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VOICEOVER:	Today at the National Press Club Professor Allan Fels on Australia's approach to mental health. The former chairman of the Competition and Consumer Commission is a long-term advocate for mental health services and a carer for his daughter. He'll talk about aiming higher with mental health services in today's National Press Club address.
LAURIE WILSON:	Ladies and gentlemen, welcome to the National Press Club for today's Westpac address, the first of two events at the club this week. Professor Allan Fels as you have just heard is the chair of the National Mental Health Commission and a passionate advocate for reform of the Mental Health system in this country. According to the commission, the system is in need of urgent redesign and repair. In a report earlier this year it called for a fundamental shift in mental health services away from a focus of crisis management and acute care to prevention and early intervention involving community-based services and primary health care. Aside from the massive social impact of mental health, the report said there is also an enormous economic cost, as much as $40 billion a year,

that's around two per cent of Australia's gross domestic product, the size of our economy. And yet, as our guest pointed out, as you may have read in this morning's media, that is an issue which is not even on the agenda for the forthcoming National Reform Summit. As well as our speaker today we are joined by Auslan interpreter Ben Suitor, thank you very much for being with us today. But now would you please welcome today's speaker, the chair of the National Mental Health Commission, Professor Allan Fels.

[Applause]

ALLAN FELS: Thanks very much, Laurie. I'd like to acknowledge the Ngunnawal people, the traditional custodians of the land and their elders and community. I'd also like to extent my regards to all Aboriginal and Torres Strait Islander people, any who may be here, any who may be watching or listening. But I'd also like to pay my respects to people with lived experience of mental health issues, their families and other supporters and particularly today I want to acknowledge the presence of the CEO of Mental Health Australia, Frank Quinlan and many people who are members of it or supporters of it, who are having quite an important forum today in Canberra about the whole future of mental health. I'm also very pleased to see Kate Carnell, former chief cinister here, CEO of ACCI, but also she's the chair of the Expert Reference Group considering our report. And finally, Senator Margaret Reid, former president of the Senate.

Now, my topic today is time to aim higher and why mental health must be part of Australia's economic and social reform agenda. So as Laurie said, we completed a national review of mental health programs and services last December. The vision for our review is highlighted in the title - contributing lives, thriving communities. And our review is based on the contributing life framework - that is, a whole of person, whole of life approach to Mental Health and to wellbeing and it recognises that if people are to live contributing lives, to have relationships, to have stable housing, to maximize participation in education, employment and the community more broadly, we will help to build an economically and socially thriving Australian community and a more productive one. But sadly a contributing life seems unattainable for people living with mental illness, at least for people living with mental illness, at least for many of them. And the review found that Australia's mental health programs and services are not maximizing the best outcomes either from a social or economic perspective. Now, as an economist, I want to emphasise that mental health is a significant problem for our economy, as significant as or more significant than tax reform or micro reform or the other issues being talked about today, including at the forthcoming summit.

The fact is that many people with mental illness don't get the support they need. Governments get poor returns on substantial investment. The economic or GDP gain from improved mental health would dwarf most of the gains, often modest ones, being talked about in current economic reform debates. This is starting to be recognised internationally. The world's

leading economics commentator, Martin Wolf of *The Financial Times*, has concluded that mental ill health is the developed world's most pressing health problem. And he said given the economic costs to society, including those caused by unemployment, disability, poor performance at work and imprisonment, the costs of treatment would pay for themselves. Recognition also comes from *The Economist* magazine, which had a special report on mental illness, the *Economist Intelligence Unit*, and even from Davos, the World Economic Forum, recently warned finance and economic ministers and advisers that they need to react to the formidable economic threat posed by non-communicable diseases, of which they mention mental health as the top one.

The OECD estimates that the cost of mental health to developed countries is about 4 per cent of GDP. That's about $4,000 a year for a taxpayer, for a family about $10,000 a year. There are the direct costs of treatments, hospitals, doctors, etc. There are indirect costs, massive costs for disability support pensions, imprisonment, accommodation, a range of other things. There are the costs of lost output and income from people not working, and finally there are costs to carers and families, that even affects their workforce participation rate when they have to care full-time or largely for a person. So reducing that cost even by a fraction would generate sizeable gains. I'll come back to that. Now, when Treasury talks about economic growth, they usually talk about the three Ps - population, participation and productivity. Let's apply that to mental health. Population - the population affected by mental illness is huge. Nearly 20 per cent of

the adult population in Australia is affected by mental health. At the clinical treatment level being required, 20 per cent are affected in any given year. And in fact, one in two Australians will experience a mental health problem at some point. That's 7.3 million Australians. And the issue is greatest for our young people, those who should be participating in the education system and embarking on their working lives. One in four 18 to 24-year-olds experience a mental ill health problem each year. Now, to reinforce that point about the size of the problem, I note that mental illnesses are the leading cause of the non-fatal disease burden in Australia. They count for about a quarter of the burden. If you take the total burden, including deaths, 13 per cent.

Now, unlike other illnesses, which are all important, mental illness is a whole of life or a long-term thing. So it has a big impact over a long period on a person's wellbeing, on their income, the expenses to support them. It adds up to being a very considerable economic burden. And I want to argue we can do something about that. So the second P, beloved by Treasury, is participation. The more people we get working, the more national productivity goes up. Now, mental illness is responsible for a very significant loss of potential labour supply and output. Today, 37.5 per cent of people with mental illness are either unemployed or not in the workforce compared to 22.3 per cent for the rest of the population. And our performance is quite low, not good by the standards of good OECD countries. The World Economic Forum estimates that the cost of lost output and income is about 1.75 per cent of GDP in countries like ours. Now,

this is not good enough and there is a clear productivity cost. Many people with mental illness want to work, they can work, they have a mild to moderate illness, but they find it difficult to get a job and to keep a job, and that also impacts 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.

Now, there are many very specific measures that could be taken. I won't go into all of them, but a lot of them would have a significant economic and social impact. For example, specific measures to get young people from school to post-school education and employment, greater individual support for those in trouble, other mechanisms, market mechanisms, to encourage sustained employment and skilled development during this difficult time. The third P is productivity. Mental ill health generates very considerable absenteeism, and also so-called presenteeism, that is a loss of productivity while at work. 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, according to PricewaterhouseCoopers study. Given that one in six people have some kind of mental health problem, then you find even small businesses frequently have to deal with people at work who have a mental illness requiring support. So it's a serious workforce workplace matter. That's why at the

commission, we formed the Mentally Healthy Workplace Alliance. We found that businesses, big and small, were very keen to participate. The alliance includes the Business Council, it includes, of course, Kate's ACCI, it includes the COSBOA, the Australian Industry Group, Comcare and a number of others, the Australian Psychological Society, SuperFriend, the Black Dog Institute, beyondblue, Mental Health Australia, SANE, the University of New South Wales. And to quote Jennifer Westacott, CEO of the Business Council, and chair of Mental Health Australia, the business case for change in mental health is not only morally and socially compelling, it is economically fundamental.

The costs. Our review identified that the direct cost to the Commonwealth Budget alone on Mental Health and suicide prevention are about $10 billion a year. So that gives rise to a whole lot of other economic questions; is the money being spent effectively and efficiently? Are the scarce resources available in this period of budgetary tightness being used most cost effectively. And are the programs that they - are they maximizing the net benefits to the community? Now, from the limited evidence, the commission concludes that much of the funding from the Commonwealth is neither effective nor efficient. One indicator is the very large amount of money, the high fraction, about 87.5 per cent, that is spent on income support and crisis responses, things like Disability Support Pension, payments for hospitals to the states, other forms of support.

So much of what the Commonwealth spends, and the states, is payment for failure, payment for failure to treat the problems early and cost effectively. Now, we believe this heavy expenditure could be reduced with a greater emphasis and investment in prevention, early detection, the focus on recovery from mental ill health and the prevention of suicide. So, our review contributing lives, thriving communities, highlighted that mental health is not just an issue for governments, it's also for every industry, every workplace, families, it's everyone's responsibility.

We heard from many people with lived experience, their families and supporters and people who work in the sector, and we found many examples of wonderful innovation, and that effective strategies do exist for keeping people and families on track to participate and contribute to the economic and social life of the community. Fundamentally, the approach we recommend is under-pinned by the need to realign the system from a focus on service providers to a focus on people, where those with lived experience, their families and support people are engaged and involved in all levels - nothing about us without us. Now, central to this is the idea that design should be centred on the needs of a person, where, through an integrated step care model, as I'll explain, services are designed, funded and delivered to match the needs of individuals and particular population groups. This involves a participative and inclusive approach, focused on achieving better outcomes for individuals, their families and communities, not on the role of providers and what activity they produce, that they are indispensable and valuable players.

Importantly, the right approach requires a holistic focus on people, taking into account all their needs, their mental health and fitness, social and emotional wellbeing, physical health and other determinants such as culture and a sense of belonging. We need to shift the focus from downstream to upstream services, from income support and crisis response, to early intervention, prevention and support for recovery-based community services, stable housing and participation in employment, education and training. We must catch people before they fall. Now, our review shows that there is really a once in a generation opportunity to create a system that will support the mental health and well-being of millions of individuals to enable them to leave contributing lives and participate in thriving communities. And the review shows this is actually achievable, largely achievable within budget, and sets out a blueprint on how we can get there and how the Commonwealth, and the states, can maximize value for taxpayers by using its quite large resources as levers, as incentives, to get desirable, measurable outcomes and we need to start that change now.

So key to this is the idea of stepped care. That just means that there is a range of options that vary in intensity, according to an individual's level of need or functional impairment. People's needs vary dramatically across that whole spectrum of mental illness. Of the 3.7 million who experience mental illness in a year, the majority, about 3 million, have mild to moderate, such as anxiety or depression at a clinical level. Another 625,000 have a persistent, complex, chronic illness, such as schizophrenia or severe

depression. 65,000 have got severe illness and suffer from an acute psycho-social disability. Now, stepped care services range across all of that, from no cost and low cost options for people with the most common mental health issues, through to support and wrap-around services that cover all aspects that might be involved for people with severe and persistent mental illness. And it includes a greater range of services being available according to need and functional impairment. For example, a graduated range of services from self help and prevention, a strengthened primary health care approach, non-clinical psycho-social support within the community and a variety of options between specialised community mental health services and accuse hospitalisation.

For example, step down, step up services, where for example people can leave hospitals and go to less restrictive and less costly accommodation, but with adequate levels of care. There's a huge gap there, sadly. More generally, we need to build community capacity and rely less on new hospital beds, both in the public and the private sectors. The overarching aim is to enable individuals as much as possible to participate within their families and communities, and to lead contributing lives. Easy access to - easy to access service delivery models, such as e-mental health, have an important role to play in assisting people and those who care for them. And this, in turn, would free up professionals and clinical people to make more effective use of their skills.

A fundamental element of a stepped-care approach is to prioritise the delivery of care through general practice, and the primary health care sector. International experience shows that countries that have a strong primary health care infrastructure - that have strong primary health care, have healthier populations and lower overall costs for health care than countries that focus mainly on specialised or acute care. Now, we propose - we point out, that there is a very important element in this situation, and that is the development of primary health care networks. We believe that these are one of the key bits of architecture in the design of the whole mental health system and we believe they should be renamed primary and mental health networks, and that would emphasise the need to bring together mental and primary health, that is a neglected topic.

The physical health of people with a mental health problem is not good, and for those with severe mental health problems, the three or four per cent that I mentioned, the fact is that their life expectancy is from about 14 to 23 years less than the rest of the population, they have a worse relative death rate even, I'm afraid, than the Indigenous population. And much of that is due to their physical health, partly the medicines, the side effects, partly the rising incidence of smoking on their part, aspects of their lifestyle, but also the system does not handle the two problems well. The mental health side tends not to deal with the physical, and on the physical side, there's a tendency somewhat to discount the mental health challenge of people who - to discount the physical health if you walk in and say I have got a mental health problem. It's

well established that tends to get a discount in terms of physical health.

So we believe a great deal of emphasis in these regional health care networks needs to be devoted to mental health. That's why we think they should be renamed. And we also think that if you can focus on regional networks, that would do a great deal to even up services. We propose that these networks be given bundled funding for planning and purchasing mental health programs, services and integrated care pathways for mental health that are tailored to individual needs in different communities. And we believe they can engage with local services, with people with lived experience and their families. That's the best way of engaging with that mental health community, to have a local system of organising mental health and tailoring it to local priorities and needs, to local demography, the local environment, the local challenges. So we also - I wanted to say a little bit about suicide.

A good example, it's a good example of how we need a regional or local approach to prevent suicides and suicide attempts. In our country, seven people die every day from suicide. That's double the road toll. Suicide is double the road toll. But also, the number of deaths on the road has sharply diminished over time. Not so with suicide. In particular, I note deaths among Aboriginal and Torres Islander people from suicide is twice the rate - the suicide is twice the rate of non-Indigenous Australians. But, there are some excellent examples of suicide prevention, treatment follow-up

and post-vention(*) in Australia, but very often the services are not coordinated, they're not joined up, they're too fragmented, they lack sufficient focus, they operate from two small a resource base to achieve a meaningful impact.

A new approach to suicide is needed and there is some evidence about a range of strategies that work. Suicide incidentally is not just about mental health, and it's not just about any one sector. And what we need are locally organised, properly coordinated or joined up responses to the major problem. So, we proposed that the Commonwealth use its resources as incentives to drive the development of community partnerships which co-create solutions at a local level for suicide prevention. And we want to commence this approach with 12 regions as the first wave of nationwide introduction of sustainable, comprehensive, whole-of-community approaches to suicide prevention. So with regard to the regions, we have to acknowledge at the start that diverse regions have got different needs and they plan and need to plan appropriately - there is a significant regional variation in need and especially in access to services and regional equity. So a one-size-fits-all approach can't be applied across metropolitan, regional, rural and remote Australia.

We need to think about the local health landscape and consider the prevalence of mental health concerns in each area. So, a regional approach provides the opportunity to provide equity in the provision of services for rural and remote communities through place-based models of care models, of care linked to a

place, and an identification of the different places and what their needs are. And there is no doubt in rural, regional and remote Australia there is poor access to services. There's not equity there.

So, the fact is the further you get away from major cities, the harder it is to access mental health-specific services. And our view is changing that will require national leadership, combined with local responses. On a per capita measure, for example, when compared to remote or very remote areas, major cities have almost four times as many psychiatrists, three times as many registered psychologists, twice as many mental health nurses. So our report recommends that measures be taken to try to deal with this. We believe that the better access funded approach under Medicare depends on whether providers are available. If fund providers are available in certain areas rather than being linked closely to the demand for the services, and so people in rural and remote communities are less able to use services under this program.

Actually, mental health services in rural and remote areas has improved the workforce situation, but the service deficit in rural and remote remains significant, and the lack of psychiatrists and psychologists particularly acute. And there is also a lack of rural incentives under better access. That seems to be an anomaly. Other programs with the rural loading, GPs, practice nurses, mental health nurses, but not better access. We have made recommendations for the Commonwealth to consider changes to the better access program that would encourage a more

equitable geographic distribution of psychological services. Now, on Aboriginal and Torres Strait Islanders, you know, in recent weeks, as in years past, we have seen news coverage that has further amplified areas of crisis in indigenous mental health, social and emotional wellbeing and suicide. 30 per cent of Aboriginal Torres Strait Islander adults report high or very high levels of psychological distress - three times the rate of other Australians. The suicide rate, as I said, is double. The system is tragically ill equipped to help. This must change. Aboriginal and Torres Strait Islander mental health and social and emotional wellbeing must become a national priority.

Throughout our report, we keep coming back to the problems of the Aboriginal and Torres Strait Islander mental health. And we have made many recommendations - specific ones, for changes in how this matter is approached, but there are a couple I want to particularly stress. Firstly, it should be a COAG Closing the Gap target. I read through this slightly disappointing COAG Closing the Gap report each year, we close it a bit here, we don't there, but they leave out one of the biggest health challenges, mental health, in the Indigenous community. It should be part of the Closing the Gap. There is also a need for many other reforms to implement the National Strategic Framework for ATSI People's Mental Health and Social and Emotional Well-Being, the National Aboriginal and Torres Strait Islander Health Plan, National ATSI Suicide Prevention, National ATSI People Drug Strategies. We also think that we need to establish mental health and social and emotional well-being team in Indigenous primary health care organisations linked to Aboriginal

and Torres Strait Islander specialist mental health services. We have made quite a few recommendations there. It is particularly important to train and employ the Aboriginal and Torres Strait Islander workforce needed to close the gap.

Now, let me conclude - as I always say when I'm a quarter of the way through a speech…

[Laughter]

…the commission would like to thank the many in the mental health sector - and there are quite a few here today, who have supported our reform plan. We are a dedicated sector. We want to work collectively to make change happen - together, we are determined not to let this opportunity pass us by. I want to quote from Mental Illness Fellowship response to the report - it's not perfect, we could argue with some of the detail, but our own experiences with mental illness and the mental health services tell us that it seems to be about right on all the big issues. Most importantly of all, it gives us a framework that we can get started on as the first part of a 10-year plan. Let's argue about the detail after we get into the implementation. So whether we measure the cost of mental illness in terms of individual misery or the burden that it places across society, it is quite clear currently we are paying too high a price for a system in urgent need of reform. Now, we had some successful policy reforms in the past, the National Competition Policy. That took 10 years. It's credited with a two per cent improvement in GDP. If we could improve mental health by 25 per cent,

we can surely do that over 10 years or less, we can deliver a one per cent improvement in GDP. That's huge. To put it another way, for every 10 per cent gain in mental health, GDP would rise by 0.4 per cent. As I said, that dwarfs most of the reforms being talked about at the moment.

And there is also, as I've said, much scope for addressing the 3 Ps that Treasury loves. There's a very - there's an immense scope for reducing the impact of mental illness on a very large part of the population. If we can improve participation, we can improve productivity at work. So, there are high opportunities to get costs down and we have delivered a very detailed, concrete report saying how that should be done. I take some comfort from the fact that at the last Leaders' Meeting the Prime Minister and state and territory leaders agreed to focus reform on health, education, infrastructure, training and when it comes to chronic care they recognise that mental health requires particular attention, requires a new focus on primary care and people keep - keeping people out of hospital.

We welcome that recognition. We urge political leaders to continue to look beyond health costs to the whole spectrum, the whole burden of mental illness, to those other variables, housing and employment and so on. And to give mental health the priority it needs. So let's set in place a world leading mental health system which we - while we have that appetite for change, it will pay dividends for decades to come. And it will not only improve the lives of many individuals and families,

it will make us a more productive society, reduce the number of people in need of support, increase the numbers of those who are contributing and help secure future economic growth. So the commission, the hard-working National Mental Health Commission, delivered on time last December, a major report with major urgent reform proposals, based on the fullest consultation with the whole mental health community and with experts. The Government - and that includes state governments, as much as the Commonwealth, needs to act on it as soon as possible to demonstrate commitment to the millions of people in the mental health sector. Thank you.

[Applause]

LAURIE WILSON: Thank you very much, Professor Fels. I just wanted to put some figures that I read recently around some of the points that you made in an article published, I think it was last year in fact by Professor- I think it was Alan-Anthony Jorm, who's an NHMRC Professorial Fellow at the University of Melbourne, and he talked about those with the most severe psychotic illness. I suppose that's the 60,000, 65,000 cohort that you alluded to, but it may have been wider than that. And he talked about the statistics, he said they're appalling - 78 per cent unemployed, 63 per cent impaired in their ability to socialise, so they're socially isolated; 50 per cent having attempted suicide, 82 per cent obese, over half having metabolic syndrome, 20 per cent with diabetes, over 60 per cent smokers.

On top of that of course we know some people in that category - I really don't know the figures, but some people in that category are drug users or drug addicts, either having … the drugs either having caused their mental problems or being used as a way for a brief period to if you like self-medicate against the impact of medication. So as you said it's not surprising these people tend to have drastically shortened life spans. Now in terms of what you're proposing, do you think that you can make genuinely significant strides to assist this category?

ALLAN FELS: Very much. I'm very familiar with this group of people at the very severe end. I see them very nearly every day, and because I'm connected with a local one, where my daughter is. Just to give you that as an example, we've got about 14 people there, and they've all had effectively life-long, really serious mental illness, schizophrenia, they have psychosis unless they're treated. They can't get jobs, of course they are victims of discrimination, but in any case, most of them have very poor life skills. Speaking of that kind of population, as you've mentioned, there may be so-called dual diagnosis, drugs or alcohol, and as you implied, it's not … the causation doesn't go from drugs to mental illness so much as people are untreated and they don't get medicine and they take drugs and alcohol as a kind of relief.

So things can be done and they need to be done generally, so in the schemes I'm involved in, we strongly emphasise the need for proper accommodation. It's no good going to hospital and

then coming out and sleeping under a bridge. You'll be back in, you'll relapse really quickly. These people are also terribly vulnerable as a rule. They're vulnerable to exploitation of all forms - economic, social, physical, sexual, to drugs and all that. They need to be looked after properly. They can be, and in the group I'm in there's been a wonderful recovery. There's been an assessment by a university showing that these people who are just all the time in hospital are hardly ever in there now. And incidentally, it's a cheaper way and it's a friendlier way, because it's a community.

LAURIE WILSON: Take a question now from Mark Kenny.

QUESTION: Mark Kenny, Professor Fels, from *The Age* and *Sydney Morning Herald*, I wonder if I could talk a little bit about social stigma and whether we're making any progress. I'm minded of the recent affair with Adam Goodes and what that told us really about attitudes to racism, and the progress that we thought we had made. Are there any lessons from that? Bearing in mind, in fact, also I suppose that there were mental health issues at least referred to in some of the commentary in terms of the pressure that was placed on the individual there. But on the plus side, there was also a very solid public rallying afterwards in support of Goodes and against any taint of racism. But I'm wondering, are there any sort of lessons and parallels you draw there in terms of public attitudes and, is it a concern?

ALLAN FELS: They're good questions. In short, public attitudes can be changed, including the mental illness. The reaction

that came out in favour of Adam Goodes, I don't think it would have happened 20 years ago. It's similar with attitudes to smoking and other things. I used to once think well, that's a life-long attitude. I believe public attitudes to mental health are improving. Also although it's never had a top rating politically unfortunately, more politicians are becoming aware of the problem and they're becoming a bit more aware of the large size of the electorate that's interested in this and for many of us it's a single issue. It's the one issue people in the mental health community care about. So I do see some signs of change in mental attitudes, but you mentioned football and that's another example of where there are inevitably life-long mental health problems. If you're a top player, think of the stress. Also, if you're not quite a top player, the stress is even greater.

Think of someone who retires at 30, got the rest of their life ahead of them. Many have a mental health problem when that happens. Think of the large numbers of people training and practicing as young men trying to get into football teams - and women these days - getting into football teams. So many of them miss out and are disappointed and there are mental health challenges, and even at schools there's bullying, and all that kind of thing. So mental health in that sector, in every sector - journalism, the law, whatever, you'll find there are very, very big challenges.

LAURIE WILSON: Belinda Merhab.

QUESTION: Hi Professor Fels, Belinda Mehaps from AAP. One of the key recommendations of your review was to take $1 billion out of hospitals and put it into community-based care. That was quickly ruled out by the Government and criticised by some interest groups. I'm just wondering if that is a source of frustration for you, and whether you think we can ever achieve true reform if big ideas are going to be ruled out so quickly?

ALLAN FELS: Well, the only other option, if you rule out diverting a bit of the growth money for hospitals - it was only I think it's one per cent of the hospital budget should go into keeping people out of hospitals. Fine, if the Government wants to spend another percent rather than - as we suggested - reallocate some money, fine, I'd be delighted if they increased mental health spending. But our terms of reference in that report were very much no extra spending, and we identified the fact there needs to be a shift in spending. And I actually read the Government as saying well, we agree with the principle, but they blinked when we put some figures on it. It is just one per cent of the hospital spending, and it would pay off, in terms … and I have seen in some other countries, I had a look in the UK recently, on a private trip by the way ...

[Laughter]

I had a look at how they are trying to manage cutting back hospital spending and doing an investment that has a long-term pay-off without disrupting the long-term end of it. In Australia it can be done through the - we suggested it should be in forward estimates, should

we start in 2017? It's true that some people just see mental health as being about spending money on people in hospitals, not keeping them out, not spending the money well. So I think this will come back to the Government. No doubt they won't go for a billion, but they'll have to do something along the lines we've suggested.

LAURIE WILSON: David Speers.

QUESTION: David Speers from *Sky News*. A two part question, Professor Fels. Firstly, are many of the problems you identified to do with the way our Federation works? Is this a good argument for the reform of Federations being considered as to who pays for and looks after these step-up, step-down programs you talk about? The second one, it's not about entitlements, but about competition law. If I can ask you as a former well-known ACCC chair, this debate that's running over an effects test, Bruce Billson says there's a strong case for it, Cabinet's looking at it. Chris Bowen says it would kill competition and kill enterprise. The Business Council and big supermarkets hate the idea as well - what do you think about it?

ALLAN FELS: Okay, on the Federation question - you're right. I mean mental health is really complicated and it's a prime area for sorting out, but the solution is quite difficult. The primary is more or less Federal, hospitals is State. There's a mixture of Federal and State programs. We have ... and by the way, it's also complicated by the many organisations involved. So these days you go to someone and they look after you in one dimension,

then you step out and you realise that you have to go to another official body or an NGO for that problem and then to someone else. So there's a poor integration and that diminishes the effectiveness of any one service, when you walk out the door and you need something else, but you don't get it.

Now, our contribution to this debate has been to push the role of primary and mental health networks. We believe that the Commonwealth should give some leadership. It is giving some leadership on this health networks topic, and get the healthcare more with a immediate regional and local approach. On the big questions - you know, should the Commonwealth do all mental health, should the States do it all? I don't see governments budging on that at the moment. We have the usual dilemmas, the Commonwealth has all the money and the States on balance probably are more expert at service delivery, although we could argue about all of that. Now on the effects test well, look, I used to say that 127 out of 129 countries have the law that Bruce Billson wants. I go to all the international conferences - at my expense.

[Laughter]

And the … you know, everyone has it. It's just normal law. It's been around since 1900 - but I'm wrong, it's 126 because there's an African country that got an AusAid program and they put in the wrong test. So their economic future is clearly limited. But I mean, it's just logical. The economic logic is impeccable. I mean, it's an economic statute. If a big powerful business with

market power takes action that damages competition, then that should be prohibited. Everyone around the world agrees on that. It was just in 1976 that in a very weak moment the Fraser Government let through our current law. It has no place. By the way, it's an example though, utterly thrilled to get this question.

[Laughter]

It is an example, the impact of that is quite small, whenever way it goes. The impact of mental health is 50 times bigger than that.

LAURIE WILSON: Michael Keating.

QUESTION: Michael Keating from Keating Media, Professor Fels. When Professor Brian Owler - who is in the room here today - the president of the AMA addressed this forum two weeks ago, he argued that health practitioners should decide the size of the health budget and the Government should be responsible for implementing it. Do you agree with that point, and how do you think the health budget should be managed?

ALLAN FELS: Well, I wouldn't mind if health practitioners decided the size of the budget providing that someone else had a say in how that cake was spent. But I'm being a little bit flippant. I do think the GPs and the medical profession do make a serious contribution. They're always worth listening to. But I mean, in the case of mental health it's always got a low priority. Every few years governments do something and then it drops off the agenda. It's not exactly dropped, but other things

take priority. Yet it remains - it's always been the weak point in the Australian health system. The Australian health system is basically a good one, but it's got two weak links. One is mental health - by the way, it's 13 per cent of the burden of illness, 7 per cent only is spent on mental health, and by the way we also need, besides that, money spent on housing and getting training jobs and employment and so on.

The other weak point is Indigenous, and a lot of that is mental health. So obviously I'd like to see a higher priority given to it, and I would link that however with actually the changes we've talked about which are more reallocating and working within current tight budgets.

LAURIE WILSON: Mark Metherell.

QUESTION: Mark Metherell from the Consumers Health Forum, Professor. Can I ask a little more about the primary health care networks? What sort of interest are you getting from the 31 entities that came into existence last month in providing linked-up networks for mental health patients? Secondly, your argument about inserting the words mental health into primary health care - can't you make the other argument that shouldn't mental health care be just a basic part of primary care? The more you distinguish it, the more the demarcation, perhaps the less resources you get out of it rather than trying to make it a more comprehensive coordinated arrangement?

ALLAN FELS: Yeah, well on the first point, the … I can't report a lot of action on the first one. I think we've still got some way to go on changing the culture in the whole field of medical and health services. There are fairly deeply entrenched cultural issues which need to be tackled. So I don't want to say that the networks aren't interested. I also have an impression that the Government is pretty interested in moving this agenda along. Now on your point, yes, you do have a point there are pros and cons for putting in mental health into that terminology, but our belief is that at the moment the argument in favour is that it needs emphasis. If it's put into the title, that will have a positive effect - getting it on the agenda, getting more support, getting more integration. I don't doubt there's some hazards to it of exactly the sort you've mentioned, but I'd still go for anything to get us moving on this neglect of the interaction of physical and mental health.

LAURIE WILSON: Peter Phillips.

QUESTION: Professor Fels, Peter Phillips, one of the directors of the Press Club. We're at that time in the cycle again, we've just seen the COAG retreat, we're next week about to see the resumption of the Parliament. It leads us on, if the experts around the place are right - and as they frequently are - it leads us onto the likelihood that next year, instead of going to a full term election we'll probably have an election in March or April instead of having a budget, given the problems which the Government could be beset if they had to go to a budget. In that situation, if that is correct, could you give us insights into the strategy which the mental

health sector would apply in its messaging in the approach to an election campaign instead of a budget?

ALLAN FELS: I'm pretty sure I speak for the mental health community when I say they would like a response, a detailed response to our report before the election from all sides of politics.

[Applause]

That's it.

LAURIE WILSON: Our final question from Steve Lewis.

QUESTION: Professor Fels, Steven Lewis from the National Press Club. I'd like to switch the subject slightly to the issue of parliamentary entitlements …

ALLAN FELS: Yes.

QUESTION: … given the role that you played- you have played as a reviewer, and I have read some of your recent comments. What has to be done, in your view, to clean up the system? And as somebody who has had a very long and distinguished career in public life, going on, what, probably several decades, have you ever seen a time when politicians where held in less regard than they currently are at present, and how much of that is do you think due to the rorting that is taking place in respect to entitlements?

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ALLAN FELS: Well I think you're right, it's had a really damaging effect. So damaging that maybe this time they will buy some more radical medicine. The 2010 report that we did on entitlements was not implemented in key respects; for example, on each Member's website there should be detailed of their spending and the reasons for it, that they should clean up the legal regulatory mess which is incredibly unclear, contradictory, and so on. What should be done is the-first of all, transparency, full transparency on their website of what they've spent and why. That is more powerful than anything. Secondly, I'm afraid the time has come to have an independent commissioner to oversight it; I know it costs more money, but for the very reason you've got it our political process is damaged in the standing of people and in the distractions that it's worth spending a bit of money having it independently regulated, monitored, enforced, and so on, rather than the present very badly organised system.

But I just want to make one other point in response to Steve. We've lost three weeks in this country discussing this issue instead of important issues. This keeps driving off things like mental health, economic reform, a whole lot of other things. It's very sad that something really important like mental health just gets totally overshadowed by this.

LAURIE WILSON: We'll finish on that point.

[Applause]

Well thank Professor Fels, and thank you to Ben Suitor as well today.

[Applause]

I think this is the seventh occasion, I think you told me that …

ALLAN FELS: Yes.

LAURIE WILSON: … I meant to check before we started but I neglected to do so, and I'll take your word for it, the seventh occasion today. I somehow suspect it won't be the last. It's always a pleasure to have you back, and also a pleasure to be able to renew your membership.

ALLAN FELS: Thank you.

[Laughter]

LAURIE WILSON: And a copy of our 50th anniversary book, *Stand and Deliver*, by the last questioner Steve Lewis.

ALLAN FELS: By Steve Lewis. Yep.

LAURIE WILSON: Thank you very much.

ALLAN FELS: Thanks [indistinct].

[Applause]

* * **END** * *

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