

An economic perspective on the rural and regional mental health challenge

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Introduction

<Slide 1—cover page slide>

Thank you Catherine McGrath (former SBS Chief Political Correspondent and Conference MC).

Good morning ladies and gentlemen.

Firstly, I acknowledge the traditional custodial owners of all the first nations on whose land this event is taking place and acknowledge both the past and present first peoples, their elders, languages, customs and culture. I extend my respect to all Aboriginal and Torres Strait Islander people in attendance today.

I would also like to acknowledge the presence of Leslie Williams, Parliamentary Secretary for Regional & Rural Health NSW ; and Tony Zappia, Shadow Assistant Minister for Medicare; and let me also thank Geri Malone, Chair of the National Rural Health Alliance for bringing us all together.

I would also like to pay my respects to people with lived experience of mental health issues, their families and other supporters.

My topic today is: *An economic perspective on the rural and regional mental health challenge.*

Our cities exist because of rural, regional and remote Australians. Their work leads to the supply of things like milk, cereal, toast, electricity, meat and vegetables and most materials.

Of the 24 million (plus) people who live in Australia, 8.8 million live in regional areas—that's about a third of Australia's population.

It's imperative that the mental wellbeing of people living in rural, regional and remote areas is firmly in the minds of all Australians.

<Slide 2—Regional and remote Australia health disparities>

Rural and regional Australia experience:

- Higher suicide rates—nationally, an average of eight people a day end their lives in Australia—that's 56 people a week—or nearly 3000 avoidable deaths a year.
- The rate of suicide in rural areas is about 40 per cent higher than in major cities (particularly the rates for Australian men aged between 15-29—they're twice as likely to be affected as those living in major cities)
- The rate of suicide in remote and very remote Australia is almost double the rate in major cities—the rate is even higher for particular groups such as young men and Indigenous Australians.

- The National Mental Health Commission has a goal to reduce the suicide rate to zero!
- Regional Australians also experience
 - a higher hospitalisation rate and have less access to services
 - lower life expectancy (compared to major cities, the life expectancy in regional areas is 1-2 years lower and in remote areas is up to 7 years lower (especially for Aboriginal and Torres Strait Islander people living in these areas).

Resilience and determination are a natural part of rural life but depression is higher in regional and rural communities—some of the things unique to country folk include:

- difficult climatic conditions, extreme weather events such as droughts and floods which produce financial and emotional stress
- unemployment—less variety of jobs, lower incomes
- isolation
- loss of support when friends or family members leave town to seek better job prospects.

People living with mental illness have poorer physical health, so it's not surprising that the proportion of people in remote Australia living with **ill health** is also higher—20 per cent more people in remote areas are living with disease when compared with those living in major cities. They can develop:

- sleep difficulties
- physical effects such as headaches and muscle tension
- anxiety and depression
- relationship and self-esteem problems
- alcohol and gambling habits

<Slide 3—Employment of GPs, psychiatrists etc.>

Since the Commission's inception, one of our key foundation pieces of work includes the Commission's *Contributing Lives, Thriving Communities* Review.

A *Contributing Life* is where people living with a mental health difficulty can expect the same rights, opportunities and health as the wider community. Simply put, it means having a home, meaningful work, good healthcare opportunities for education and training, all without experiencing discrimination due to having a mental health difficulty.

Our *Contributing Life* Review found high levels of unmet mental health need in rural and regional communities.

Country areas experience shortages of mental health and medical workers.

Statistics show that 90 per cent of psychiatrists and around two thirds of mental health nurses work in major cities.

We know there is a significant shortfall in mental health-specific services in areas outside major cities and inner regional areas, and this deficit tends to worsen with remoteness. Compared to remote/very remote areas, per capita, major cities:

- have almost four times as many psychiatrists, three times as many registered psychologists and twice as many mental health nurses
- receive around six times more in Medicare subsidies for mental health services (\$43 compared to \$7)
- are twice as likely to provide specialist psychiatric care to people admitted to hospital for mental health reasons.

Research suggests that unavailability of GPs, infrequent GP travel to remote areas and the transient nature of GPs in some areas affects referral pathways for people seeking mental health assistance in rural Australia.

<Slide 4—Economic Impacts>

The mental wellbeing of Australians is not only important on a personal level, it makes economic sense.

The OECD estimates the average overall cost of mental health to developed countries is about four per cent of GDP.

This equates to more than \$60 billion in Australia—about \$4000 a year for each person who lodges a tax return—or over \$10,000 per family.

The costs include the direct costs of treatment; the indirect costs such as disability support pensions, imprisonment, accommodation and so on; the costs of lost output and income. And, finally costs to carers and families—not to mention that their workforce participation is held back because of caring demands.

Reducing this cost—even by a fraction—would generate sizeable gains. I'll come back to this.

Treasury looks at economic growth through the three Ps: population, participation and productivity. I will address each in turn.

<Slide 5—Annual distribution of mental ill-health in Australia>

Population

The population impacted is huge, with as many as 20 per cent of adults affected by mental ill-health in any given year.

One in two Australian adults will experience mental ill-health at some point—this is 7.3 million Australians (aged 16-85). And the issue is greatest for those in rural, regional and remote Australia, and younger people—one in four 18-24 year olds experience a mental ill-health problem every year.

- Severe episodic and persistent mental ill health is experienced by 625,000 people

- While 65,000 people suffer severe persistent/complex multiagency needs and psychosocial disability.

To reinforce the point about the size of the problem, I note that mental illnesses are the leading causes of the non-fatal disease burden in Australia—they account for about a quarter of the total burden. Mental illness also accounts for about 13 per cent of our total burden of disease (including deaths).

Unlike other diseases, a major impact of mental illness on our economy is due to lost income from unemployment and expenses to support an illness that begins when we're young and lasts many years—this is what makes this economic burden so great.

Participation

Labour force participation is the second major variable in economic growth. The higher the number of people working, the higher the rate of economic growth. Mental illness is responsible for a very significant loss of potential labour supply and output.

Today 37.5 per cent of people affected by mental ill-health are either unemployed or not in the labour force. This compares to 22.3 per cent of people without mental health conditions. And our performance is low by the standards of the leading OECD countries.

The World Economic Forum estimates the cost of lost output and income as being about 1.75 per cent of GDP.

This is not good enough and there is a clear productivity cost. Many people with mental illness want to work but find it difficult to find a job, also impacting on families, carers and other support people. We need to provide better support for people living with mental illness to get into the workforce and stay in it, not only for the benefit of individuals, their families and support people but also for the benefit of the whole population.

There are many very specific measures that can be taken that would have a substantial economic impact. For example, specific measures to get young people from school to post-school education and employment; greater individual support for those in trouble; and other market mechanisms to encourage sustained employment and skill development during this period.

Productivity

The third variable is productivity. Mental ill-health generates considerable absenteeism and presenteeism (on the job productivity loss). Those with mental health difficulties are both more likely to take time off from work and to accomplish less than they would like to when they are on the job.

Mental health conditions result in around 12 million days of reduced productivity for Australian businesses each year.¹ And given one in six people in employment experience a mental health issue each year, even small businesses are likely to employ people with a mental illness, which requires proper support.

Mental health and wellbeing is recognised as a serious workplace matter. That's why at the Commission we have formed a collaboration with a very interested business sector, the mental health sector and government through the Mentally Healthy Workplace Alliance.

The Alliance is made up of important entities including the Business Council of Australia, the Australian Chamber of Commerce and Industry, COSBOA, Australian Industry Group, Comcare, Australian Psychological Society, Safe Work Australia, SuperFriend, the Black Dog Institute, beyondblue, Mental Health Australia, SANE, and The University of New South Wales.

I believe this heavy expenditure could be reduced with a greater emphasis and investment in prevention, early detection, a focus on recovery from mental ill-health and the prevention of suicide.

<Slide 6—Design of a person-centred approach>

To address these specific problems, our Review recommended nine key directions and those that are pertinent to regional, rural and remote Australia include:

- a person-centred mental health system
 - providing local engagement with individuals, their families and carers
- a mental health and suicide prevention plan agreed by all governments
- a new Closing the Gap target for the social and emotional wellbeing of Aboriginal and Torres Strait Islander people
- a regional model of service delivery based around Primary Health Networks
 - integration of health services in smaller rural communities
- resource reallocation from acute to community-based services—defining a central role for Primary Health Networks, regional commissioning of services with pooled funding, implementing place-based care and longer term contracts, and targeting at-risk groups
- improved access to services using innovative technologies such as **telehealth support**—e-mental health services and other Medicare Benefits Schedule-subsidised services
- trial of personal budgets for people with serious mental illness; more equitable distribution of psychological services.

Since our Review recommendations, the Australian Government Response was to agree to provide the enabling framework.

It's now an Australian Government priority to address service gaps for people in rural and remote areas, and other underserved or hard-to-reach populations.

Just last week, the Government announced that from November this year, people living in rural and remote regions of Australia will get the same access to psychologists as those living in our major cities, under a new **telehealth initiative** (recommended in our 2014 Review).

This will remove a major barrier to rural residents accessing vital mental health treatment with the introduction of a new Medicare rebate for online videoconferencing consultations with psychologists.

This means rural people who were likely going untreated will now receive appropriate care as a result.

From November, people in rural and regional Australia will be able to claim a Medicare rebate for timely and convenient online videoconferencing consultations with psychologists and other health professionals who might be thousands of kilometres away.

Investment in the Royal Flying Doctors Service will enable this service to reach people in remote communities.

Another change since our recommendations has seen the 31 Primary Health Networks (PHNs) and 87 Local Health Networks (LHNs) work at implementing services at the regional level.

PHNs are also responsible for commissioning all regionally delivered Australian Government Department of Health mental health programs.

- The Federal Government has made mental health a priority and this year announced four more regional suicide prevention trial sites around the country—expanding on its \$192 million election commitment to 12 rural sites made in 2016.
- The aim is to expand and help regional communities suffering from the effects of mental health issues at the local level, by providing increased services and local resources.
- It's about more outreach workers, people who are on the ground, people who can work with each community—the government has given particular priority to the areas experiencing higher than average loss of life.
- The additional suicide sites will be in western New South Wales, Central Queensland, Darwin and Geraldton region in Western Australia.

The Government has also moved to appoint Australia's first National Rural Health Commissioner.

Legislation is currently with parliament for consideration. Once appointed the new Rural Health Commissioner will be attached to the Department of Health.

It's proposed the role of the new Commissioner would include a focus broadly on healthcare needs, not just workforce needs.

I'm aware there's current discussion on the scope of the work that will be undertaken and pleased to see recognition of the broader rural health issues.

<Slide 7—last slide>

Conclusion

This is an exciting time for those of us who've worked in mental health and suicide prevention for many years.

The national mental health reforms happening in Australia are significant—and not least for rural and regional communities.

The reforms currently underway are shifting the mental health system architecture. They aim to change the way services are planned and delivered to enable better outcomes for people who need mental health support.

They're focused on delivering a more person-centred, locally based, stepped-care approach to mental health and suicide prevention.

Martin Wolf of the Financial Times believes mental health is our biggest health problem, and he states that given considerable economic costs to society, treatment pays for itself.

Investment into improving services with a continued focus on mental wellbeing is vital for economic growth and happiness in regional, rural and remote Australia.

Reference

1. PwC PricewaterhouseCoopers Australia, Creating a mentally healthy workplace: Return on investment analysis, 2014. Available from www.headsup.org.au

Presenter

Professor Allan Fels is currently the Chairman of the National Mental Health Commission.

In the field of mental health Professor Fels serves or has served on several government advisory boards. He is also Chairman of the Haven Foundation, which seeks to provide accommodation, support and care for the long-term mentally ill. He is also patron of many mental health networks. He was a member of the Bayside Health Board for several years.

Professor Fels is a long-term advocate of mental health policy reform and a carer for his daughter.

He is former Chairman of the Australian Competition and Consumer Commission (1995-2003). Prior to that he was Chair of its predecessor bodies, the Trade Practices Commission (1991-1995) and of the Prices Surveillance Authority (1989-1992).

He is currently a professorial fellow in the University of Melbourne, both in the Melbourne Law School and in the Faculty of Economics and Business, an adjunct professor at Monash University in the Faculty of Business and Economics, and visiting professor at the Division of Social Sciences in the University of Oxford. Professor Fels is former Dean of the Australia and New Zealand School of Government (ANZSOG), a position he occupied from 2003 (as Foundation Dean) until 2012.

Professor Fels is Chair of the Commonwealth Government Migrant Workers Taskforce, Chair of the Visy Australasia Governance Board and member of the Global Advisory Board of Uber.