.4% of national spending coming from state and territory governments, 36.6% from the Australian Government and 4.0% from private health insurance funds in 2008–09.

Funding from state and territory governments for mental health-related services adjusted for inflation increased by an average annual rate of 3.5% over the period 2008–09 to 2012–13, while funding from the Australian Government increased by an average annual rate of 5.0%.

## Reference

[AIHW 2014](#). Health expenditure Australia 2012–13. Health and welfare expenditure series 52. Cat. no. HWE 61. Canberra: AIHW.

# Expenditure on specialised mental health services

## State and territory specialised mental health services

### Recurrent expenditure

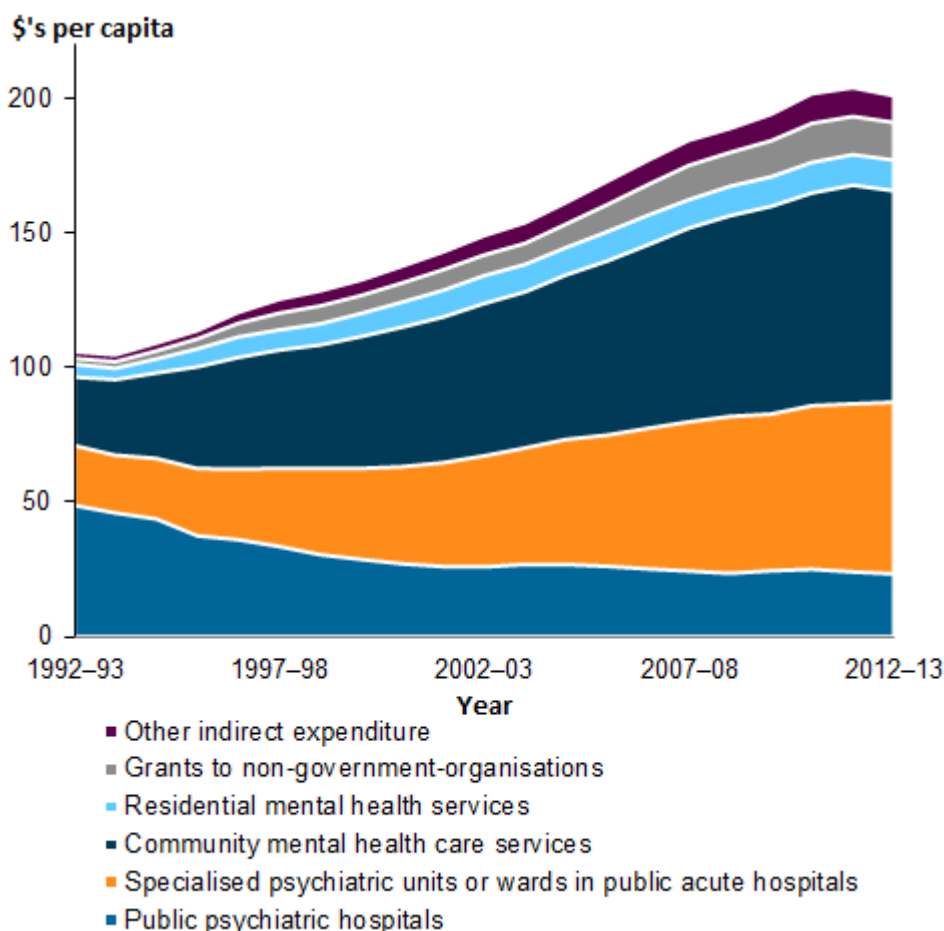
Over \$4.6 billion was spent on state and territory specialised mental health services in 2012–13. The largest proportion of this recurrent expenditure was spent on public hospital services for admitted patients (\$2.0 billion), comprising public acute hospitals with a specialist psychiatric unit or ward (\$1.5 billion) and public psychiatric hospitals (\$0.5 billion). This was closely followed by expenditure on community mental health care services totalling \$1.8 billion.

Per person expenditure on specialised mental health services ranged from \$184 per person in Victoria to \$252 per person in Western Australia, compared to the national average of \$201 per person during 2012–13.

Expenditure on state and territory specialised mental health services, adjusted for inflation, increased by an average annual rate of 1.6% between 2008–09 and 2012–13. This equates to an increase of \$12 per person, from \$189 in 2008–09 to \$201 in 2012–13.

Over 20 years of detailed expenditure data are available covering the period 1992–93 to 2012–13 (Figure EXP.1). The data illustrates the change in spending patterns, which is a reflection of changes to the state and territory specialised mental health service profile mix over this time.

**Figure EXP.1: Recurrent expenditure (\$) per capita on state and territory specialised mental health services, constant prices, 1992–93 to 2012–13**



## Funding

The majority (94.5% or \$4.4 billion) of funding for state and territory specialised mental health services was from state or territory governments in 2012–13, with a further 3.3% (\$150 million) provided by the Australian Government, and 2.3% (\$104 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 \$2.0 billion of recurrent expenditure for public sector specialised mental health hospital services during 2012–13 equates to an [average cost per patient day](#) of \$929. The Northern Territory (\$1,377) had the highest average cost per patient day, while the average cost in Victoria (\$827) 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

Services provided to the general population (\$1.4 billion or 71.1%) accounted for the majority of recurrent expenditure for public sector specialised mental health hospital services during 2012–13. Child and adolescent services (\$1,531 per patient day) were the most expensive, continuing a long term trend of these services being more expensive than general (\$920 per patient day), older person (\$784 per patient day) and forensic services (\$1,014 per patient day). While child and adolescent services were the most expensive target population, this expenditure has remained relatively stable over the five years to 2012–13, reducing by an average of 0.3% each year. Conversely, expenditure per patient day for the other three target populations has increased by an average of between 2.4% and 2.9% each year since 2008–09.

## Program type

Average patient day costs for acute public sector specialised mental health hospital services (\$996) were more expensive than those for non-acute services (\$777) during 2012–13.

## Community mental health care services

Community mental health care services accounted for \$1.8 billion of recurrent expenditure on mental health services during 2012–13. Nationally, the majority of these funds were spent providing general community mental health care services (\$1.2 billion or 68.8%). Expenditure on child and adolescent community mental health care services (\$346 million or 19.2%) was the next largest item.

## Residential mental health services

Of the \$261 million spent on residential mental health services during 2012–13, the majority was spent on 24-hour staffed services (\$224 million or 85.7%). General services (\$173 million) accounted for nearly 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 \$353 per day in 2012–13. Average costs varied across the jurisdictions, ranging from \$227 per patient day in New South Wales to \$483 per patient day in Tasmania.

## Expenditure by target population

Recurrent expenditure for public sector specialised mental health hospital, community and residential services can be combined and reported by target population. Expenditure on general services (\$195 per person) was

the highest of the 5 target populations during 2012–13, reflecting that many jurisdictions do not have the other specialised target population hospital services which contribute substantial costs to the overall expenditure profile. Expenditure on child and adolescent services increased by an average of 4.6% per year between 2008–09 and 2012–13, and was the highest of all the target population categories. Expenditure on forensic services increased by an average of 2.4% over the 5 years to 2012–13, and was the lowest of all the target populations.

## Private hospital specialised mental health services

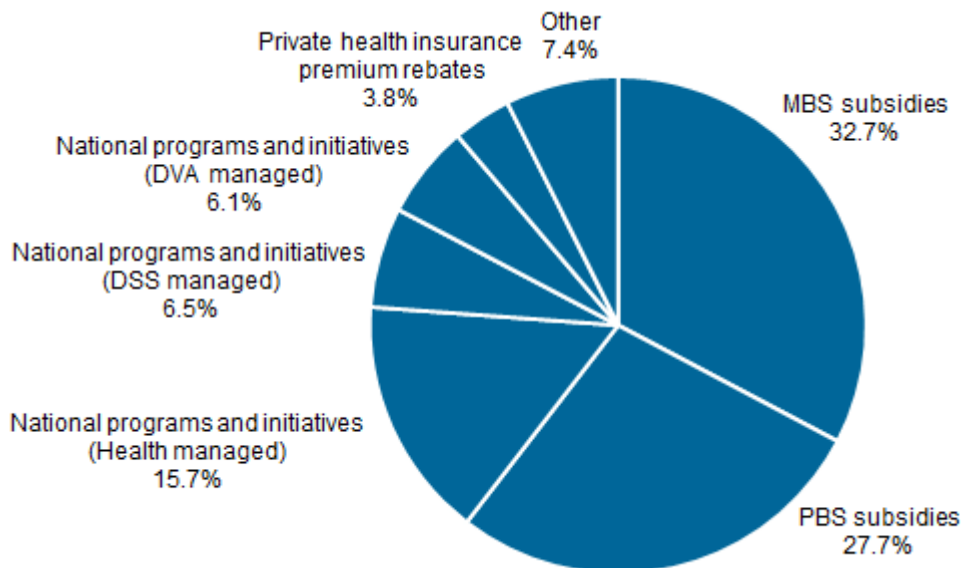
Expenditure on specialised mental health services in private hospitals adjusted for inflation increased from \$281 million to \$330 million between 2008–09 and 2012–13. This equates to an average annual increase of 2.5% in per person expenditure from \$13 in 2008–09 to \$14 in 2012–13.

## Australian Government expenditure

### Australian Government expenditure on mental health-related services

Australian Government expenditure on mental health-related services was estimated as \$2.8 billion in 2012–13. However, as 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. Expenditure on MBS-subsidised mental health services and medications provided through the PBS accounted for 65.4% of the total (Figure EXP.2). (See the [data source](#) section for technical information regarding the calculation of these figures.)

**Figure EXP.2: Australian Government expenditure on mental health-related services, 2012–13**



Key: 'Other' includes Research (2.4%), National Suicide Prevention Program (2.0%), Mental health specific payments to states and territories (1.8%), Department of Defence funded programs (0.9%) and National Mental Health Commission (0.2%).

Note: Percentages may not add to 100 due to rounding.

Source: Australian Government Department of Health (unpublished data). Source data Expenditure on mental health services Table EXP.28 (1.55MB XLS)

For the first time in 2012–13, data are available for Australian Government expenditure on Department of Defence funded programs for the period 2009–10 (\$15 million) to 2012–13 (\$24 million). When the number of permanent Australian Defence Force (ADF) personnel is taken into consideration (56,172 people; Department of Defence, 2013) this equates to \$433 per permanent ADF member in 2012–13.

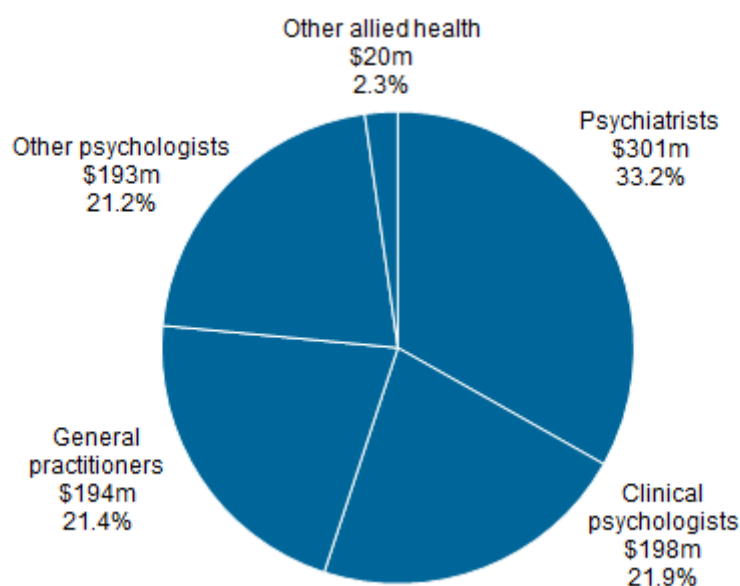
Australian Government expenditure on mental health-related services, when adjusted for inflation, increased by an average annual rate of 5.0% between 2008–09 and 2012–13. This is an increase of \$15 per person, from \$106 per person in 2008–09 to \$121 in 2012–13. Much of this was due to increased expenditure on MBS-subsidised services (specifically psychologists/allied health services) and national programs and initiatives managed by the Department of Health.

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

Australian Government expenditure for 2012–13 Medicare-subsidised mental health-related services is presented in this section. These include mental health-related services provided by psychiatrists, general practitioners (GPs), psychologists (both clinical and other) and other allied health professionals. These services are defined in the Medicare Benefits Schedule (MBS). Refer to the [data source](#) section for further information.

In 2012–13, \$906 million was paid in benefits for Medicare-subsidised mental health-related services, equating to 4.9% of total Medicare expenditure (\$18.6 billion) (DHS 2014). Expenditure for services provided by psychologists (\$391 million or 43.1%) made up the largest proportion (Figure EXP.3), comprising mostly Psychological Therapy Services (clinical psychologists; \$198 million) and Focussed Psychological Strategies (other psychologists; \$191 million). Expenditure on services provided by psychiatrists was the next largest expenditure group (\$301 million or 33.2%). GP expenditure comprised \$194 million (21.4%) of total Medicare-subsidised mental health-related benefits.

**Figure EXP.3: Australian Government expenditure (\$ million) on Medicare-subsidised mental health-related services, 2012–13**



Note: Totals may not add due to rounding to the nearest \$million.

Source: Medicare data (Department of Health). Source data Expenditure on mental health services Table EXP.16 (1.63MB XLS)

Nationally, benefits paid for Medicare-subsidised mental health-related services averaged \$40 per person in 2012–13. The average benefits paid per person in Victoria (\$49) was above the national average, while those in the Northern Territory were much lower (\$10 per person).

There was an average annual increase of 6.0% in the total expenditure on Medicare-subsidised mental health-related services, adjusted for inflation, between 2008–09 and 2012–13. This change equates to an average annual increase (per person) in spending of 4.3%, adjusted for inflation, from \$33 in 2008–09 to \$40 in 2012–13.

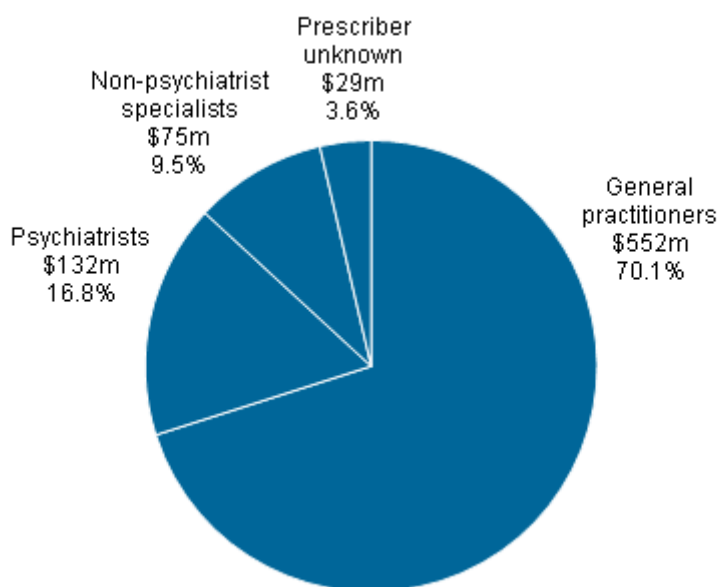
## Australian Government expenditure on mental health-related subsidised prescriptions

Data on Australian Government expenditure for 2012–13 are 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 \$788 million, or \$34 per person, in 2012–13. This was equivalent to 8.3% of all PBS and RPBS subsidies (DHS 2013). For further information on data quality, coverage and other aspects of the PBS and RPBS refer to the [data source](#) section.

Over 70% (\$552 million) of the expenditure on mental health-related subsidised prescriptions was for prescriptions issued by general practitioners (GPs) (Figure EXP.4). This was followed by prescriptions written by psychiatrists (\$132 million or 16.8%), with non-psychiatrist specialists' prescriptions accounting for the remaining 9.5% (\$75 million).

**Figure EXP.4: Australian Government expenditure (\$ million) on mental health-related subsidised prescriptions, by prescribing medical practitioner, 2012–13**



Sources: Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme data (Australian Government Department of Health). Source data expenditure on mental health services Table EXP.23 (1.63MB XLS).

Prescriptions for antipsychotics (56.9%) and antidepressants (36.7%) accounted for the majority of mental health-related PBS and RPBS expenditure in 2012–13, followed by prescriptions for psychostimulants and nootropics (3.8%), anxiolytics (1.7%) and hypnotics and sedatives (1.0%).

Real expenditure (constant prices) for mental health-related prescriptions remained relatively stable between 2008–09 and 2012–13 despite a modest rise in the number of prescriptions (see Prescriptions section). Expenditure decreased between 2011–12 and 2012–13 (\$66 million) due to a decrease in the subsidised cost of a number of prescriptions.

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## Reference

DHS 2013. Department of Human Services annual report 2012–13. Canberra: Department of Human Services.

DHS 2014. Medicare group reports. Canberra: Department of Human Services. Viewed January 2014, [https://www.medicareaustralia.gov.au/statistics/mbs\\_group.shtml](https://www.medicareaustralia.gov.au/statistics/mbs_group.shtml)

Department of Defence 2013. Defence Annual Report 2012–13. Canberra: Department of Defence.

## 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 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 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 Mental Health Establishments NMDS, however, are reported as Supported housing places. Expenditure on the HASI program is reported as Grants to non-government-organisations. See this link for further information about the NSW HASI program



## Rates for target populations

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 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.

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## 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 the Department of Health. 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* (NHDD) published on the AIHW's Metadata online Registry (METeOR) website. 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 2014). 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 include private psychiatric hospitals and specialised psychiatric units or wards within other private hospitals. To allow for comparisons across time, historical data have 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 were collected for the 2012–13 period. Additional information on the Private Health Establishments Collection can be obtained from the ABS publication *Private hospitals, Australia* (ABS 2013). Caution is required when comparing data for 2012–13 to earlier years as the survey was altered such that psychiatric units can no longer be separated from alcohol/drug treatment units. Therefore, the data for beds, patient days, separations and staffing are estimates based on reported 2012–13 data and trends observed in previous years.

## References

ABS 2014. Private hospitals, Australia, 2012–13. 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.

[National health data dictionary \(NHDD\) Version 16](#). Viewed January, 2015.

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## 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 for publication in the National Mental Health Report and related reports. Estimated Australian Government expenditure reported in table EXP.28 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. Expenditure that can be directly linked to specialised mental health service provision but not counted in the table includes:

- nursing home and hostel subsidies provided to psychogeriatric nursing homes managed by states and territories;
- all administrative overheads except for those associated with the Department of Health's mental health policy and program management areas; and
- contributions to the running of state and territory specialised mental health services provided through the non-specific 'base grants' or activity-based funding payments provided to states and territories under the former Medicare Agreements (1993–98), Australian Health Care Agreements (1998–03 and 2003–09) and National Healthcare Agreements (2009–), other than mental health specific payments made under those Agreements.

Accurate estimates of the costs of the mental health related components of these items are not possible.

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 of the National Mental Health Report on specialised mental health services, 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. For the period 2009–10 to 2011–12, the Australian Government provided Specific Purpose Payments (SPP) to State and Territory governments for health services under the National Healthcare Agreement (NHA). According to the Intergovernmental Agreement on Federal Financial Relations, under which these SPPs were provided, State and Territory governments were required to expend the SPP on the health sector, but had budget flexibility to allocate funds within that sector as they deemed appropriate. Consequently, specific mental health funding cannot be separately identified in the Australian Government funding provided to State and Territory governments under the NHA. From 2012–13, the payments made under the SPP were replaced by new funding approaches specified in the National Health Reform Agreement, including Activity Based Funding for future years. However, 2012–13 specific payments made to state and territory health services for mental health cannot be separately identified.

Additionally, from 2008–09 onwards, the amounts include National Perinatal Depression Plan—Payments to States; and from 2011–12, the National Partnership—Supporting Mental Health Reform and specific payments to Tasmania under the Tasmanian Health Assistance Package. Note that 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.

### **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).
- Department of Health-administered programs funded by the Australian Government under the COAG Action Plan on Mental Health 2006, excluding MBS expenditure through the Better Access to Psychiatrists, Psychologists and General Practitioners initiative. (Note: Full details of all expenditure by the Australian Government on the Action Plan initiatives can be found in COAG National Action Plan Progress Reports ([www.coag.gov.au](http://www.coag.gov.au))). These include the following programs:
  - 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
  - Improving the Capacity of Health Workers in Indigenous Communities
- National Mental Health Program
- National Depression Initiative (beyondblue)
- Better Outcomes in Mental Health Care program (including ATAPS)
- Youth Mental Health Initiative (headspace)
- Mental Health Support for Drought Affected Communities
- OATSIH Emotional & Social Wellbeing Action Plan (base mental health funding only)
- Program of Assistance for Survivors of Torture and Trauma
- 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

## National program and initiatives (DSS managed)

This refers to funding outlays on 3 initiatives funded by the Australian Government under the COAG Action Plan on Mental Health (Personal Helpers and Mentors, More Respite Care Places to Help Families and Carers, Community based programmes to help families coping with mental illness) managed by the former Department of Families, Housing, Community Services and Indigenous Affairs (now the Department of Social Services).

## 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 2012–13.

### DataSource EXP.1: Department of Veterans Affairs mental health expenditure, 2012–13

	2012–13 (\$M) <sup>(a)</sup>
Private hospitals <sup>(b)(c)(d)</sup>	34.7
Public hospitals <sup>(b)(e)</sup>	35.9
Consultant psychiatrists	18.8
Veterans and Veterans' Families Counselling Service	27.3
Pharmaceuticals	20.1
Private psychologists and allied health	3.1
General practitioners <sup>(f)</sup>	24.0
Australian Centre for Posttraumatic Mental Health	1.4
Veterans' mental health care—improving access for younger veterans	3.5
Other programs	0.2
<b>Total</b>	<b>168.9</b>

- (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 MDC 19 (Mental Diseases and Disorders) under the 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) Public hospital figures include payments to hospitals only.
- (f) An approximation method which has been used historically was 12 per cent of GP consultations being related to mental health. For the 2012–13 data this has been increased to 13 per cent based on information received from the Bettering the Evaluation And Care of Health (BEACH) program.

## Department of Defence-funded programs

This is the first year that the Department of Defence has reported mental health-specific expenditure. Expenditure reporting commences for 2009–10, and covers a range of mental health programs and services delivered to Australian Defence Force (ADF) personnel. Changes in expenditure over the period reflect, in part, increased accuracy of data capture. Details of the ADF Mental Health Strategy are available from the [Department of Defence](#).

The Department of Defence provided the following information in respect of its mental health related expenditure in 2012–13.

### DataSource EXP.2: Department of Defence mental health expenditure, 2012–13

Mental Health Actuals	2009–10 (\$M)	2010–11 (\$M)	2011–12 (\$M)	2012–13 (\$M)	Total (\$M)
JHC Direct Mental Health Program and Implementation Costs	5.166	9.929	6.576	4.114	25.785
Civilian Salaries and Overheads	1.112	1.783	3.449	4.488	10.832
FFS Garrison Psychology Services	2.447	2.598	3.403	3.210	11.657
FFS Garrison Psychiatrist Services	1.591	1.855	2.582	2.100	8.127
Mental Health Treatment Programs <sup>(a)</sup>	..	..	..	0.878	0.878
Contracted General Practitioner Costs <sup>(b)</sup>	4.647	5.053	5.318	5.208	20.225
Contracted Mental Health Professionals <sup>(c)</sup>	..	..	..	3.779	3.779
MIMS Dispensed Therapeutic Classification Drugs <sup>(d)(e)</sup>	..	..	..	0.550	0.550
<b>Total Actuals</b>	<b>14.963</b>	<b>21.217</b>	<b>21.327</b>	<b>24.326</b>	<b>81.833</b>

.. Not applicable.

(a) Capture of costings for Mental Health Treatment Programs commenced with the introduction of the ADF Health Services contract in financial year 2012–13.

(b) Represents the methodology whereby 10% of contracted General Practitioners consultations relate to mental health.

(c) Contracted Mental Health Professionals for financial year 2009–10 to financial year 2011–12 was coded into a generic Health Contractor GL account and therefore no costs could be identified.

(d) Data collection processed refined to include data from Pharmaceutical Integrated Logistic System (PILS) dispensing records from financial year 2012–13.

(e) Totals include those pharmaceuticals dispensed in the financial year and do not reflect the cost of purchasing pharmaceuticals within the financial year.

### National Mental Health Commission

The Commission commenced operation in January 2012.

### National Suicide Prevention Program

Reported expenditure includes all Australian Government allocations made under the national program, including additional funding made available under the COAG Action Plan.

### 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 included 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 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 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 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 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 (except prochlorperazine); 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)*.

### 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. For illustration 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 2012–13 are as follows (current prices):

#### **DataSource EXP.3: Estimated amounts spent on private hospital care, 2012–13**

	2012–13 (\$M)
(A) Total Australian Government outlays on private health insurance subsidies	5,144
(B) Estimated component of Australian Government private health insurance subsidies spent on hospital care	2,882

Source: [AIHW 2014](#). Health expenditure Australia 2012–13. Health and welfare expenditure series no. 52. Cat. no. HWE 61. Canberra: AIHW.

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):

**DataSource EXP.4: Estimated mental health share of amounts spent on private hospital care, 2012–13**

	2012-13 (\$M)
Estimated component of Australian Government private health insurance subsidies spent on hospital care	2,882
Per cent of total private hospital revenue earned through the provision of psychiatric care	3.69%
Estimated 'mental health share' of Australian Government private health insurance subsidies spent on hospital care	106.4

Details of the estimation of private hospital revenue earned from psychiatric care are provided in Appendix 10 of the National Mental Health Report 2010 (DoHA 2010). Total private hospital revenue was sourced from Private Hospitals Australia 2012–13, Australian Bureau of Statistics.

**Research**

Reported expenditure includes mental health-related grants administered by the National Health and Medical Research Council. Data were sourced from the [NHMRC website](#).

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**

The Department of Human Services collects data on the activity of all persons making claims through the Medicare Benefits Scheme and provides this information to the Department of Health. Information collected includes the type of service provided (MBS item number) and the benefit paid by Medicare for the service. The item numbers and benefits paid by Medicare are based on the *Medicare benefits schedule book* (DoHA 2012). 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.

**DataSource EXP.5: Medicare-subsidised mental health-related items**

Provider	Item group	MBS Group & Subgroup	MBS item numbers
Psychiatrists	Initial consultation new patient <sup>(a)</sup>	Group A8	296, 297, 299
	Patient attendances—consulting room	Group A8	291 <sup>(a)</sup> , 293 <sup>(a)</sup> , 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 <sup>(b)</sup> , 361 <sup>(b)</sup> , 364, 366, 367, 369, 370
	Case conferencing		855, 857, 858, 861, 864, 866
	Electroconvulsive therapy <sup>(c)</sup>	Group T1 Subgroup 13	14224
	Referred consultation for assessment, diagnosis and development of a treatment and management plan for autism or any other pervasive developmental disorder (PDD) <sup>(d)</sup>	Group A8	289
General practitioners	GP Mental Health Treatment Plan—accredited	Group A20 Subgroup 1	2710 <sup>(a)(f)</sup> , 2715 <sup>(g)</sup> , 2717 <sup>(g)</sup>
	GP Mental Health Treatment Plan—non-accredited <sup>(a)</sup>	Group A20 Subgroup 1	2700 <sup>(g)</sup> , 2701 <sup>(g)</sup> , 2702 <sup>(e)(f)</sup>
	GP Mental Health Treatment—other	Group A20 Subgroup 1	2712 <sup>(a)</sup> , 2713 <sup>(a)</sup> , 2719 <sup>(g)(h)</sup>
	Focussed Psychological Strategies	Group A20 Subgroup 2	2721, 2723, 2725, 2727
	Family Group Therapy	Group A6	170, 171, 172
	Electroconvulsive therapy <sup>(i)</sup>	Group T10	20104
	3 Step Mental Health Process—general practitioner <sup>(j)</sup>	Group A18 Subgroup 4	2574, 2575, 2577, 2578
	3 Step Mental Health Process—other medical practitioner <sup>(j)</sup>	Group A19 Subgroup 4	2704, 2705, 2707, 2708
Clinical psychologists	Psychological Therapy Services <sup>(a)</sup>	Group M6	80000, 80005, 80010, 80015, 80020
Other psychologists	Enhanced Primary Care	Group M3	10968
	Focussed Psychological Strategies (Allied Mental Health) <sup>(a)</sup>	Group M7	80100, 80105, 80110, 80115, 80120
	Assessment and treatment of PDD <sup>(c)</sup>	Group A10	82000, 82015
	Follow-up allied health service for Indigenous Australians <sup>(k)</sup>	Group M11	81355
Other allied health providers	Enhanced Primary Care—mental health worker	Group M3	10956



Focussed Psychological Strategies (Allied Mental Health)—occupational therapist <sup>(a)</sup>	Group M7	80125, 80130, 80135, 80140, 80145
Focussed Psychological Strategies (Allied Mental Health)—social worker <sup>(a)</sup>	Group M	80150, 80155, 80160, 80165, 80170
Follow-up allied health services for Indigenous Australians—mental health worker <sup>(k)</sup>	Group M11	81325

- (a) Item introduced 1 November 2006.  
(b) Item introduced 1 November 2007.  
(c) Item may include services provided by medical practitioners other than psychiatrists.  
(d) Item introduced 1 July 2008.  
(e) Item introduced 1 January 2010.  
(f) Item discontinued after 31 October 2011.  
(g) Item introduced 1 November 2011.  
(h) Item discontinued after 30 April 2012.  
(i) Item is for the initiation of anaesthesia for electroconvulsive therapy and includes services provided by medical practitioners other than GPs.  
(j) Item discontinued after 30 April 2007.  
(k) Item introduced 1 November 2008.

The MBS data presented 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, 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 2012. Medicare Benefits Schedule Book, effective 1 November 2012. Canberra: Commonwealth of Australia.

## Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme data

The Department of Human Services provides data on prescriptions funded through the Pharmaceutical Benefits Scheme (PBS) and Repatriation Pharmaceutical Benefits Scheme (RPBS) to the Department of Health. 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 relate to the number of mental health-related prescriptions processed by Medicare 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.

- Until 1 April 2012 the PBS and RPBS excluded non-subsidised medications, such as private and under co-payment prescriptions (where the patient co-payment covers the total costs of the prescribed medication) and over-the-counter medications. As of 1 April 2012, under co-payment prescription data are supplied directly to the Department of Human Services (DHS 2013). This permits a more accurate count of this data, similar in quality to that of PBS and RPBS data, so they can be incorporated in the same tables. However, a time series presentation of these data is not possible at this time and comparison with the data from the previously used Drug Utilisation Sub-Committee (DUSC) database should be interpreted with caution as the DUSC survey methodology may have been an underestimate of under co-payment prescriptions volumes.
- The level of the co-payment 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 co-payment level and thus be excluded in following years.
- Programs funded by the PBS that do not use the Medicare PBS processing system include
  - most Section 100 drugs funded through public hospitals (although the pharmaceutical reform measures for public hospitals under the National Healthcare Agreement and the Chemotherapy Pharmaceutical Access Program are paid through Medicare)
  - 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 Prescriptions and Expenditure sections: 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 (WHO 2011). 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 another 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 the following table).

**DataSource EXP.6: 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 2011–12 <sup>(a)</sup>
Prochlorperazine	N05AB04	A04AD	603,540
Lithium carbonate	N05AN01	N06AX	104,754

(a) Prescriptions data using date of service basis.

Source: Drug Utilisation Sub-Committee database (Australian Government Department of Health).

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 age group as age is calculated at the time of supply, and patients' ages will be one year greater for prescriptions supplied after their birthday than before it.

State and territory are determined by the Department of Health 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, rather than the date of prescribing or the date of supply by the pharmacy.

### **Drug Utilisation Sub-Committee (DUSC) database**

From 1 April 2012, under co-payment prescription data are supplied directly to the Department of Human Services (DHS 2013). That is, the DUSC-sponsored Pharmacy Guild survey ceased to be the source of under co-payment prescription data. This permits a more accurate count of these data, similar in quality to that of PBS and RPBS data. Therefore, time series data should be interpreted with caution as the previous survey methodology may be an underestimate of the volumes of under co-payment prescriptions.

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### **Reference**

WHO (World Health Organization) 2011. ATC: Structure and principles. Oslo: WHO Collaborating Centre for Drug Statistics Methodology. Viewed January 2015, [http://www.whocc.no/atc/structure\\_and\\_principles/](http://www.whocc.no/atc/structure_and_principles/)

DHS (Department of Human Services) 2013. Collection of under co-payment prescription data, Canberra: Commonwealth of Australia. Viewed March 2014, <[http://www.medicareaustralia.gov.au/provider/pbs/pharmacists/collection\\_of\\_under\\_co-payment\\_prescription\\_data.jsp](http://www.medicareaustralia.gov.au/provider/pbs/pharmacists/collection_of_under_co-payment_prescription_data.jsp)>.

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## Key concepts

### Expenditure on mental health services

Key Concept	Description
<b>Average cost per patient day</b>	<b>Average cost per patient day</b> is determined by dividing the total recurrent expenditure of the specialised mental health service by the total number of <a href="#">patient days</a> as presented in the Specialised mental health care facilities section.
<b>Constant price</b>	<b>Constant price</b> 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 2014).
<b>Current price</b>	<b>Current price</b> refers to expenditures reported for a particular year, unadjusted for inflation. Changes in current price expenditure reflect changes in both price and volume (AIHW 2014).
<b>Health expenditure</b>	<b>Health expenditure</b> 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 2014).
<b>Health funding</b>	<b>Health funding</b> 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 2014). The national recurrent expenditure on all mental health-related services can be estimated by combining funding from three sources: <ul style="list-style-type: none"><li>• state and territory contributions to specialised mental health services</li><li>• Australian government expenditure on mental health-related services and contributions to specialised mental health services</li><li>• private health insurance fund component estimated by the Department of Health.</li></ul>

**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 (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)

**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 2014).

**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 five **target population** groups (see METeOR identifier [445778](#)):

- Child and adolescent services focus on those aged under 18 years.
- Youth services focus on those aged 16–24 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.

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## Reference

[AIHW 2014](#). Health expenditure Australia 2012-13. Health and welfare expenditure series 52. Cat. no. HWE 61. Canberra: AIHW.