

To Fix, or Not to Fix, Structural Imbalance in Mental Services: That is the Choice

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To Fix, or Not to Fix, Structural Imbalance in Mental Health Services: That is the Choice

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The systemic nature of economic inefficiency in Australia's mental health services sector is serious.

Yet another impasse in mental health has developed, as manifested by the latest (2013) reports on Australia's mental health sector.^{1,2} Inefficiency and economic waste are spoken of but, despite report after report after report over the decades in Australia, still nothing happens about the sector's core resourcing problem. Why? This impasse is long-standing. Why?

The reason is that, under our current system, this economic problem cannot, of itself, be fixed by the system. There is a serious systemic problem which continues to flourish, involving economic inefficiency in the provision of mental health services. Various mechanisms are actually in place that finance inefficiency; incentives are operating that sustain wasteful resource deployment. The problem is overlooked at the individual or personal level by service providers and by consumers, not surprisingly.

The impasse is due to the structural imbalance in this sector, the phenomenon at the root of the problems in Australia's mental health sector. Structural imbalance describes the resource misallocation between need and service use. This problem has been defined^{3,4,5} and measured^{3,4,5}.

Resource misallocations of various types are ever-present in any economy and mental health services are no different; however, the structural imbalance in mental health services is not found in other sectors of the economy. In general, the following statements are axiomatic in all societies: vegetarians do not buy meat for their own consumption; people who do not own cars do not buy petrol; and so forth.

Such axiomatic statements cannot be made in the context of mental health sectors. Some people with no clinical mental illness consume mental health services: this group has met non-need. Simultaneously some other people who have clinical manifestations of mental illness do not consume mental health services (for various reasons): this group has unmet need. The term that can be applied to the co-existence of these two categories is structural imbalance. The Australian evidence from both time-series⁴ and cross-sectional³ data indicates that the structural imbalance in mental health services is extensive. The people with no clinical mental illness who consume mental health services are approximately numerically equal to the non-consumers with mental illness. Data from ABS epidemiological studies measure the size of the problem.

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It is not suggested here that service use and illness are completely misaligned in mental health sectors. Also, some people with no current symptoms are prone to relapse and require a maintenance approach to therapy.⁶ The source of structural imbalance lies with people with no clinical mental illness consuming mental health services, and the financial arrangements of Australia's sector that sustain this behaviour.

We emphasise that structural imbalance is not some theoretical concept or hypothesis: it is a reality based on empirical results. Structural imbalance is also not some financially trivial gripe or grievance but, rather, a serious economic matter, having severe fiscal implications for Medicare, and miserable effects upon the lives of those with unmet need, often seriously ill. It is imperative to recognise these empirical results, as they show the source of the problem. Crucial facts are now known.

The problem of the economic waste in Australia's mental health sector is largely fixed when the mental health services under Medicare spent on resourcing met non-need are redirected to the unmet need category. For once with this sector, here is a problem that in large part requires no more resources spent on the sector.

But no one wants to hear this. Why? The reason is that the problem is 'unfixable', under our current system.

The unfixability has several components. Australia's health system under Medicare works largely on consumers seeking services: to see a General Medical Practitioner (GP), just make an appointment; and if the GP advises that the person needs to see a specialist, then 'you get a referral' if a patient convinces the gatekeeper, and then you make the specialist appointment. (One can see a specialist without a referral but a rebate from Medicare is not available. A small point.)

In a consumer-initiated system, it is relevant to ask if consumers have misplaced beliefs about their health status or a heightened sense of entitlement to their use of health services under Medicare. This raises ethical issues. Clearly, the health system is also characterised by producer interests; and the supplier-induced demand (SID) literature in health economics is concerned with this very matter. The empirical literature has varying estimates of the SID effect. SID behaviour also has a moral or ethical dimension.

In physical medicine, such problems are less severe, as diagnosis largely separates the ill from the non-ill. The mental health sector does not have the powerful diagnostic armamentarium available to medical practitioners in treating physical illnesses and conditions. Powerful diagnostic testing does not exist; and there is a large civil or ethical issue for consumers consuming mental health services under Medicare who are not mentally ill. There is another large civil or ethical issue for mental health practitioners under Medicare, using their time on the Worried Well.

How could anyone mount an argument that more resourcing of mental health services is problematic? Often those calling for more expenditure on mental health services are inclined to overlook the resource mismatching that characterises the problem of structural imbalance. Under the current conditions, increasing expenditure on services is likely to exacerbate the structural imbalance. Existing resources will only move even further away from the unmet need since some of the additional resources will go to the met non-need category.

Are there solutions?

One solution would be to remove all mental health issues from consumer-initiated processes. This solution probably means that Australia would have to abandon Medicare and move to a British NHS-type system. This solution is not politically feasible in Australia.

Another solution would be to implement a system of surveillance of specialists. Some scrutiny seems to be regrettably necessary. For example, in Parliament in September 1996, the (then) Australian Minister for Health and Family Services, Michael Wooldridge MP, explained a specific policy change (introducing Item 319) which was designed to address specific instances of ‘over-servicing’. The implementation of the policy change proceeded, despite considerable pressure applied by various interest groups adversely affected by this change. Although some degree of scrutiny of charging practices under Medicare-financing seems indispensable, can any more surveillance be undertaken? The answer is straightforward: probably not much.

Another possible solution is to appeal to people's civic and ethical instincts. Trust dimensions of social and civil behaviour may have fallen away in recent times. The occurrence of this phenomenon, jointly for both consumers and services providers, following the establishment of the NHS is described by Le Grand.^{7,8} Social capital may have depreciated in Australia; however, appealing to people to improve their behaviours is unlikely to be an efficacious approach to changing social mores.

A further aspect, having no moral dimension whatsoever, is that a heightened state of misinformation about mental illness can develop and prevail.⁹ Although pervasive misplaced beliefs can be turned around, misguided views tend to turn very slowly, ie over decades.

The above avenues provide little scope for cranking supply or demand levers. Is there any other way forward? Indeed there is. Progress in this sector takes only the eyes to see the nature of the problem and the will to follow it up.

The source of the economic problem is rooted in the information and diagnosis stage in mental health services. Whereas in physical medicine diagnosis is well-developed, diagnosis is relatively more embryonic in mental health; but this is where the solution lies. It is where the financing of diagnosis of mental illness operates and misplaced economic beliefs are alive and well. Right here. And there is also a solution.

The necessary reform is for all mental health expenditure currently allocated to psychologists, and the allied mental services (on referral from GPs and psychiatrists) to be re-directed to administering psychological and mental health tests. A positive diagnosis of a mental disorder is to be a pre-requisite under Medicare before **any** therapeutic mental health services are financed by Medicare. Such a process will, assuming ethical behaviour on the part of those undertaking the diagnostic tests, eliminate the met non-need part of the structural imbalance problem. This system is to replicate the diagnostic sectors in physical medicine (radiology, pathology etc).

In Australia the problem of structural imbalance is unique to mental health services. Thus, a policy choice needs to be made to remove the waste associated with met non-need.

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