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Getting more value from mental healthcare funding and investment

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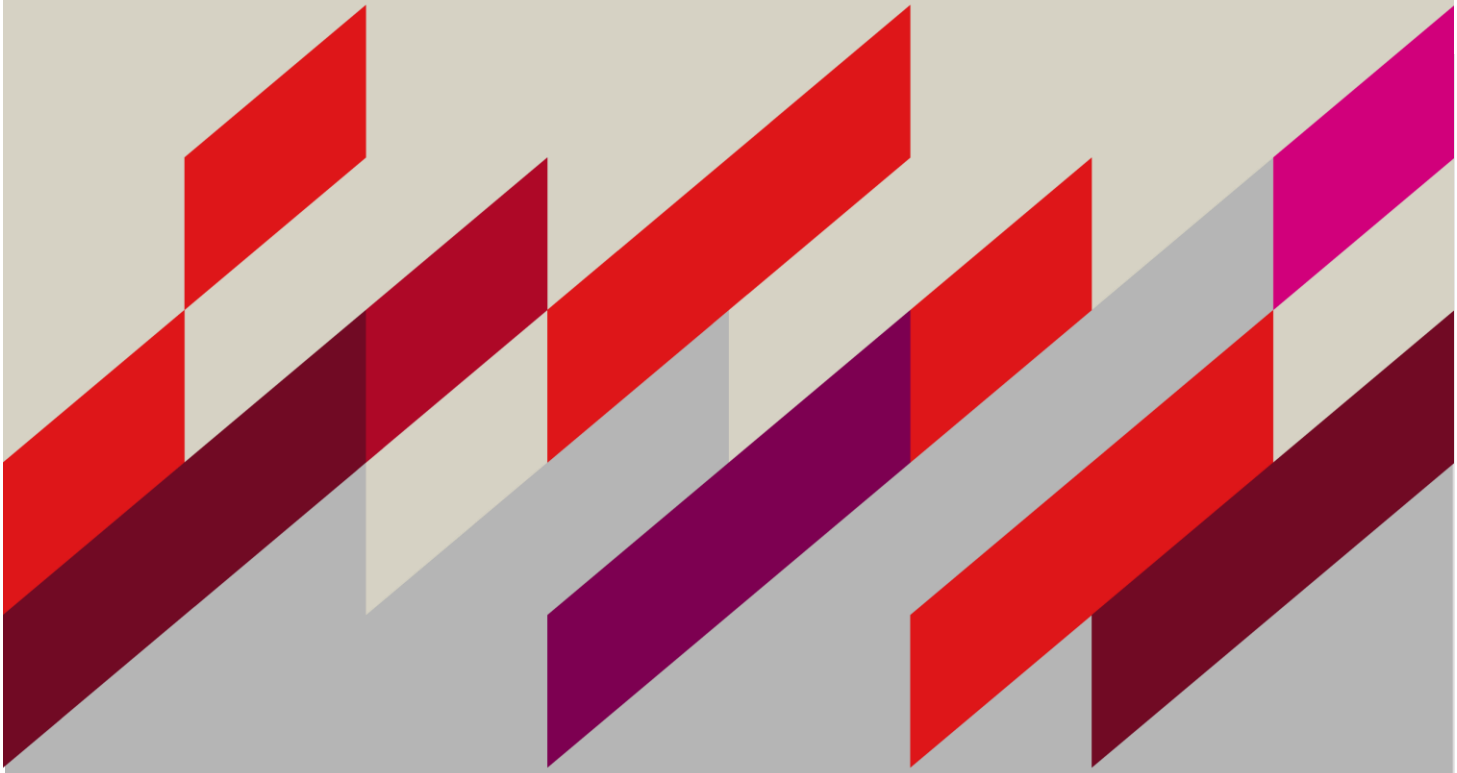

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About MUCHE

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

Good mental health is essential for a happy and productive society, yet Australia's mental healthcare system struggles to meet the needs and preferences of consumers. In 2022, Australian governments agreed to reform the mental healthcare system, signing the National Mental Health and Suicide Prevention Strategy. While reform has begun, major change within the mental healthcare system is required to ensure consumers receive comprehensive, coordinated, consumer-focused and compassionate care.

Our study sought to provide additional direction to Australian governments on reforming mental healthcare funding and investment. The intent was to build on recommendations made within the Productivity Commission Inquiry into Mental Health, the Royal Commission into Victoria's Mental Health System and the 2030 vision outlined by the National Mental Health Commission. All organisations have recommended reforms to mental healthcare funding and investment.

A consultation paper was publicly released in 2023, which presented a process for shifting some funding from Medicare to value based payments, and a process for promoting a unified, systematic, transparent and evidence based approach to making government mental healthcare investment decisions.

A national consultation process followed, which included interviews with government stakeholders and workshops with non government stakeholders, that included peak bodies, providers, consumers and carers, and academics. Perspectives were collected and analysed using thematic analysis and schema analysis.

This report summarises two papers produced from our study. One evaluated stakeholder perspectives on introducing more value into mental healthcare funded, while the other evaluated stakeholder perspectives on introducing more value into government investment decisions. Both papers are supplementary to this report.

An overview of the proposed funding and investment decision processes presented within the consultation paper is discussed, along with a summary of stakeholder perspectives collated into identified themes and schemas, and recommendations for governments to move towards reforming mental healthcare funding and investment.

Overall, stakeholders supported a shift to more value based payments in mental healthcare, and supported a more unified approach to government investment decisions. Some stakeholders were concerned about introducing our proposed Independent Value Based Payment Authority. Some were

concerned about a potential misalignment between a unified approach and differing political objectives, economic circumstances and healthcare system structures within jurisdictions.

This report recommends that governments proceed with our suggested approaches to embedding more value into mental healthcare funding and investment.

It recommends that governments first lay the groundwork, by better defining value in mental healthcare and identifying outcomes that consumers value. Governments must also invest in better data collection and infrastructure to support all stakeholders, and stakeholders should be further informed on the need for reform.

This report recommends that governments develop strategy and implementation plans to help guide and communicate reform directions. Plans should align with broader reform directions established within Australian government policy, including paying for outcomes and value and harmonising the process for assessing expensive healthcare technology within jurisdictions.

1. Introduction

Good mental health improves every part of our lives. It positively contributes to our relationships, social interactions, educational outcomes and workplace productivity. Prevention of mental ill health and effective mental healthcare are cornerstones of a prosperous and happier society.

Australian governments recognise the importance of good mental health. They strive to improve the lives of Australians living with mental ill health by funding and delivering a multitude of prevention and treatment services, mainly through Medicare and activity based funding. Psychosocial services within the disability sector are also funded through the National Disability Insurance Scheme. (National Disability Insurance Agency, 2021)

A struggling mental healthcare system

Australia's mental healthcare system has struggled to provide services that align with the needs and preferences of many Australians. (Productivity Commission, 2020) Chronic underinvestment and fragmented service delivery models have made it difficult for consumers and carers to access and navigate the system. Providers are often required to respond to a crisis, rather than preventing the crisis from taking place. Many people receive services that are not based on evidence, limiting improvements in health outcomes and creating waste within the system (Productivity Commission, 2020)

In 2020, the Productivity Commission made 24 recommendations (with many more actions) to reorganise Australia's mental healthcare system around the person receiving care and their carers. Recommendations included filling service gaps in healthcare and online treatment and delivering more services in sectors outside the healthcare system, such as community care, education, workplaces, housing and justice. Recommendations also sought to stop cost shifting and strengthen accountability through a whole-of-government approach, reforming funding arrangements to improve efficiency and equity, while increasing monitoring, evaluation and research. (Productivity Commission, 2020)

Almost in parallel, the Victorian Government established the Royal Commission into Victoria's Mental Health System. Its final report released in 2021 contained 65 recommendations to improve the mental healthcare system in Victoria. (Armytage et al., 2020) Recommendations covered the entirety of care, from investing more in prevention to addressing crisis driven services. The Royal Commission recommended improving mental healthcare funding, investment, governance, workforce, and reducing stigma. It suggested developing a better support system for communities and carers. (Armytage et al., 2020)

Most Australian mental healthcare services are funded through Medicare, a fee for service funding model that structurally remains unchanged since 1984. Fee for service funding models can incentivise providers to deliver more services compared to a salaried or capitation model. The more services provided, the more revenue a provider receives.

While the incentive to over-service consumers is well recognised, empirical results on whether additional services improve health outcomes are mixed (Brekke et al., 2020, Hennig-Schmidt et al., 2011) Copayments are unlikely to solve the over-servicing incentive problem in mental healthcare due to large information asymmetries between providers and consumers. (Conrad, 2015) Regardless, Medicare delivers no direct incentive for providers to deliver good care quality or improve health outcomes.

Medicare and activity based funding has stopped healthcare providers from working together to deliver appropriate care, while Medicare has also created financial barriers to accessing care. (National Mental Health Commission (NMHC), 2022b) Poor financial incentives and ambiguity around which tier of government is responsible for funding some services have made integrating care more challenging. (Productivity Commission, 2020) Funding rules have limited the ability of providers to deliver innovative care outside a public hospital. (Huxtable, 2023)

Navigating mental healthcare in Australia remains complex. Some providers deliver low value or no value care as care is not aligned with evidence. Some government funded mental health care programs also exist based on little evidence of effectiveness or cost effectiveness, limiting the value of government and consumer spending. (Productivity Commission, 2020) Research outcomes have not been used by healthcare system managers and providers effectively, creating a large research-to-practice gap, which is likely wider with social disadvantage. (Horvitz-Lennon, 2020)

Ongoing mental healthcare reform

In 2022, state, territory and federal governments established the National Mental Health and Suicide Prevention Agreement (*the Agreement*), which laid out the shared intention of Australian governments to:

- improve the mental health of all Australians;
- ensure sustainability; and
- enhance mental health and suicide prevention services. (Commonwealth of Australia, 2022)

Specific objectives 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 government-funded services and ensuring equitable access to the appropriate level of mental health care needed. (Commonwealth of Australia, 2022)

The Agreement set a shared reform agenda across governments, outlining joint responsibility to deliver a fair share of funding, to determine funding policy, and to explore innovative models of care within the national funding model. It prioritised regional planning and commissioning, allowing jurisdictional governments to determine local planning and commissioning frameworks.

More recently, the independent review into the National Disability Insurance Scheme has called on governments to develop a new approach to supporting psychosocial disability and for an integrated care coordination approach with the public mental healthcare system for people with complex needs. (Department of Prime Minister and Cabinet, 2023)

A focus on funding and investment

While the Agreement outlined key funding and investment principles and responsibilities among governments, more work is required to understand better what funding models are best suited to delivering integrated mental health care, and how to improve government investment decisions to ensure they are more evidence based.

The Productivity Commission stopped short of recommending value based payment models for mental healthcare, noting health outcomes were not measured well enough to inform funding decisions. (Productivity Commission, 2020) The need to develop a universally accepted, co-designed set of outcome measures attributable to services has since been identified by the National Mental Health Commission. (National Mental Health Commission (NMHC), 2022b)

States and territories have acknowledged that healthcare system planning and commissioning should pay for value and outcomes. (Commonwealth of Australia, 2022) The mid term review of the National Health Reform Agreement recommended developing a structured work program to start embedding bundled payments and implement payment models that reward and penalise high and low value care respecitvely. (Huxtable, 2023)

Further reform of mental healthcare funding and investment mechanisms is required for governments to achieve their Agreement goals. This requires greater coordination between policy makers, researchers and service providers, and further investment in research, translation and ongoing evaluation. (National Mental Health Commission (NMHC), 2022a)

2. Study objectives

This study sought to provide additional direction to state, territory and federal governments on reforming mental healthcare funding and investment in Australia.

The intent was to build off the substantial analysis and recommendations already made by the Productivity Commission, (Productivity Commission, 2020) the Victorian Royal Commission, (Armytage et al., 2020) and the National Mental Health Commission. (National Mental Health Commission (NMHC), 2022b)

Government and non-government stakeholder perspectives were collected to answer two primary questions:

1. How should value based payments be implemented in the Australian mental health care system.
2. How can a more systematic, transparent and evidence based approach to government mental health care investment decisions be embedded into government processes.

This study sought to answer the *'how'* of funding and investment reform. It has already been established that value based funding models and a systematic and transparent investment decision process for mental health care are warranted. (Productivity Commission, 2020, Australian Government, 2020)

This study aligns with the broader healthcare policy debate on shifting towards blended payment models that reward improved outcomes, as outlined within the National Health Reform Agreement. (Australian Government, 2020, Huxtable, 2023) and more recent federal government policy to shift healthcare funding away from Medicare towards alternative value based funding models. (Department of Health, 2022)

Within this context, this study sought to account for the unique sector characteristics within mental healthcare, such as highly uncertain outcomes, and the breadth of impacts mental ill health has on broader economic and social outcomes. Mental ill health often requires more than a discrete episode of care, reflecting complex socioeconomic and social environments that can lead to and exacerbate poor mental health. These special characteristics must be addressed within any funding and investment reform.

3. Methodology

This study systematically collected and analysed stakeholder perspectives on funding and investment reform in mental healthcare. Two new approaches to funding and investment were presented in a detailed consultation paper developed within this study and publicly released in 2023.

The consultation process included interviews, workshops and written submissions with government and non government stakeholders, consumers and carers, between September and November 2023. The analytical methods included thematic analysis and schema analysis.

An external Reference Committee was established to guide and provide feedback on consultations, analysis and interpretation of results. It comprised members from federal and state government agencies, a peak organisation, a provider and academia.

Consultation paper

A rapid literature review was undertaken in 2022 to explore the international funding and investment landscape in mental healthcare, focusing on models that sought to incentivise providers to deliver high quality care and to improve health outcomes.

The literature review informed the development and public release of a consultation paper in August 2023, (Cutler et al., 2023) which outlined the nationally agreed vision for mental health care, (Commonwealth of Australia, 2022) problems associated with current mental healthcare payment models in Australia, and summarised conclusions and recommendations related to paying for mental health care within the Productivity Commission Inquiry into Mental Health. (Productivity Commission, 2020)

The consultation paper proposed a new funding framework to embed value based payment models into mental health care. It proposed that payment model trials be orchestrated by a newly established Independent Value Based Payment Authority. The consultation paper discussed principles that could underpin new payment models in mental health care and the potential challenges to implementation that would need to be overcome. (Cutler et al., 2023)

The consultation paper also proposed a unified national approach to mental healthcare government investment decisions that included a systematic, transparent and evidence-based process to the investment assessment procedure. It comprised developing a set of principles for underpinning the evaluation process, and developing a process that includes a single point of entry for investment applications. The consultation paper suggested forming an independent Mental Health Advisory

Committee, which would make recommendations to ministers on whether a proposed large investment in mental healthcare should proceed.

Consultation process

A national consultation process was undertaken between September and November 2023 that included semi structured interviews with senior executives from government. Twenty-five individuals consented and attended an interview; 21 were from state and territory government departments and agencies, and four were from federal government departments and agencies.

Three national online workshops were also conducted with non-government mental health stakeholders, including providers, peak bodies, consumers, carers and academics. A total of 70 people attended the three workshops. One national online workshop was specifically targeted at consumers and carers, given they had not substantially contributed to group discussions within the two workshops where stakeholder types were mixed.

The study also received 12 written submissions from organisations (4 consumers, 1 provider and 7 peak bodies), which were incorporated within the analysis alongside the perspectives of interview and workshop participants.

Analytical methods

Government stakeholder perspectives collected from interviews were analysed using thematic analysis, a systematic method that codes qualitative data into themes to extract meaning by identifying, analysing, and interpreting patterns. (Clarke and Braun, 2017)

Themes were mapped to the Consolidated Framework for Implementation Research (CIFR) to categorised them within commonly established taxonomy, terminology, and definitions. The CFIR is a common ‘meta-theoretical’ framework developed from a synthesis of nearly 500 published sources, 18 existing theories and consensus among the implementation science community. (Damschroder et al., 2009)

Non-government stakeholder perspectives from the three workshops were analysed using schema analysis, a systematic way of summarising, and offering a clear and succinct presentation, of the essential elements within an original text. (Rapport et al., 2018) The schema analysis employed group-working activities within the research team to reveal essential textual elements in the qualitative data, enabling the research team to interpret and form a consensus view on what data meant.

Outputs

Two papers were written based on an analysis of stakeholder perspectives (see Supporting Papers). One paper (Paper 1) focused on stakeholder perspectives related to shifting some of Australia's mental healthcare funding from Medicare towards value based funding models.

The other paper (Paper 2) focused on stakeholder perspectives related to developing a unified, systematic, transparent and evidence-based investment decision process for government when deciding on mental healthcare investments. Both papers were used to form recommendations for moving towards funding and investment reform within Australia's mental healthcare system.

Papers 1 and 2 are provided as supplements to this summary report.

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4. Value based payments

There is a growing appetite for healthcare payment reform within Australia. This comes from all governments, with the Addendum to the National Health Reform Agreement (2020-25) proposing a shift the Australian healthcare system towards paying for value and outcomes. This included enabling new and flexible ways for governments to pay for health services to enable them to deliver care in the most appropriate place.

Within this reform context, our study sought government, non-government, consumer and carer views on shifting mental healthcare funding away from Medicare towards a proposed value based payment approach in Australia. This chapter provides an overview of the key themes drawn from stakeholder perspectives on our proposed approach to funding reform and offers recommendations to embed more value into mental healthcare funding. More detailed information is presented in Paper 1, which is supplementary to this report.

A proposed approach to funding reform

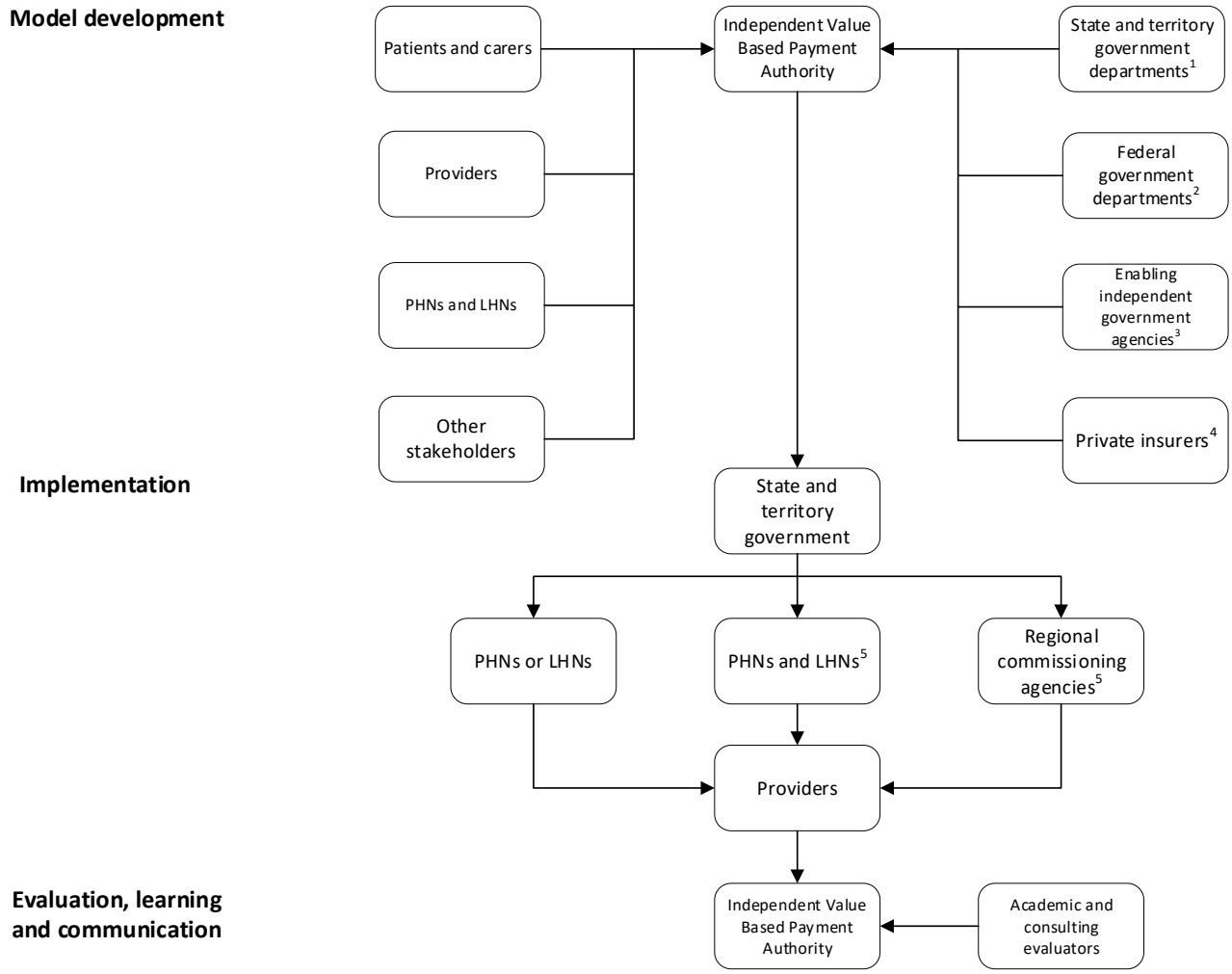
A proposed approach to implement funding reform within mental healthcare was contained within our consultation paper, which was publicly released in August 2023.

The approach suggested that governance in developing, implementing and evaluating a value based payment model should come from a newly formed Independent Value Based Payment Authority (IVBPA) to coordinate model development, implementation and learnings across multiple government departments and agencies, and across states and territories (see Figure 1).

The consultation paper suggested the IVBPA should be responsible for developing all types of value based payment models for mental health and physical health, rather than just mental healthcare alone. This recognised the strong association between good mental and physical health, and that many integrated care pathways, particularly for people with more severe mental ill health, are likely to require both mental and physical health services.

While it was proposed that the IVBPA develop value based payment models, the consultation paper suggested that implementation of these models should be led by state and territory governments. This could be done through PHNs, LHNs, a combination of both, or by independent regional commissioning agencies as described by the Productivity Commission. (Productivity Commission, 2020)

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.

The consultation paper noted that PHNs, LHNs, or agencies would require ongoing support from state, territory and federal governments to implement a value based payment model. Activities could include motivating providers to participate (unless participation was mandatory), 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. (Cutler, 2022)

The proposed governance structure did not preclude PHNs, LHNs or regional commissioning authorities from identifying service gaps, undertaking local planning or commissioning services. The consultation paper suggested a national approach would provide a consistent application of value based payments across Australia.

An important component within the proposed governance structure was evaluation, learning and communication of outcomes. The consultation paper noted that embedding value based payment models is a long term proposition. Some models would fail but would provide important lessons for the development of subsequent models. The consultation paper noted that lessons should be incorporated within an iterative learning process to create impetus for further trials for long term improvement.

The consultation paper suggested that iterative improvement of value based payment models could be facilitated through staged rollout, interim monitoring and evaluation, dedicated change coordinators, workshops, improvement logs, and continual refinement of treatment protocols and outcome measures. Risk adjustment methodologies should similarly be continuously reviewed, refined and lessons disseminated, along with the implementation of new value based payment models in real-world settings.

An overview of stakeholder perspectives

Government perspectives drawn from interviews resulted in six core themes with various subthemes. The core themes included:

1. Clear payment model definitions and place.
2. Ensuring patient focused care.
3. Payment model characteristics.
4. Addressing workforce challenges.
5. Embedding appropriate governance structures.
6. Circumventing barriers to payment reform.

There was consensus among respondents for implementing value-based payment models in mental health care. Some respondents were concerned about how a value based payment model would fit into the current healthcare system, how the proposed development and implementation process would fit into overlapping system governance structures, and whether mental healthcare funding reform should be prioritised compared to fixing workforce challenges, for example. Some respondents supported the establishment of an IVBPA, while others did not.

Respondents noted several potential barriers to introducing value based payment models into the Australian mental healthcare system. These included:

- defining value (to whom and for what);
- identifying measurable outcomes that matter to consumers;
- data scarcity to measure outcomes and attribute to services;
- implementation complexity;
- little evidence supporting the potential benefits of value based payment models; and
- challenging political and economic environments.

Government and non-government respondents recognised workforce gaps and inequities in access to care for consumers in regional and remote areas as critical issues that require attention before implementing funding payment reform. Consumer and carer respondents noted the need to define value from a consumer perspective that allows outcomes to be attributed to services. Non-government respondents noted the importance of promoting equity within a value based payment model by allowing consumers to choose their service and by focusing outcomes around improving their functions and capabilities.

Respondents acknowledged the complexity of defining and measuring value in mental health care, While clinical measures and surveys are helpful for specific diagnoses, they were perceived by respondents as insufficient in capturing the holistic aspects of wellbeing and the ability to function in society. Alternatively, some respondents were concerned that attributing services to outcomes other than those related to health would be problematic, given non-health factors can impact health outcomes.

Existing mental healthcare outcome measures were criticised for their limited usefulness in enabling cross-diagnosis and cross-sector comparisons. Stakeholders highlighted challenges in mapping outcomes to health utilities and the potential inadequacies of survey instruments to capture outcomes that matter to people with mental ill health. Consumers, carers, and lived experience groups stressed the importance of outcomes outside clinical domains.

Differing perspectives and alternative weights were seemingly placed on themes across government and non-government stakeholders. This may reflect different objectives. Government respondents focused on the macro complexities associated with reforming payment models, while non-government stakeholders focused more on the complexities of building and measuring outcomes around the consumer. Themes and schemas highlighted the importance of *'laying the groundwork'* by addressing broader issues within the mental healthcare system before implementation occurs. Examples included workforce challenges, system and service fragmentation and more explicit government roles and responsibilities.

Respondents suggested that a change in governance structures was necessary for value based payment models to be successful in mental health care. This aligns with the views presented by the National Mental Health Commission. (National Mental Health Commission (NMHC), 2022b) The National Health Reform Agreement and the National Mental Health and Suicide Prevention Agreement were not seen by respondents as providing enough guidance on funding reform, nor generating enough political will for change.

Opponents of an IVBPA noted the potential for duplicated government functions when trying to incorporate into state, territory and federal government structures. Proponents noted that an IVBPA would ensure a clear allocation of responsibility, allow concentrated development of expertise, and ensure disciplined use of evidence. Respondents noted potential gaps in civil service capability to implement a value based payment model.

This study underscores the need for a more nuanced and comprehensive approach to defining and measuring value in mental health care, with a focus on consumer-centric outcomes, before seeking to introduce value based payments. Complexity identified by stakeholders in developing and implementing a value based payment model within mental healthcare, and the potential barriers to success, suggests further learning and patience are required to reform mental health care funding in Australia. Nonetheless, there was consensus from stakeholders that shifting some funding towards value based payments is needed within Australia to promote more consumer oriented, integrated care.

Recommendations

Recommendations to state, territory and federal governments were developed from the detailed analysis of stakeholder perspectives. They relate to embedding value based payments into mental healthcare, as described within the consultation paper. They seek to add upon reform directions proposed by the National Mental Health Commission, such as promoting a connected and integrated system of care, whole of government leadership, and improving outcome measures. (National Mental Health Commission (NMHC), 2022b) They also seek to contribute towards recommendations made by

the mid term review of the National Health Reform Agreement to develop a new 10 year National Health Funding and Payments Framework. (Huxtable, 2023)

Short term actions (1-2 years)

1. **Develop an agreed definition of value within mental healthcare** in consultation with all stakeholders.
2. **Develop a universally accepted set of outcomes** in mental health care in consultation with all stakeholders.
    a. Outcomes should reflect value, be measurable and be attributable to services.
    b. Outcomes should not be restricted by data availability, instead new data collections should be proposed where required.
3. **Develop a greater stakeholder understanding** of the need to move towards value based payment models that provide more flexible funding.
    a. Include public awareness campaigns, advertising schemes, local and national media, social media, and academic outputs.
    b. Include national workshops and webinars.
4. **Develop a 10 year strategy and implementation plan** on embedding value based payment models into mental health care.
    a. Engage early with consumers and providers to motivate system change and ensure greater provider and consumer investment, ownership, and accountability.
    b. Ensure the strategy aligns with any new National Health Funding and Payments Framework resulting from a new National Health Reform Agreement. (Huxtable, 2023)

Medium term actions (3-4 years)

5. **Develop and implement data infrastructure strategy to fill data gaps** that create barriers to attributing outcomes to mental health care services and to measuring net benefits from introducing value based payment models.
    a. This should include a national audit of data currently collected that could potentially be used to fill data gaps.

6. **Integrate mental healthcare funding reform** into the next National Mental Health and Suicide Prevention Agreement to align governments with the 10 year strategy and implementation plan on embedding value based payment models (see Recommendation 4)
7. **Integrate mental healthcare funding reform into primary care reforms** outlined within Australia's primary health care 10 year plan. (Department of Health, 2022)
    a. Stream 2 of the strategy seeks to develop more person-centred primary health care supported by funding reform that pays for better quality and outcomes.
8. **Develop an independent value based payment authority** supported by the next National Health Reform Agreement, which would work with state, territory and federal governments to develop, coordinate, and evaluate new value based payment models in mental health and physical health.

5. A new approach to investment

Many governments are trying to deliver better mental healthcare services to meet increasing demand, within an environment of increasing service costs and large budget deficits. This has created a need for a more systematic, transparent, and evidence based approach to evaluating the relative effectiveness and cost effectiveness of publicly funded mental healthcare interventions, to increase value for money.

No blueprint for such an investment decision process in mental healthcare exists within Australia. This is despite Australia having world leading systematic and evidence based approaches to evaluating medicines subsidised by the federal government. Investment uncertainty has potentially led to government underinvestment in mental healthcare and expensive interventions with low value relative to other potential interventions. (Productivity Commission, 2020)

This chapter provides an overview of key themes drawn from stakeholder perspectives on a proposed process to evaluate large, government funded mental healthcare investments. It offers recommendations on how to design a more systematic, transparent, and evidence based approach to investment decisions based on stakeholder perspectives. More detailed information is presented in Paper 2, which is supplementary to this report.

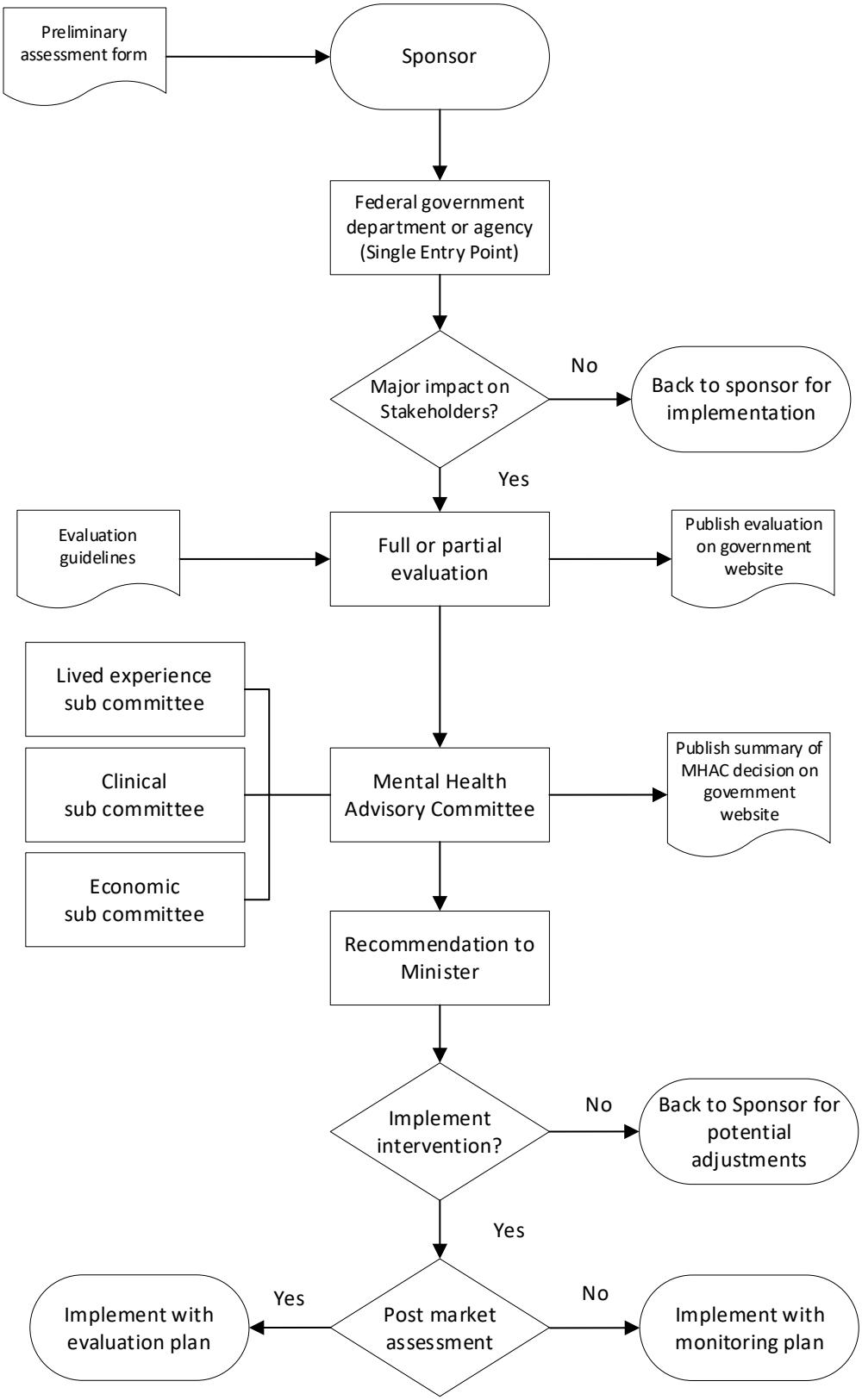
A proposed approach to investment

A proposed process for evaluating mental healthcare investments was contained within our consultation paper, which was publicly released in August 2023.

The consultation paper proposed a unified national approach to mental healthcare investment that included a systematic, transparent and risk-based approach to assessing large investments. (see Figure 2) This would inform governments on the comparative value of alternative investments, including areas where disinvestment is worthwhile, and provide ongoing guidance to inform future mental healthcare policy and research directions.

The consultation paper proposed that a sponsor first apply for an investment to be evaluated within the process. While a sponsor may likely comprise state, territory and federal governments, other organisations such as PHNs and LHNs should not be excluded from being a sponsor, nor should provider and patient groups.

Figure 2: Proposed process for considering mental healthcare investments



Any application would be initiated by a sponsor using a preliminary assessment form submitted through a dedicated web-based portal. There would be a single entry point for applications, upon which a federal department or agency would decide whether the application should proceed to an evaluation stage, based on whether the investment would have a major impact on stakeholders.

The consultation paper suggested that investment proposals should be evaluated by independent academics or consultants using an established set of guidelines and reporting templates. Whether a full or partial evaluation be undertaken should be determined by the investment characteristics, such as the expected impact on mental health outcomes, the healthcare system, society and the economy. Availability of clinical evidence, its quality and access to cost data should also contribute towards choosing the evaluation type.

Recommendations to the appropriate minister (this could be stateministers, federal ministers, or both) would be made by an established independent expert committee, termed within the consultation paper as the Mental Health Advisory Committee. It 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.

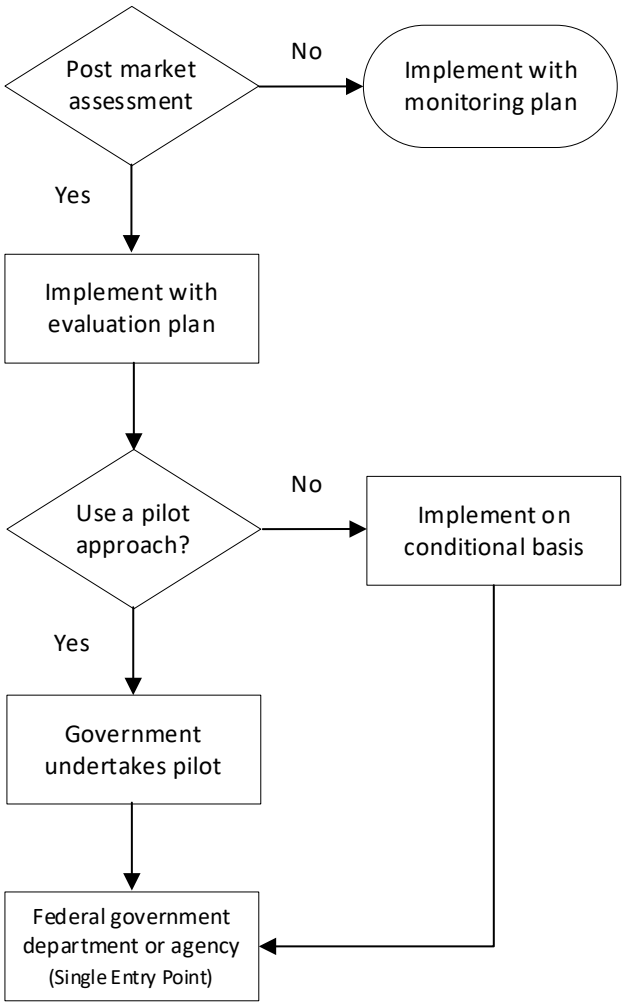
It was proposed that the Mental Health Advisory Committee would be supported by three sub committees. These include:

- Lived Experience Sub Committee, comprising consumers and carers;
- Clinical Sub Committee, comprising clinical experts in mental healthcare; and
- Economic Sub Committee, comprising experts in economic and program evaluation.

All recommendations made by the Mental Health Advisory Committee should be made public, and include a summary of the investment proposal, the recommendations made and their reasons why, and future areas for research.

The consultation paper suggested that the Mental Health Advisory Committee should also provide guidance on whether implementation should consist of either post market monitoring or implementation with an evaluation plan. The pathway would depend on the level of uncertainty within the recommendation made by the Mental Health Advisory Committee (see Figure 3). A recommendation with monitoring would be given to investments with greater certainty attached to their effectiveness and cost effectiveness.

Figure 3: Proposed process for post-market surveillance



The consultation paper suggested that implementing an investment with an evaluation plan could be undertaken using a pilot approach or be conditional on collecting more data. While pilot programs are useful when there is ambiguity regarding outcomes and costs, pilot programs can be expensive and delay access to effective and cost effective mental healthcare. A conditional approach could allocate funding temporarily, and once additional data is collected, an evaluation is conducted to determine whether funding should continue.

An overview of stakeholder perspectives

Government perspectives drawn from interviews resulted in four core themes with various subthemes. The core themes included:

1. Perspectives on and measurement of outcomes and value.

2. Roles of the evaluating institution.
3. Complexity and uncertainty in mental health care.
4. Within-stakeholder competition.

There was stakeholder consensus for a systematic, unified process for evaluating mental healthcare investments in Australia. Respondents thought that a process could build on existing approaches used in Australia to evaluate pharmaceuticals and medical services, but address challenges specific to evaluating mental health care, such as increased decision uncertainty from less reliable data and measuring a greater set of outcomes valued by consumers.

Government stakeholders noted that implementing a unified decision process would be complex within Australia's federated structure, given diverse policy strategies and economic circumstances. There was some concern among government stakeholders that a unified approach may not align with government policy setting processes, suggesting the need for designated pathways to evaluate investments within specific jurisdictions.

Some government respondents expressed concern that a Mental Health Advisory Committee investment recommendation may not fit within established state and territory healthcare strategies, or potentially reduce the capacity for governments to meet local mental healthcare needs. It was suggested that these perceived constraints in flexible policy responses may reduce the desire for jurisdictional governments to adopt a unified approach.

This study identified three main areas where investment decision processes must be tailored to address the unique characteristics of mental healthcare, including:

- the greater scale of uncertainty associated with investment decisions in mental healthcare, given poorly defined outcomes, the unpredictability of outcomes, difficulty in attributing outcomes to services, and the negative effects from mental ill health on non-healthcare sectors.
- the centrality of service bundles relative to pharmaceutical and medical services, given mental health interventions delivered to consumers may include several services delivered by providers within and outside the healthcare system; and
- the less developed methodology for economic evaluation of mental health care services compared to evaluating pharmaceuticals and medical services based on randomised clinical trials, with some mental health conditions likely to be more multifaceted and complex, comprising a greater range of health and non health outcomes to measure, and a greater need to control for other factors beyond healthcare that impacts outcomes.

Respondents identified several additional barriers to implementing the proposed process as outlined within the consultation paper. The need to account for the greater importance of social determinants for mental health outcomes and a wider range of care costs were mentioned. Respondents noted that an investment decision making process should be adaptable to local needs and accommodate innovative care programs.

Respondents noted that a wider range of perspectives should be considered when evaluating mental healthcare investments. Evaluations should include a central role for lived experience, measure the potential improved social effects from care, and assess whether the available workforce has the capacity and capability to deliver the model of care proposed within the investment. The degree to which a model of care was delivered as intended must therefore be assessed.

Respondents suggested the mix of potential investments in mental healthcare may contain a greater share of locally developed, patient and location specific programs compared to investment decisions related to pharmaceuticals and medical services. This unique characteristic of mental healthcare may limit the transferability of evidence when deciding on whether to recommend investments to larger cohorts of patients in various locations.

Respondents also suggested that more significant uncertainty regarding whether an investment provides a net benefit to society may exist within mental healthcare. Respondents noted that past investments in mental healthcare workforce and infrastructure could impact success, which means effectiveness may be location specific. Evaluations must draw out the potential heterogeneous impacts of a mental healthcare investment.

It was suggested that strict investment and disinvestment criteria used within the decision process could lead to adverse outcomes. Governments often face the challenge of balancing the need to provide some care within a community, with the desire to optimise value for money. Respondents were concerned that rules to disinvest mental healthcare investments within the decision making process could leave some consumers without access to services, particularly those in rural and remote regions.

The need to retain strong equity principles within investment decisions was highlighted as essential. Lived experience, clinical experts, and experts in methodological research were considered central to inform evaluations, investment recommendations made by the Mental Health Advisory Committee, and the development of new outcome measures and service models.

Despite identified political challenges, this study suggests that developing a systematic, transparent and evidence based investment decision process unified across jurisdictions could help governments make mental healthcare investment decisions that promote cost effective, evidence based care. The proposed process for considering mental healthcare investments outlined within the consultation paper was refined based on our analysis of stakeholder perspectives (see Figure 4 and 5).

Figure 4: Proposed refined process for considering mental healthcare investments

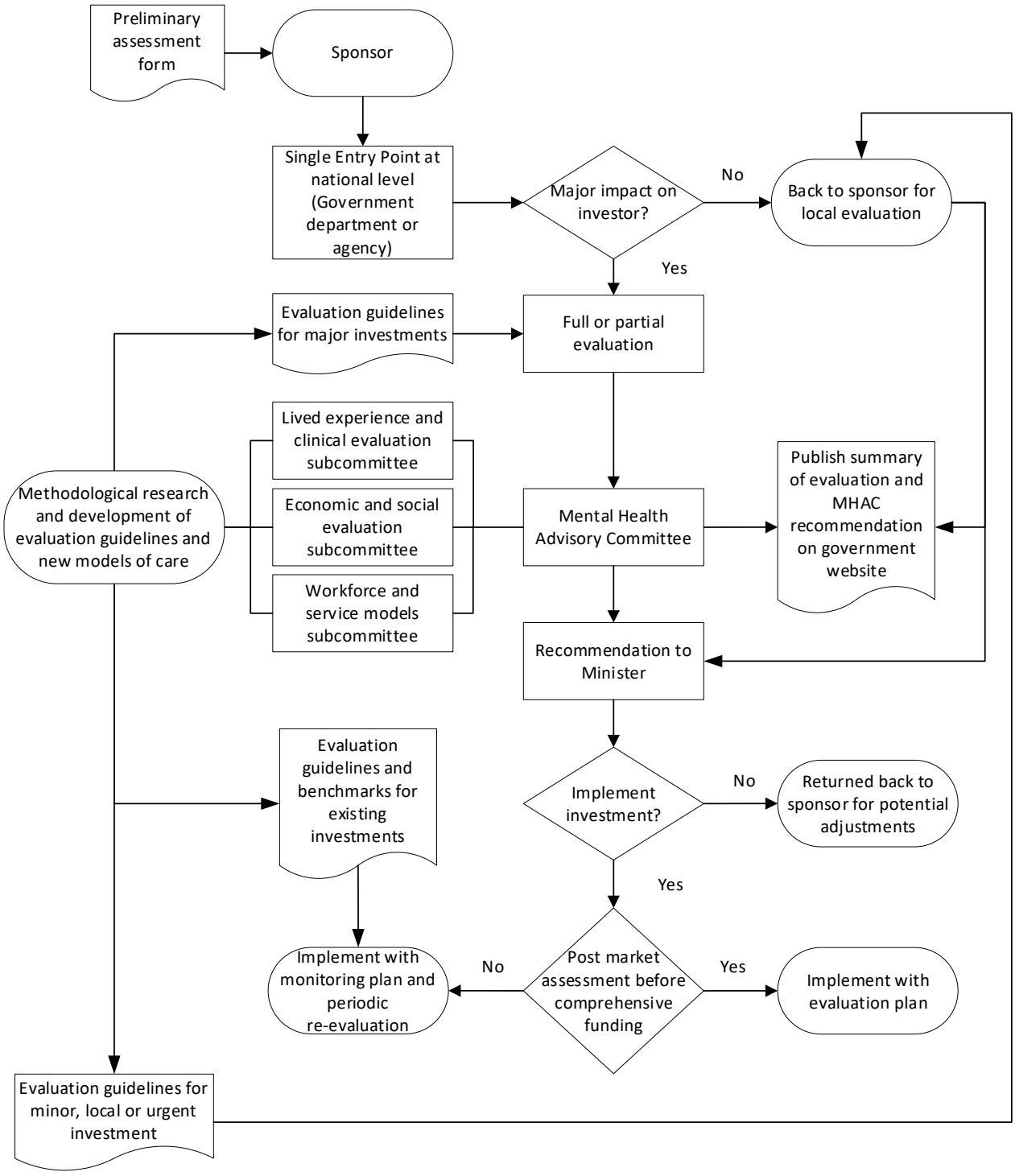
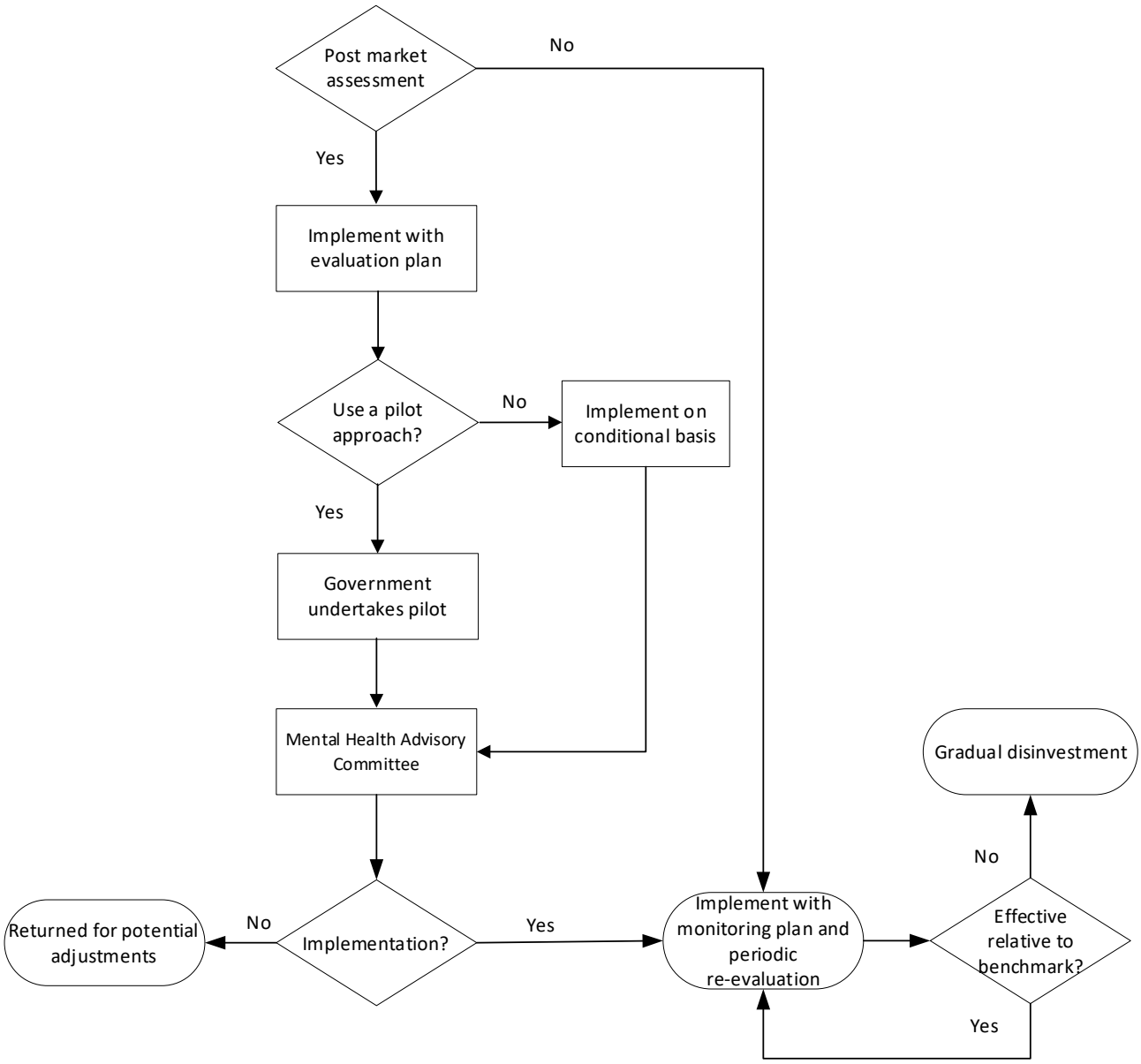


Figure 5: Proposed refined process for post-market surveillance



In summary, changes were made to account for:

- eligibility for being considered within the decision making process being based on expected cost, expected national reach, and potential level of urgency in addressing an identified need;
- a stronger focus on contributions by lived experience groups across all stages of evaluation, and a greater consideration of integrating new services into existing and other new models of care;
- an explicit post-implementation evaluation stage for investments, and the use of pilots and provisional implementation;

- expanding the roles of sub-committees to engage in research, knowledge development and setting of standards that inform the scope of evaluations undertaken; and
- broader investment in methodological research, and broader contribution of lessons learned within the evaluation process to potentially new mental healthcare investments.

The primary change within the process was the addition of guidelines for more minor, local or urgent investment options and the evaluation of these types of investments by local authorities. For example, a suicide prevention program targeted within a specific local health network may not meet the criteria for being evaluated within the proposed process, but should still have an avenue to be considered by the relevant minister for investment if a local evaluation shows promise. These investment types should also be implemented with consideration to whether post market assessment is required, and if so, which assessment is best suited.

Recommendations

The National Mental Health And Suicide Prevention Agreement notes the importance of a coordinated national approach to formal evaluation to inform investment decisions and support improvements in planning, purchasing and program management. (Commonwealth of Australia, 2022)

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 program's cost, risk and complexity.

Within this context, eight recommendations were developed for state, territory and federal governments to shift mental healthcare investment decisions towards a more systematic, transparent and evidence based approach.

Short term actions (1-2 years)

1. **Develop a formal process for lived experience in mental health investment decisions,** and educate consumers and carers on how to contribute their insights to evaluations and methodological development, such as within defining and measuring relevant outcomes.
2. **Define outcomes of primary importance for mental healthcare investment evaluation in consultation with all stakeholders,** including clinical measures, measures of functioning, economic participation.

3. **Develop greater stakeholder understanding of investment decision uncertainty, criteria for strong methodology, and requirements for rigorous decision support** to develop capability in methodological development.
4. **Develop a 5 year strategy and implementation plan** to establish the process for considering mental healthcare investments. This should include:
    a. Educating stakeholders through workshops and webinars on the need for a unified, systematic, transparent and evidence based approach to investment decisions in mental healthcare.
    b. Developing preliminary criteria for determining whether investments require full, or partial evaluation by the Mental Health Advisory Committee.
    c. Developing guidelines for evaluating investments assessed by the Mental Health Advisory Committee.
    d. Developing a model of financing for establishing and operating the Mental Health Advisory Committee. Costs should be shared between governments and sponsors.
    e. Ensure overall integration of a process for investment decision support in mental health with other decision support systems and health technology assessment in public and private health care.

Medium term actions (3-4 years)

5. **Establish an agency that administers the process for considering mental healthcare investments,** and appoint a Mental Health Advisory Committee and associated sub committees.
6. **Pilot the process for considering mental healthcare investments** using a set of first candidate investments and adjusting the process based on learnings.
7. **Develop guidelines and benchmarks for post-market assessment,** both for conditional and pilot implementations and recurring evaluations to determine whether disinvestment is advisable.
8. **Develop guidelines and benchmarks for out of scope and urgent investments that support in house evaluations by sponsors,** in collaboration between the Mental Health Advisory Committee, and state, territory and federal governments.

6. Conclusion

Reforming mental healthcare funding is complex, hard and requires substantial government investment. It will require strong, consistent national leadership, within a structured and supportive policy and institutional framework, to trial and evaluate value based payment models and to build a systematic, transparent and evidence based investment process. (Cutler et al., 2023)

Nonetheless, integrating funding across the mental health care pathway, and ensuring investment is allocated effectively and efficiently, are essential for governments to align mental health care resources toward person-centred care. The mental health and suicide prevention system envisioned by governments (National Mental Health Commission (NMHC), 2022b, Commonwealth of Australia, 2022) is not possible without reforming mental healthcare funding and investment.

This study has proposed several recommendations for progressing mental health care funding and investment in Australia towards more value, based on perspectives collected from government and non-government organisations, consumers and carers.

Recommendations were developed within the context of potential ongoing change in mental health care funding and investment, as recommended by the *Mid-Term Review of the National Health Reform 2020-25*. That Review calls for ensuring its recommendations on models of care, financing, innovation and performance monitoring, are reflected in a separate National Mental Health and Suicide Prevention Agreement. (Huxtable, 2023)

Value based payments and better investment decisions are inextricably linked. While investments may be cost effective within the evaluation process, the investment may not be sustainably adopted by providers or consumers, or services may not align with trial protocols, rendering the service less effective. Value based payment models can provide incentives to help steer providers toward delivering services as intended. (Horvitz-Lennon, 2020)

Actively engaging evaluators of mental healthcare investments in methodological and conceptual work when designing new models of care can provide additional benefits compared to a passive approach of just evaluating investment decisions. Generating new lessons on designing optimal models of care through evaluation, and the potential barriers to implementation with service provider types, can help contribute towards an iterative improvement in care models that ultimately achieves greater value for government investment.

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