The health reform landscape

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There is a German saying: "The less the people know about how laws and sausages are made, the better they sleep at night".[1]

With the risk of disturbing our sleep, I want to outline how governments make budgetary policies, particularly those relating to health policy, and to suggest that good mental health policy doesn't fit easily into this process – a process shaped by an obsession with the fiscal bottom line, by the legacies of past priorities, by muddled (or absent) thinking about policy principles, and by an "illness" model of health care.

In spite of these impediments, there have been successes, thanks to champions like Ian Hickie, Patrick McGorry, Louise Newman and many others. We have come a long way towards de-stigmatizing mental illness. We are learning more about the determinants of mental illness, most recently in the context of incarcerated asylum-seekers. We are coming to realize the huge cost of mental illness – not just the direct costs of treatment, but also the pain and suffering of those with mental illness, the costs which fall on carers, the costs imposed on the criminal justice system, and more generally the costs borne by whole community in the form of lost potential – in the language of economists an "opportunity cost" or the waste of human capital. While many illnesses occur in our retirement years, mental illness often strikes in or at the start of what should be our most productive years.

Our present Commonwealth Government, I believe, is taking mental health seriously: the appointment of a minister, Mark Butler, with specific responsibility for "mental health and suicide prevention" is a significant development, and this year's Budget Statement on Mental Health Reform shows an awareness of many of the problems in mental health policy.[2]

Yet, as that statement acknowledges, it is no more than "the start of a journey". It makes the best of a few spending initiatives which amount to $2.2 billion over five years. Some of that is shifted from other programs, and even if it were all "new" money, it is only $0.44 billion a year in a total annual Commonwealth health budget of $60 billion, or total annual health spending from all sources of around $120 billion. Another way of looking at $2.2 billion is $20 a year from every Australian – a bottle of mid-quality Shiraz.

If there is to be significant progress in mental health reform, in fact in health reform more generally, there needs to be a significant break in the thinking of policymakers. So, let me walk through those present ways of thinking, mainly at the Commonwealth level.

The Commonwealth Perspective

The budgetary process

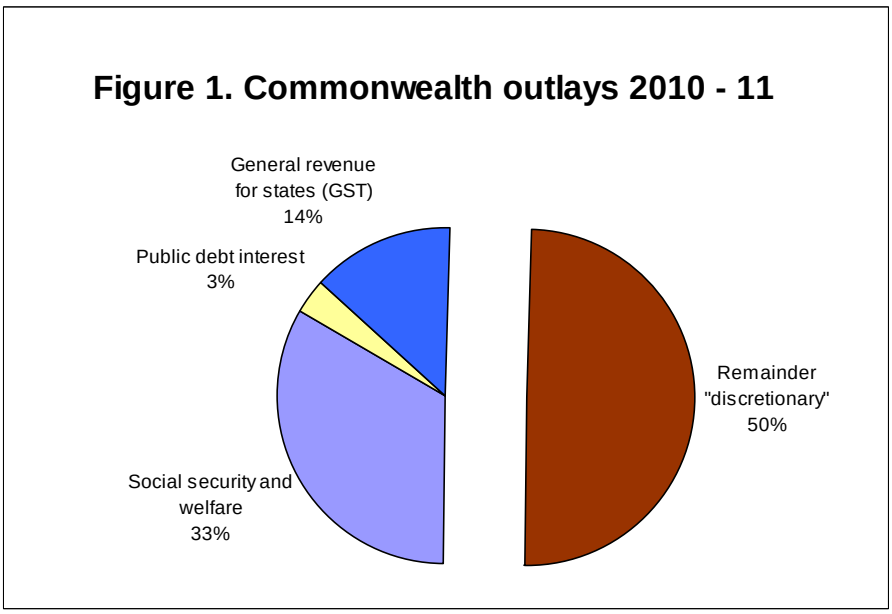
The Commonwealth budgetary process is in three steps.

First in the macroeconomic process, the Government sets its own constraints in terms of the amount of revenue to be raised and the size of the deficit. This year (2011-12) the amount of revenue to be raised through taxes is set on the criterion that it should be "below the 2007-08 level on average", or 23.6 percent of GDP. The deficit target for this year is 1.4 percent of GDP and a razor-thin surplus for next year.

As an exercise in arithmetic, once revenue and the deficit are set, so too is the level of outlays. Such arithmetical precision, however, carries an inference of objectivity, of inevitable constraints, but these constraints are political ones, self-imposed by the government.

Then there is another level of constraint, because the second stage of the budgetary process is to calculate the cost of what are known as "entitlement" programs, mainly pensions, and to take these largely as given. These are projections of previous years' outlays and there is rarely any review of these programs. (I await the Commonwealth's release of mid-year fiscal estimates in a few days, and will be surprised if, in any fiscal response to these estimates, they cut any of these "entitlement" programs.)

These programs, classified as "social security and welfare", comprise one third of the Commonwealth budget. Politically it is very tempting, in times of plenty, to increase the scope of entitlements, as the Howard Government did with family benefits, but once granted they are very hard to curtail. The present government took a great deal of heated criticism when, in this year's budget, it made some very minor changes in family tax benefits. Treasury projections estimate that entitlement outlays will grow in real terms by 3.5 to 4.5 percent a year, and even the most optimistic projections by the Reserve Bank are that the economy will grow by only 3.0 to 4.0 percent a year.[3] In short, every year about 0.5 percent of GDP, or $700 million (two percent of the Budget), will be allocated to increased entitlements.

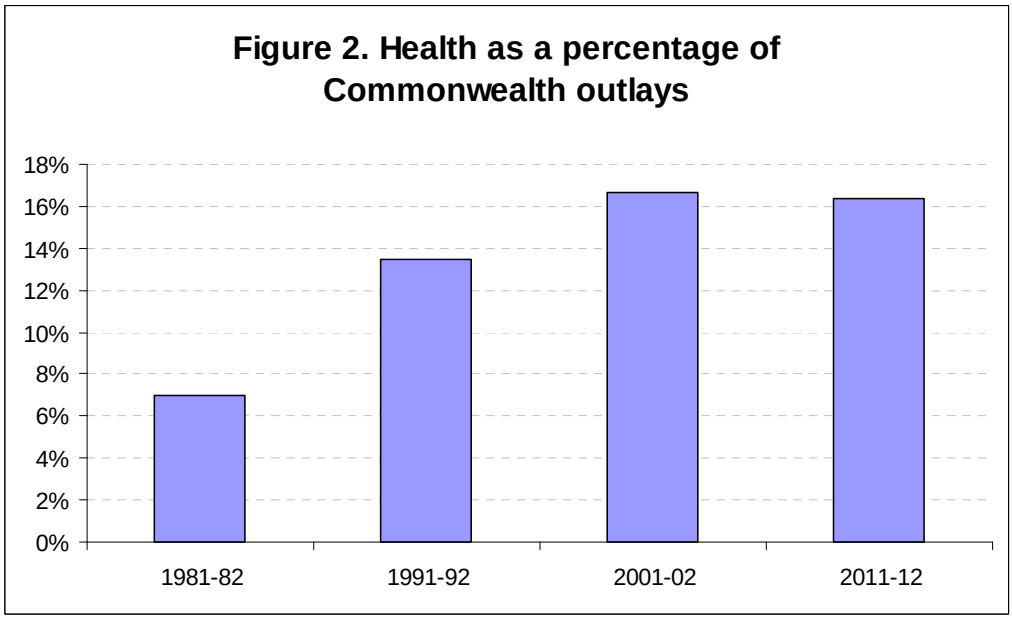


The other large non-discretionary outlays are interest on public debt and general revenue payments to the states, the latter being constrained by the agreement to pass all GST funding to the states.

Once the Commonwealth has accepted the macro expenditure figures, and subtracted entitlement programs, the remainder is left for government programs. (See Figure 1.) Allocations for defence, education and all other programs, including health, must be fitted into this slice of the pie. This year, only 50 percent of the budget is available for these programs, and the true discretionary component within that 50 percent is quite small, because in most programs there are long-term contractual arrangements and reasonable community expectations of continued services. It's hard to get a share of this for any new initiatives, and it's particularly hard for new initiatives in health.

The health budget

In this process of allocation to portfolios, health is particularly problematic because health outlays have been taking a greater share of the budget, more than doubling their share over the 30 years to 2001-02. In what is essentially a zero-sum process, any growth in the health budget is seen to be at the expense of other priorities.



Although government health expenditure has stabilized in the last few years, projections are for strong growth in the future. The 2010 *Intergenerational Report* projects Commonwealth outlays for health care to rise steadily – from 4.0 percent of GDP in 2009-10 to 7.1 percent of GDP in 2049-50. These are projections of recent trends, disregarding any possible policy changes.

Over the 23 years to 2007-08 Commonwealth outlays on health have been growing at a real rate of 5.1 percent a year. In part this is accounted for by population growth (1.3 percent) and age structure (0.5 percent), but that leaves a large residual component attributable to "non demographic factors", which are higher prices and more services per capita (even once the effects of ageing are factored out).

This dismal analysis has a compelling logic. Expenditure is constrained by limits on revenue, there are mandated and political commitments to maintain certain cash entitlements, and health has to compete with all other programs for what's left over. Even without any new policy initiatives, health expenditure is bound to grow. Therefore, a lobby group or a health minister should consider it a marvellous stroke of luck to get anything for new programs.

The limits of the fiscal perspective

But, from a wider perspective, what should it matter if the government is spending more on health, provided it is giving taxpayers good value for money?

To deal first with the projections in the *Intergenerational Report*, consider the implications of Commonwealth health expenditure rising by another 3.1 percent of GDP over the next 30 years.

At first sight we might consider that such growth has to come from other government programs, but there is no reason to assume such a constraint. Even if our per-capita annual growth in GDP is only one percent, and we don't raise taxes as a share of GDP, we can devote an extra 3.1 percent of GDP to Commonwealth health expenditure, and in 2040 still have 30 percent more per head for education, defence and other publicly-funded programs than we do now.[4] They may take a smaller share of funding but will still enjoy absolute growth.

That is a projection based on current macro policy settings, but there is no inherent logic in constraining Commonwealth revenue to 23.6 percent of GDP. Contrary to some political myths, Australia is a low tax, small government country. Among the OECD countries, taxes average 35 percent of GDP.[5] Australia's taxes, from all three tiers of Government, are only 29 percent of GDP. Only five OECD countries, including the USA, have a lower level, and if America's outlays on private health insurance were included – it's essentially a privatized tax in that country – its taxes would be around 33 percent of GDP.[6]

The *Intergenerational Report*, introduced by the Howard Government and continued by the present Government, embodies a narrow view of public policy. Most notably it projects *Commonwealth government* outlays only. Although its style is deadpan, the inference drawn by many of its readers is that we must do something about this runaway expansion in public spending – and health care is one of the main culprits.

The two assumptions behind such an inference are that there is something inherently problematic about spending more on health, and that if health spending is to rise it should be shifted out of the public budget.

The first assumption is easily dismissed. As John Deeble often points out, our spending patterns change over time. Compared with a generation ago, we spend relatively more on entertainment and communication and less on food and clothing. In an ageing society, with the availability of medical technologies, there is every reason to believe we should be spending more on health care and public health. What counts is how well we spend that money; clearly there is something wrong in the USA, for example, which spends far more on health care than any other OECD country, and has generally poorer health outcomes.

That leads to the second assumption – that health spending should be shifted off public budgets. The division between the optimal mix of public and private funding for health is a complex one, to do with community values (the extent to which we want to share the burden

of health costs) and problems of market failure (inefficiencies and limits in private markets in both public health and health care). If we try to resolve this division by a simple ideological rule such as "private is better" or to sustain some historical division, then the outcome is bound to be far less than ideal in terms of equity and efficiency.

We find some of the worst outcomes when we accept the notion of shared funding, but choose to do this through private health insurance. Private insurance carries all the moral hazard (i.e. incentive for over-use because of the suppression of price signals) of public insurance, but it lacks the strong discipline that can be exercised by a single government insurer. It is administratively expensive, it carries incentives for "cherry picking" easy cases, and it has inbuilt disincentives for spending on health promotion and disease prevention – what insurance company is going to undermine its own market? When we look around the world, at other developed countries, we find that the more a country relies on private health insurance the more it spends on health care, without any improvement in health outcomes. Private insurance buys more expensive health care, but not better health outcomes. Economists such as Naomi Caiden and Aaron Wildavsky coined the term "privatized tax" to describe mechanisms such as private insurance; if we want to share our health costs with others, the most equitable and efficient way to do it is through our tax system.

In the case of mental health, I suggest that private insurance is particularly inappropriate. The insurers' business models are best suited to single expensive but contained episodes of care, such as childbirth and hip replacement. They tend to protect themselves against long-term, open-ended commitments. All Australian insurers have a 35 day rule, limiting their liability for hospital care.[7] Clinical psychology is excluded from basic policies, and even on top cover there are limits of a few hundred dollars for clinical psychology – enough to pay for three or four consultations with Medibank Private's most generous policy which allows $600 for psychology.

Some may believe that through legislation or regulation we could get the insurers to change their business models, but that's to misunderstand the nature of insurance. Insurers, of all types – house, automobile, commercial – avoid open-ended and long-tail risks. This has to do with the risk-averse corporate cultures (we don't find too many Bill Gates style entrepreneurs in insurance) and with their need to raise finance from risk-averse investors.

As Herman Leonard of Harvard's Kennedy School of Government has often said "the hard jobs are left to the public sector". Covering the costs of mental illness is one such hard job.

At this point, I want to add what should be an unnecessary disclaimer. Whenever economists or other commentators point out the shortcomings of private health insurance, there is an outburst of emotive claims that the alternative is some horror of "socialized medicine", such as the imagined worst of Britain's NHS, with images of cold waiting rooms with hard benches and broken white tiles.

The point is about *funding* health care, not *delivering* health care. Public funding does not have to be tied to public provision. It is only through a weird set of arrangements that private hospitals, for example, have tied their fortunes to private insurers and that public hospitals have tied themselves to government funding. There is nothing set in stone about these arrangements – indeed, our own Department of Veterans' Affairs operates a neat purchaser-provider split: public funding is directed overwhelmingly to private providers. But I'm getting into another area of concern – the needless rigidities in the Commonwealth's health care arrangements.

Rigidities and fragmentation

To draw an analogy with our health care arrangements, think of an old country homestead shaped over 100 years or more with additions and modifications, some minor, some major, some done in times of plenty, others done in times of stringency, and all reflecting the fashions and technologies of the time. Those who are familiar with the language of public policy will recognize, in this analogy, the ideas of Charles Lindblom who contrasted root-and-branch or comprehensive reform with what he called "muddling through".[8] In health policy we have been muddling through since 1788 without going back to fundamental design principles.

Like the country homestead, our health care arrangements are a mess. To continue with the analogy, the government's recent reforms are like a major refurbishment, but the old floorplan remains and the new bits do not fit easily with the old bits.

The most basic problem is fragmentation in government programs. There are too many disparate programs, and for the most part, these programs are designed around the convenience of suppliers rather than users. They do not join up.

It is refreshing to see that some in the Government can see this problem, which is writ large in the case of mental health. Included in the Budget Statement on Mental Health Reform is the acknowledgment:

> There are a number of highly effective services, but they are often patchy and not connected and, for reasons of program design or funding, struggle to deliver a truly integrated service response based around the individual's needs. This fragmentation of services also creates gaps, which prevent people receiving the full range of services that provide an optimal path to recovery.

It is one matter to acknowledge that fragmentation; it is another matter to do something about it. That fragmentation is built in to our health care programs, developed in different times, reflecting the fashions, political ideologies and budgetary situations of times past.

Our public hospitals date to colonial times, generally as state-subsidized charities for the poor. Doctors worked in public hospitals on an unpaid "honorary" basis – a system of *noblesse oblige*, or as economists would say, they cross-subsidized public patients from high fees imposed on the well-off in doctors' rooms and in private hospitals. Those arrangements held until the middle of last century, when public hospitals became the more inclusive institutions we now know, but we still see remnants of the old culture in the differing remunerations of staff in public and private hospitals, and the notion that the well-off should use private hospitals.

Of particular relevance to mental health is the history of psychiatric services. A half century ago the old state psychiatric hospitals gave way to the trend of de-institutionalization, and to the incentives in Commonwealth-State agreements to have psychiatric services moved to mainstream public hospitals where they could share in the bounty of shared funding. Even now there are unresolved disputes in psychiatric services between primary care, now a Commonwealth responsibility, and hospital care.

Our main pharmaceutical program – the PBS – dates to the years following the Pacific War, when Australians were seeking access to the wonder drugs of the time, antibiotics in particular. It started as a generous program, paying fully for the cost of prescription pharmaceuticals (there were fewer of them 60 years ago), and has remained as the only

health program where the Commonwealth exercises strong control over providers' prices and patients' usage.

Our main medical program, Medicare, dates to the Whitlam Government's vision for a universal health insurance scheme – Medibank. It was largely pulled apart by the Coalition Government between 1976 and 1982, but was resurrected again as Medicare in the 1980s – the idea of it being a component of the "social wage" being embraced by the Hawke Government. Whitlam's Medibank and Hawke's Medicare weren't really universal; rather they were fill-in schemes complementing existing public schemes – the PBS and state public hospitals.

The Hawke and Keating Governments were content to allow private insurance to wither away: by the time the Howard Government was elected in 1996 coverage had fallen from 80 percent to 30 percent. In a series of initiatives between 1996 and 2001, the Howard Government brought in a set of subsidies for private insurance, which had the effect of boosting hospital cover to present levels of around 45 percent.

The Commonwealth, under both Labor and Coalition Governments, has consistently avoided any fundamental review of health policy. In 1977 the Industry Commission (now known as the Productivity Commission) called for a "broad public inquiry into Australia's health system"[9], but the closest we have come in recent years has been the Rudd Government's National Health and Hospitals Reform Commission, which, even in its name, separated hospitals from health, and which was constrained in its brief with the requirement that there should be no change in the mix of individual, health insurance and public funding. Also, its composition was of health insiders; it lacked the objectivity and detachment that could be exercised by a body such as the Productivity Commission. With these constraints it would have been amazing if it had not seen reform only in terms of incremental changes.

This legacy of past initiatives, subject to a series of incremental reviews, leaves us with three separate programs, arranged around provider demarkations:

- public hospitals
- the PBS
- the MBS

And sitting alongside these are private hospitals funded by subsidized private insurance, with some other insurance funding directed to "ancillary" services.

Some blame for this rigidity can be assigned to the historical division of Commonwealth and state responsibilities but even within the Commonwealth there is fragmentation, most notably between the PBS and MBS, which operate on quite different funding and eligibility criteria. At the time Medibank was introduced, medical and pharmaceutical lobbies ran a strong fear campaign against integrating these programs, on the basis of "privacy". This separation has implications for researchers who may wish to use PBS and MBS records for research, because there is no way they can be matched. The opportunity for data capture was one of the original visions for Medibank, but that opportunity has been little used, in part because of this separation. This is particularly relevant for mental illness, where treatment often involves a variety of interventions – some within the MBS, some within the PBS, and some other non-subsidized services, such as counselling and non-prescription pharmaceuticals, without any means of data capture or cross-matching. Although the Commonwealth's rhetoric is about evidence-based health care, it is blocking an important means for productive research.

This separation of programs is a structure which industrial economists would recognize as a relic from another era. There was a time when, for example, auto companies were organized around their input specializations – a casting division for engines, a pressing division for body panels, an assembly division, a sales division etc. Such structures made sense when competitive advantage was based on exploitation of scale economies in manufacturing, but by the 1980s in most industries such structures had given way to customer-oriented divisions.

It was fifty years ago, in 1960, that Theodore Levitt of the Harvard Business School described such a transformation in businesses, which had previously defined themselves by the products they produced, to defining themselves by the needs they satisfied.[10] Gillette does not make razor blades, it provides services for skin care; Canon does not make cameras, it helps people record images. And so on. This transformation is generally described as moving from a production orientation to a customer orientation.

This transformation was also recognized by governments. In the 1980s the Commonwealth moved its budgetary processes away from an input focus to an output and outcome focus. Health care, however, has remained largely untouched by these transformations. It still has provider-based divisions.

One consequence of this provider-based division is that the Commonwealth's focus remains on inputs, rather than results. For example, over the five years to 2003-04, while the Commonwealth's total health expenditure was growing in real terms by 5.9 percent a year, expenditure on pharmaceuticals was rising at an average rate of 12.8 percent.[11] This led to a strong focus on pharmaceutical costs – a focus which has continued to the present day. Given the role of pharmaceuticals in treating certain forms of mental illness, this stringency has clear implications. But it shouldn't matter if some costs are rising faster than others; it may be that pharmaceutical therapies are resulting in savings in other areas of health care. Imagine an auto company becoming obsessed with a rising bill for plastic, not noticing that plastic is replacing steel.

Rather than being concerned with inputs, the Commonwealth would almost certainly have been in a better situation to make wise policy had they looked at expenditure by illness category or demographic group. Such an output-based focus is more likely to expose areas of systemic waste or over-servicing.

From a consumer's point of view our health care arrangements are a mess, with physical separation of services, duplication of records, separation of partial records between different providers, and a lack of continuity of care. There are high search costs, high bureaucratic costs and high risks of conflicting therapies.

From a provider's point of view, however, our program structure could not have been more favorable had the lobbyists designed it themselves. For example the Commonwealth Department has separate divisions for pharmaceuticals, medical services, and private insurers: each provider group has an easily identified point of influence.

By far the biggest lobby, even if not recognized as such, is the public hospital system. Taking 40 percent of all government health expenditure, backed by eight state and territory governments and by health unions, it has a great deal of institutional strength in our health care arrangements. Its strength is enshrined in the new regional hospital networks (note that they are *hospital* networks, not *health* networks.) Hospitals, like universities and big factories, are concentrated social systems. As sources of institutional power they contrast with small clinics, primary schools and mum and dad businesses.

The COAG National Health Care Agreement glosses over this *de facto* provider-based structure, however. Its rhetoric is about a patient-based structure, and integration of health care, disease prevention and health promotion. To quote its stated principles, it says:

> ...that Australia's health system should:
>
> (a) be shaped around the health needs of individual patients, their families and communities;
>
> (b) focus on the prevention of disease and injury and the maintenance of health, not simply the treatment of illness;
>
> (c) support an integrated approach to the promotion of healthy lifestyles, prevention of illness and injury, and diagnosis and treatment of illness across the continuum of care[12]

The reality, however, is the same old structures, with the benefits of a little modification and a new mechanism called "Medicare locals" designed to carry out some level of coordination.

Mental health does not sit easily in this provider-based program structure. Nor, for that matter, would any initiative based on people's condition – cardiac health, sexual health etc. There is nothing intrinsically wrong with mental health programs such as the Better Access Program and "Headspace" (they have their critics who see specific design flaws, but that's outside my territory). My point is that even if these could have all their bugs ironed out, they are always going to be struggling for funding and recognition in an area where programs are designed around provider rather than user interests.

Policy confusion

The outcome of this fragmentation is policy confusion.

Our funding arrangements have elements of insurance, safety nets, social exclusion, consumer subsidies, industry subsidies, means-tested support, compensation for market failure, and in cases, almost total neglect where the consumer is left to the mercies of a market structured in favour of providers.

Let me describe some of the mess – and what follows on the next two pages is a gross simplification. To get a sense of the whole ghastly complexity, see Jennifer Doggett's excellent work for the Centre for Policy Development.[13] The mess is most easily illustrated in the variety of funding systems.

The three main programs – hospitals, pharmaceuticals and medical – all have their own inconsistencies and the inconsistencies between programs are even more marked.

Public hospitals are free for all users, with no co-payments and no means testing. Private hospitals are closely linked to private insurance. Because the 30 percent subsidy and the Medicare Levy Surcharge (MLS) make private insurance more attractive for the well-off, those who are better-off are encouraged to drop out of the public system.

This is an odd policy, because taking the well-off out of the public arrangements is a form of social exclusion (at odds with the Government's stated objective of social inclusion). Because of the way the MLS is structured, its subsidy for PHI is directly proportional to income, so that those on very high incomes are actually subsidized for more than 100 percent of their

insurance cost. Because it encourages insurance, it worsens moral hazard and it effectively penalizes those who pay for their own health care from their own resources – a penalty on self-reliance. And it supports queue-jumping. By no conceivable political ideology, "right" or "left", could this be called good policy, unless one holds the belief that there is some intrinsic merit in supporting a high-cost financial intermediary.

Pharmaceuticals are available with a structured system of capped co-payments, which are more generous to those of limited means (quite the opposite to private insurance subsidies). To the consumer this comes close to a well-designed insurance scheme – the insurer (the Commonwealth) bears the high costs, and the consumer is left with a known and limited co-payment. Other pharmaceuticals, however, designated as "pharmacy only" and "pharmacist only" are given no support; in fact the consumer is left relatively powerless in a market cornered by the pharmacy industry which, through political pressure, has exempted itself from competition policy.

When Medibank was introduced it was structured so that there was a strong incentive for direct billing. That is, it was envisaged as a comprehensive insurance system. But over the years Medibank and now Medicare co-payments ("gap" payments) have increased and for many services, it acts more as a partial subsidy to consumers rather than as an insurance system.

Then there are services for which support is capped, as with Medicare funding for psychologists or other professionals – now down from 18 services a year to 10. This is diametrically different from the PBS, in that the consumer is left bearing the open-ended risk.

Services such as dental care receive very little support. Those with private insurance receive some support for "ancillary" services, but this support is capped to limit insurers' risk. Those without private insurance – more than half the population – receive no support unless they have "chronic medical condition and complex care needs being managed by a GP under specific Medicare care plans" – and the Government is trying to close this scheme.

Safety nets underpin some of these arrangements, some on an individual basis, some on a family basis. Most operate on a calendar year, but there is a 20 percent tax rebate for health expenses above $1500, operating on a financial year basis.

Table 1 shows how individual payments vary across programs. This covers only specific monetary transactions. Importantly it does not include the costs borne by carers who sacrifice some or all of their earning capacity, a particular issue in relation to long-lasting chronic illness, an area where mental illness is heavily represented. Budget-obsessed bureaucrats rarely even think about these costs, let alone bring them to account in official reports.

It is easy to dismiss criticism of fragmentation and policy conflicts. Public policy is intrinsically messy; governments do what they can when they can, getting around political, legal and constitutional constraints. Governments change and even within parties there are factions. Surely what counts is that we have a system that delivers excellent outcomes by most criteria used by organizations such as the OECD.

Table 1. Individual payments for health care 2009-10

Area of health care	Individual payments $m	Total payments $m	Individual payments as percentage of total payments
Public hospitals	933	36 238	3%
Private hospitals	1 228	10 050	12%
Medical services	2 641	21 242	12%
Prescription pharmaceuticals	1 537	9 586	16%
Other health practitioners	1 593	3 742	43%
Dental care	4 698	7 690	61%
Aids and appliances	2 456	3 501	70%
Non-prescription pharmaceuticals	6 206	6 717	92%
Other	496	17 540	3%
All health care	21 788	116 306	19%

Source: AIHW *Health Expenditure Bulletin* 2009-10

But this mess does matter, for four reasons.

First, consumers and those health professionals advising them are likely to be drawn to services which are free or low cost at the point of delivery, supported with either private or public insurance, and away from services with significant out-of-pocket costs. In the case of psychology services, there is an incentive to use the first to tenth service, but a big penalty on the eleventh service. By contrast, if one runs up $1157.50 (the safety net threshold) of out-of-pocket costs for expensive medical specialists, subsequent consultations cost only 20 percent of the "gap" payment.

Such distortions are bound to result in resource misallocation, with some over-use of free services and some under-use of paid services.

Second, it imposes big transaction costs on both users and providers. Both private and public providers are burdened with paperwork. Professionals who should be providing care are engaged in bureaucracy. Users too are burdened with search costs, and many will miss out on services simply because they don't know about their existence. Duplication of records, often on physical paper, leads to errors.

Given the multiplicity of services which may be encountered by someone with mental illness this would seem to be particularly relevant for mental health. (In this regard the promises in the 2010 election campaigns that mental health funding could be provided by abolishing electronic records is illustrative of the way health funding involves shuffling funds between programs.)

Third, this input/provider focus focuses on short-term costs. The Commonwealth focus is on the immediate budget and what is known as the "forward estimates period" – the budget year in question and the following four years. It's a process that builds in short termism. That's why political promises are always made over four or five years.

No business expecting to be around in the future would base its decision-making on a four year projection. They would use proper discounted cash flow analysis over a long period, and governments have available the same techniques in the form of benefit-cost analysis – a process which considers not just budgetary costs, but also all of the community costs, now

and into the future. It's a useful technique, but, apart from specific areas such as in evaluation of pharmaceuticals for PBS listing, it is not used in health programs.

This is particularly relevant for mental illness, because so many mental illnesses become manifest at a young age, and many affective disorders persist for 50 or more years. In this regard it has a profile unlike so many acute conditions and conditions which manifest mainly among the aged.

Fourth, and perhaps most important from the perspective of advocacy groups, there is no base of consistent principles on which to make a case for new resources or resource re-allocation. Whatever the principles on which one argues, there are other principles which can be used to rebut the argument. An argument based on cost-effectiveness can be rebutted by an argument based on budgetary constraint. Any attempt to use precedent can be rebutted by finding a contrasting precedent.

The general government perspective

States, too, are involved in health services. States see health care in terms of hospitals – the more so since the recent agreements to separate primary care more decisively.

Over the ten years to 2000-10, state expenditure on hospitals rose from 16 percent to 19 percent of state outlays. A proportion of this has been tied money under Commonwealth Health Grants, but, just like the Commonwealth, states find health care outlays are crowding out other budgetary functions. New arrangements under the National Health Reform Agreement will put the states on a firmer footing, with growth funding shared between the Commonwealth and states, but there will still be growth, crowding out other budget priorities.

This is at a time when two of the states' revenue sources are under strain – their share of GST funding which is tied to discretionary consumption expenditure and stamp duty which is tied to the value of real estate transactions.

Yet states are responsible for policies which have strong influences on health, including mental health. I would not step so far outside my own territory to say I have any more than a lay person's knowledge of the determinants of mental illness. But I am reasonably assured that there are many correlations between social and environmental conditions and mental health and that there are some factors which may or may not be causal, but which almost certainly aggravate the symptoms of mental health, and can determine the difference between someone with mental illness living a life of full participation and a life of dependence.

State governments run the criminal justice system. They regulate the alcohol service industry and gambling. They run primary and secondary public education, which cover the ages when so many mental illnesses are first manifest. They run housing authorities. They determine the shape of cities, and there is a reasonable amount of work linking mental health to aspects of spatial design.

I suspect, however, that state health ministers and their departments don't have time for these matters. They would be mainly concerned with hospital budgets, industrial disputes, and the inevitable hospital misadventures which the tabloid press inflates into major scandals.

That brings us back to the Commonwealth and its responsibilities which at first sight lie outside the health portfolio. The Commonwealth has responsibility for aboriginal affairs,

immigration (including refugee policy), labour relations, education, industry policy, pensions and taxation. The connections of mental health to immigration policy are obvious. The other policies mentioned have large and long-term influence on unemployment, on the distribution of income and wealth, on whether people have meaningful and well-paid work that uses their capabilities and provides for social participation – all matters of concern to mental health practitioners.

As a rhetorical question, we can ask whether the Minister for Health and Ageing or the Minister for Mental Health and Ageing get to have a strong say on these policies.

Conclusion

To that last question, it is notable that the Minister for Mental Health and Ageing reports to the Prime Minister. That is an indication that as far as mental health is concerned, the Commonwealth recognizes the policy interactions.

In a recent review of the Public Service the problem of policy coordination got a reasonable airing.[14] We may be seeing some winding back of the public service "reforms" of 25 years ago, which gave ministers and departments more autonomy at the expense of policy coordination and integration.

It is notable that the Commonwealth, initially through the Australian Bureau of Statistics, has been working for some years on developing broad indicators of progress. Australia is taking a leading role in looking for broader indicators than the traditional national accounting measures of GDP and GDP per-capita. The Appendix to this document shows the set of values of "social progress" which the ABS is developing, with a view to developing specific indicators. These are to sit alongside three other sets covering economic, environmental and governance values. Not only does mental health get specific mention, but so too do many other areas of concern, including social inclusion, caring and family support.

A cynic may see such a project as an exercise in public relations, or as an attempt to deflect attention from poorer GDP measures (organizations are adept at developing new indicators when their present ones are turning in the wrong direction). We may believe that hard-nosed bureaucrats see mental ill-health as a collateral cost of economic progress.

But this exercise is being taken seriously by economists in agencies such as Treasury. The insurer Australian Unity has developed a wellbeing index. Internationally, President Sarkozy, a politician on the "right" of the political spectrum, has initiated a Commission on the Measurement of Economic Performance and Social Progress, led by Nobel Prize winners Joseph Stiglitz and Amartya Sen. These are not touchy-feely political exercises to appease the "left" or intellectual pursuits to keep statisticians employed. I believe that the economic problems of the last three years have shaken the confidence of policymakers, contributing to an unease about what we see as good policy and a widespread recognition that we need better indicators.

In the meantime, present practices and ways of thinking have their inertia, which, if left unchallenged, will take many years to run down. Policymakers will go on with their obsession with budgetary costs. They will continue to think of three provider-based programs and will find it too hard to accommodate user-based needs. Hospitals will go on dominating the

landscape. People seeking a better outcome for mental health will have to go on working within these systems.

But those same advocates need to keep some resources for working on more basic reform. Opportunities will arise. Our present arrangements at best will see Commonwealth and state governments through two electoral cycles without some new funding crisis. (Tasmanians would say it's come already.) There will be political shifts, not only from one party to another, but also within political parties.

In response to these developments the temptation for governments will be to go on with incremental reform, with even more layers of complexity and bureaucracy, while appeasing interest groups. But that process is not inevitable. Those who seek more fundamental change need to keep up the pressure.

I was privileged to observe, initially from outside government and later from within, the long, slow process of reform of industry policy. I grew up with the notion that tariff protection was something hard-wired into the Australian political system; it was naive to think it could be changed. But it happened, and the process took about thirty years. By the time the Hawke Government was elected in 1983, there had already been twenty years of patient work, often by people who kept a reasonably low profile like Liberal Party dissident Bert Kelly. There were reversals, but had those individuals and groups not done all that groundwork I believe that the Hawke Government would not have been able to pursue its far-reaching reforms. We need to pave the way for a government willing to take on the hard task of fundamental health reform.

Notes

1. "Je weniger die Leute darüber wissen, wie Würste und Gesetze gemacht werden, desto besser schlafen sie nachts." – misattributed to Bismarck, but much older.

2. Budget Paper *National Mental Health Reform*, Statement by the Ministers for Health & Ageing, Families, Housing, Community Services & Indigenous Affairs, and Mental Health & Ageing May 2011

3. Reserve Bank *Statement on Monetary Policy* November 2011 www.rba.gov.au

4. At first sight that arithmetic may not seem to add up. But with compounding:
   $1.01^{30} = 1.3478$ (i.e. GDP grows by 35 percent)
   3.1% of 1.3478 = 0.0418 (3.1 percent of the higher GDP)
   1.3478 – 0.0418 = 1.3060 (what's left over – 31 percent more)

5. Data from OECD www.oecd.org. Average outlays are even higher, at 40 percent of GDP, but these reflect the high deficits of many countries in recent years. Taxes provide a more conservative guide to the sustainable level of public expenditure.

6. America's taxes as recorded by the OECD are 27 percent of GDP. Health expenditure is around 16 percent of GDP, of which at least 40 percent is through private health insurance – indicating an impost of an extra 6 percent of GDP.

7. Medibank Private's website states this rule as "If you no longer need acute care and stay in hospital for more than 35 days, you'll be classified as a nursing home type patient. If this happens, we'll only pay a small portion of the daily hospital charges and you may need to pay the rest of the cost of your care. If you're in a private hospital, these costs may be substantial."
   http://www.medibank.com.au/healthcover/things-worth-knowing.aspx

8. Charles E Lindblom, "The Science of 'Muddling Through'" *Public Administration Review* Spring 1959.

9. Industry Commission *Private Health Insurance* Report 57 1997 www.pc.gov.au

10. Theodore Levitt "Marketing Myopia" *Harvard Business Review* vol 38 #4 July/Aug 1960, Republished July 2004.

11. HEB 2008-09 Tables 3.4 and 4.15

12. COAG National Health Care Agreement 2011
    http://www.federalfinancialrelations.gov.au/content/national_agreements/healthcare/Healthcare_Agreement.pdf

13. Jennifer Doggett *Out of Pocket: Rethinking Health Co-payments* Centre for Policy Development 2009. www.cpd.org.au

14. Advisory group on reform of Australian Government administration *Ahead of the game: blueprint for the reform of Australian Government administration* (AKA the "Moran Review") March 2010.

Appendix

Australian Bureau of Statistics "Aspirations for social progress" (draft as at November 2011)

Australians aspire to a society that values, cares for, and provides opportunity for all its members, optimising their wellbeing.

1. Health

Australians aspire to a society that optimises population health – emotional, mental and physical – and both the length and quality of lives

Components

- Emotional
- Physical
- Mental
- Intellectual

and (*for all the above*)

- Health systems and services (including carers)
- Prevention (of poor health) and education (empowerment)
- Healthy lifestyles (responsibility)
- Health outcomes

2. Equity and opportunity

Australians aspire to a society where all members are enabled, and not disadvantaged, in realising and expanding their potential and aspirations

Components

- Education and training (skills and knowledge)
- Employment
- Economic resources (income, housing)
- Services
- Access to and engagement with all the above (removal of barriers to)
- Social inclusion
- Assistance for disadvantaged
- Acknowledgement/measurement of disadvantage

3. Close relationships

Australians aspire to a society that nurtures the close relationships between people that provide support for individuals, especially at crucial times.

Components

- Quality of support from families/other support networks
- Support for families
- Time spent on close relationships
- Relationship education

- Relationship support services

4. Safety and security

Australians aspire to a society where people feel, and are, safe and secure

Components

- Crime rates
- Perceptions of safety
- Criminal justice system (quality, people involved in)
- National security

5. Social connection and community resilience

Australians aspire to a resilient society with healthy communities and social connections

Components

- Social capital *including*:
- Volunteering, community, civil society (participation and support for)
- Social / community connections, social support mechanisms
- Trust
- Services and infrastructure (quality and access) (health, employment, education, legal, government and non-government)
- Creativity and innovation
- Preparation for future change (population, climate, economic, etc)

6. Cohesion and diversity

Australians aspire to a cohesive society that celebrates diversity

Components

- Attitudes to difference
- Cultural activity / participation
- Reconciliation between Indigenous and non-Indigenous peoples
- Endangered cultural practices (Indigenous languages)

7. Non-material aspects of life

Australians aspire to a society that values non-material aspects of life – such as family, caring, culture, connection to the environment, and feelings about life – as much as material aspects of life

Components

- Subjective wellbeing (eg, feelings of contentment, satisfaction, happiness, wellbeing, autonomy)
- Unpaid work, carers and the caring professions
- Leisure time (work/non-work balance)
- Culture and the arts
- Environment (connection to, impact on wellbeing)
- Spirituality