

Population Approaches to Mental Health

Alan Owen
Senior Research Fellow
Centre for Health Service Development
Faculty of Commerce
University of Wollongong

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Abstract

The population approach has a long history and mental health is part of the bigger picture that includes the goal of geographic area responsibility. This goal has been progressively built into health systems since the 1970s, particularly in NSW. About 7% of the NSW health budget goes to mental health, and the Commonwealth has been a key contributor to change in how that money has been spent under the three National Mental Health Plans. This has included strategic investments in planning, information management and integration initiatives, including the Illawarra MH Integration Project. To some extent the State and Commonwealth-based systems are complementary, but persistent inequalities and inconsistencies still exist, and integration of the public and private sectors is still hard to achieve.

Lessons about meeting the needs of the whole population can be drawn from many of these system-level reforms and demonstrations. The strategic significance of primary care and the NGO sector stands out, but a major limitation to a population focus is that planning is still limited in scope and a coherent primary health care policy approach is still lacking at Commonwealth and State levels.

This presentation draws on a series of key messages from research and development work based at the Centre for Health Service Development. The presentation illustrates how a practical 'whole of government' focus can be encouraged to evolve over time, using examples of lessons from evaluation studies and system-level pilots. These examples indicate how to turn the tide by designing systems using information that can strengthen the mental health system's links to primary care services, self help groups and non-government organisations. However, what we see at this point is not so much a complete picture but pieces of a puzzle that is slowly coming together.

Alan Owen has worked in health care provision as a community mental health worker, was a senior planner in Eastern Sydney Area Health Service and has worked on community health policy at various levels over a period of 25 years. As well as working at the University of Wollongong in the Centre for Health Service Development (CHSD) since 1996, he is currently also a part-time member of the Guardianship and Mental Health Review Tribunals in NSW and is a policy advisor for ACOSS.

The Population Approach

I want to cover four main points in the time available and hope to open up some useful discussion at the end of the session.

1. The population approach has a long history and many barriers.
2. It implies goals for the whole system of geographic area responsibility, resource distribution, service planning and representation.
3. The goals of a population approach are not ends in themselves but serve to improve continuity for the client and integration at local levels.
4. Some useful lessons based on a population approach have been learned as result of the National Mental Health Strategy and from national integration projects.

A Bit of History

When I think of the population approach I think of it as the latest expression of one side of the long standing debate on different models of medicine and the medical task¹.

On the one hand is the focus on the individual person and their disease and on the other is the focus on the social origins of disease and distress. In ancient Greece the god of medicine and healing illness was Aesculapius, and it was his daughter Hygeia who was the goddess of positive health and the means of preserving it.

These two figures represent the continuing struggle to cure on the one hand and to go beyond the curative culture of late intervention on the other. Hygeia has always had the harder task.

Scientific medicine began to evolve towards our contemporary view in the 17th Century, when Thomas Sydenham wrote of the “method of treating fevers” which distinguished measles from scarlet fever, and at the same time gout was distinguished from rheumatism. The practical significance of the identification of specific diseases was that it allowed the separation of the malady from the sick person, breaking with the Hippocratic tradition of looking at the afflicted person and their constitution.

In the 18th Century Linnaeus systematically began to classify diseases, building up an increasingly clear picture of specific, constant and repeatable illnesses, associated with specific signs. By the late 19th Century this had formed the basis for the very important concept of specific aetiology, demonstrated by the dramatic public events staged by Louis Pasteur, which showed the one to one relationship between a disease (in this case anthrax) and its specific causative agent. When these agents could be visualised by the use of staining dyes, we had the basis for the germ theory of disease.

Straightforward causal relationships between outside agents and disease fitted well with the Newtonian model of mechanics and the resulting clockwork model of medical science with its quest for “magic bullets” is still popular today, not least because of its continuing technical successes.

¹ Underwood, P, Owen A and Winkler, R (1986). Replacing the Clockwork Model of Medicine. Community Health Studies 10, 3 pp 275-283.

In the face of this, population approaches as a form of social medicine continue to be the poor relation, both in terms of the resources at its command, and in the popular imagination, but do not go away.

Finding solutions to health problems by way of social reform still makes sense because biological conditions arise from social conditions. However, sanitary reform and public health movements are less glamorous, more politically contentious and until recently less “scientific”, than individual medicine and germ theory.

Friedrich Engels explained the relationship between working and living conditions and specific diseases when he reported on the situation in Manchester in 1844, arguing that the ability to resist disease depends on class and social position, while prevention is possible though changes to the social structure, the organisation of work and the quality of living conditions.

It is ironic that Rudolf Virchow, the famous author of the first book on Cellular Pathology, was another of the early formulators of social medicine. His observations of a typhus epidemic in Upper Silesia in 1848 revealed that there were many factors responsible for the disease. The treatment he recommended included adequate nutrition, better housing, better training of doctors, increased employment and free public education.

The repression that followed the revolutions of 1848 successfully dampened enthusiasm for the potential of social medicine, and Virchow went on to devote his career primarily to the safer science of pathology.

His outstanding early contributions are now little recognised, but he did leave us with a particularly pithy statement that holds true as much now as it did in the equally stormy times of 1848:

“Medicine is a social science, and politics is nothing more than medicine in larger scale.”

Rudolf Virchow, 1848.

Where we are now

I'd now like to jump to more contemporary times and examine the current NSW population approach and then get to mental health in particular.

In 1926 the Commonwealth established a Royal Commission on Health with familiar terms of reference that included the better coordination of hospital, general medical and public health work, and an increased emphasis on primary care and prevention². For various reasons including the Depression and the War, the unified service model that the Royal Commission recommended did not prevail, and the surge of post-War specialisation, sustained by a period of continued economic growth, led to a situation in the early 1970s where fragmentation prevailed, both bureaucratically and in health services generally.

The separate central administrations which existed for general hospitals (about 300 of them, each with their own hospital boards), psychiatric hospitals, and public health

² Neville Hicks. Area Health Management. [Health Forum](#), September 1992, p.18.

services were brought under the umbrella of the NSW Health Commission in 1972 and administration was regionalised.

These Regions, under the impetus of new Federal funds and policies, and with strong State government support, began to plan and manage health services on a basis of geographic as well as institutional concerns.

In 1975 the Task Force on Regionalisation and the Management Structure of the Health Commission of NSW reviewed the function of the Commission and its Consultative Document³ proposed a new form of health services management - District Hospital and Health Services Boards.

Within the services themselves at local level, community health services already had integration and geographic area responsibility within their objectives⁴, and the Health Commission's Standing Committee on Community Health had begun to canvas the Area Health Board concept as a way to embody these goals in a formal structure. Meanwhile, in relationship to hospitals, some Regional management also began experiments and pilot programs in area administration⁵.

With the amalgamation of regions in 1982 a period of continuous organisational change began. Since the early 1980s a series of policy and discussion documents canvassed the options for the integration of services and hospital rationalisation and began to shape the establishment, functions and organisation of Area Health Boards. The various reports, reviews⁶ and policy initiatives culminated in the introduction of Area Health Services in October, 1986, with the objectives enshrined in the legislation of the Area Health Services Act, 1986.

Area Boards have an obvious advantage for Ministers in that they distance and localize decisions, giving them someone to sack when things go wrong. They are also a way to manage the tensions in Australia's health system between the parochial institutional interests of each hospital, private medical interests, public provision to ensure principles of equity and accessibility in services, and attention to public health concerns and disease prevention.

³ Health Commission of NSW, Consultative Document: Regionalisation and the Management Structure of the Health Commission of NSW, 1977.

⁴ Health Commission of NSW: Monitoring Community Health Services: Objectives, strategies and measures. Division of Health Services Research (D75/4), March 1976; see also Community Health. Book No. 2, Goals for Community Health Services, 1977, pp.19-22.

⁵ Mary Foley. The Business of Providing Health Services. The Area Health Service Conference. NSW Department of Health, 7-8 February, 1991. Conference Proceedings, p.6.

⁶ First Report of the Independent Committee on Hospital Consolidation, presented to the Minister for Health, June 1982.
Interim Evaluation Team - Community Health Services. Area Health Boards: A Discussion Paper, December 1982.
Health Department of NSW (Mc Harg Report): Coordination of Health Services in the Community, 1984.
Policy Document on Area Health Services, Australian College of Health Service Administrators (NSW); August, 1984.
Review of Area Management of Health Services : New South Wales Health Department; April, 1986.
Area Health Services, New South Wales Health Department : April, 1986.

The area-based population approach attempts to balance these competing concerns and this illustrates why Sid Sax, the principle architect of population approaches and health planning in Australia, called health policy a “Strife of Interests”⁷.

Mental Health in a Population Context

A little examination of the political economy of health shows the Commonwealth contribution to total health expenditure is increasing.

Grants to the States are decreasing as a % of Commonwealth expenditure.

The percentage of the total made up of fixed program grants is going down while Commonwealth outlays for MBS and PBS and the Private Health Rebate are going up. We will revisit this point later when we look at integration projects.

Year	Government			NGO ^(a)	Total	% of total health funding by source		
	C'wealth ^(a)	State and local	Total			C'wealth	State and local	NGO
1989–90	12,164	7,513	19,677	9,122	28,800	42.24%	26.09%	31.67%
1990–91	13,200	7,958	21,158	10,112	31,270	42.21%	25.45%	32.34%
1991–92	14,167	8,138	22,305	10,783	33,087	42.82%	24.60%	32.59%
1992–93	15,291	8,202	23,494	11,499	34,993	43.70%	23.44%	32.86%
1993–94	16,683	7,868	24,550	12,237	36,787	45.35%	21.39%	33.26%
1994–95	17,551	8,460	26,010	12,957	38,967	45.04%	21.71%	33.25%
1995–96	18,997	9,260	28,257	13,526	41,783	45.47%	22.16%	32.37%
1996–97	19,806	10,315	30,122	14,730	44,851	44.16%	23.00%	32.84%
1997–98	21,621	11,397	33,018	14,629	47,648	45.38%	23.92%	30.70%
1998–99	23,892	11,852	35,745	15,266	51,011	46.84%	23.23%	29.93%
1999–00 ^(b)	25,771	12,519	38,291	15,366	53,657	48.03%	23.33%	28.64%

(a) Commonwealth and non-government expenditure has been adjusted for tax expenditures.

(b) Based on preliminary AIHW and ABS estimates.

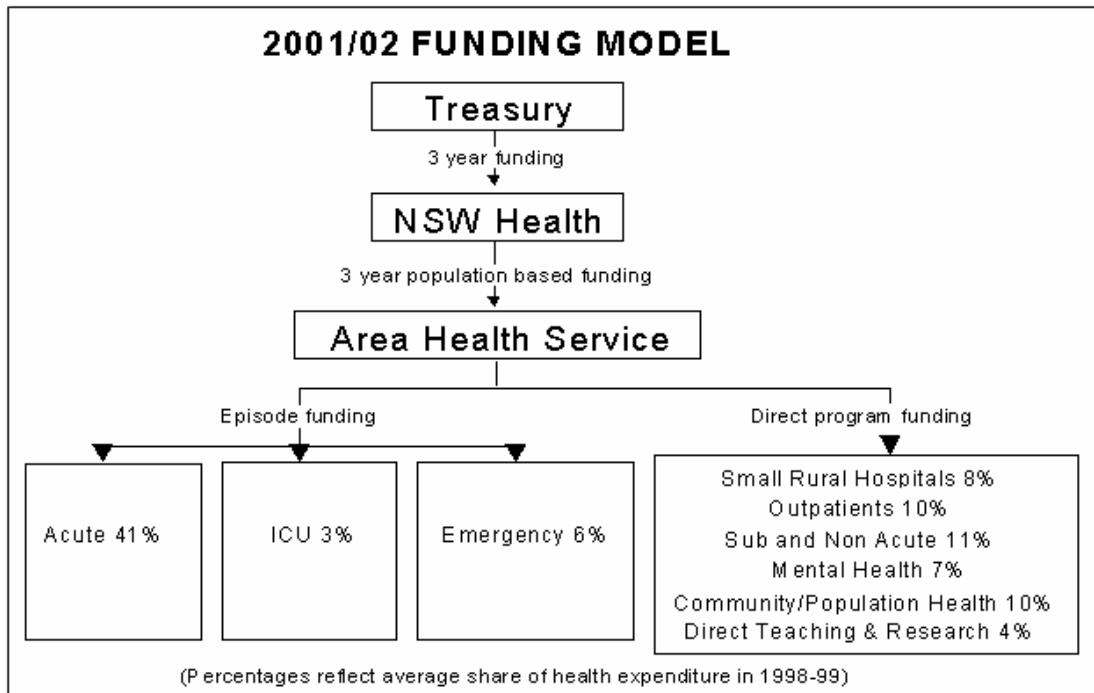
Source: AIHW health expenditure database.

The most likely scenario when considering these clear trends is that no more resources can be expected under traditional program grants, and little overall expansion except where there is the potential for growth and direction that a 3rd National Mental Health Plan potentially offers.

So, with the exception of the new money to be committed under the 3rd National Mental Health Strategy be agreed in 2003, the specialist mental health sector cake will not expand, except at the cost of other sectors. And these trade-offs then have opportunity costs for sectors that evidence supports (and most practitioners agree) we want to expand – non-government organisations, safe housing, employment opportunities and so on.

In NSW, about 7% of total health funding goes to the specialist mental health sector. The overall distribution still looks something like this:

⁷ Sid Sax (1984). A Strife of Interests. Allen and Unwin, Sydney.



The NSW funding model is a 2 tiered system (which used to have bipartisan support). With the exception of mental health, funds are distributed from NSW to Area Health Services in proportion to population need using a formula called the Resource Distribution Formula (RDF). With the exception of mental health, NSW has done well in achieving population equity. The Department has data suggesting that all Areas are within about 2% of their RDF share.

Mental Health has historically resisted the introduction of formula-based funding, preferring a submission-based approach instead, much like disability services. There is also a history of under-development in the approach to bed management, with the influence of the old institutions being strong. This approach has been changing under pressure from the central agencies, and the aim should be to bring mental health in line with the practical demonstrations from other parts of the health sector such as Intensive Care where beds and resources are allocated on the basis of where the population currently is.

At the next level, Areas distribute health funding to services either by way of episode funding or by using traditional block funding.

So within each area the allocation is also being shaped by the concept of funding direct care by episodes, based on a patient's classification and the expected costs associated with that class. This is a performance or output based system, rather than a system of historical allocations to institutions or specific service types. This is where the idea of casemix comes in - orienting the funding of the system around the needs and costs of the person, and the goal of care, not just the service structures.

Episode funding has the distinct advantage of helping managers understand where effectiveness and efficiency can be encouraged. Block funding of program activity tends to reinforce 'the way we do things around here', but from the viewpoint of the population as whole, and outside the specialist mental health service, it has some

advantages. People don't have to be cases and have a casemix class before they get any attention or resources. With a block grant you can also cross subsidise activities and substitute different models of care because the funding is not tied so closely to the individual case.

Specialist mental health services in NSW have been slow to move systematically and progressively toward funding based either on population need or service outputs.

Work on developing the required systems (work practices, information tools, routine and collectable outcome measures) that is called for under the funding provided for this purpose by the Commonwealth, was slow to start in NSW (and is several years behind Victoria). This is one reason that the current MH-OAT initiative is creating stress in the system – work to develop better information systems and better data, should have started years ago and now there seems to be a bit of a rush, which is not helpful.

The only realistic strategy to improve mental health services in NSW is to clearly delineate roles – government, non-government, specialist mental health, primary care. Short of winning the lottery, there also has to be a re-investment in changing the methods of delivery – the way that care is funded, organised and delivered. This strategy is already part of the agreement with the Commonwealth under the National Mental Health Strategy.

What roles do those changes imply? The main point is that mental health is everyone's business. This idea is illustrated with (non-exhaustive) examples below.

The mental health continuum					
Intervention:	Prevention	Early identification and intervention	Acute treatment	Rehabilitation	Maintenance and support
Those with a role beyond health	Families Schools Child care Recreation Employment etc	Families Schools Child care Employers Police NGOs etc	Families Schools Police NGOs etc	Families Schools Employers Housing etc	Families Schools Employers Housing etc
Other health sectors with a role	GPs Child health Community health Drug & alcohol etc	Emergency departments Obstetric services GPs etc	Emergency departments Obstetric services GPs etc	C'wealth Rehabilitation Service Health NGOs	GPs Pharmacists Disability services
Role of the specialist mental health sector	None, other than perhaps staff training (but even that is doubtful)	Triage and assessment Rapid and effective response to 1st episode of serious mental illness	Acute treatment, either in an inpatient unit or in the community	Structured and time limited programs that are designed to improve functioning and reduce disability	Primary responsibility with mental health NGOs, but delivered in partnership with community MH teams

The specialist mental health sector is at the receiving end of failures in other sectors such as the police, disability, drug and alcohol and adolescent services.

There is real danger that more beds, in a context of little or no extra funding, and an inadequate funding model, will mean resources are sucked out of the places we want to grow them in across the wider continuum – community rehabilitation, primary mental health care, non-government agencies.

The national mental health reports clearly show the total services expenditure allocated to non-government mental health organisations⁸. Nationally, NGOs increased their share of annual mental health expenditure from 2% to 5% over a five year period. Growth was strongest in Victoria (9.6%) and most limited in New South Wales where the figure stood at 2.1% in 1998. Things may have got better overall since then, but it is hard to see the evidence and what there is, is patchy.

Strategic issues and lessons to consider

Beds are important, but what is important about them is how they are managed. And they are only one part of a part of a bigger picture. It is easy enough to say that changing the way that care is organised and delivered, rather than simply focusing on how much money is spent on it, is a way forward. But how is it to be done?

Under the Second National Mental Health Plan, which took the Strategy forward from 1998 until 2003, emphasis was given to the private mental health sector, and the complementary role it plays with the public sector. Fostering partnerships between the two sectors was a priority of the Second Plan.

The mental health integration projects (MHIPs) and what they have achieved will have come up elsewhere in this conference, so I'll not go into detail here. However, one of the lessons from 1999 to 2003 was that integration between the public and private psychiatry sectors is hard and that resources and policy attention at the Commonwealth level shifted to the primary care sector. So we saw incentives rolled out for GPs and others to be useful in support of mental health services, and the recent Medicare Plus Package will reinforce this trend.

We learned from the MHIP here in the Illawarra (as if we didn't already know!), that mental health requires a whole of government approach, with the roles of the various sectors clearly delineated as in the continuum.

The target group for specialist mental health should not be the whole of the population who have a mental disorder – the national survey says 18% of population have a mental disorder, but this includes substance abuse and other problems. NSW Mental Health policies (and subsequently plans developed by Area Health Services) suggest that their target group is this part of the population. This is creating unrealistic expectations and increasing stress in the system.

When many of the 18% turn up, they are sent away. Even at maximum efficiency and with funding being doubled, the specialist mental health sector could not cope with servicing 18% of the population, nor would it be good clinical practice to do so. Pressures on acute beds in mental health can be seen as resulting from a lack of strategies like those to plan the use of beds in other parts of the health system.

⁸ Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care (2000). National Mental Health Strategy *Sixth Annual Report* Changes in Australia's Mental Health Services under the First National Mental Health Plan of the National Mental Health Strategy 1993-98. See figure 21, page 30

Comparisons with ICUs or the way Neonatal Intensive Care Unit cots are managed are instructive.

The result of our current system is that too often mental health services restrict their entry criteria mainly to the strict requirements of the involuntary treatment provisions of the Mental Health Act. The dominant model of care leaves too much out.

The target group for the specialist mental health sector should be people who have a mental illness or disorder and who are experiencing disability as a consequence of their disorder. The important point is disability, not the dangerousness criterion we fall back on when the system is overloaded and has entered failure mode.

In some cases services are clearly not adequate – they may have contracted under the pressures of staff leaving and recruitment difficulties, or as a result of poor management and badly planned organisational changes. Whatever the cause, the resulting workforce issues are considerable.

The corollary of role delineation in mental health is that other parts of the health system should be responsible for prevention, early intervention etc, with specialist services providing training and support if necessary.

The debateable issue is whether more specialist services are needed or whether what is needed is more effective intervention by the primary and secondary tiers of the health system and, more broadly, the human services beyond health.

Big gaps in NSW remain in key areas:

- drug and alcohol treatment services
- community care for people with intellectual disabilities
- dual diagnosis
- forensic and gaol-based services

The consequence of which is that failures in the system elsewhere flow over into mental health services (and prisons). This is increasing the pressure on mental health, adding to bed management problems and a lack of assertive follow-up. Access to secure units and detoxification facilities require strategies not unlike those facing bed management in intensive care units, or in solving other problems in the health sector such as organising post acute services, rehabilitation and coping with an increasing number of day procedures.

The message from taking a population approach, and one that our radical friend Rudolf Virchow would have supported in 1848, is that we should focus on the bigger picture and if we do, mental health will eventually not be blamed for being at the receiving end of system failures elsewhere.

The other relevant message is that NSW needs to expand the NGO sector. NSW spends less (in both actual terms and as a proportion of its total), on NGOs than other jurisdictions and we still need a plausible strategy for growth in the sector⁹.

The message from the conference, from the Mental Health Coordinating Council and its affiliates, should be that we have enough evidence of the need for a clearer and more legitimate role for NGOs, as part of a better division of labour for mental health services in general.

⁹ NSW Government Action Plan Mental Health Implementation Group. NGOs and Mental Health: A framework for partnership.

The next logical step is to gather and use the evidence on what already works in practice. The MHIP projects have demonstrated important steps in the right direction. But there is much more to be done – like better bed management, support for community rehabilitation, links to housing and employment, more primary mental health care in the general community health sector and with NGOs.

The national mental health report card has an outstanding set of figures for NSW, featuring the low level of NGO funding and support. NSW has been, and still is, at the bottom of the table when considering the level of the States' contributions to support for NGOs. The consistency over time and the size of the differences cannot be explained away by different methods of counting.

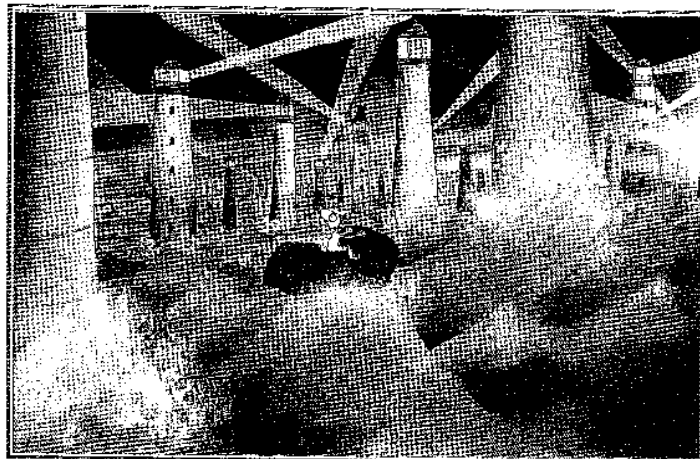
Having figures like that really helps and is an important part of the national strategy because the comparisons are instructive. We have to get better at using the data we have and in collecting more useful data, not just more data per se.

The current information systems we have are underdeveloped but arguable getting bit better. But they don't give us a good map of where we are or a set of directions on how to go somewhere else. We might feel from time to time like another of those great historical figures – in this case Michael Leunig's Vasco Pyjama, shown here on a particularly perilous part of his voyage – navigating the Strait of a Thousand Lighthouses.

Which is a place I'd rather be for not too long!

Thank you.

The Curly Pyjama Letters



Vasco Pyjama's perilous voyage through the dreaded Strait of a Thousand Lighthouses