CENTRE FOR THE
HEALTH ECONOMY

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Getting more value from mental healthcare funding and investment

Consultation paper

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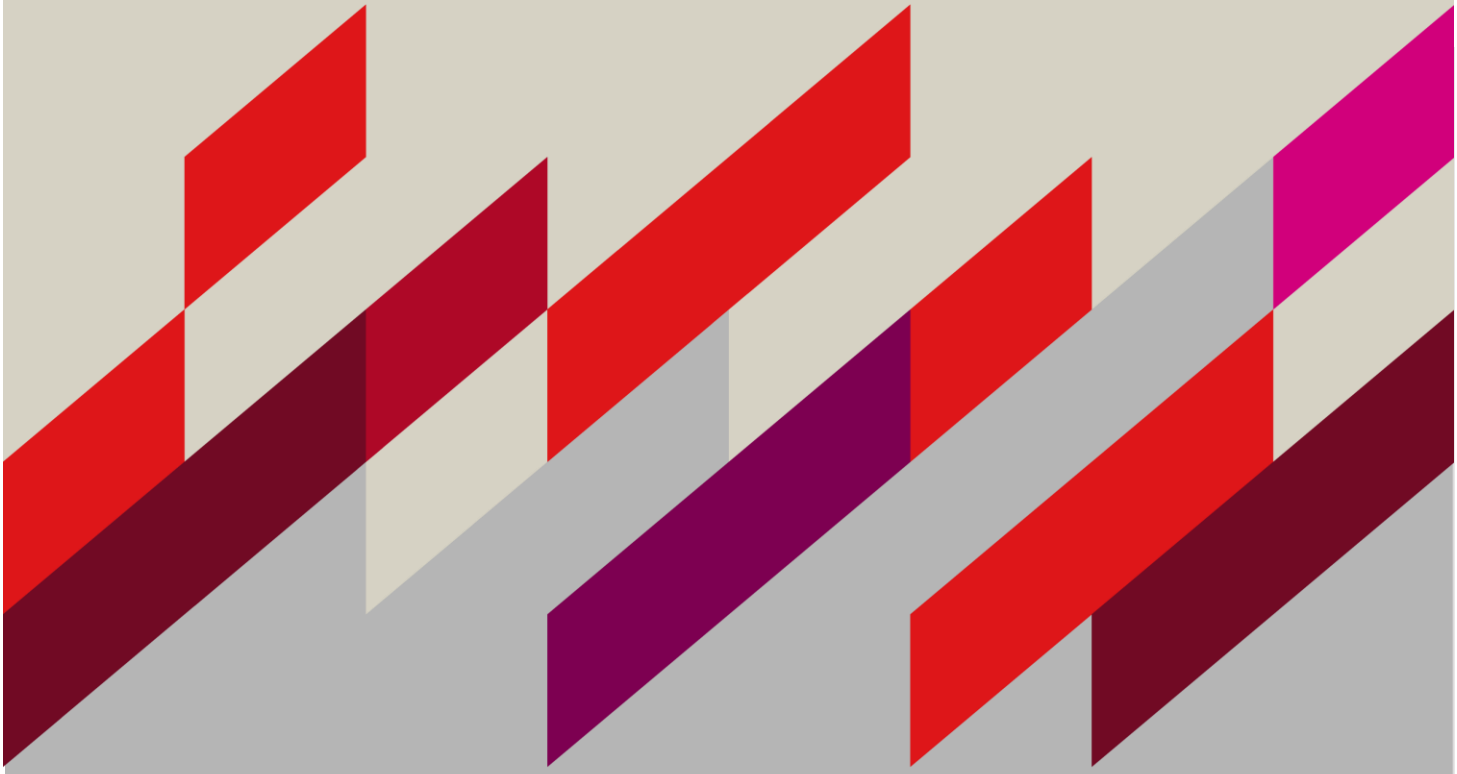

DISCLAIMER

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About MUCHE

Macquarie University is recognised as one of Australia's leading research universities, with an enviable reputation for excellence. While still relatively young, success of the past 50 years has positioned our distinctive approach to deliver ground-breaking research with world-changing impact. We are consistently ranked in the top 1% of universities worldwide.

The University's objectives are to accelerate world-leading research; to prepare world-ready higher degree research candidates; to actively engage externally as a world-recognised research collaborator and partner of choice. We believe collaborating with industries, governments, communities, professions and academic colleagues around the world is paramount to our success.

The Macquarie University Centre for the Health Economy (MUCHE) is a university strategic initiative created to undertake innovative research on health and aged care. We are one of four research centres within the Australian Institute of Health Innovation (AIHI), the largest and most influential health systems research institute in Australia. The AIHI is owned by the Faculty of Medicine, Health and Human Sciences and the Macquarie University Business School.

Our vision is to create a world where decision makers and the public are empowered with trusted and impactful research. Our mission is to be Australia's most influential health economics research centre in academic and public policy debate.

We undertake research funded by competitive academic grants and by government and non-government organisations. We actively promote our research through clear communication to inform public debate, assist decision-making, and help formulate strategy and policy.

We investigate the Health Economy at the macro level, focused on the interdependency of these systems with each other and the broader economy. We investigate factors beyond the health and aged care sectors that impact the health and wellbeing of populations.

While MUCHE primarily consists of specialist health economists, researching the Health Economy requires many skills sets and experience. Solving complex problems within health and aged care requires teams with multi-disciplinary skills working closely together.

We actively collaborate with Macquarie University academics within the Macquarie University Business School, Faculty of Medicine, Health and Human Sciences, and Faculty of Science and Engineering. We collaborate with Macquarie University research hubs and centres and collaborate widely with world leading academic groups from universities in Australia, Europe and Asia.

We take pride in combining our professional approach to partner engagement, with our academic approach to methodology, to deliver innovative and translational research.

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Contents

Executive summary

The Macquarie University Centre for the Health Economy is developing a framework for embedding more value into Australia's mental healthcare funding and investment environment.

This consultation paper provides a background to proposed funding reforms, outlines key characteristics of a proposed value based mental health care funding and investment framework and poses questions to mental healthcare stakeholders on developing and implementing a framework that can guide state, territory and federal governments to generate more value from their spending.

Mental healthcare in Australia is funded through antiquated payment mechanisms that impose barriers to person centred care. Medicare encourages over-servicing and payments have no relation to care quality or mental health outcomes. Siloed primary and acute care funding, along with siloed state, territory and federal government funding, makes it difficult to integrate care. Navigating mental healthcare remains complex and care pathways have service gaps.

There has been little attempt from governments to reform the bulk of mental healthcare funding. This has potentially discouraged investment and innovation within mental healthcare because funding streams do not reward it. Government investment in mental healthcare is not being allocated based on the best available evidence, with many in the sector complaining that embedded mental healthcare models receive most government funding with limited evidence of effectiveness.

There is a recognised need for mental healthcare funding and investment reform in Australia to develop an integrated, patient centred mental healthcare system and to reduce service gaps and fragmented care, particularly for those with complex needs including 'the missing middle'.

The missing middle includes people with symptoms that are too complex, severe or enduring to be adequately treated by rebated general practitioner and psychologist sessions, but who are also inhibited from accessing state and territory funded specialised mental health services and private health care. Due to their complex and unmet needs, and the importance of coordinated, multidisciplinary care, the missing middle is an important starting point for reforming funding models to encourage more integrated and continuous care.

In 2020, the Productivity Commission released an ambitious mental healthcare reform program developed from its landmark inquiry of the mental healthcare system. It considered funding, monitoring, evaluation and research as part of a broader set of reform enablers.

The Productivity Commission provided a set of recommendations to improve the monitoring of mental healthcare system changes and provider performance, to fill data gaps and improve evaluation, and to better coordinate and align research with policy priorities. It offered recommendations to stop cost

shifting and encourage activity, but stopped short of recommending value based payment models as it believed health outcomes were not measured well enough to inform funding decisions.

The National Mental Health and Suicide Prevention Agreement has since set the reform agenda for state and territory governments to better embed value within mental health care, outlining joint responsibility with the federal government to deliver a fair share of funding, to determine funding policy, and to explore innovative models of care within the national funding model.

The Agreement prioritised regional planning and commissioning, allowing state and territory governments to determine their own planning and commissioning frameworks to meet local needs. No direction was provided on funding model types that should be introduced, although states and territories acknowledged that planning and commissioning should pay for value and outcomes.

Australia and other developed countries are seeking greater value from their healthcare system, driven primarily by increasing expenditure relative to national income and substantial financial waste. Value based healthcare is being implemented in NSW and other states and territories, although the focus is currently on delivering outcomes that matter to patients with physical chronic conditions.

One component of value based healthcare is paying for services using value based payments. Value-based payment models seek to use financial incentives to extrinsically motivate providers to deliver better health outcomes.

Value based payment models broadly consist of pay for performance, capitation, bundled payments and accountable care organisations. Pay for performance and capitation have been explored in Australia, albeit not for mental healthcare and with little success. Bundled payments and accountable care organisations comprise multiple providers contractually obliged to deliver care services within a budget constraint. Their development and testing has mostly occurred in the US, where restraint on healthcare spending growth is paramount.

There are few examples of value based payment models funding mental healthcare compared to physical health services. This is despite mental healthcare providers being likely to respond to financial incentives to improve care quality. Providers may be reluctant to participate in value based payment models because they shift financial risk from payer to provider. Encouraging providers to adopt may be more challenging in mental healthcare where episodes of care are not easily defined.

There are also additional complexities attributing outcomes to service delivery within mental healthcare compared to physical care. Social determinants and access to informal care can substantially impact mental health outcomes but are outside the control of providers. Nonetheless, research suggests value based payment models hold promise for enabling providers to deliver better integrated, patient centred care.

A new mental healthcare funding framework

Mental healthcare funding reform must take a long-term view. It requires moving beyond recommendations made by the Productivity Commission and the reform agenda presented in the National Mental Health and Suicide Prevention Agreement and the National Mental Health and Suicide Prevention Plan.

Responsibility for developing, implementing, monitoring and evaluating value based funding models should sit with a federal independent value based payment authority. Its remit should include funding models for physical and mental healthcare given the interaction between the two, and with non-health factors that impact health outcomes (see Figure 1).

Provider engagement is vital for the success of value based payment models and providers will consider several factors when deciding to participate in value based payment models, including benefit to care delivery and patient health, potential profit, risk tolerance, access to investment capital and organisational readiness. Providers should be supported through improved data collection, analysis and sharing, and government investment in provider education, training and innovation.

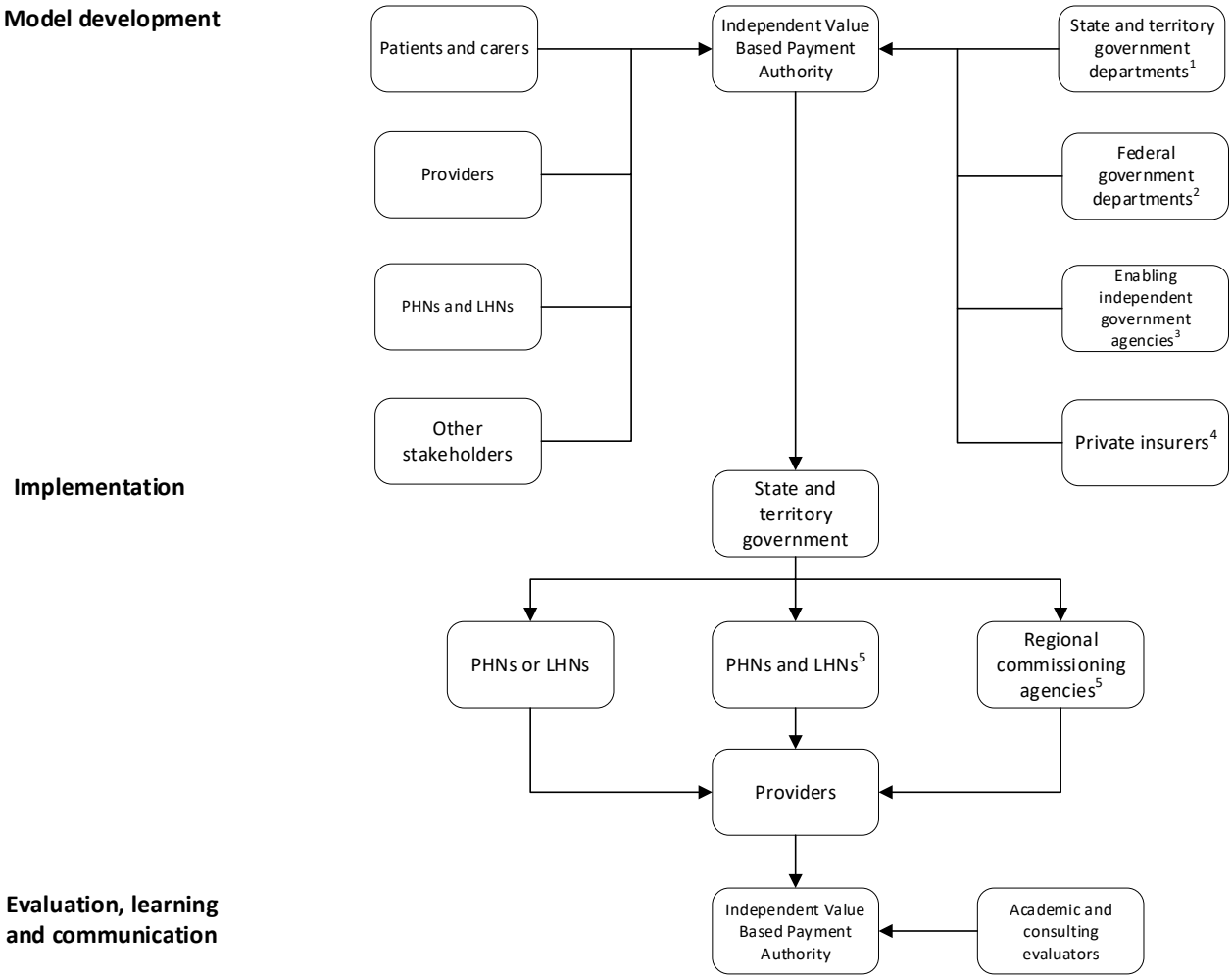
Strong government leadership, informational technology improvement, and encouraging a value based healthcare culture are enabling factors for implementation. Logistical support and initiatives enabling providers to pool resources and create learning collaboratives may increase provider benefits.

Mental healthcare funding reform should include developing, trialling, and evaluating payment models in an iterative and transparent way, seeking to meet a cohesive national vision and national plan for value based payment integration. This would provide some certainty to providers that must decide whether to invest in changing care models, and help government integrate value based payment models into future policy reform, such as investment in information technology infrastructure.

An independent value based payment authority would allow necessary skills and experience to be aggregated in one organisation, allow trials to be coordinated across states and territories, allow a whole of government approach to funding, and maximise opportunities to iteratively learn from trials. An independent value based payment authority would better represent funding models in broader policy discussions, such as access to data and investment in data infrastructure.

A coordinating government department or agency representing the mental healthcare sector could help develop, communicate and gain support for a long term mental healthcare value based payment reform agenda. It could also participate in the evaluation and learning phase of each trialled value based payment model.

Figure 1: Proposed governance structure for value based payments in mental healthcare



Note: (1) State and territory government departments should include health and non-health related departments where spending impacts mental health outcomes, such as Departments representing education, housing, social services, justice and treasury. (2) Federal government departments should include health and non-health related departments where spending impacts mental health outcomes, such as the Department of Social Services, Department of Defence, Department of Education, Department of Employment and Workplace Relations, Department of the Treasury, Department of Veteran's Affairs (3) Enabling independent government agencies should include Independent Health and Aged Care Pricing Authority, National Health Funding Body, National Health and Medical Research Council, Australian Digital Health Agency, Australian Commission on Safety and Quality in Health Care, and Australian Institute of Health and Welfare. (4) Private insurers should include private health insurers and other private insurers that cover income loss, permanent disability and workers compensation. (5) Commissioning by PHNs and LHNs working together, along with regional commissioning agencies, were proposed by the Productivity Commission but have not been fully implemented across Australia.

Mental healthcare funding reform will need to meet several challenges. Deciding what patient populations to target is non-trivial as early success can encourage greater future adoption. Outcomes that matter to patients must be identified, measured and attributable to service use. The missing middle identified by the Productivity Commission seems like a logical starting point, considering their need for integrated care and support services across multiple provider types, both within and outside the healthcare system.

Transitioning to value based payment models will require upfront investment in creating and updating information technology, billing practices, models of care, administration and governance structures. Larger provider networks may be better equipped with resources to make systematic changes. Providers will likely need to change the way they account for costs to better reflect costs along care pathways and smaller providers may need additional government support.

All this will require national standardisation of data and substantial government investment in data collection and analysis.

A new mental healthcare investment framework

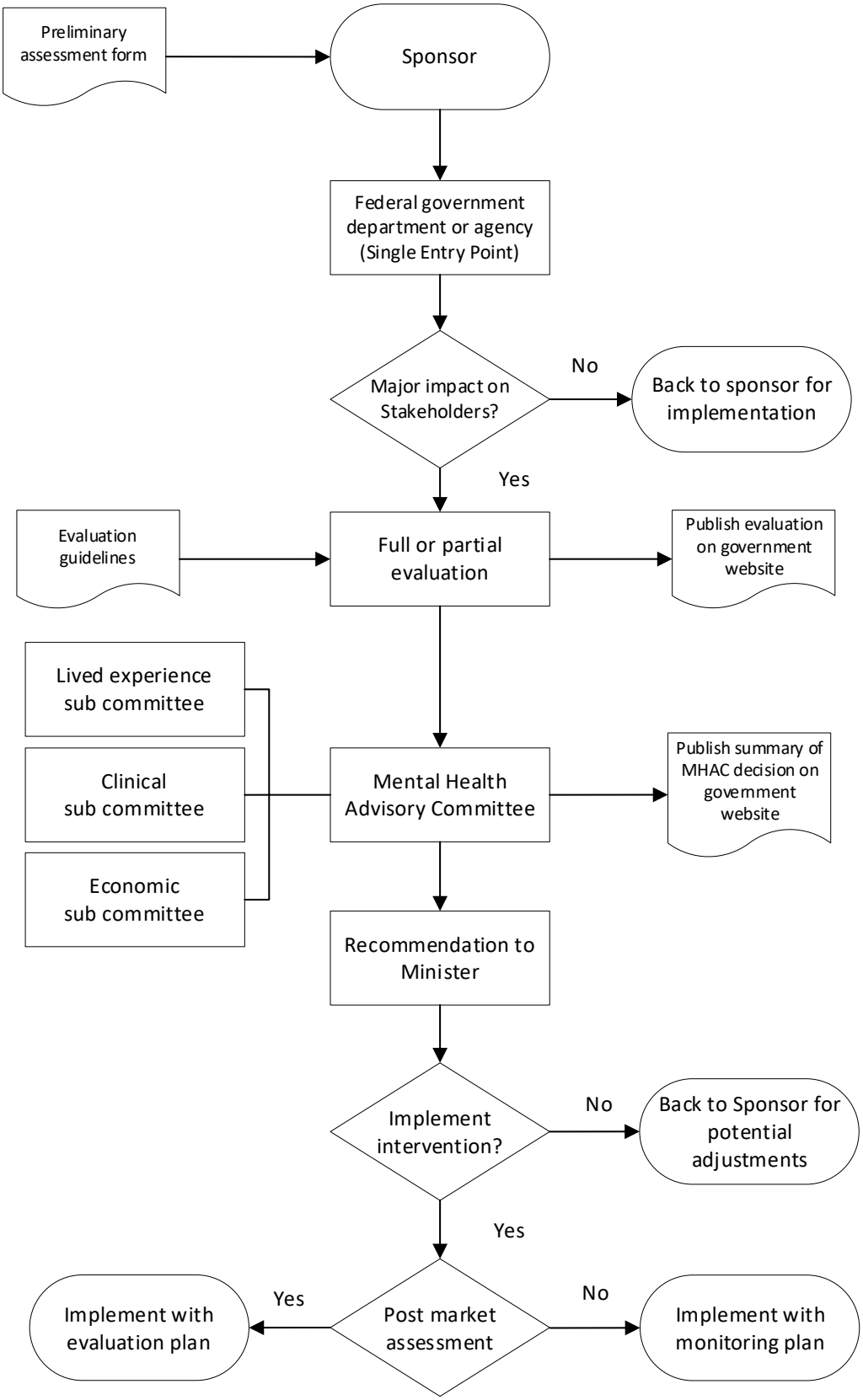
The Productivity Commission noted that many government investment decisions for mental healthcare were not based on evidence of effectiveness or cost effectiveness. It also suggested that research outcomes were not being used by policy makers effectively, recommending a more systematic approach to investment decisions, along with greater coordination between policy makers and researchers.

This consultation paper presents a potential unified national approach to mental healthcare investment decisions that includes a systematic, transparent and risk-based approach to the investment assessment procedure (see Figure 2). It comprises developing a set of principles for underpinning the evaluation process, and developing a process that includes a single point of entry for investment applications and recommendations made by an independent Mental Health Advisory Committee to ministers on whether a proposed investment in mental healthcare should proceed. Investment based on best available evidence, along with expert opinion from economists, clinicians and people with lived experience, will reduce healthcare system financial waste and improve treatment outcomes.

Timeframes and the way forward

This project represents the beginning of the journey towards understanding and motivating value-based payment and investment reform in the Australian mental healthcare system. This journey will take years and may experience some initial failures. We do not advocate for overnight change. Our aim is to propose sensible and progressive change over the next decade and beyond, informed by views from key groups within the mental healthcare sector and embedded within a culture of continuous evaluation, learning and iterative improvements to funding and investment models.

Figure 2: Proposed process for considering mental healthcare investments



Long-term change to value based payment and investment models in mental health must be supported by strong and consistent national leadership. The likelihood of developing a program of successful value-based payment models in mental health will be substantially greater if state, territory and federal governments develop a structured and supportive policy and institutional framework around the intent to trial and evaluate ongoing value-based payment models nationally.

Consultation process

Stakeholders can participate in a consultation workshop by registering for a workshop on the MUCHE website.[1] You will be provided with further information on the date and time of each workshop upon which you can register.

Stakeholders can also provide a written submission to MUCHE that addresses the questions outlined within this consultation paper. Please send your submission to Alicia Norman (alicia.norman@mq.edu.au). MUCHE team members may contact those with submissions to follow-up on key points.

[1] https://www.mq.edu.au/research/research-centres-groups-and-facilities/prosperous-economies/centres/centre-for-the-health-economy

1. Embedding value

The Macquarie University Centre for the Health Economy (MUCHE) is developing a framework for embedding value into Australia's mental healthcare funding and investment environment. Key points from this chapter include the following.

- The project purpose is to develop frameworks for embedding value into Australia's mental healthcare funding and investment environment. It will complement and extend reforms already announced within government agreements and outcomes from the Productivity Commission Inquiry into Mental Health.
- The mental healthcare sector needs systemic funding and investment reform to complement activities being undertaken by state, territory and federal governments to develop an integrated, patient centred mental healthcare system and reduce service gaps and fragmented care, particularly for those with complex needs ('the missing middle'). This project comes at a time when the federal government is focused on reforming Medicare, and state, territory and federal governments have agreed to explore paying for value within healthcare.
- The consultation process for this project will involve six national workshops for mental healthcare stakeholders to express their views on funding and investment reform. Questions presented throughout each chapter of this consultation paper will be used as a starting point for discussions within workshops. Written submissions from stakeholders addressing specific questions will also be accepted.

The Vision for mental healthcare

The 2022 National Mental Health and Suicide Prevention Agreement lays out the shared intention of the Commonwealth, state and territory governments to improve the mental health of all Australians, ensure sustainability and enhance the services of the Australian mental health and suicide prevention system.[1] This Agreement lays the foundation for motivating and implementing landmark mental health and suicide prevention reform.

Specific objectives mentioned within the Agreement include moving towards a unified and integrated mental health and suicide prevention system, delivering a mental health system that is comprehensive, coordinated, consumer-focused and compassionate, reducing system fragmentation through improved integration between Commonwealth and State-funded services and ensuring equitable access to the appropriate level of mental health care needed.

The Agreement also mentions several key principles related to the need to better embed value within the mental health care system, reduce waste and duplication through better coordination, and create clarity on funding and investment principles and responsibilities. These include[1]:

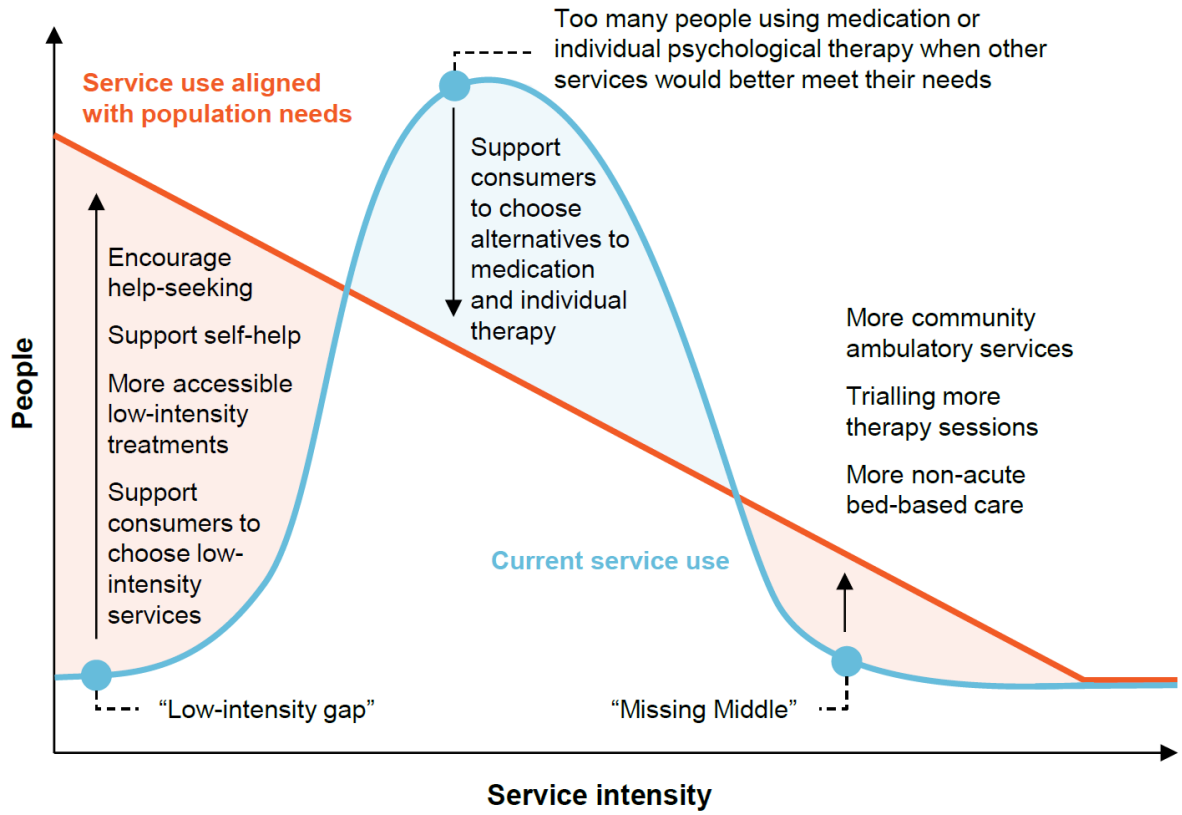
- facilitating an effective investment, policy and service mix that reduces gaps and overlaps in mental health and suicide prevention services to best support mental health outcomes;
- reducing system fragmentation, gaps and duplication across prevention, primary and secondary care specialist settings with an increased focus on prevention, early intervention and effective management of severe and enduring conditions in the community and tertiary settings;
- facilitating an effective investment, policy and service mix that reduces gaps and overlaps in mental health and suicide prevention services to best support mental health outcomes;
- evaluating new models of care to drive improvement and ensuring the best reforms are implemented, with consideration given to outcomes achieved and value for money; and
- establishing clear roles, responsibilities and accountabilities for the funding and delivery of mental health and suicide prevention services across the entire mental healthcare system.

Developing a framework for embedding value into mental healthcare funding and investment, informed by insights from key stakeholders within the system, will help facilitate this ambitious vision for mental health care. Taking a longer-term view and commitment to better embedding value within the system is required to improve the mental health of Australians, within a sustainable, equitable and better integrated system of care that meets consumer needs, and measures and delivers outcomes that are valued by consumers and the community.

Focusing on the ‘missing middle’

The Productivity Commission Inquiry Report highlighted the pressing issue of the ‘missing middle’ in the Australian mental healthcare system (see Figure 1.1). The missing middle refers to a service gap encountered by several hundred thousand Australians with mental ill health symptoms that are too complex, severe or enduring to be adequately treated by general practitioners and limited Medicare-Benefits Schedule-rebated psychologist sessions. These individuals also do not meet the condition severity threshold for accessing state funded specialised mental health services and they are prevented from accessing private psychiatrists or private hospitals due to long waiting lists and/or prohibitively high out-of-pocket costs.[2]

Figure 1.1: The 'missing middle' gap in the Australian mental healthcare system



Source: [2]

Within the missing middle gap, many people with mental ill health in need of care and support do not have their needs met, may reach a point of crisis and have significantly reduced quality of life and social and economic opportunities. The gap encompasses different service types including individual psychological therapy, rebated psychiatric services, community ambulatory care, bed-based services and psychosocial supports.

The Productivity Commission's Inquiry report noted that the missing middle gap reflects both service under-provision (including under-supply of community mental health care) and issues with current funding arrangements in the mental health system. Service under-provision and unmet needs often lead to people with complex needs having emergency department admissions or cycling in and out of hospital instead of receiving continuous and integrated support.

The fragmented nature of mental health service provision, planning and funding hampers efforts to provide person-centred integrated and coordinated care to the missing middle, and may create perverse incentives to duplicate care, lead to inefficiency and waste, and result in care not meeting continuous and complex health needs.

Both the Productivity Commission Inquiry and Victorian Government Royal Commission into Mental Health highlighted that addressing care gaps for the missing middle will require reforms to funding and commissioning services to create effective incentives for both intra-government and inter-government coordination and cooperation, with clear responsibility and accountability for consumer outcomes ('commissioning for integration') [2 3]

Due to their complex needs and the importance of coordinated care, the missing middle is an important starting point for reforming future funding models. Embedding value through new funding models (described in Chapter **Error! Reference source not found.**) is expected to encourage more integrated and holistic mental health care and reduce the missing middle service gap.

Project purpose

The Australian mental health care system is set to undergo substantial change. The National Mental Health and Suicide Prevention Agreement has placed mental health care funding squarely on the reform agenda. State and territory governments have agreed to improve health outcomes by realigning funding incentives and improving value.

The Macquarie University Centre for the Health Economy received a grant from the National Mental Health Commission to develop a framework for embedding value into Australia's mental healthcare funding and investment environment. The purpose is to:

- Inform reforms outlined within the National Mental Health and Suicide Prevention Agreement and associated bilateral agreements with state and territory governments.[1]
- Inform reforms outlined within the Addendum to the National Health Reform Agreement (2020-25).[4]
- Provide a framework for shaping mental healthcare funding models across Australia over the next decade, extending recommendations made by the Productivity Commission in their landmark inquiry into mental healthcare.[2]

Integrating mental healthcare funding across the care pathway, and ensuring investment is allocated in an effective and efficient way, are essential if governments are to successfully align healthcare resources toward person-centred care.

The value-based funding and investment framework presented in this consultation paper is scaffolded by the value-based health care (VBHC) movement occurring within Australia and in other developed countries. It concentrates on funding and investment within a VBHC system. Other components of VBHC, such as integrating models of care, developing the workforce, and embedding an enabling information technology system, are outside the scope of this framework.

The frameworks presented in this consultation paper focus on funding and investment to improve health outcomes for the 'missing middle'. They also account for unique characteristics within the Australian mental healthcare sector, such as the federated approach to care delivery and funding, and the impact of mental ill health on economic and social outcomes. The frameworks also consider the complex social determinants of mental ill health, which are often impacted by non-healthcare sectors, but must also be addressed to improve mental health outcomes that matter to patients.

Why examine mental healthcare funding and investment?

Mental ill health in Australia is common. Approximately 44 per cent (about 8.6 million Australians) aged 16 to 85 years have experienced a mental health disorder in their lifetime.[5] Mental ill health and substance use disorders were responsible for 13 per cent of the total Australian disease burden in 2018, the fourth highest disease group after cancer (18 percent), musculoskeletal conditions (13 percent) and cardiovascular diseases (13 percent).[6]

The economic impact of mental ill health is considerable. Total health expenditure on mental health in Australia was $11.0 billion in 2019-20.[7] Overall, 34.7 percent ($3.8 billion) was funded by the federal government, 60.0 percent ($6.6 billion) by state and territory governments and 5.3 per cent ($584 million) by private health insurance and other third party insurers.[7] A significant proportion of expenditure is also paid by consumers' out of pocket, with many people forgoing needed mental healthcare because of high costs.[2]

An increase in expenditure on mental healthcare has not substantially reduced the prevalence of mental ill health in Australia. Recurrent expenditure per capita (constant prices) on state and territory specialised mental health services increased 18 per cent between 2007-08 and 2019-20.[8] In contrast, the proportion of the Australian population aged 16-85 years that experienced any 12 month mental disorder increased from 20 per cent in 2007 to 21 per cent in 2020-21. [5 9]

State, territory and federal governments have sought to re-orient resources to deliver better mental healthcare models. Despite substantial government investment in mental healthcare services over the last decade, a large proportion of care is not evidence based, care remains fragmented, and many people find identifying and navigating care pathways difficult with large service gaps and discontinuity of care for those in the 'missing middle' and those with a need for low-intensity services.[2] Mental ill-health and equitable access to care remains a significant public health issue in Australia.[10]

Australia's geographic size, cultural diversity, aging population and the COVID-19 pandemic have all contributed to, and amplified, the challenges faced by our mental healthcare system.[10 11] Siloes in

care responsibility have created service gaps within care pathways, as people transition from one silo to another. Service gaps are particularly acute within rural and remote regions, and regions that have experienced natural disaster events, where the demand for mental healthcare is great and access to basic mental healthcare is constrained.[2 10 12]

All state, territory and federal governments have agreed to share responsibility for improving mental health outcomes. The Productivity Commission Inquiry Report into mental health and the National Mental Health Commission's 'Vision 2030' have advocated for a person-centred mental health system to help people manage their own mental health where possible, providing access to timely and affordable services when additional care is required.[2 11]

State, territory and federal governments have not fully explored the role of funding models and financial incentives to help align services around a person-centred approach. The National Mental Health and Suicide Prevention Agreement has taken the first step towards funding reform, seeking to develop a co-commissioning approach through primary health networks and local health networks. This fits neatly within the broader healthcare reform direction, with state and territory governments agreeing to pay for value and outcomes in the Addendum to the National Health Reform Agreement (2020-25). Their objectives are to incentivise best-practice clinical care, improve equity in access to care, and realign the healthcare system on the whole patient journey.

Current provider concerns

The mental health workforce in Australia faces many different challenges. The Productivity Commission estimated the mental health workforce as approximately 56,000 full time equivalent clinical practitioners, 20,000 paid peer and community health workers, and a large but unknown number of unpaid carers.[2]

Mental health care providers and carers work in a range of occupations and settings, have different levels of training and experience, and are remunerated under different payment structures (see Chapter 2). Because of these differences, pressures on providers vary but could include workforce shortages (particularly in rural areas), insufficient mental health training for generalist clinicians, lack of care coordination, insecure funding streams, high workloads, and resource limitations.[2]

Some providers have complained about short-term fixed funding arrangements within mental healthcare, inflexible funding, and a focus on pilot projects rather than long term investments. This has created an environment where providers are required to focus their efforts on retaining staff within an uncertain environment, and consumers are faced with disruption in their mental healthcare pathway.[13] Providers will consider several factors when deciding to participate in value based payment models. These factors may include the perceived benefit to care delivery and patient health,

potential profit, risk tolerance, access to investment capital and organisational readiness.[14] Ongoing provider engagement is vital for the success of value based payment models.[15 16]

Timeframes

This project represents the beginning of the journey towards understanding and motivating value-based payment and investment reform in the Australian mental healthcare system. This journey will take years and may experience some initial failures. Our aim is to propose sensible and progressive change over the next decade and beyond, informed by views from key groups within the mental healthcare sector and embedded within a culture of continuous evaluation, learning and iterative improvements to funding and investment models.

Long-term change to value based payment and investment models in mental health will need to be supported by strong and consistent national leadership. The likelihood of developing a program of successful value-based payment models in mental health will be substantially greater if state, territory and federal governments develop a structured and supportive policy and institutional framework around the intent to trial and evaluate ongoing value-based payment models nationally.

Implementing reforms will also require substantial government investment in better information technology, improved data collection and information sharing to inform and support measurable and attributable care outcomes agreed across patients, providers and funders.[17]

The implementation timeframe will need to incorporate resolute testing of innovative funding models within a strong learning eco-system, to help government build funding models that complement future mental health care needs and meet the preferences of patients. Transparency on risk-bearing and the distribution of benefits must also be ensured and factored into implementation to predict and manage uncertainty. Providers will need to be supported through education, training, information and assistance tools to encourage best practice care and innovation.

The ultimate benefits of investing in a long-term and evaluative approach to embedding value in mental health care will be reduced financial waste and improved consumer and provider outcomes. It will provide a necessary platform for state, territory and federal governments to better integrate and coordinate care to better meet consumer needs and preferences.

Consultation process

MUCHE invites stakeholders to register for one of three national workshops, where questions presented in this consultation paper will be discussed. The purpose of the workshops is to gather insights from stakeholders on the following.

- What stakeholders would like changed within the mental healthcare funding and investment environment, in addition to Productivity Commission recommendations (see Chapter 2).
- Whether stakeholders align with the proposed framework for introducing value based payments in mental healthcare and whether to make any changes (Chapter 3)
- Whether stakeholders align with the proposed framework for making mental healthcare investment decisions and whether to make any changes (Chapter 4)

Workshops will be arranged to include all stakeholder types to ensure differing points of view are canvassed and discussed. Stakeholders include:

- Mental healthcare providers
- Primary health networks
- Local health districts
- Aboriginal Community Controlled Health Organisations
- Mental healthcare peak bodies
- Consumer and carer groups
- Academics

Stakeholders can register for a workshop by going to the MUCHE website.[2] You will be provided with further information on the date and time of each workshop upon which you can register.

Workshops will last for two hours and include group activities aimed at generating insights in response to questions proposed in this consultation paper. MUCHE team members may contact individual participants after the workshop to follow-up on key points.

Stakeholders can also provide a written submission to MUCHE that addresses the questions outlined within this consultation paper. Please send your submission to Alicia Norman (Alicia.norman@mq.edu.au). MUCHE team members may contact those with submissions to follow-up on key points.

Information collected within the consultation process and submissions will be used by MUCHE to draw out key themes from the consultation process. Consultation outputs will act as one input into developing a value based mental health care and investment framework and recommendations for implementing that proposed framework.

[2] https://www.mq.edu.au/research/research-centres-groups-and-facilities/prosperous-economies/centres/centre-for-the-health-economy

2. Mental healthcare funding and investment

Current mental healthcare funding and investment approaches in Australia are not fit-for-purpose. Services are funded through antiquated payment mechanisms that impose barriers to person centred care, while investment is not based on best available evidence. Key points from this chapter include the following.

- Mental healthcare is funded by state, territory and federal governments, private insurers and individuals. Funding silos have fragmented services, created service gaps, made it difficult for patients to navigate their care pathways, and do not reward better health outcomes.
- Investment in mental healthcare is not allocated based on the best available evidence in Australia. There is limited ongoing evaluation of care services, with investment often allocated to incumbent services without formal prospective evaluation. A significant proportion of care is misaligned with guidelines and best practice.
- The Productivity Commission Inquiry into Mental Health proposed a reform agenda within mental healthcare. It made several recommendations to reform funding and commissioning, including changes to current funding models to stop cost shifting and encourage activity. It also made several recommendations to improve monitoring, evaluation and research within the mental healthcare sector.
- The National Mental Health and Suicide Prevention Agreement was signed by state, territory and federal governments in 2022, creating joint responsibility to deliver the best possible mental health and wellbeing outcomes across the lifespan. The Agreement prioritised regional planning and commissioning for mental healthcare services, while state and territory governments acknowledged commissioning should align with paying for value and outcomes.

Mental healthcare funding structures

Mental healthcare services in Australia are funded by state, territory and federal governments, private insurers and individuals. The federal government is responsible for providing rebates for services listed on the Medicare Benefits Scheme, such as primary care consultations, allied mental health professionals, and specialist care delivered outside the hospital and within private hospitals.

The federal government directly funds Primary Health Networks (PHNs) to commission mental healthcare services through the Primary Mental Health Care Flexible Funding Pool. Aboriginal Community Controlled Health Services (ACCHS), some mental healthcare organisations, such as Beyond Blue, and some online mental healthcare services, such as the MindSpot Clinic, receive direct grants from the federal government to deliver mental health and wellbeing services.

The federal government is responsible for funding mental health and suicide prevention services for veterans, defence force personnel and people in immigration detention. It also provides substantial funding each year for research into mental health and suicide prevention, such as through the National Health and Medical Research Council and the Medical Research Future Fund.

Rebates for medications listed on the Pharmaceutical Benefits Scheme and Repatriation Schedule of Pharmaceutical Benefits are also funded by the federal government. The federal government indirectly funds private inpatient psychiatric treatment or drug and alcohol rehabilitation paid for by private health insurers, through the rebate it provides members to cover a component of health insurance premium costs.

State and territory governments provide the bulk of mental healthcare funding. They are responsible for purchasing mental healthcare services from local health networks, such as inpatient public hospital mental healthcare, residential mental healthcare, subacute services and community ambulatory mental healthcare.

State and territory governments share funding responsibility with the federal government for public hospital services. They also share responsibility for funding the National Disability Insurance Scheme (NDIS), which covers some service costs for people that have a psychosocial disability and may provide funding to ACCHS for state based mental health and wellbeing programs.

Private health insurers fund private inpatient psychiatric treatment or drug and alcohol rehabilitation, including accommodation costs and some part of the medical fees. Some also provide rebates for psychology and counselling services. Other private insurers, such as workers compensation insurers, provide funding to cover services required to treat a psychological injury obtained at work.

Government funding not related to mental healthcare can also impact mental health outcomes. For example, low education and low access to stable housing can impact mental health outcomes. So too can socioeconomic factors that are somewhat impacted by government spending, such as income, employment opportunities, inequitable social distribution, discrimination and social isolation.[18]

Mental healthcare payment models are not fit-for-purpose

The complex web of funding and unclear responsibility for mental healthcare service provision has led to service fragmentation and gaps in services.[2 10 12] Current funding structures restrict access to the right level of care at the right time, leading to an over-reliance on emergency care and a shortfall of community based mental healthcare and low intensity services.[2 3]

Primary and specialist care and hospitals are funded using fee-for-service and activity based funding. These payment models incentivise service volume rather than value. Fee for service models, such as Medicare, pay providers for the service provided, regardless of quality or what outcomes were achieved. In contrast, a 'valuable' service could be considered one that delivers outcomes that matter to patients while minimising costs.[19] Although activity based funding includes elements of quality, safety, and efficiency in the price, only a small proportion of recommended prices are directly linked to value, such as a zero price recommended for sentinel events.[20] Similarly, activity based funding can discourage local health networks to deliver care outside of hospital given funding does not always follow the patient.

Mental healthcare is not being funded in a way that supports integrated care. One example is the Better Access Program, which has received substantial funding increases from subsequent governments with limited evidence on its effectiveness or cost effectiveness, and little incentive to provide team based care.[21] Past government investment has provided limited preventative and treatment support to people living with mental illness and their carers, nor provided incentives for healthcare and non-healthcare sectors to integrate their services. This has resulted from a combination of under-funding and the application of resources in a way that has not accounted for individuals' needs and preferences.[2 3]

Attempts to reform primary mental healthcare have achieved limited success. The Better Access Initiative increased access to psychologists and allied mental health professionals,[22] however clinicians argue that caps on services limit its effectiveness in patients with chronic mental health conditions and access in some regions and populations remains limited.[22] The Mental Health Care Flexible Funding Pool has similarly faced challenges with delivering equitable services across regions.[2] It has resulted in cost-shifting, where service offerings are driven by access to MBS items instead of patient care needs and preferences.[2]

There are limited pathways to fund new models of care. Innovative providers have described a Catch-22 where service commissioners require evidence to support the alternative model of care, but funding for

evidence development is scarce.[3] The lack of long term funding to support the growth and evaluation of new models of care discourages innovation and stifles development.[3]

Investment is not allocated based on the best available evidence

Allocation of valuable investment to mental healthcare models has often been made without supporting evidence in Australia.[23] Limited ongoing evaluation of services means there is some uncertainty on whether previous investments in mental health and wellbeing have improved mental health outcomes.[2 3 23]

A consistent and objective investment decision cannot be made without robust, authoritative evidence.[12] Service commissioning by PHNs and Local Health Networks (LHNs) has been hindered by too much and too little guidance. For example, PHNs are required to devote about one third of the Mental Health Care Flexible Funding Pool to support *headspace* centres, reducing their flexibility to meet local needs. However, PHNs have limited guidance on what other evidence-based services could be commissioned with remaining funds.[2]

Digital mental health platforms are proliferating with little guidance or coordination. Telephone and internet services are being introduced and operate in parallel, funded by different agencies with limited visibility of what services are being funded elsewhere.[24] An integrated approach to funding and evaluating digital health would reduce duplication and support investment in services that work.

Investing in and paying for healthcare without robust evidence is not unique to the mental healthcare system. For example, there is little systematic robust evaluation of procedures undertaken within public hospitals. Inconsistent health technology evaluation leads to inefficiencies, duplicates effort, unequal access to care, and can delay access to new health technologies.[4]

State, territory and federal governments recognise the need for a nationally cohesive health technology assessment process for public hospitals. They have agreed to jointly develop a federated approach to health technology assessment to ensure it contributes more to government decisions on policy, investment and disinvestment, and service delivery mix across all healthcare system levels. This will include building the health technology assessment framework, public and stakeholder guidance, and an information sharing platform to promote collaboration across state, territory and federal government departments and independent agencies.[4] A framework for allocating investment based on the best available evidence would need to align with any reform to developing a national health technology assessment process for public hospitals.

Payment reform direction in Australia

There is a growing appetite for healthcare payment reform within Australia. The Addendum to the National Health Reform Agreement (2020-25) outlined six long-term reforms agree to by state and territory governments, of which three directly relate to increasing value within the healthcare system. These include:

1. Paying for value and outcomes: Enabling new and flexible ways for governments to pay for health services;
2. Enhanced health data: Integrating data to support better health outcomes and save lives; and
3. Nationally cohesive health technology assessment: Improving health technology decisions will deliver safe, effective, and affordable care.[25]

The Medicare Benefits Schedule Review Taskforce recognised the need to improve funding models to support the healthcare system. It recommended the MBS be complemented with alternative funding models to better target prevention and coordinated care, better management of chronic conditions, and to increase efficiency.[26]

Public healthcare funding has started to shift towards paying for value. The national framework for activity based funding and a national efficient price introduced in 2012 increased public hospital efficiency but was not expected to improve outcomes. More recently, IHACPA recommended a zero price on an episode of care with a sentinel event, and reduced prices for any episode of care where a hospital acquired complication occurred, or for an avoidable hospital readmission.[27]

Recent government plans and reviews of the mental healthcare system have identified the need to change the way mental healthcare is funded to support better integrated care. Implementation remains embryonic and no significant change to the way mental healthcare is funded has occurred beyond broader healthcare payment reforms, such as activity based funding, the National Disability Insurance Scheme, and commissioning through PHNs.

The Fifth National Mental Health and Suicide Prevention Plan aimed to direct state, territory and federal governments to better integrated mental healthcare within Australia. It outlined eight priority areas, each specifying actions for governments. Priority Area 1: ‘Achieving integrated regional planning and service delivery’ includes actions for government to examine ‘innovative funding models, such as joint commissioning of services and fund pooling for packages of care and support, to create the right incentives to focus on prevention, early intervention and recovery’.[24]

Where do funding models fit among government levers

Governments use policy levers to incentivise desired behaviours and achieve outcomes such as quality and safety within the mental healthcare system. 'Sticks' punish 'undesirable' behaviours and outcomes, while 'carrots' reward favoured behaviours and outcomes.

Sticks within the mental health care system include legislation, regulation, and monitoring, provider accreditation and standards, protocols and best practice guidelines, contractual arrangements and key performance indicators. Carrots include indirect incentives based on quality and price competition, and direct financial incentives such as through certain funding models.

Value based payments seek to extrinsically motivate providers using financial incentives to align their care around improving value, either through reduced costs, improved health outcomes, or both (see Appendix A for a detailed discussion on value based payment models). There are few examples of value based payment models for mental healthcare compared to physical healthcare services.

Value based healthcare is being pursued by several developed countries to reduce financial waste and manage expenditure growth in their healthcare systems. NSW is leading the way towards value based healthcare in Australia, seeking to improve health outcomes, improve patient and provider experiences, and improve care effectiveness and efficiency. Little focus has been placed by payers on value based mental healthcare.

Value based payment models incentivise providers to improve value by shifting some financial risk from the payer to the provider. Pay for performance and capitation models have been explored within Australia but with little success. Bundled payments and accountable care organisations are the second generation of value based payment models, using savings from more effective and efficient care to financially reward providers.

Social impact bonds are also being explored in Australia. They fund providers based on measurable outcomes and are usually targeted at funding services that indirectly impact mental health outcomes, such as employment, homelessness, education, child and family welfare and criminal justice.

Value based payment models in mental healthcare have achieved mixed success internationally. In the US, where most value based payments have been piloted, some value based payments led to reduced inpatient mental healthcare spending, while others had no significant impact. The US Government will invest $10 billion over the next decade to continue piloting value based payment models, and will seek to expand coverage for mental healthcare services within these models.

The Productivity Commission Inquiry into Mental Health

The Productivity Commission Inquiry into mental health presented a strong case for comprehensive mental healthcare system reform.[2] This included changes to system governance by developing a more strategic and cross-portfolio government approach, reforming the funding and commissioning of services, and embedding a strong learning culture through better monitoring, reporting and evaluation.[2] Recommendations from the inquiry formed the basis for the National Mental Health and Suicide Prevention Agreement.

Funding and commissioning

The Productivity Commission recommended reforming the planning, commissioning and funding of mental healthcare services (see Table 2.1). Key to this was changing the way services are governed, recommending PHNs and LHDs formally cooperate to jointly identify clinical and psychosocial service gaps with consumers and carers, and jointly determine the mix of mental healthcare services to purchase. PHNs would then be responsible for commissioning services.

The Productivity Commission was pragmatic in recommending better cooperation between PHNs and LHNs. It raised some concerns that PHNs and LHNs may not improve mental health outcomes due to incumbent funding models placing adverse incentives towards cooperation, suggesting effective cooperation was unlikely without funding reform.[2]

The Productivity Commission recommended the federal government give responsibility to state and territory governments to develop regional commissioning authorities. These would take responsibility from PHNs to commission mental healthcare services, and from state and territory governments to commission psychosocial support services, by pooling funds from state, territory and federal governments. It suggested this would result in a clearer delineation of responsibility for mental healthcare service commissioning.[2]

The Productivity Commission recommended that the Primary Mental Health Care Flexible Funding Pool continue, but to reform the way funding was determined to improve geographic equity. It suggested the federal government develop a weighting system that accounts for population need and variation in costs not within the control of providers (e.g., wages). It also recommended allowing co-funding of MBS related mental healthcare services by regional commissioning authorities and state and territory agencies.

Table 2.1: Funding model reforms proposed by the Productivity Commission

Services	Current funding model	Responsibility	Initial reforms
• Primary care consultations • Allied mental health professionals • Specialist care delivered outside the hospital and within private hospitals	• Medicare (using the Medicare Benefits Schedule) • PHN Primary Mental Health Care Flexible Funding Pool	• Federal government • Private insurers • Patients	• Allow co-funding of MBS related mental healthcare services by regional commissioning authorities and state and territory agencies.
• Aboriginal Community Controlled Health Services (ACCHS)	• PHN Primary Mental Health Care Flexible Funding Pool • Medicare (using the Medicare Benefits Schedule) • Direct federal and state government grants	• Federal government • State and territory governments	• Make ACCHSs preferred providers of Aboriginal and Torres Strait Islander mental health services.
• Medicines	• Pharmaceutical Benefits Scheme • Repatriation Schedule of Pharmaceutical Benefits	• Federal government • Patients	• None.
• Emergency Department presentations • Inpatient public hospital mental healthcare	• Activity based funding • Block payments	• Federal government • State and territory governments	• Develop an RCA that would hold budget responsibility for emergency department presentations and inpatient admissions. State and territory governments would still determine what services are purchased from local health networks. • Incorporate mental health-related avoidable hospital readmissions into broader activity based reforms. This suggests these types of readmissions would receive a risk adjusted reduction in price.
• Public residential mental healthcare	• Block payments	• Federal government • State and territory governments	• None.
• Community ambulatory mental healthcare	• Block payments[1]	• Federal government • State and territory governments	• Use an activity based funding model.[1] • While waiting for activity based funding to be introduced, use a fee-for-service payment model with payment based on time spent treating a patient.
• Psychosocial support services	• National Disability Insurance Scheme	• Federal government • State and territory governments	• The federal government should provide state and territory governments with sole responsibility for commissioning psychosocial support services outside

Services	Current funding model	Responsibility	Initial reforms
	• Block payments • PHN Primary Mental Health Care Flexible Funding Pool	• Patients	services funded by the National Disability Insurance Scheme. • Remove the requirement that round one third of Primary Mental Health Care Flexible Funding Pool be devoted to *headspace* centres. • Provide state and territory governments with the option to establish RCAs to commission psychosocial support services, including transferring funds for the Primary Mental Health Care Flexible Funding Pool to RCAs
• Private inpatient psychiatric treatment • Drug and alcohol rehabilitation	• Medicare (using the Medicare Benefits Schedule) • Individual private health insurance contracts	• Private health insurers • Patients	• Review regulations that prevent private health insurers from funding community-based mental healthcare.
• Justice and forensic mental healthcare	• Block payments	• Federal government • State and territory governments	• None.

Note: (1) Block payments were being used for community ambulatory mental healthcare when the Productivity Commission finalised its inquiry but have since transitioned to an activity based funding model.

Source: [2]

The Productivity Commission recognised the need to reduce incentives to stop cost shifting between primary care services and LHN services. It proffered that introducing activity based funding or fee-for-service models for community ambulatory mental healthcare would increase incentives to produce more care activity.

The Productivity Commission commented little on introducing value based payment models, such as pay-for-performance, capitation, bundled payments or accountable care organisations. It suggested that 'shifts to these types of funding models was premature' and that 'policy should focus on encouraging and learning from regional variations'.[2] Its reluctance to explore value based payment models stemmed from a recognition that mental health outcomes were poorly measured.

The Productivity Commission suggested that the federal government establish a Mental Health Innovation Fund to support PHNs, LHNs, regional commissioning agencies, state and territory governments to trial new payment models. Within this, it was recommended that the federal government allow MBS rebates for allied mental healthcare and psychiatry to be cashed out for trial purposes.

Monitoring, evaluation and research

The Productivity Commission outlined deficiencies in monitoring, evaluation and research within the mental healthcare system. It noted there was 'no policy framework to guide monitoring, evaluation and research in mental health and related sectors', [2] and proposed a framework, along with a set of recommendations to collect the right data, inform decision makers, and promote continuous improvement.

The Australian mental healthcare system currently lacks a robust evidence base to help government understand whether they receive value for money, whether services improve mental health outcomes in a cost effective manner, and whether mental healthcare policy is appropriately set to ensure those most in need receive the services they require and prefer. Government service investment decisions are most likely leading to wasted resources in mental health care.[2]

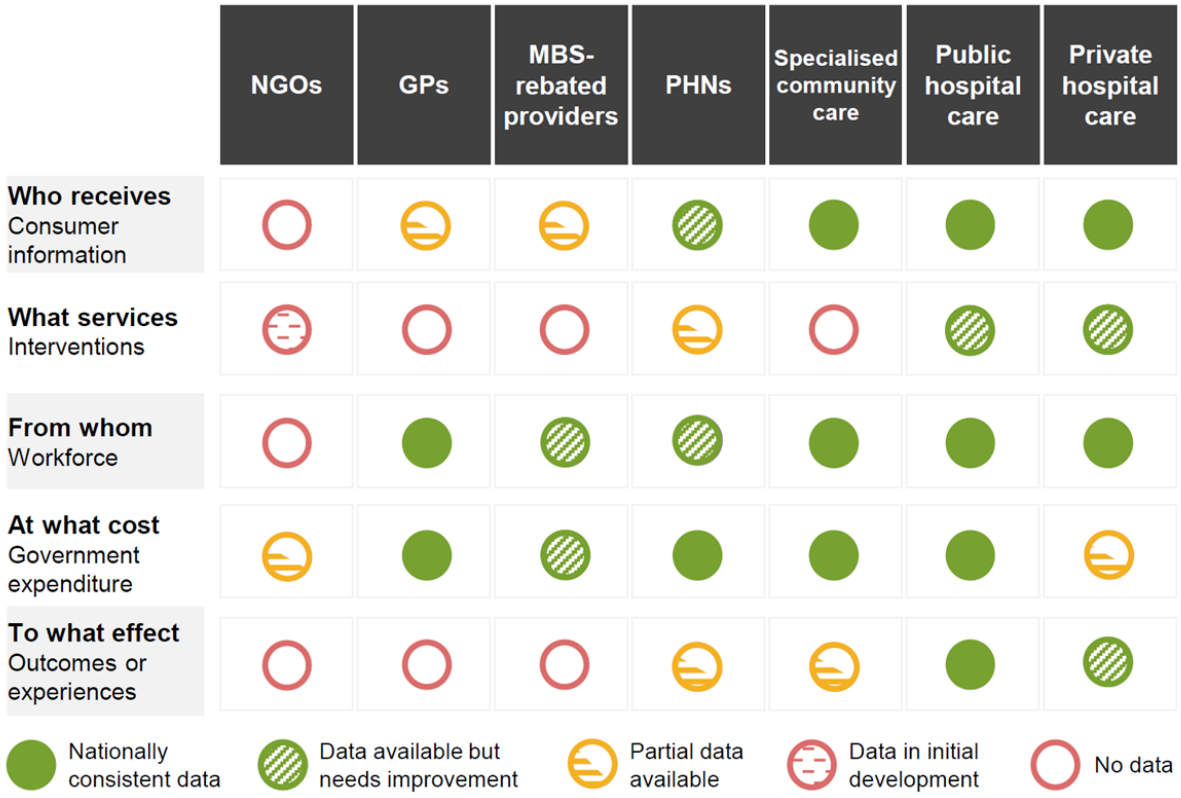
While a substantial amount of data is collected from mental healthcare providers, its use for policy and care model decisions is somewhat ineffective. Data is difficult to access due to privacy legislation and difficult to use due to low quality, while technological challenges in linking data reduce its value. Non-standardisation of data means comparing one jurisdiction to another is challenging.

There are also substantial data gaps that impede evaluation of services and programs (see Figure 2.1). There is a distinct lack of outcomes data being collected within mental healthcare. Providers funded through Medicare are required to report on activity only, and not outcomes. This reflects the way Medicare was initially established as a payment mechanism, with reporting to the federal government directed around the administration of its expenditure. Data collected was never meant to be used to evaluate the value of services, although the MBS Review recommended that outcomes data be collected

for Medicare funded services to ensure patients improve their mental health and to help improve mental health services.[28]

While consumer information is collected on people that receive public and private hospital services, this is clinical in nature, with only basic demographic information accompanying this data. Little data is collected when receiving care on the social determinants of mental health outcomes, such as education, employment and social supports. This data may be available from other portfolios, but its format and access are restrictive, making it challenging to attribute mental health outcomes to services received.

Figure 2.1: Data gaps in mental healthcare provision [a,b,c,d,e,f]



a. A 'No data' label shows that no ongoing, nationally consistent, consolidated collection of data exists; **b.** Although there is no data on NGO consumer outcomes, data on consumer experiences is 'in initial development'; **c.** For GPs and MBS-rebated providers, consumer information on demographics (such as age and gender) is nationally consistent, but no data is collected on diagnoses. MBS-rebated providers are office-based specialists (such as psychologists and psychiatrists); **d.** Although PHN data on consumer experiences is only partially available, data on consumer outcomes is 'available, but needs improvement'. PHNs are mandated to collect outcomes data.; **e.** Specialised community care includes public community and residential mental health services only. For specialised community care data, data on consumer experiences is partially available, but data on consumer outcomes is 'nationally consistent'; **f.** Public and private hospital care includes admitted mental health services only (excludes emergency departments). Outcomes data is 'nationally consistent', or 'available, but needs improvement', for public hospital care and private hospital care, respectively, but data on consumer experiences is only partially available.

Source: [2]

A substantial amount of data is collected on government expenditure related to mental healthcare. MBS and PBS data provides information on the volume of services received from what type of mental healthcare service, along with government and consumer expenditure, yet there is limited information on the types of services received and no information on the cost to the provider for delivering those services. Public hospital data provides information on the type of service received and the cost of delivering those services to the extent that services fit within Australian refined diagnosis related groups (AR-DRGs), which can be broad and relate to different types of conditions (e.g., AR-DRG U67Z has the most separations and relates to *Personality disorders and acute reactions*).

Data gaps create greater uncertainty for policy makers when deciding where to best invest valuable government funding to improve mental health outcomes. Data gaps reduce the opportunity to monitor the performance of the mental healthcare system and the performance of providers. It reduces the robustness of program and service evaluation and constrains the breadth and depth of mental healthcare research and learning. This is particularly the case where a randomised control trial is not feasible, for example, when evaluating national policy change, such as the extension of the Better Access initiative.

The Productivity Commission recommended a suite of changes to improve monitoring, evaluation and research within the mental healthcare system (see Table 2.2). This included collecting additional data to better monitor the mental healthcare system, particularly towards achieving set targets agreed to by state, territory and federal governments. One theme running through its recommendations was making sure performance data is transparent to the public at the service provider level, to hold government and providers accountable for outcomes.

Evaluation of mental healthcare programs was considered 'ad hoc, uncoordinated and lacking in objective evidence' by the Productivity Commission.[2] Of evaluations undertaken, stakeholders suggested they lacked transparency, accountability and independence, and findings could not be usefully used by government or providers to improve services.[2] The Productivity Commission recommended that the National Mental Health Commission, acting as a statutory independent agency, take responsibility for program and service evaluation, along with its recommended monitoring and reporting role. A more systematic approach to evaluation, including piloting services and requiring a cost effectiveness study before scaling up, was also recommended.

The Productivity Commission also identified a disconnect between academic research in mental healthcare and policy direction, noting there are limited mechanisms to direct mental healthcare research beyond targeted calls within the Medical Research Future Fund. The negative impact from this disconnect is compounded by the lack of consideration of relevant research by policy makers when making policy decisions. [2]

Table 2.2: Monitoring, evaluation and research recommendations

Area	Productivity Commission recommendations

Monitoring	• State, territory and federal governments should develop a strategy to support data usability in mental health and suicide prevention.
	• The Australian Government should support the Australian Bureau of Statistics to conduct a National Survey of Mental Health and Wellbeing no less than every 10 years.
	• State, territory and federal governments should collect high-quality and fit-for-purpose data to inform decision making and improve service delivery and outcomes for people with lived experience and carers.
	  ○ Update the statement on National Mental Health Information Priorities (NMHIP)
	  ○ develop and adequately fund strategies to address identified data gaps and information priorities in the statement on NMHIP.
	  ○ ensure a nationally consistent dataset is established in all States and Territories of non-government organisations that provide mental health services.
	  ○ National Mental Health Commission should publicly report on the progress made against the statement on NMHIP, five and ten years after its release
	• State, territory and federal governments should agree on a set of targets that specify key mental health and suicide prevention outcomes that Australia should achieve over a defined period.
	• State, territory and federal governments should fund the facilitation and coordination of benchmarking analyses across mental healthcare providers.
	• State, territory and federal governments should require all publicly funded mental health service providers (clinical and non-clinical) to commit to public reporting at the service provider level.
	• The Australian Government should release data collected on and by Primary Health Networks for annual publication by the Australian Institute of Health and Welfare (AIHW).
	• State, territory and federal governments should authorise the AIHW to report all data relating to the performance of mental health and suicide prevention services at a level defined by Primary Health Network and Local Hospital Network regional boundaries, as well as at a State and Territory and national level.
	• State, territory and federal governments should develop, in consultation with regional commissioning bodies, standardised and outcome-focused reporting requirements for service providers.
	• State, territory and federal governments should give the AIHW permission to annually publish, at both a national and State/Territory level:
	  ○ independent estimates of National Mental Health Service Planning Framework (NMHSPF) benchmarks of all mental health services, including psychosocial support services, included in the NMHSPF, at both a national and State/Territory level.
	  ○ gap analyses based on a comparison of these benchmarks with services that are currently provided (where this data is available).
	  ○ data on the amount of time that clinical staff in community ambulatory mental health services are spending on consumer-related activities (with and without the consumer present).
	• State, territory and federal governments should enhance and make all parts of the NMHSPF publicly available, including the Planning Support Tool and all supporting documentation.

Evaluation	• The NMHC should lead monitoring and reporting on mental health and suicide prevention outcomes, activities and reforms across portfolios. • The NMHC should consult with stakeholders, including consumers and carers, Aboriginal and Torres Strait Islander people and sector experts in finalising a set of indicators to monitor and report on progress against outcomes derived from the Contributing Life Framework. • The NMHC should consult with stakeholders and sector experts to identify mental health related expenditure in non-health sectors, such as justice and education, that could be routinely reported on.

Area	Productivity Commission recommendations
	• The NMHC should continue to monitor and report on progress against mental health reforms under the National Mental Health Strategy. • The NMHC's monitoring and reporting activities should inform and support its program evaluation function. • Governments should require all funding applications for mental health programs or interventions to include an assessment of the expected cost-effectiveness of the proposed program or intervention. • All new mental health programs or interventions should be first trialled as pilot programs, before they can be progressively scaled up.
Research	• The Australian Government should fund the establishment of a national clinical trials network in mental health and suicide prevention. This network should consider research across all areas of the mental health system, including care provided in community settings.

Source: [2]

There have not been any nationally agreed research priorities in mental healthcare, nor are there mechanisms to ensure an efficient and effective allocation of mental healthcare resources to trialling mental healthcare programs across states and territories.[2] This has likely duplicated research and missed opportunities for valuable coordination of research and sharing ideas. The Productivity Commission recommended developing a national clinical trials network for mental health and suicide prevention to ameliorate this potential inefficiency.

The NMHC has since publicly released a National Mental Health Research Strategy that outlines five principles to guide funders and researchers when deciding on what areas of mental healthcare to research.[29] These principles address many of the evaluation and research concerns highlighted by the Productivity Commission, seeking to improve focus and better coordinate research and evaluation within the mental healthcare system, while strengthening the mental healthcare research workforce.

The National Mental Health and Suicide Prevention Agreement

The National Mental Health and Suicide Prevention Agreement (the Agreement), a complement to the Addendum to the National Health Reform Agreement (2020-25), was developed to build upon reform directions set out within the Fifth National Mental Health and Suicide Prevention Plan, and Productivity Commission recommendations made within their inquiry report on mental health.[1] Bilateral agreements were developed with states and territories as a schedule to the Agreement.

The Agreement outlined joint responsibility between state, territory and federal governments to deliver the best possible mental health and wellbeing outcomes across the lifespan. There is shared responsibility to ensure equitable access to effective and integrated mental healthcare services, and to support priority populations who are at higher risk to mental ill health.[1]

States, territory and federal governments are also responsible for funding, including:

- providing their fair share of funding for eligible activities;
- determining funding policy and exploring innovative models of care within the national funding model; and
- working together on policy decisions that impact each other's responsibilities.[1]

The Agreement prioritised regional planning and commissioning to 'drive better outcomes for communities by improving system integration and coordination; addressing gaps, duplication and fragmentation in services; and evidence-based decision making to inform future policy and planning strategies'. [1]

The Agreement allows states and territories to determine their own planning and commissioning to meet local needs, although states and territories acknowledged that planning and commissioning must align with the 'Paying for Value and Outcomes' long-term reform priority agreed to within the Addendum to the National Health Reform Agreement (2020-25).

Questions for consultation

1. Do you agree with the Productivity Commission recommendations to reform commissioning and funding models presented in Table 2.1?
    a. What additional reforms to commissioning and funding would you like to see government implement?
2. Do you believe there should be a greater role for a single entity to evaluate current and future government investments in a systematic and transparent manner?
    a. Is it appropriate for a federal government agency to undertake this role?
    b. If not, what other type of entity could undertake this role?
3. Do you agree with the Productivity Commission recommendations to reform monitoring, evaluation and research presented in Table 2.2?
    a. What additional reforms to monitoring, evaluation and research would you like to see government implement?
4. Do you believe the National Mental Health and Suicide Prevention Agreement sets an appropriate agenda for reform within state and territories?
    a. What are the most important changes you would like to occur within the next two years to funding and investment?

3. A new mental healthcare funding framework

Mental healthcare funding reform must take a long-term view, moving beyond recommendations made by the Productivity Commission and moving beyond the agenda set within the National Mental Health and Suicide Prevention Agreement. Key points from this chapter include the following.

- PHNs and LHNs, along with proposed regional commissioning agencies, are unlikely to have the required skill set for developing a value based payment model, nor the leverage to pull government levers to maximise their chance of success. Decentralised development and implementation of value based payment models will likely lead to duplication of models within and across states and territories, missed opportunities to iteratively learn, and inequitable access to care depending on where someone lives.
- The development of value based payment models for mental healthcare would benefit from being undertaken by a national independent value based payment authority. It could better coordinate model development across multiple government departments and agencies, coordinate implementation through states and territories, and coordinate evaluation, learning and communication. It would better represent funding model needs within broader government policy, such as investment in information technology infrastructure. PHNs and LHNs or regional commissioning authorities could still identify service gaps and undertake local planning and commissioning services.
- Several barriers to developing a value based payment model for mental healthcare must be overcome. These include deciding what population or condition to target, measuring and attributing outcomes to service delivery, measuring costs along a care pathway, accounting for heterogenous patient populations in pricing, and collecting and sharing sensitive data.

Governing the development of value based payment models

The Productivity Commission recommended that PHNs and LHNs cooperate better to identify clinical and psychosocial service gaps with consumers and carers, and jointly determine the mix of mental healthcare services to purchase. For PHNs and LHNs where cooperation is lacking, the Productivity

Commission recommend the federal government give responsibility to state and territory governments to develop regional commissioning authorities (see Chapter 2 of this consultation paper)

Allocating responsibility to PHN and LHNs, or regional commissioning agencies, provides these organisations with the flexibility to plan and respond to local mental healthcare needs. Planning and delivery are within the domain of skills and experience held by these organisations given PHNs and LHNs are primarily governed by clinicians and administrators experienced in organising healthcare services.

Developing and implementing a value based payment model requires a different skill set. It requires understanding the marginal cost of delivering services to appropriately set incentives. Data must be collected, collated, cleaned and analysed on provider and patient characteristics, requiring access to data sources traditionally owned and curated by state, territory and federal governments. An algorithm must be developed to risk adjust prices to reduce the incentive for providers to attract low risk patients.

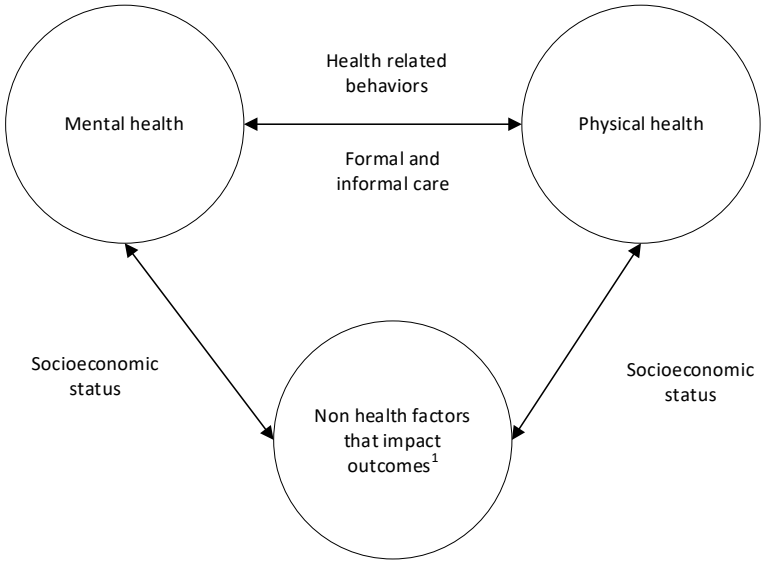
PHNs, LHNs and regional commissioning authorities are unlikely to have the required leverage to pull government levers to maximise their chance of success. This will also limit their capacity in the design of value based payment models. While states and territory governments may help, this may be more difficult at the federal level, particularly support from non-health government departments is required, given there is no formal structure for cross-border collaboration, unlike within the healthcare system through the Health Ministers Meeting.

Developing a value based payment model will require a substantial amount of resource and impose an opportunity cost associated with turning attention away from delivering care. PHNs, LHNs and regional commissioning authorities are likely to be myopic, seeking short term gains to demonstrate their performance, and will mostly consider impacts from the value based payment model on the healthcare system. They are less likely to consider the broader benefits from improving mental health outcomes compared to governments, such as the impact on education or justice. This could lead to some benefits not being identified and measured and subsequently underinvestment in trialling value based payment models for mental healthcare.

Decentralised development and implementation of value based payment models through PHNs, LHNs and regional commissioning authorities will likely be inefficient, leading to duplication within and across states and territories, missed opportunities to iteratively learn, and inequitable access to care depending on where someone lives. Appetite for value based funding within PHNs and LHNs may also wane within a decentralised model if success is not achieved early. They may treat the trial as a ‘one off’ event, or may not have the resource capacity to retrial the value based model.

Mental health and physical health are often intertwined (see Figure 3.1). While mental health is treated within the mental healthcare system, social determinants of mental health often need to be addressed, requiring coordination and collaboration with non health government departments and agencies. A model that incorporates multiple service providers funded by health and non health departments, seeking one objective to improve outcomes that matter to patients, such as a bundled payment or accountable care organisation, is best suited to integrate mental health and non-health services.

Figure 3.1: Factors that impact mental health outcomes



Note: (1) Non health factors that impact mental and physical health outcomes differ across the life course. Common non-health factors include access to social support, work and employment, access to transport, built environment, family and community connections, economic climate, and genetic disposition to certain conditions.

Treating mental health parallel to physical health, such as chronic disease, can improve physical health outcomes. Consequently, mental healthcare providers should also be included within a value based payment model that seeks to improve physical health outcomes. Good mental health builds resilience to physical and mental health shocks, such as those resulting from natural disasters.

Independent Value Based Payment Authority

The Productivity Commission recognised that government investment is required to trial new funding models, recommending that a Mental Health Innovation Fund be established and to trial new system organisation. [2] It stated that 'decisions about allocating funding should be made at the regional level by regional decision-makers that undertake rigorous assessments of their region's needs to guide their decision making'.(p.1,135 [2]) This consultation paper takes a different view. While it recognises that substantial investment is required, it also suggests that the skills, experience and ability to pull policy

levers and take a whole of government approach to mental healthcare cannot be achieved through PHNs, LHNs or regional commissioning authorities.

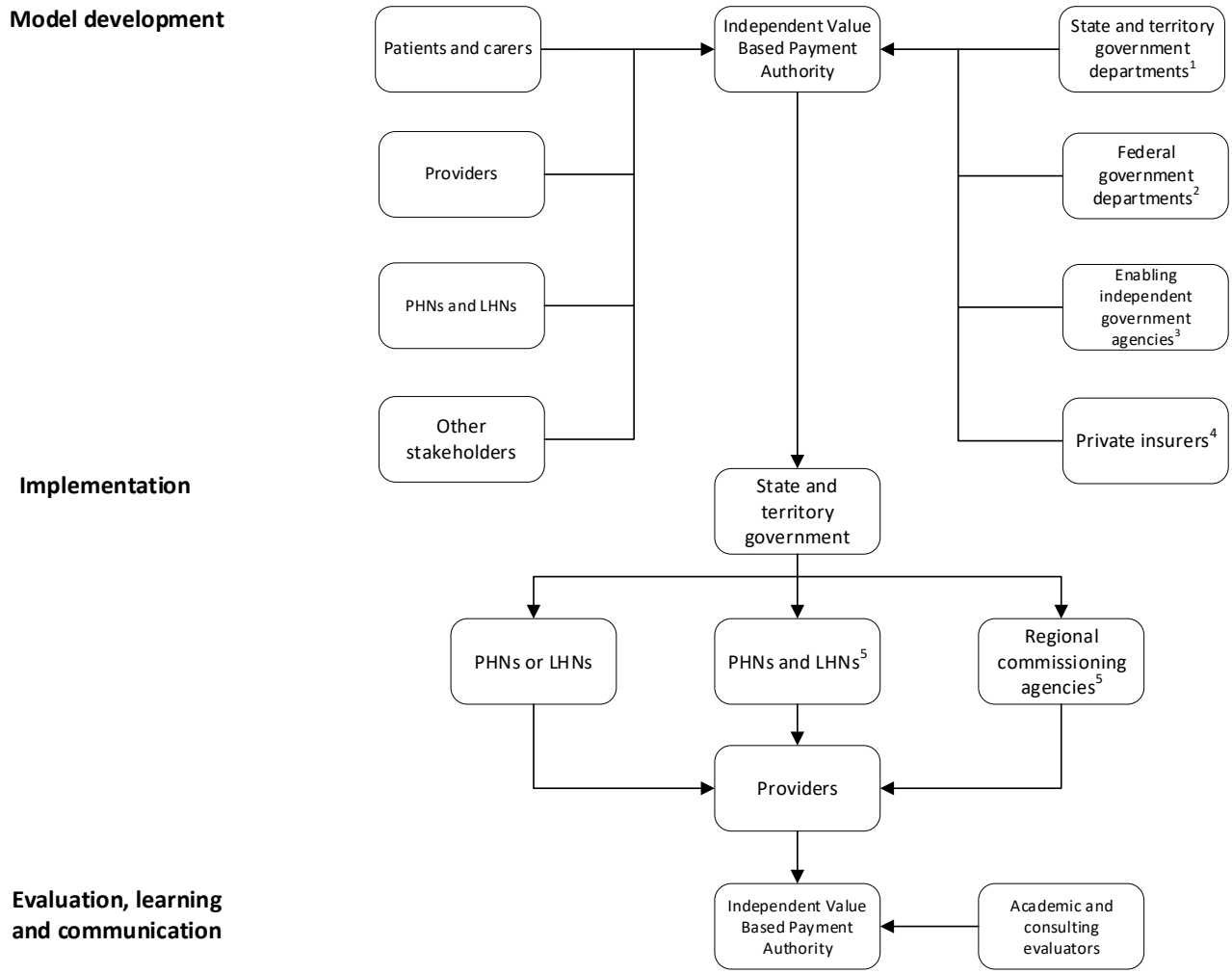
Governance in developing, implementing and evaluating a value based payment model should instead come from an independent value based payment authority that can coordinate model development across multiple government departments and agencies, coordinate implementation through states and territories, and coordinate evaluation, learning and communication. This authority should be responsible for developing all types of value based payment models for mental health and physical health.[17] It should be supported by state, territory and federal government departments, enabling independent government agencies and private insurers (see Figure 3.2).

A federal government department or agency could be given responsibility for representing the needs of patients, providers and other stakeholders through consultation with the sector. One option is the National Mental Health Commission, while another is the federal Department of Health and Aged Care. It would work closely with the independent value based payment authority to develop a long term value based payment model development agenda. This should fit within a cohesive national vision and ambitious 10 year plan for integrating value based payments within the Australian healthcare system, which has been recommended elsewhere.[17]

A federal government department or agency could also be responsible for monitoring, reporting and managing the evaluation of value based payment models. This role aligns with the Productivity Commission's recommendations for a greater independent role regarding monitoring and evaluation for the National Mental Health Commission. Alternatively, evaluation should be undertaken by an organisation independent from the mental healthcare sector.

Another alternative is to not give responsibility to a federal government department or agency for representing the mental healthcare sector, instead having stakeholders directly work with the proposed independent value based authority. One advantage of this alternative approach is that stakeholders directly interact with the value based payment authority. A disadvantage is that the independent value based payment authority would have less understanding of mental healthcare sector needs given it would not focus solely on mental healthcare. This may increase the likelihood that the value based models are not successful.

Figure 3.2: Proposed governance structure for value based payments in mental healthcare



Note: (1) State and territory government departments should include health and non-health related departments where spending impacts mental health outcomes, such as Departments representing education, housing, social services, justice and treasury. (2) Federal government departments should include health and non-health related departments where spending impacts mental health outcomes, such as the Department of Social Services, Department of Defence, Department of Education, Department of Employment and Workplace Relations, Department of the Treasury, Department of Veteran's Affairs (3) Enabling independent government agencies should include Independent Health and Aged Care Pricing Authority, National Health Funding Body, National Health and Medical Research Council, Australian Digital Health Agency, Australian Commission on Safety and Quality in Health Care, and Australian Institute of Health and Welfare. (4) Private insurers should include private health insurers and other private insurers that cover income loss, permanent disability and workers compensation. (5) Commissioning by PHNs and LHNs working together, along with regional commissioning agencies, were proposed by the Productivity Commission but have not been fully implemented across Australia.

Within this proposed governance structure, implementation of value based payment models would be led by state and territory governments, relying on PHNs, LHNs or regional commissioning authorities to implement the value based payment model 'on the ground'. These organisations would require ongoing support from state, territory and federal governments to motivate providers to participate (unless participation is compulsory), access and share data, and support providers by developing standardised tools to appropriately assess patient health risks, ensuring high quality clinical guidelines are available, identifying and disseminating best practice clinical care, implementing training programs to help providers change business and care models, and creating platforms for peer-to-peer learning.[17]

This proposed governance structure does not preclude PHNs, LHNs or regional commissioning authorities from identifying service gaps, undertaking local planning or commissioning services as recommended by the Productivity Commission. A national approach will provide consistency in the application of value based funding models across Australia, allowing greater samples and more heterogenous populations and care environments to be evaluated for their impact on outcomes. Most likely, mental healthcare service gaps, and the needs of patients are more common across PHNs and LHNs than not, lending itself to a common value based payment model.

An important component within this governance structure is evaluation, learning and communication of outcomes. Embedding value based payment models into mental healthcare is a long term proposition. Some models will fail but provide important lessons. These should be incorporated within an iterative learning process to create impetus for further trials for long term improvement.[30-32]

Local and international experiences of measurement based care and value based payment models may inform the initial development and implementation of a value based payment model for mental healthcare in Australia.[30-37] Evaluation methods included document reviews, discussions with key stakeholders, and focus groups with providers and patients.[31 36] Evaluations explore context, objectives, payment and delivery reform strategy, barriers and facilitators, progress and results, and lessons learned.[30] They can consider how investment and policy were used to roll out new payment models, factors that progressed multi-payer alignment, and strategies that encouraged provider involvement in value based payment models and accountability for patient outcomes.[30 31]

Iterative improvement of value based payment models can be facilitated through staged rollout, interim monitoring and evaluation, dedicated change coordinators, workshops, improvement logs, and continual refinement of treatment protocols and outcome measures.[32 34 37] Risk adjustment methodologies should similarly be continuously reviewed and refined.[37] The implementation of new value based payment models in real-world settings should be evaluated and disseminated.[32 36 38]

Principles underpinning value based payment models

A mental healthcare value based payment model agenda should be guided by the vision, objectives and strategic plan jointly established by state, territory and federal governments and prosecuted by the independent value based payment authority.[17] Model development should be guided by a set of principles to ensure it meet the needs of patients, providers and government, and there is some consistency within their design.

The National Mental Health Performance framework provides some guidance on what principles could be used. These are presented in Table 3.1, along with additional proposed principles specific to developing a value based funding model. While these principles relate to mental healthcare, they are equally applicable to value based payment models applied to physical health services given the consistency of performance sub-dimensions with the National Health Performance Framework.

Table 3.1: Proposed principles underpinning mental healthcare value based payment models

Principle	Description
Accessibility[1]	• The model allows people to obtain health care at the right place and right time, taking account of different population needs and the affordability of care.[1]
Adaptability	• The model can be adapted to identified needs of PHNs, LHNs and regional commissioning authorities
Alignment	• Objectives of the model are aligned with healthcare system policies and procedures, along with delivering best clinical practice and outcomes that mater to patients.
Appropriateness[1]	• The model funds services that are person-centred, culturally appropriate, rights-based, trauma-informed and recovery oriented.[1]
Choice	• The model funds universal access to quality mental healthcare while allowing patients to participate in choices related to their care, such as treatment type and where treatment is received. • The model promotes diversity of provider choice and competition among providers.
Continuity of care[1]	• The model funds uninterrupted and integrated care or service across program, practitioners and levels over time. • The model funds coordination mechanisms that work for mental health consumers, carers and health care providers. • The model funds holistic care and support, and includes psychosocial and physical dimensions
Effectiveness[1]	• The model funds care that achieves the desired outcome from both the clinical perspective (clinician-reported outcome measure–CROMs) and the mental health consumer and carer perspective. • The model funds care that is delivered based on evidence-based standards.
Equity	• The model allows patient with equal need to gain equal access to mental care, and allows patients with greater need to gain greater access to mental healthcare.

Principle	Description
Efficiency and sustainability[1]	• The model funds care at minimum cost and covers the cost of appropriate human and physical capital and technology needs. • The model promotes innovation o improve efficiency and allows providers to respond to emerging needs.
Safety	• The model incentivises the avoidance of, or reduction to, acceptable limits of actual or potential harm (physical or psychological) from health care management or the environment in which health care is delivered.

Note: (1). This definition was derived from the National Mental Health Performance framework. [39].

Addressing challenges

Motivating providers

Provider engagement is vital for the success of value based payment models.[15 16] It is important to acknowledge and discuss providers' valid concerns prior to the implementation of value based payment models to address them and ensure sufficient support for success.

Providers may consider several factors when deciding to participate in value based payment models. These factors include the perceived benefit to care delivery and patient health, potential profit, risk tolerance, access to investment capital and organisational readiness.[14] The potential benefits of value based payment models should to be clearly articulated, and the potential risks (financial, operational, clinical, and strategic) associated with the proposed model. Strong government leadership, informational technology improvement, and encouraging a value based healthcare culture are enabling factors for implementation.[40] Giving providers access to the new data collected as part of measurement-based care can make participation in value based payment initiatives more attractive.[31] Logistical support and initiatives enabling providers to pool resources and create learning collaboratives may also increase provider benefit.[31 41 42]

An evaluation of alternative payment models in the United States suggests that provider participation should be made mandatory where possible, given the advantages associated with this, including:

- simplified adoption (because all providers move to a new payment model at the same time);
- lower costs compared to gradual uptake of the new payment model;
- fairer competition; and
- improved evaluation results[43]

Deciding what population or condition to target

Treating mental ill health is complex given the unique circumstances of patients and the factors that lead to their ill health. The potential success of psychotherapy or pharmacotherapy is often unknown before treatment begins, so resources required to treat someone with mental ill health, particularly those experiencing severe symptoms, is often uncertain.

Treatment pathways and associated outcomes will depend on the mental health condition being treated and its severity upon presentation. Age and gender can also moderate treatment outcomes. Care pathways will need to account for other comorbid conditions present, preferences for treatment types, and the interaction of any substance use disorders on the behaviour of patients.

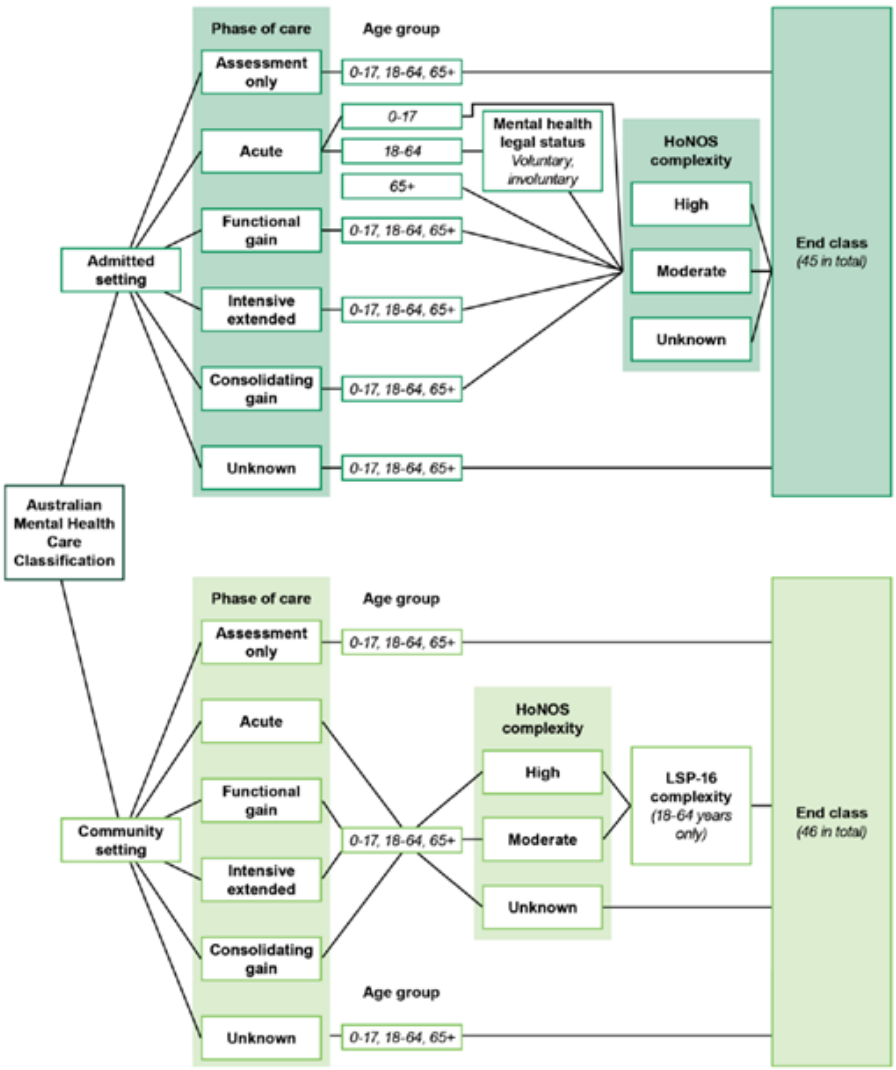
Shared savings models, such as bundled payments and accountable care organisations, provide the opportunity for multiple providers to work together to develop a treatment pathway that extends beyond traditional healthcare system boundaries. These models should be explored within the Australian healthcare system.

Not all mental healthcare services will require a value based payment model. Treating mental health conditions where the outcome is easily defined and measured (without confounding) may be better suited to fee for service. For example, Medicare seems appropriate for funding anxiety and depression screening for new mothers because it encourages activity and the outcome (i.e., screening using a standardised diagnostic tool) is easily defined and measured.

Bundled payments and accountable care organisations are best suited to promoting integrated care across health and non-health service domains. However, deciding on what population or condition to target will be challenging because a heterogenous patient mix will make it difficult to appropriately set prices given the expected variation in cost. It is therefore worthwhile to categorise patients into relatively homogenous groups and develop a targeted bundled payment or accountable care organisation.

The Australian Mental Health Care Classification (AMHCC) developed by the Independent Health and Aged Care Pricing Authority is potentially appropriate for targeting a bundled payment or accountable care organisation (see Figure 3.3). It contains six phases of care across the community and acute care settings, with subcategories defined by three age groups and by three ratings within the Health of the Nation Outcome Scales (HoNOS). While the AMHCC is consumer based, categorising patients according to mental health phases of care, it does not consider the type of mental health condition being treated. Consequently, providers would be required to treat patients at the same phase of care but potentially with different conditions and comorbidities.

Figure 3.3: Structure of the Australian Mental Health Care Classification



Source: [44]

Measuring outcomes

Quality measurement is an integral part of value based payment models.[45 46] Measurement based care benefits patients and providers by enhancing diagnosis and treatment, improving communication and collaboration, and increasing engagement and adherence to treatment.[37] It also facilitates quality improvement and accountability at the micro, meso, and macro levels within mental healthcare.[36]

Care quality can be assessed through structure, process and outcome measures.[37] Structure measures assess whether an organisation has the capacity to deliver evidence-based care and measure quality.[37] Process measures provide information about whether and how an intervention occurred.[36 37] Outcome measures assess whether the care a patient received actually improved their symptoms and wellbeing.[36 37] For example, a process measure for depression could be improving detection through

screening at a GP clinic and an outcome measure for depression could be assessing treatment response using a patient health questionnaire.[47]

Process measures are often used to assess value because few outcome measures exist for mental health.[23 37 48-50] However, many widely used process measures lack evidence demonstrating how they improve patient outcomes.[36 51] Process measures can be developed by operationalising clinical practice guidelines.[16 36]

Value based healthcare requires measuring outcomes that matter to patients.[35 36 41 48 49] Outcome measures must be robust, validated, and acceptable to providers.[16 32 37 41] Outcome measures should be clinically relevant, evidence based, meaningful, and easy to collect.[16 41 50 51]

Outcome measures commonly used include mental health rating scales, such as the nine-item Patient Health Questionnaire (PHQ-9) or seven-item General Anxiety Disorder (GAD-7) scale.[35] Outcomes that measure illness severity as well as binary (yes versus no) improvement could assist in measuring progress for patients with severe conditions or with complex needs.[52] Some countries have developed new measurement tools with patients and providers that meet the specific mental healthcare needs.[32 41 53]

Measuring costs

Data must be collected to fully understand the cost of care pathways to appropriately set prices within a value based payment model.[49] This must reflect not only costs but also the required rate of return if the provider is not a public organisation. However, the true cost of delivering mental healthcare services are mostly unknown for payers, as they do not have access to detailed private organisation data in Australia (e.g., GPs, specialists and allied health professionals). Similarly, costs associated with a specific care pathway or bundle of services delivered to a patient is not wholly understood by providers.[54]

Shared savings models require providers to understand the distribution of costs across a care pathway to identify potential savings and to assess the risk of participating in a funding model that financially incentivises providers based on shared expenditure savings. Resource costs within a care pathway are likely to differ substantially across conditions,[55] and geographical settings, with care provided in rural and remote regions typically more expensive.

Many providers do not fully understand the cost of treating a patient, instead using fees to proxy for costs.[54] Cost accounting methods currently used by providers do not break down costs by condition, nor account for differences in patient complexity. This uncertainty introduces financial risk and can discourage providers from participate in a shared savings model,[56] unless they are offered a substantial reward to compensate for taking on that additional risk.

Increased costs

Transitioning to value based payment models requires upfront investments. These investments include creating or updating information technology, billing practices, models of care, and governance structures. Creating new partnerships with other providers, staff training and implementing cultural changes across an organisation also requires time and resources. A review of 24 US pay for performance programs noted that larger provider networks had more resources available to make systemic changes, such as integrating electronic health records, and hiring dedicated staff to deliver care management services.[15] In Australia, governments could connect smaller providers or supply additional resources to mirror the conditions for success observed in larger organisations.

Changes to cashflow may also affect the ongoing success of value based payment models. Long term contracts help providers recoup upfront investment costs but do not help estimate future costs, making initial budget negotiations uncertain. Public hospitals and some private service providers are funded prospectively, but most Australian practitioners are paid retrospectively from government.[17] Shifting between prospective and retrospective payment structures will affect providers' cashflow. Compounding this, new technology may provide better outcomes but be more costly forcing providers to make difficult decisions. Unanticipated cost increases may also squeeze provider budgets.

Accounting for heterogenous patient populations

Many providers delivering mental healthcare are solo or part of a small group of specialists, so their ability to manage financial risk may be limited. Small providers may not treat enough patients to generate valid outcome measurements [35]

Effective risk adjustment is required to ensure providers are not penalised for treating patients with complex needs and high health care costs. [36 57 58] Value based payment models should not unintentionally incentivise cherry-picking healthier patients, patients more likely to demonstrate improvement, or selective reporting of patient outcomes.[35 57 59]

Risk adjustment methods include grouping patients by diagnoses and comorbidities and using baseline costs of treatment.[47 57 60] Risk adjustment may also be required for socioeconomic factors such as rurality, social fragmentation, poverty, nutrition instability and unstable housing.[45 48 61] Health disparities based on race, age, and socioeconomic factors may widen if funding models fail to address them.[62]

Collecting and sharing data

Timely and trustworthy data are an essential component of any value based payment model.[36 63 64] Their success requires timely data on quality measures, both process and outcome, to promote continuous improvements in care.[32 36 49] Inaccurate or missing outcome data undermines clinician

and patient confidence and limits the effective adoption and evaluation of value based payment models.[15 31] Conversely, feedback loops that supply real time quality data and analytics make data collection useful to providers and support decision making at the individual patient and practice level.

Effective risk adjustment requires timely and accurate information on diagnoses and social determinates of health.[16 61] Data on costs, provider performance relative to process measures, and patient health status relative to outcome measures are also required.[35 41 65] Without these data, the impact of service delivery on health outcomes cannot be established without unacceptable uncertainty, potentially leading to unfair allocation of payments within a shared savings model. [35 37 41 64]

Data collection and coding must be consistent and validated for each measure included in the value based payment model.[16 49] Information technology infrastructure should be robust and facilitate the collection, analysis and sharing of quality and cost indictors to provide actionable data and meaningful incentives for providers operating within a shared savings model.[32 36 49 66]

There are many challenges to data collection, access, and sharing.[42] Insufficient health infrastructure limits providers' capacity to measure, report, and improve quality care.[15 35 36] Incompatible electronic health records also make it difficult for patients to access care, limit necessary follow up, and impede effective communication between providers.[36 41 45] Australia does not currently have a comprehensive, connected, and accurate data set able to measure the effectiveness of interventions in primary care.[49] However, the Australian Institute of Health and Welfare and other government and private agencies are all working towards this goal.[49]

Questions for consultation

1. What are the special characteristics we should consider within mental healthcare when thinking about value based payments?
2. Do you agree or disagree that the development of value based payment models should be governed by a federal independent value based payment authority? What are your reasons?
3. Do you agree or disagree with the proposed governance structure for value based payments in mental healthcare presented in Figure 3.2?
4. Should there be a government department or agency coordinating input from the mental healthcare sector and helping the independent value based payment authority develop a long term agenda for implementing mental health value based payments?
5. What do you believe should be further considered or changed within the governance structure?

6. Do you agree or disagree with the principles underpinning value based payment models presented in Table 3.1? What do you believe should be changed within those principles?
7. Is there a specific patient population you believe value based payments should first target to improve outcomes and service delivery efficiency?
8. Do you agree or disagree that the Australian Mental Health Care Classification is appropriate for identifying potential patient populations to target? What are your reasons?
9. Do you believe outcomes using mental health rating scales, such as PHQ-9, are well suited to representing outcomes that matter to patients? What other outcomes could be used that are measurable and attributable to mental healthcare services?

4. A new mental healthcare investment framework

Many government investment decisions for mental healthcare are not based on evidence of effectiveness or cost effectiveness, and research outcomes are not being used effectively by policy makers. Key points from this chapter include the following.

- There should be a unified national approach to deciding on alternative investments in mental healthcare services. This would help government make investment decisions based on best available evidence. It would align with other processes used by governments to assess the effectiveness and cost effectiveness of alternative investment opportunities, such as the Office of Impact Analysis, the Pharmaceutical Benefits Advisory Committee and the NSW Gateway Policy.
- An approach for considering mental healthcare investments should be pragmatic, efficient and risk-based to determine whether a proposed investment requires a formal evaluation. An appropriate federal government department or agency should administer the process, with substantial input from state and territory governments.
- The process should employ a formal evaluation of the proposed mental healthcare investment, with the type of evaluation undertaken determined by the characteristics of the investment and the availability of clinical evidence and other relevant data. An Independent Mental Health Advisory Committee, supported by a Lived Experience Sub Committee, Economic Sub Committee and Clinical Sub Committee, should be responsible for making recommendations to the appropriate minister on whether to implement the intervention.
- Post market surveillance should be implemented to determine whether the outcomes and costs estimated within the evaluation are aligned with intervention outcomes. In some cases, a pilot should be undertaken first, while in other cases there may be enough confidence in the evaluation to roll out the service. Another approach is to implement the service to all eligible patients on the condition that funding is temporary until effectiveness and cost effectiveness can be demonstrated.

A unified national approach to investment

State, territory and federal government investment should seek to ensure all patients have equitable access to timely and cost effective mental healthcare services. Services should align with patient

preferences to the greatest extent possible and seek to produce mental healthcare outcomes that matter to patients. Governments should invest in prevention services and reduce determinants of mental ill health using a whole of government approach guided by the National Mental Health And Suicide Prevention Agreement. This notes the importance of facilitating an effective investment, policy and service mix to reduces gaps and overlaps in mental health and suicide prevention services to best support mental health outcomes.[1] It highlights the importance of making investment decisions that are appropriately informed by evaluation, while supporting new and innovative initiatives to be trialled and tested.

There will never be enough government resources to address all mental healthcare needs. It is incumbent on governments to prioritise investment that will produce the greatest benefit per dollar spent in an equitable way. This may, on occasions, require investing to reduce mental ill health in target populations that does not maximise health outcomes compared to alternatives, but is considered fair given their significantly reduced mental health and limited options for treatment. For example, the National Mental Health and Suicide Prevention Agreement notes that one area for immediate reform is prioritising further investment in prevention, early intervention and effective management of severe and enduring mental health conditions. Targeting of certain populations could be done by formally incorporating equity into economic evaluations.

Government must consider effectiveness relative to costs of programs that are presented for investment, and the opportunity cost of not investing in alternatives. Governments should undertake regular reviews of incumbent mental healthcare programs to determine the potential for improvements, and to identify programs where disinvestment and reallocation of funds to a more effective program is worthwhile.

The Productivity Commission noted that more could be done to improve investment decisions in the mental healthcare system, suggesting many investment decisions were made with little to no evidence on effectiveness or cost effectiveness. It recommended that ‘funding applications for mental health programs include an assessment of their expected cost-effectiveness and require all new programs to have been trialled as pilots, before they can be scaled up’. (p. 1184, [2])

This recommendation aligns with the long term health reforms agreed to by state, territory and federal governments to develop a nationally consistent health technology assessment process.[4] It also aligns with processes being used to help inform major health investment and non health government investment decisions with state, territory and federal government, such as the Office of Impact Analysis, the Pharmaceutical Benefits Advisory Committee and the NSW Gateway Policy (see Table 4.1).

Table 4.1: Examples of systematic approaches to government investment decisions

Government level	Process and responsible department	Investment type	Details
Federal	• Office of Impact Analysis • Department of Prime Minister and Cabinet	Regulatory change	An Impact Analysis is required when a federal minister requests a new policy or more than minor change to a program to be approved by the Prime Minister or the Cabinet. A Regulatory Impact Statement (RIS) is developed that seeks to answer seven questions, including what policy options are being considered and what is the benefit and costs of each option. The formal RIS assessment process has two parts, the first part providing formal feedback from the Office of Impact Analysis that can be incorporated into the second phase, which is the final assessment. The Impact Assessment usually includes substantial consultation with stakeholders. The RIS and Office of Impact Analysis assessment is published before the final decision or public announcement. In some cases, a Post Implementation Review is required to determine whether the policy or program is operating as intended.
Federal	• Pharmaceutical Benefits Advisory Committee • Department of Health and Aged Care	Listing pharmaceuticals on the pharmaceutical benefit scheme (PBS) for public funding.	A sponsor must apply to the Pharmaceutical Benefits Advisory Committee (PBAC) for a new medicine to be listed on the pharmaceutical benefits scheme (PBS) and receive public funding. The PBAC is an independent expert body appointed by the Australian Government under the *National Health Act 1953*. An application must include details on the condition and population for which the medicine is intended, and analysis based on clinical evidence regarding the safety, effectiveness and cost effectiveness of the medicine relative to the most likely alternative treatment. It must also assess the potential impact on the government budget. The PBAC makes a recommendation to the minister on whether to list the medicine on the PBS. It is supported by two sub committees, including an Economics Sub Committee and a Drug Utilisation Sub Committee. A new medicine cannot be listed unless the Minister receives a positive recommendation.
State (NSW)	• NSW Gateway Policy • NSW Treasury	Significant capital and recurrent NSW government expenditure.	The NSW Government operates a Gateway process for assessing and monitoring significant investments made by all NSW government agencies, businesses and state owned corporations. Three Gateway coordination agencies implement three Gateway Coordination Frameworks for infrastructure, information and communication technology (ICT) and recurrent expenditure respectively. Agencies with program proposals that are expected to cost more than $100 million over four years, or more than $50 million in one year must register the proposal with the NSW Treasury and go through the Recurrent Expenditure Assurance Framework. The Treasury determines the level of project risk and assurance requirements and arrange appropriate Gateway Reviews. Agencies are required to report on actual to expected costs, the delivery of milestones, and any significant changes to project risk.

Similarly, the Victorian Government released in 2022 its Early Intervention Investment Framework to help direct investment decisions regarding early intervention. The objective is to estimate outcomes and potential avoided government costs associated with a reduction in acute care use, to be incorporated within the annual state budget process.[67]

The National Mental Health And Suicide Prevention Agreement notes the importance of a coordinated national approach to formal evaluation with the aim of informing investment decisions and supporting improvements in planning, purchasing and program management within mental health and suicide prevention.[1] The Agreement underscores that evaluations should be made available for multiple users including the public, health service users, providers, planners, funders and commissioners. It notes that the overall cost of evaluations to inform investment decisions be managed by building evaluation into program design, collecting and monitoring data during the program and ensuring evaluations are proportionate to the cost, risk and complexity of the program.

Independence is key to ensuring government investment is based on the best available evidence analysed without bias or political interference. Independence is essential for instilling public trust in investment decisions. The Office of Impact Analysis and the Pharmaceutical Benefits Advisory Committee both operate independently to application sponsors, making objective recommendations to Ministers and Cabinet on what they believe is a cost effective investment.

This consultation paper recommends that a unified national approach to mental healthcare investment be developed that includes a systematic, transparent and risk-based approach to the investment assessment procedure. The procedure should inform governments, providers, clinicians and patients on the comparative value of alternative potential investments to improve mental health outcomes, including areas where disinvestment in services is worthwhile, and provide ongoing guidance to inform future mental healthcare policy and research directions.

A unified national approach administered by an appropriate federal government department or agency should provide transparent objective recommendations on worthwhile investments (and disinvestments) to ministers. It requires involving state and territory government when evaluating investment decisions given their knowledge of planning, managing and aligning state based mental healthcare programs. An approach to assessing investments must provide timely advice to ministers to avoid undue delays in implementation.

We suggest an independent expert committee should be formed to recommend (or not) investments to proceed. This committee would operate similarly to the Pharmaceutical Benefits Advisory Committee, which is established through the *National Health Act 1953* to provide independent expert advice to the Minister within the Department of Health and Aged Care.

Principles underpinning investment evaluation process

The Productivity Commission developed a high level framework for monitoring, evaluation and research within mental healthcare,[2] based on a set of principles that could also be used within developing a mental healthcare investment evaluation process (see Table 4.2).

Other principles could be used to underpin a mental healthcare investment evaluation process. A review of health technology assessment in Australia undertaken by the Department of Health and Ageing proposed a set of principles for underpinning Commonwealth health technology assessment processes (see Table 4.3).

Table 4.2: Proposed principles underpinning a mental healthcare investment evaluation process

Principle	Description
Fit-for-purpose	• Data collected should inform decision making at all levels of the mental health system, including by consumers and carers, governments, service planners and commissioners and providers.
Maintains social licence	• Data collection and use should meet public expectations.
Supports continuous improvement	• Information from monitoring, evaluation and research should support continuous improvement of mental health outcomes.
Independent	• Bodies tasked with monitoring, evaluation and research should be independent of areas responsible for policy, program development and implementation.
Transparent	• Monitoring, evaluation and research should be made publicly available through appropriate, ethical and collaborative consent processes.
Person-centred	• Monitoring, evaluation and research should aim to improve outcomes for people with mental ill-health and their carers. Monitoring should include measures of consumer reported experiences and outcomes.
Culturally capable	• Bodies undertaking monitoring, evaluation and research should consider different cultural needs that may affect approaches and aim to address them.
Generating a net value	• Resources should only be allocated to monitoring, evaluation and research if the benefits outweigh the costs.

Source: [2]

Table 4.3: Proposed principles underpinning health technology assessment in Australia

Principle	Description
Sustainable	• Assessments and appraisals contribute to a sustainable Australian health system through informing evidence-based decisions about the subsidised use of health technologies. • Appraisals inform, and are informed by, evidence from post-market monitoring of subsidised health technologies to guide the continued investment or disinvestment in these technologies. • An health technology assessment workforce with up-to-date skills and expertise is built and maintained.
Transparent, accountable and independent	• Assessments and appraisals are undertaken objectively and impartially. • Functions, roles and responsibilities are clearly defined and evident to all interested parties. • Processes and information requirements are publicly communicated and clearly explained. • Involved parties are kept informed of the progress of applications throughout the assessment and appraisal processes. • Processes are fairly and consistently applied, and provide all interested parties with an opportunity to contribute. • Applicants and other parties can seek access to an independent review mechanism of Commonwealth health technology assessment and appraisal processes. • The outcomes of appraisals meet the information needs of Australian Government decision-makers. • Advice and recommendations arising from appraisals (with supporting facts and reasons) are publicly disclosed. • Key activity and performance data are reported.
Consultative and reflective of Australian community values	• Takes into account broader societal perspectives on health technology, including access, equity and the financial impacts on consumers. • Structured consultation occurs with interested parties, including consumers. • Appraisals consider the impact of health technologies on the other relevant aspects of the health system as reflected in government policy and in Australian community values.
Administratively efficient	• Process duplication is minimised by coordination to share relevant information and expertise. • Regulatory burden and costs are minimised (without diminution of scientific rigour and health system sustainability). • Assessment and appraisal processes are streamlined to provide a timely outcome. • The health technology assessment workforce is expert, experienced and equipped to process the full range of applications received.
Flexible and fit for purpose	• Processes and methodologies are adaptable to technological change. • The full range of current and emerging types of health technologies can be appropriately assessed. • Applications are efficiently directed, assessed and managed through the relevant process(es). • The assessment of a health technology is commensurate with the risk of harm to the patient and cost to the Australian Government and community. • Appraisals inform any risk sharing arrangements considered between the Australian Government and applicants.
Informed by robust and relevant evidence	• Assessments are based on a systematic review of the best available evidence and aligned with contemporary clinical practice. • Assessments utilise internationally generated evidence where relevant to the Australian context. • Assessments consider appropriate comparators within the relevant Australian clinical context. • Assessments and appraisals are informed by multi-disciplinary expertise to ensure their overall credibility. • Methodologies for assessing health technologies are continually reviewed and updated in the light of validated Australian and international developments.

Source: [68]

Process for considering investments

A systematic and transparent process to evaluating proposed government investment in mental healthcare is presented in Figure 4.1. It represents a combination of health technology assessment processes currently used within the federal government for pharmaceuticals and medical devices, and other systematic processes used by state and federal governments to assess investment decisions.

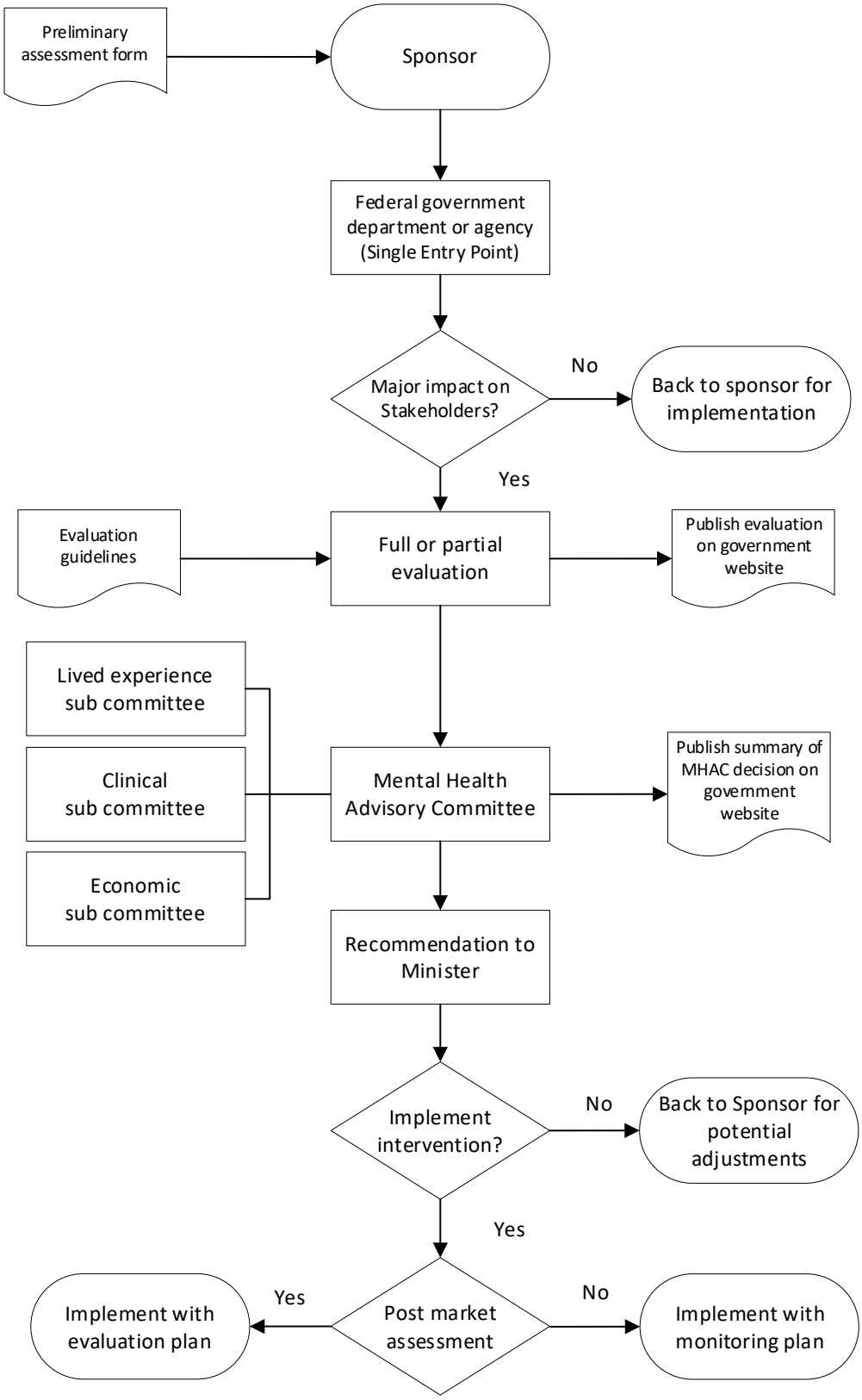
The proposed process seeks to deliver a pragmatic, efficient and risk-based approach to making investment decision recommendations to territory, state and federal ministers. It relies on a federal government department or agency managing the process, along with monitoring and tracking progress once an application is submitted by a sponsor. It uses an initial quick assessment to determine whether the proposed investment requires a formal evaluation, and if so, an independent organisation undertaking either a full or partial evaluation depending on stated criteria.

Evidence presented to the Mental Health Advisory Committee from the evaluation, and from reports delivered by a Lived Experience Sub Committee, Clinical Sub Committee, and Economics Sub Committee would be used to recommend to the relevant minister (or ministers) whether the investment should take place.

A recommendation from the Mental Health Advisory Committee would not be binding, although it would be publicly reported to ensure transparency in the decision making process.

Implementation channel would depend on the investment characteristics, with either a monitoring plan or an evaluation plan accompanying the implementation. An evaluation plan would be used for investment decisions that may be cost effective but the decision is uncertain, for example, due to poor quality data. This will provide an opportunity for investment decisions to capture innovative programs that have limited ‘gold standard’ information on clinical and cost effectiveness (e.g., clinical trial data), but the innovation is considered potentially beneficial by the Mental Health Advisory Committee on advice from its sub committees.

Figure 4.1: Proposed process for considering mental healthcare investments



Sponsors

Sponsors for an investment recommendation application will most likely comprise state, territory and federal government departments and agencies. Other stakeholders should not be excluded from sponsoring an application for an investment decision. PHNs and LHNs are likely to find the process worthwhile, given it will generate valuable information on the likelihood of the effectiveness and cost effectiveness of a service they seek to commission.

Similarly, providers and patient groups should also have an opportunity to sponsor an application. For example, a national service provider that seeks government funding to deliver a new service, or significantly expand a service already being delivered, should be required to sponsor an application and receive a recommendation from the Mental Health Advisory Committee for the minister to consider before being implemented.

Initial application

The application would be initiated by a sponsor using a preliminary assessment form submitted to via a dedicated web-based portal. There would be a single entry point for applications, upon which the responsible department or agency will decide whether the application should proceed to an evaluation stage based on transparent criteria.

The decision to proceed to an evaluation could be subjective based on responses provided by the sponsor within the preliminary assessment form. A subjective approach is used by the Office of Impact Analysis when determining whether an investment should proceed to a Regulatory Impact Assessment. It judges whether the proposed regulatory change or program will have a substantial impact on businesses, community organisations or individuals.

Alternatively, the decision to proceed to an evaluation could be objective, such as whether the expected public expenditure is greater than some threshold. This approach is used by the NSW Treasury when deciding whether an investment proposal should go through the Recurrent Expenditure Assurance Framework.

Evaluating investment proposals

Investment proposals should be evaluated by individuals experienced in undertaking economic and program evaluations. They should be undertaken by independent academics or consultants using an established set of guidelines and reporting templates. This would promote consistent evaluation across different investment proposals, and consistent public reporting.

The type of evaluation undertaken should be determined by the characteristics of the investment proposal, and its expected impact on mental health outcomes, the healthcare system, society and the

economy more broadly. Availability of clinical evidence, its quality and access to cost data should also determine the type of evaluation undertaken.

An economic evaluation and program evaluation should be undertaken to the greatest extent possible. These can provide a good understanding of the potential effectiveness, mechanisms of impact on outcomes, and the cost effectiveness of investments. However, drawing conclusions from economic evaluations when data is uncertain will inherently embed uncertainty within the recommendation. Uncertainty can be reduced by undertaking sensitivity analysis, but this will not remove all uncertainty. In some instances, the economic evaluation may need to draw on lived experience and clinical opinions to capture some model inputs, for example, expected demand for services and expected impacts on mental health outcomes.

Significant time and resources are often required to undertake an economic evaluation. Economic evaluations can also be considered complex by decision makers, reducing trust in their ability to interpret results appropriately.[69] Economic evaluation results from other healthcare service settings are seldom transferrable. The underlying premise of using cost-effectiveness decision rules has also been questioned.[70 71]

Systematic priority setting tools are an alternative to economic evaluation to help make investment decisions.[72] Debate exists over whether priority setting can be improved through more technical analysis, better decision processes, or something in the middle.[73] What is agreed upon is the need for transparent and accountable priority setting within healthcare systems.

The most widely explored priority setting tools are program budgeting and marginal analysis (PBMA) and multicriteria decision analysis (MCDA) (see Table 4.4).[74] Decision makers are generally supportive of using systematic priority setting tools to improve decision making. Priority setting tools can help transfer knowledge, can identify important factors to consider, and can facilitate communication for decisions.[75]

However, implementing a priority setting tool can be complex and resource intensive. Governments of publicly funded systems have failed to implement a formal priority setting framework.[76] Consequently, there are calls for further research and evaluation of priority setting tools to improve the quality, consistency and transparency of healthcare investment decisions.[77]

Table 4.4: Description of popular priority setting processes

PBMA (Steps)	MCDA (Steps)
1. Determine the aim and scope of the priority setting exercise	1. Define the decision problem
2. Compile a ‘‘program budget’’	2. Select and structure decision criteria
3. Form a ‘‘marginal analysis’’ advisory panel	3. Measure performance in a ‘matrix’
4. Determine locally relevant decision making criteria	4. Score alternatives
5. Identify options for (a) service growth (b) resource release from gains in operational efficiency (c) resource release from scaling back or ceasing some services	5. Weighting criteria
6. Evaluate investments and disinvestments	6. Calculate aggregate scores
7. Validate results and reallocate resources	7. Assess uncertainty
	8. Report and examine findings

Source: [78 79]

Making recommendations

The role of the Mental Health Advisory Committee is to assess the evidence and make a recommendation to the relevant minister (or ministers) on whether the proposed public investment in mental healthcare should take place. This should include whether the government should disinvest in services deemed not cost effective through the evaluation process, which could occur through removing the government rebate, changing the eligible patient population, or decreasing the price of the government rebate.[68]

The proposed Mental Health Advisory Committee would comprise representatives from state, territory and federal governments, mental healthcare providers, people with lived experience, and representatives from non-health government departments where their services impact mental health outcomes. This would help facilitate a whole of government approach to making investment decision recommendations.

The Mental Health Advisory Committee would be supported by three sub committees, including a Lived Experience Sub Committee, Clinical Sub Committee and Economic Sub Committee.

The Lived Experienced Sub Committee would comprise of consumers and carers. Their role would be to provide their individual and collective perspective on investments presented to the Mental Health Advisory Committee, to ensure their core values, principles and preferences are represented within recommendations.

The Clinical Sub Committee would be comprised of clinical experts in mental healthcare. It would provide advice on the potential adoption of the proposed mental healthcare service, its potential impact

on outcomes, other services that could be used as an alternative option, and impacts on other services if the proposed mental healthcare service were introduced.

The Economics Sub Committee would comprise experts in economic and program evaluation, along with clinical experts. Its role is to assess investment proposal evaluations for their rigour and highlight uncertainty within their conclusions, and offer suggestions where further collection of evidence is worthwhile.

Any Mental Health Advisory Committee decision should be published. It should include a summary of the investment proposal, the advice given by the Mental Health Advisory Committee and the recommendation. It should also include any suggested future areas for research to provide researchers with a greater opportunity to align their research portfolio around identified sector needs. This would provide further opportunity for government to identify research projects to fund, such as through the Medical Research Future Fund.

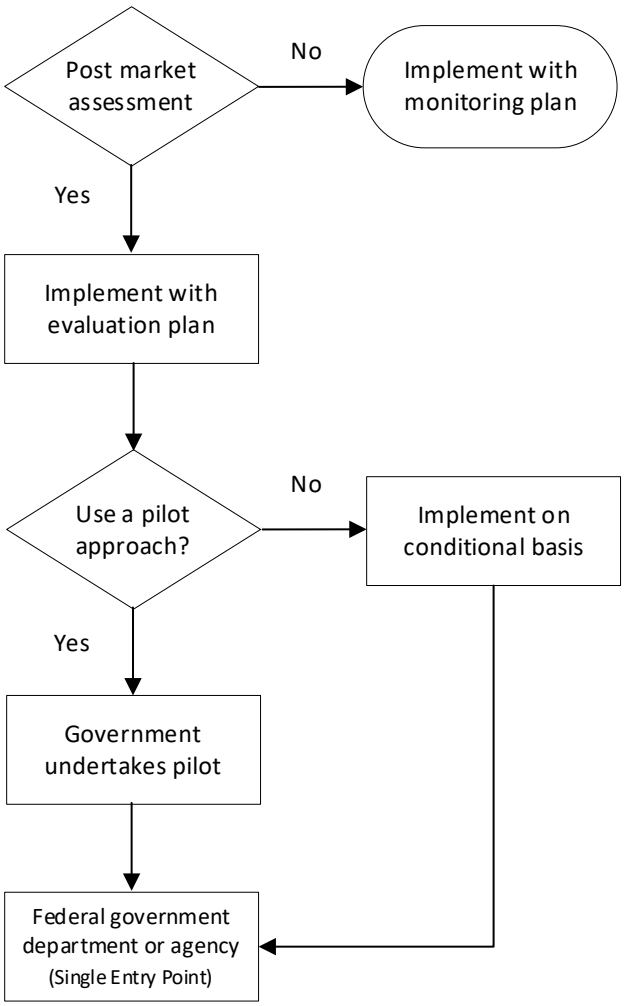
Post market surveillance to guide future investment

Recommendations from the Mental Health Advisory Committee on whether to invest in a proposed service should include whether implementation consist of either post market monitoring or implementation with an evaluation plan (see Figure 4.2). The pathway would depend on the level of uncertainty within the recommendation made by the Mental Health Advisory Committee. If the decision was deemed uncertain but the investment would likely be effective and cost effective, a proactive approach to collecting and assessing data on effectiveness, costs and the volume of services for a subsequent evaluation would be worthwhile, to ensuring government investment is value based.

Implementing a service with an evaluation plan could be undertaken using a pilot approach. The Productivity Commission recommended that all new interventions should be first trialled through a pilot program before being scaled up. This could be undertaken either through government, or any national clinical trials network in mental health and suicide prevention established by the federal government, also recommended by the Productivity Commission.

However, all new interventions need not be trialled through a pilot program, although pilot programs are useful when there is ambiguity regarding outcomes and costs. Some interventions will have sufficient data to make a somewhat certain recommendation on whether to invest. These programs should be implemented with a monitoring plan to inform continual improvement.

Figure 4.2: Proposed process for post-market surveillance



Often uncertainty regarding the value of an investment decision can be reduced by collecting additional information. For example, clinical trials already conducted could suggest the service is effective and cost effective, but there may be some uncertainty on whether clinicians will implement the service according to guidelines and if not, what outcomes result. Data collection can therefore focus on this uncertainty and be used in a subsequent evaluation.

Requiring all new interventions to be trialled through a pilot program could delay access to effective and cost effective mental healthcare, reducing potential improvements in mental health outcomes. In some cases, this could be a matter of life and death, so the costs of delaying access to new mental healthcare to undertake a pilot (i.e., lost mental health outcome improvements if the intervention is effective) must be weighed against the benefits of delaying access to those patients not included in the pilot (i.e., wasting valuable resources if the intervention is not effective). A value of information approach could help inform the decision on whether to undertake a pilot to collect more information.

Another approach is to implement the service to all eligible patients on the condition that funding is temporary, and once additional data is collected, an evaluation is conducted at the end of the temporary funding period. This would occur through the proposed process for considering mental healthcare investments, again relying on the Mental Health Advisory Committee to make a recommendation. While this would not allow a randomised control trial to take place, it may not be necessary to reduce uncertainty within the Mental Health Advisory Committee recommendation. For example, additional data maybe collected from accessing and linking state, territory and federal government datasets to add value to a subsequent evaluation.

Questions for consultation

1. Do you agree that a unified approach to investment decisions in mental healthcare is required? What are your reasons?
2. Do you agree with the principles underpinning the development of an investment evaluation process presented in Table 4.2? What do you believe should be changed or added to those principles?
3. Do you agree with the proposed process for considering investments and making recommendations in Figure 4.1? What do you believe should be further considered or changed?
4. Do you believe investment decisions should be primarily based on prospective economic evaluation and program evaluation?
5. Do you believe other priority setting tools, such as PBMA or MCDA, should be used when making investment recommendations?
6. Do you agree that some new interventions should be implemented without a pilot program? What are your reasons?
7. Do you believe some interventions should be implemented on a conditional basis to collect more data and information to reduce uncertainty in the final recommendation to invest?

5. The way forward

The 2022 Mental Health and Suicide Prevention Agreement highlights the Government's future vision of improving the mental health of all Australians, ensuring sustainability and enhancing the services of the Australian mental health and suicide prevention system. The Agreement recognises that this Vision cannot be achieved within current mental healthcare funding and investment environment, and propagates the need to better embed value within the system, reduce waste and duplication through better coordination, and create clarity on funding and investment principles and responsibilities[1].

Developing a framework for embedding value into mental healthcare funding and investment will help push forward this ambitious Vision and help lay the foundations for future reform. This consultation paper recognises that ongoing consultations with mental health care stakeholders are crucial for informing the design and potential future implementation of such a framework within the Australian mental healthcare. A well-informed, co-designed framework for funding and investment will increase the likelihood of success of future value-based reforms aimed at improving sustainability, integration, continuity and patient and provider outcomes.

Mental healthcare funding and investment reform must take a long-term view. It will require moving beyond recommendations made by the Productivity Commission and the reform agenda presented in the National Mental Health and Suicide Prevention Agreement and Plan.

Responsibility for developing, implementing, monitoring and evaluating value based funding models for both physical and mental healthcare should rest with a federal independent value based payment authority. A unified national approach to mental healthcare investment is also needed, that includes a systematic, transparent and risk-based approach to the investment assessment procedure based on evaluation principles and a single point of entry for investment applications, and recommendations made by an independent committee.

This research project represents the *beginning* of the journey towards understanding and motivating value-based payment and investment reform in the Australian mental healthcare system. Long-term, iterative changes must be supported by strong and consistent national leadership, with state, territory and federal governments developing a structured and supportive policy and institutional framework around the intent to trial and evaluate ongoing value-based payment models nationally.

Implementing reforms will require substantial, upfront government investment in better information technology, improved data collection and information sharing to inform and support measurable and attributable care outcomes agreed across patients, providers and funders.[17] Costs will be initially imposed through implementing new billing practices, models of care, and governance structures.

Creating new partnerships with providers, staff training and implementing cultural changes across an organisation will also require upfront time and resources.

Transparency on risk-bearing and the distribution of benefits must be ensured and factored into implementation to predict and manage uncertainty. Providers will need to be supported through education, training, information and assistance to encourage best practice care and innovation. Giving providers access to the new data collected as part of measurement-based care may help facilitate provider participation , and logistical support and initiatives enabling providers to pool resources and create learning collaboratives may also help increase provider benefit.

The implementation timeframe will need to incorporate resolute testing of innovative funding models within a strong learning eco-system, to help build funding models that complement future mental health care needs and meet the preferences of patients.

Overall, embedding value-based payment models into the mental health care system must travel down a digital road, while maintaining clinical safety and promoting health equity. Implementation must be structured and systematic. Funding models must be adapted to their local context and sit within a strong evaluation and learning culture.

While the journey to embedding value within the mental healthcare system may be long and experience some initial failures, the potential benefits of such transformative and ambitious reform may be substantial, encompassing improved consumer and provider outcomes, care that better meets population needs and preferences, integrated and coordinated care that helps bridge service gaps such as the missing middle, and increased efficiency and sustainability within Australia's mental health care system.

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Appendix A: Value based payment models

Many developed countries are focused on increasing public healthcare spending value. They recognise that healthcare resources are finite, yet demand is infinite. The way healthcare is currently delivered and remunerated creates substantial financial waste from overuse of medical services and technology,[80] along with inefficient healthcare system administration.[81]

The Australian healthcare system is no exception. The proportion of healthcare encounters where appropriate care was received by adults in Australia ranging from 13 per cent (alcohol dependence services) to 90 per cent (coronary artery disease), with an average of 57 per cent across 22 conditions. Only 55 per cent of encounters for depression were deemed to have delivered appropriate care, despite mental health being a National Health Priority Area.[82]

A value-based healthcare (VBHC) system delivers outcomes that matter to patients.[83] According to Porter and Tiesberg, value based healthcare can be achieved by:

- integrating care around medical conditions;
- measuring all outcomes and costs;
- delivering funding through bundled payments;
- integrating multi-site care delivery systems;
- expanding geographic reach of Centres for Excellence; and
- supporting an enabling information technology platform.[84-86].

Enabling factors for VBHC implementation include strong government support, a focus on information technology improvement, and instituting a VBHC culture among providers.[40]

All Australian state, territory and federal governments have agreed to improve value within their healthcare systems. This includes harnessing financial incentives to improve patient health outcomes and patient equity, using a more coordinated and integrated approach, while concurrently driving system efficiency.[4] Funding reform is proposed to start with developing a National Health Funding

and Payments Framework, removing legislative, regulatory and technical barriers to funding reform, and trailing and evaluate new funding models by the end of 2024-25.[87] [3]

The NSW Ministry of Health defines value as outcomes and experiences that matter most to the people receiving and delivering care, relative to the costs of achieving those outcomes.[88 89] Their quadruple aim framework strives to:

(i) improve health outcomes that matter to patients;

(ii) improve patient care experiences;

(iii) improve provider experiences; and

(iv) improve care effectiveness and efficiency.[90]

The NSW VBHC framework consists of four interrelated programs, including Leading Better Value Care, Integrated Care,[91] Commissioning for Better Value,[88] and Collaborative Commissioning.[92] Investment to collect patient reported outcomes and experience measures, along with improving data infrastructure, supports these programs. Most VBHC initiatives in Australia are targeted at physical chronic conditions, such as diabetes management, coronary heart disease and chronic obstructive pulmonary disease.

Value based mental healthcare

While developed countries are exploring VBHC to improve quality and slow expenditure growth for services mostly related to physical chronic disease, adoption of VBHC for mental healthcare is limited.[41 42 59] Implementing VBHC for mental health can be challenging. Measuring and collecting outcomes that matter to patients is not straightforward as they can be patient specific.[41] There is usually no broad agreement on what should be considered an effective outcome,[36] and there is some uncertainty regarding the effectiveness of specific care models and treatment approaches.[58]

Despite these challenges, some mental healthcare providers have started pursuing VBHC. VBHC has been applied by stand-alone mental healthcare services. [19 41] This includes specialised services for specific conditions, where a consensus exists on outcomes that matter to patients, and intervention costs can be estimated accurately. For example, the Schön Clinic in Germany for eating disorders and Sahlgrenska University Hospital in Sweden for managing bipolar disorder are providers that have adopted VBHC for a specific condition.[32]

[3] This timeline is unlikely to be fulfilled given the impact from the COVID-19 pandemic on the Australian healthcare system, and the required realignment of government and provider resources.

Some mental healthcare providers are exploring ways to transform their entire organisation to VHBC. For example, St Andrew's Healthcare, a non-profit medium-sized mental health organisation in the UK, started to shift all services towards VHBC in 2015.[32] Based on co-production principles, clinical outcomes and process measures were defined through the active participation of clinicians, staff, patients, and carers. Moreover, a data registry was established for collecting and analysing clinical outcomes, process measures and financial data to monitor and evaluate patient outcomes and the organisation's performance. Integrated practice units were developed based on the global collaboration principle to deliver integrated services to patients.

Little focus has been placed on delivering value based mental healthcare in NSW or other jurisdictions. In 2006, the Australian Government introduced Better Access to Mental Health Care initiative to deliver effective and efficient care for patients with anxiety and depression. This included new Medicare Benefits Schedule (MBS) items to improve access to psychiatrists, psychologists and allied health professionals.[93] However, this program had no emphasis on value, and provider payment was not linked to outcomes [22]. While it increased the use of mental health services substantially, it had no significant impact on the prevalence of very high psychological distress or the suicide rate.[94]

Value based payments

The traditional way of paying mental healthcare providers in Australia is through block payments, fee-for-service, and activity based funding. These payment models are poorly aligned with delivering value as they provide no extrinsic incentive to deliver outcomes that matter to patients in an efficient manner (see Table A.1).

Block payments are prospective lump sum payments covering a range of services independent of the actual volume provided. While block payments can help government control expenditure, they can encourage providers to deliver fewer services than optimal for patients. Providers are not directly held accountable for waste.

Fee-for-service payments, such as Medicare, are retrospective payments, and each service is paid for separately. Fee-for-service typically incentivises providers to increase service volume and subsequently associated government expenditure. While activity based funding encourages public hospitals to maintain costs below the national efficient price or national efficient cost, there is no financial incentive to ensure the best patient outcomes are achieved within hospital, and perverse incentives to keep patients in hospital when it may be more efficient, and preferred by the patient, to receive care in the community.

Table A.1: Key characteristics of alternative healthcare funding models

Value based	Funding recipient	Model	Description	Australian example	Potential incentive:			
					Quality	Unit Costs	Patient Volume	'Per patient' service volume
Not value based	Individual provider	Cost reimbursement	Funding is paid (prospectively or retrospectively) based on the cost of delivering services.	Medical training and research.	None	None	None	None
		Historical block payments	Funding is paid in one instalment on a periodic basis based on funding received the period prior. Typically does not reflect patient need.	Aboriginal Community Controlled Health Services and some smaller regional hospitals.	None	None	Decrease[1]	Decrease[1]
		Fee for service	Providers are paid retrospectively per unit of service delivered based on an established price.	Medicare.	None	None	Increase	Increase
		Activity Based Funding	Providers are paid per National Weighted Activity Unit (NWAU) delivered, reflecting effort across multiple services.	Public hospitals.	None	Decrease	Increase	Decrease

Note 1. This assumes that any funding left over can be kept by the provider.

Table A.1: Key characteristics of alternative healthcare funding models (continued)

Value based	Funding recipient	Model	Description	Australian example	Potential incentive:			
					Quality	Unit Costs	Patient Volume	'Per patient' service volume
Value based	Individual provider	Pay for performance	Providers are rewarded (or penalised) for achieving (or not) a set performance threshold. Usually blended with other funding models, such as fee-for-service.	Practice Incentive Program for primary care.	Increase	Decrease	Decrease or Increase	Decrease or Increase
		Pay for performance - Best practice tariff	Providers are rewarded for delivering care that aligns with designated clinical best practice.	NSW Leading Better Value Care program	Increase	None	Increase	None
		Capitation – Condition specific	Providers are paid (usually individual risk adjusted) per enrolled patient for managing a specific condition.	Diabetes Care Project (now defunct) and Health Care Homes trial (now defunct).	Increase[1]	Decrease	Increase	Decrease
		Capitation - All health	Providers are paid (usually individual risk adjusted) per enrolled patient for managing all health conditions.	Australian National Aged Care Classification model for residential aged care.	Increase[1]	Decrease	Increase	Decrease
		Capitation - population	Providers are paid for managing a defined population (usually geographically bound)	Primary Healthcare Networks	Increase[1]	Decrease	Decrease	Decrease

Table A.1: Key characteristics of alternative healthcare funding models (continued)

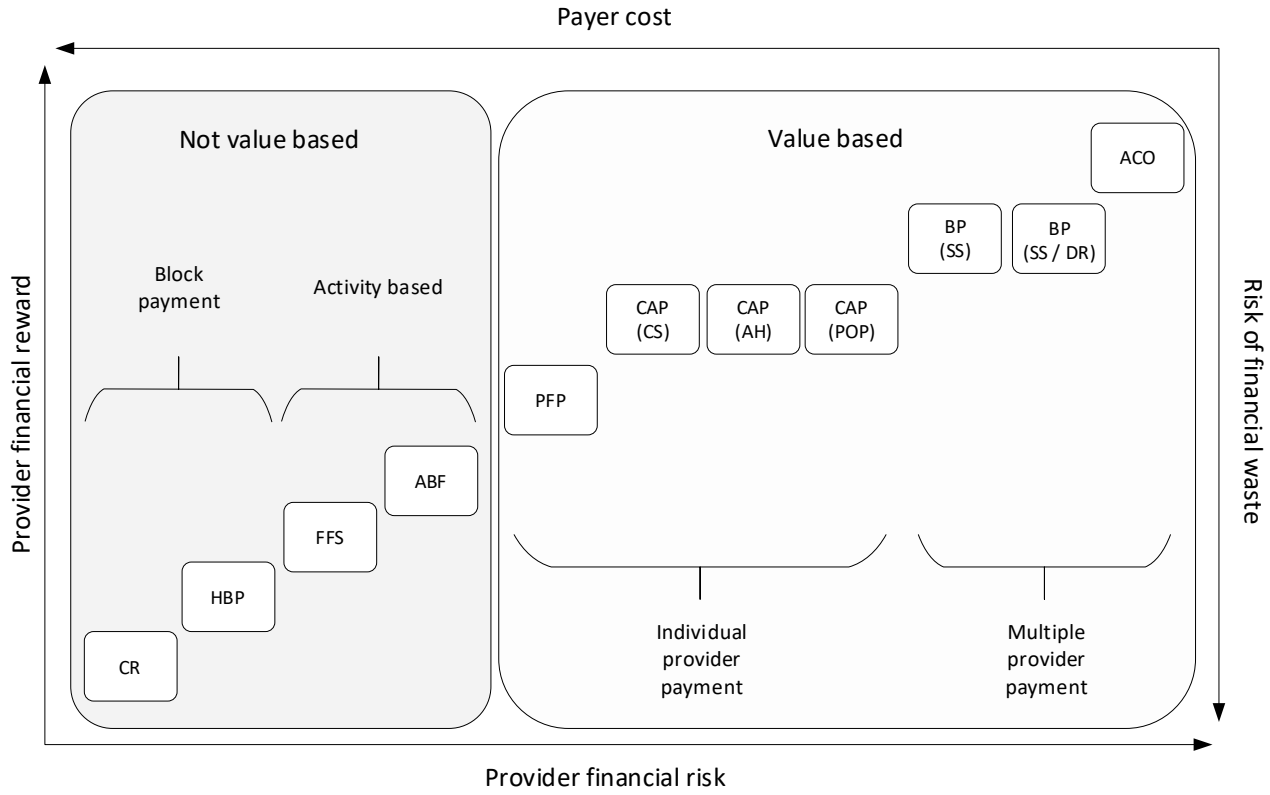
Value based	Funding recipient	Model	Description	Australian example	Potential incentive:			
					Quality	Unit Costs	Patient Volume	'Per patient' service volume
Value based	Shared across providers	Fee for service / Bundled payment with shared savings	Providers delivering different services within a defined bundle are reimbursed through fee-for-service up to a cap. Any savings are shared among providers.	None	Increase[1]	Decrease	Increase	Decrease
		Fee for service / Bundled payment with sharded savings and downside risk	Providers delivering different services within a defined bundle are reimbursed through fee-for-service up to a cap. Any savings are shared among providers. Any payments above the cap are reimbursed to the payer.	None	Increase[1]	Decrease	Increase	Decrease
		Accountable Care Organisations	Providers voluntarily collaborate to be held accountable for the total cost and quality of care delivered for an enrolled patient cohort or define population.	None	Increase[1]	Decrease	Decrease	Decrease

Note: 1. These models may not explicitly incentivise quality improvement. Instead, quality improvement is implicitly incentivised as it may reduce 'per patient' service volume, from which savings can be derived.

Source: [17]

Value-based payments seek to extrinsically motivate providers to deliver outcomes that matter to patients in an efficient manner (see Table A.1).[95] They shift financial risk onto providers, where either a financial reward or financial penalty is used to motivate providers to reach some specified target (see Figure A.1). In return, providers typically have greater self-agency to deliver care types, greater access to data, and government support in recording performance and interpreting feedback to improve care.[31 34]

Figure A.1: Risk and reward profiles of payment models across the value based spectrum



Note: CR = Cost reimbursement (retrospective); HBP = Historical block funding; FFS = Fee for service; ABF = Activity based funding; PFP= Pay for performance; CAP (CS) = Capitation (Condition specific); CAP (AH) = Capitation (All health); CAP (POP) = Capitation (Population based); BP (SS) = Bundled payment (Shared savings); BP (SS / DR) = Bundled payment (Shared savings with downside risk); ACO=Accountable care organisation.

Source: [17]

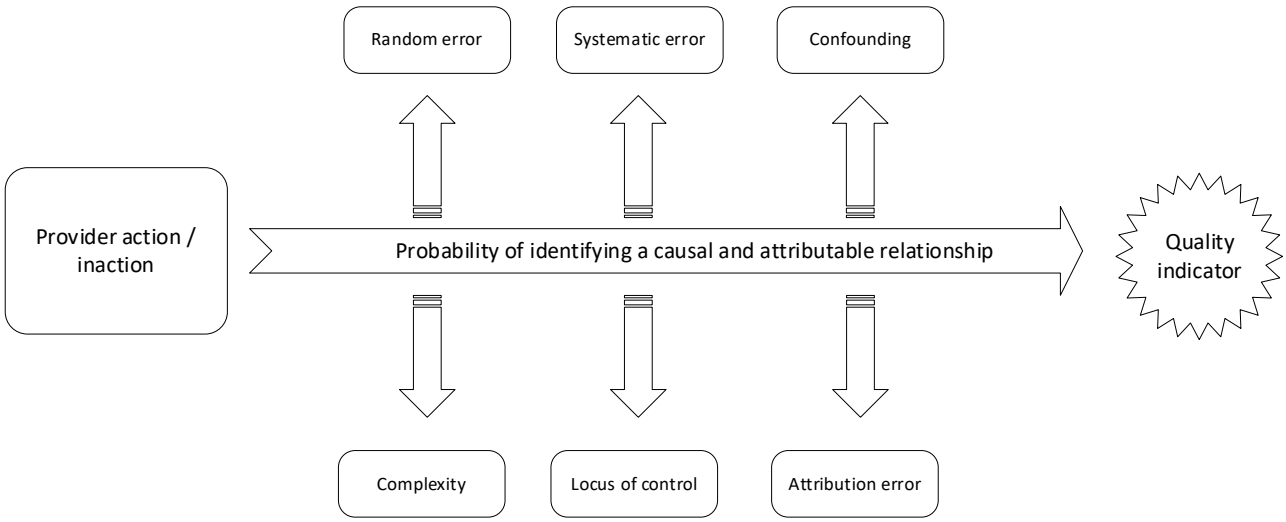
Success of a value based payment model depends on how well providers can govern within their new environment and manage additional financial risk, along with potential increased strategic risk, operational risk and clinical risk associated with changing business practices and care models. The extent of risk sharing between payer and providers, and providers themselves within a shared savings model, is determined on a case-by-case basis. This requires providers having a good understanding of the risk they face relative to their reward, and whether that risk aligns with their risk appetite.

Any value based payment in mental healthcare will need to adjust for differences in patient risks to minimise the chance that providers seek only less complex patients. Risk adjustment will never be perfect so providers will potentially treat patients that are more complex and costly or conversely, less complex and costly than anticipated.

A value based payment model should include an appropriate algorithm to adjust prices for variations in patient risk serviced by providers. This requires access to data on patient characteristics that impact patient risk related to their health status, along with their living and working environment, health related behaviours, and any formal and informal care received beyond the healthcare provided.[17]

In some instances, value-based payment model targets may reflect improved health outcomes, while in other instances targets may seek to improve efficiency by motivating providers to reduce costs and share the savings. Health outcome measures can be noisy. Errors, confounding, patient and care complexity and where the provider sits within a care pathway (locus of control) can make it difficult to attribute provider actions (or inaction) to outcome measures (see Figure A.2). This could bias outcome metrics and create a mismatch between funding outcomes and true health outcome performance.

Figure A.2: Challenges attributing provider action to outcomes



Source: [96]

Individual provider value based payments

Value based payment models broadly include pay for performance, capitation, bundled payments, and accountable care organisations, although in many instances funding models are blended, mostly with a fee-for-service model, to ameliorate some provider financial risk.

Pay for performance

Pay-for performance models tie financial incentives to the providers' performance, either through a financial reward for reaching a target, or imposing a financial penalty for not reaching that target. As targets can reflect desirable value-based outcomes, pay for performance can nudge providers toward value-based care. Targets can include process measures that correlate with better outcomes and reduced costs or can directly include patient outcome measures or cost measures.[97]

The magnitude of the financial incentive required to influence provider behaviour is often ambiguous as it depends on the marginal cost of changing provider and clinical behaviour to meet targets.[95] However, pay for performance models are typically used with other payment models, such as fee for service, and generally comprise one to five per cent of total revenue.[98]

While it is more desirable to measure patient outcomes within a pay for performance model, this is often not possible. Outcomes are often not directly measured or are not easily attributable to service delivery because socioeconomic characteristics, patient behaviours (e.g., medication adherence) and access to supplementary care, such as informal care from family or friends, may confound outcome measures. This is of particular concern for mental healthcare where changes in these factors are outside the control of providers but are likely to impact outcomes.

Capitation

Capitation models provide periodic payments for providers to manage patient healthcare needs over a defined period. As payments are not tied to services, it gives providers full flexibility over the services they choose to deliver to patients. Provider revenue is derived from the number of patients cared for and the associated price per patient.

When payment is based on each patient registered, providers are incentivised to attract more patients that are less complex because they are less costly to manage, unless payments are adjusted for differences in healthcare service utilisation risk. Capitation models can be targeted to manage a patient with a specific condition (e.g., diabetes) or targeted to manage all patient health conditions. While most capitation models require patients to be registered, some capitation models pay providers to manage the health of a population within a defined geographical area. These are sometimes called 'population based models'.

Capitation models place providers at some financial risk. Providers are exposed to changes in healthcare unit costs and unexpected increases in care volume.[99] This means providers are incentivised to keep unit costs down, improve service delivery efficiency, and manage care volume by providing more preventative care services, for example.[100]

Multiple provider value based payments

Bundled payments

In a bundled payment arrangement, multiple providers are reimbursed under contractual arrangements for delivering a specified bundle of services within a defined episode of care, rather than being reimbursed for each service.[56] Ensuring the bundle of services meets patient needs is important because excluding services could incentivise providers to shift care outside the bundle.[56]

A bundled payment is intended to incentivise a reduction in costs as providers can participate in savings made from improving health outcomes and delivering more efficient care. As multiple providers work together to deliver outcomes, there is greater scope to incentivise better integrated care and care coordination across a care pathway, compared to pay for performance or capitation models. Providers within a bundled payment arrangement will seek to shift care outside expensive hospitals, for example through implementing preventative care, reducing hospital length of stay, and reducing hospital readmission rates.

In some bundled payment models, providers only share in savings, while in other models, providers may also be exposed to downside risk. This requires providers to repay the payer if expenditure exceeds a specified target, usually based on historical spending. Providers must therefore trade-off the potential cost savings from reducing care service volume with the potential for worsening health and associated increase in costs. [56 58]

Accountable care organisations

An accountable care organisation is a contractual arrangement between multiple providers that holds them accountable for the total cost and quality of care delivered for a defined population.[101] Most ACO models are implemented in the US, with others operating in Europe, Singapore and New Zealand.[102] Their characteristics vary in terms of which types of providers are included, care models used to achieve outcomes, risk and reward structures, contractual obligations, and payers. Older ACOs have used historical expenditure benchmarks to set targets, while newer ACOs have employed targets that are risk adjusted based on population health.[102]

Providers participating in an ACO are primarily incentivised to reduce expenditure given that expenditure savings from delivering care is shared across providers. However, some ACOs are penalised by seeking compensation if expenditure is greater than targets.[102] ACOs sometimes align with characteristics typically found within a capitation based payment model, the difference being the ACO must account for all participating providers rather than just one. For example, the US Centres for Medicare and Medicaid Innovation (CMMI) pays ACOs under the Global and Professional Direct

Contracting Model either a partial or full capitated payment. ACOs pay participating providers using their own payment arrangements or rates, which can include fee for service, but they also participate in either 50 per cent or 100 per cent of shared savings or losses generated.[101]

Blended funding models

Blended funding models mix two or more funding models together. Models are typically blended with fee for service models, and in some cases, funding is delivered by multiple payers.[103] For example, pay for performance is usually mixed with fee for service, with the pay for performance component making up a small proportion of total revenue to avoid financial risk becoming too great for providers to manage. Many bundled payment models that have operated in the US reimburse participating providers using fee for service up to a cap. Blended funding models aim to utilise financial incentives and ameliorate financial risk not otherwise found in one funding model alone. Multiple payment models can be complementary and compensatory, however they can create contradictory incentives if not well aligned.[103]

Social impact bonds

Social impact bonds are being explored in Australia and internationally to fund services delivered to vulnerable people. Most social impact bonds are aimed at services that are likely to indirectly impact mental health outcomes, such as employment, homelessness, education, child and family welfare and criminal justice. Some social impacts bonds are directly aimed at improving mental health outcomes (see Box A.1).

Social impact bonds primarily aim to reduce high cost acute service use by funding greater access to preventative and early intervention services delivered in the community. Private funding partners invest in the social impact bonds and receive a return from the traditional payer (usually government) based on whether stated outcomes are achieved by the provider receiving the bond. In most case, not-for-profit organisations seek funding through social impact bonds, delivering services either through their own programs or by partnering with other organisations, including the public sector.

There is some interest in social impact bonds in Australia and other countries, such as the UK and US, and some European countries. The NSW Office of Social Impact Investment is a government agency promoting social investment in NSW, with eight social impact investments launched since 2013.[104] A 2018 review of social impact bonds in the UK suggested they could overcome fragmentation and silos across government services by focusing on achieving outcomes.[105]

Box A.1: Resolve Social Benefit Bond

The Resolve Social Benefit Bond is Australia's first social impact bond aimed at improving mental health. It will provide $7 million between 2017 and 2025 to Flourish Australia to fund recovery oriented services, including intensive residential care, psychosocial, medical and mental health support, linkages to other existing support services. Service recipients include people who have spent between 40 to 270 days as a mental health inpatient over the year prior to their enrolment, with Resolve expected to fund 530 patients in total. Payments to investors are based on public hospital savings achieved by Flourish Australia. Investors receive a baseline 2 per cent per annum fixed coupon over the first 4.75 years and additional payment made by NSW Health based on performance directly linked to the reduction in the number of Nationally Weighted Activity Units (NWAU). Evaluation to date suggests the Resolve Social Benefit Bond has resulted in around $10.3 million in savings for the public healthcare system.

Source: [106]

Value based payments in mental healthcare

Pay-for-performance and capitation models have been tested multiple times in the Australian healthcare system to improve physical health, although with little success.[17] There are no recent examples of value based payment models being implemented for mental healthcare in Australia. However, capitation is used by the Australian Government to pay aged care providers to deliver care within residential care homes under a risk assessment that considers mental health along with physical ability, cognitive ability, and behaviour.[17]

Bundled payments and accountable care organisations are being explored internationally, particularly in the US where the CMMI will receive $20 billion between 2010-30 from the US government to shift all Medicare funded care into a value based payment model by 2030.

The CMMI seeks to build upon learnings collected over the last decade from implementing and testing more than 50 alternative payment models. Little work has been undertaken by CMMI on developing value based payment models for mental healthcare, although mental health has become a greater focus more recently as CMMI seeks to contribute towards the US strategy to address the national mental health crisis.[107]

Examples of value based payment models applied to mental healthcare are presented in Table A.2. Value based payment models in mental healthcare have achieved mixed success in improving quality and reducing expenditure.[108] For example, within the Medicare Shared Savings program and the

Pioneer accountable care organisation, two large Medicare accountable care organisations, only the Pioneer accountable care organisation led to reduced inpatient mental health spending, mostly due to reduced admissions. The Medicare Shared Savings program did not reduce mental healthcare utilisation or spending, and both programs did not lead to significant improvements in care quality.[109] The US government has since sought to improve mental health care by expanding coverage for mental healthcare services within accountable care organisations.[110]

Table A.2: Value based payment model case studies for mental healthcare

Funding model	Case study
Pay for performance	Washington State Mental Health Integration Program (MHIP) in the United States shifted from fee-for-service to pay for performance in 2009.[111]. Under the pay for performance scheme, 25 per cent of the annual funding to providers was linked to the fulfilment of several quality indicators, including PHQ-9 score, timely follow-up of patients, and regular tracking of medications. MHIP participants had major depression accompanied by other psychiatric issues and substance abuse.[111] The majority of participants experienced timely follow up, and the overall PHQ-9 score substantially improved. Although the care was focused on mental health treatment, participants also had fewer complaints about their physical health.[111]
Capitation	Colorado in the United States moved towards capitation payment in mental health services in the mid 1990's to manage costs that had been increasing in a fee-for-service model.[112] A series of severe or persistent mental health conditions were qualified for capitation. Mental Health Assessment and Service agencies (MHASAs) were established to provide capitated services directly or through contracts with other providers. Capitation rates were 95 per cent of the fee-for-service payment, while payment was determined by enrolment at month's end.[112] Service utilisation, cost and health outcomes under the capitation were compared with fee-for-service payment in early implementation (9 months) [112], mid-term (two years)[113], and in the long run (five years)[114]. The capitation scheme reduced inpatient costs and outpatient service use. There were no apparent differences in symptoms, quality of life, and welfare outcomes over two years.[113]
Bundled payment	In 2008, the Depression Improvement Across Minnesota, Offering a New Direction(DIAMOND) project introduced a bundled payment in Minnesota in the United States to manage integrated mental health services costs.[115] DIAMOND was a partnership between the Minnesota Department of Human Services, primary care providers and six major health insurance providers. Primary care providers implemented integrated care for depression, receiving a negotiated monthly bundled payment for every patient who received depression-related care. The PHQ-9 was the primary outcome measure. The bundled payment rate covered all clinical costs, including care managers' salaries.[115] Evidence indicated that bundled payment provided enough incentives for providers to bear the initial cost of delivering integrated care, such as hiring a care manager or establishing the patient registry and measuring the health outcomes.[115]
Blended payments	North East London Foundation Trust (NELFT) provides mental health services for adults living in six geographical areas in London. In 2015, NELFT adopted mental health cluster-based activity payments and capitation payments to pay for mental health services. A risk share agreement was in place, which limited the financial exposure for both NELFT and providers. There was also substantial investment in developing a patient registry and data collection to enable health outcome monitoring while keeping costs low.[116] After shifting to blended capitation, the gap between predicted and actual activity reduced. Moreover, providers better understood the cost associated with their services and realised the benefits of investment in the patient registry and data collection.[116]