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Understanding views on prospective value based mental healthcare payment reform in a complex healthcare system. The Australian experience

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Abstract

Many developed countries have fragmented mental healthcare systems that are wasteful and misaligned with patient preferences. To improve integration of care, insurers are exploring new payment methods that promote collaboration among multiple providers. Our study aimed to draw key themes from stakeholder perspectives on shifting mental health care payments away from a traditional fee-for-service model in Australia known as Medicare, toward value based payments models that reward providers for delivering better care quality and improved health outcomes.

We gathered data by interviewing 21 executives from state and federal government departments, agencies, and mental health commissions in Australia. We conducted three national online workshops with 70 non-government respondents, patients and public respondents, with one workshop specifically targeted at consumers and carers. Responses were transcribed and analysed to identify common themes using thematic and schema analysis methods. Themes were organized using the Consolidated Framework for Implementation Research to offer a concise overview of stakeholder perspectives.

Respondents generally agreed on the need for value-based payment models in mental healthcare but differed on how these new models should be governed in a federated system like Australia. Primary barriers to implementation included defining outcomes that matter to consumers, lack of evidence, workforce gaps, political complexities, procedural challenges, and costs. Contrasting perspectives between government and non-government respondents highlighted potential differences in objectives regarding payment models that may need to be addressed before implementing payment reforms.

Reforming payment models in mental healthcare is complex and challenging, magnified by large uncertainty in attributing outcomes to care. This study highlights barriers and facilitators for realigning funding models towards value based payments at scale in mental healthcare, across governance and planning, evidence-based care promotion, and laying the groundwork for reform.

Introduction

Mental ill health accounts for 16 per cent of global disability-adjusted life years and costs the global economy USD 5 trillion annually. (Arias et al., 2022) Some burden could be reduced by aligning care with either best practices or guidelines. Nearly half of all encounters to treat depression are deemed inappropriate and consequently of low value. (Runciman et al., 2012) Siloed care between different service types, providers and payers has embedded inequitable access to services, poorer health outcomes, and utilisation of more expensive acute inpatient care. (Knapp and Wong, 2020)

While countries operate their mental health care systems differently, many countries under-provide mental health care and allocate resources to more expensive care without commensurate returns on improved health outcomes. This reflects mental healthcare systems designed around crisis rather than prevention. A common characteristic within mental healthcare systems is too little care delivered in the community relative to acute inpatient care. (Kovess-Masfety et al., 2023) Care is often misaligned with consumer preferences, and many consumers do not seek care because they cannot afford the copayments. (Lambregts and van Vliet, 2018)

Governments in developed countries, including the US, UK, Canada, Netherlands and Australia, are seeking to transition health care from hospital-centric services to integrated care systems, by prioritising person-centred services delivered in the community. (Baxter et al., 2018) While several payment model types are used to pay for mental health care in developed countries, most community based care is paid for using a fee-for-service model, where providers receive a fixed scheduled payment for the type and volume of service delivered. This has potentially misaligned provider behaviours with consumer preferences, given a fee-for-service payment model incentivises greater care volumes. (Brekke et al., 2020, Hennig-Schmidt et al., 2011)

Transitions towards integrated care models within mental health care require more complex payment models to realign provider incentives. A body of evidence is emerging that demonstrates some benefits from financially incentivising mental health care providers to deliver better care quality compared to using a fee for service payment model. (Carlo et al., 2020) However, healthcare payment model reform is challenging, having to address complex system redesign, and having to shift embedded provider behaviours and business models. A sticking point equilibria with large fixed costs and weak incentives potentially explains over-reliance on fee-for-service payment models and poor care coordination among providers in health care. (Frandsen et al., 2019)

Payment model reforms that incentivise better care outcomes shift revenue from one provider to another, and shift financial risk from the payer to providers. This can create adverse reactions from providers that consider themselves under financial threat, culminating in an unwillingness to participate

in a new payment model. (Medicare Payment Advisory Committee, 2021, Mjaset et al., 2020) Provider elf-selection bias within a value based payment model trial can make it challenging to demonstrate the trial has reduced costs and improved outcomes. (Werner et al., 2021, Centres for Medicare and Medicaid Services, 2022)

Mental healthcare payment model reform in developed countries has been piecemeal. The CMS Innovation Centre in the United States is treating mental health as an addendum to physical health payment models. Examples include the Primary Care Behavioural Health Model and the Collaborative Care Model, which focus on chronic disease and mental health. (Yuhua et al., 2017)

These early US mental health payment reforms have mostly been evaluated using a case study approach. (Hyatt et al., 2021, Yuhua et al., 2017, Castillo et al., 2017, O'Grady et al., 2020) Overall, reforms that sought to lower costs and improve quality using alternative payment models have had limited success. Similar limited success is found in the UK. Two pay-for-performance incentive programs for mental health delivered through the UK Prescribed Specialised Services Commissioning for Quality and Innovation (PSS CQUIN) had no effect on reducing hospital length of stay for adults or children. (Feng et al., 2019)

Payment model reform failure is not unique to mental health care. Just under half of programs that use financial incentives result in a positive and statistically significant outcome. (Scott et al., 2016) Successful payment model reforms are characterised by relatively small effects that dissipate over time. (Eijkenaar et al., 2013, Van Herck et al., 2010) These mixed payment model reform results are found within multiple countries and healthcare settings. (Milstein and Schreyoegg, 2016)

Key implementation challenges to mental health care payment reform include confounded quality measurement, limited provider capacity, limited oversight and collaboration, stringent privacy regulations, and costly data sharing. (Soper et al., 2017) Ways to overcome these barriers include undertaking a ‘what’s in it for me’ analysis, early dissemination of results, return on investment analysis, and tools to implement care models. (O'Donnell et al., 2013) Integrated care standards, improving quality measures, and leadership can facilitate successful payment reform that seeks to promote integration between mental health care and primary care. (Barrett et al., 2018)

More broadly within the healthcare system, common barriers to successful payment reform include small incentive payments relative to costs and providers unwilling to participate because of increased financial risk. (Damberg et al., 2019, Mjaset et al., 2020) Other barriers include a reluctance by payers to shift financial accountability to providers, information asymmetry, a lack of trust among providers and between providers and payers, and conflicting incentives between providers and payers. (Van Herck et al., 2010, Werner et al., 2021, Hogle et al., 2019) Deficiencies in data infrastructure to support

information exchange among providers, regulatory impediments, and a lack of competition have also created barriers. (Damberg et al., 2014, Conrad et al., 2016)

There is little literature analysing stakeholder perspectives on using value based payment models where provider incentives are designed to achieve good outcomes. Most stakeholder perspectives on payment reform are derived from stakeholder engagement for a specific payment model or offer frameworks for stakeholder engagement to develop future co-designed payment models. (Bao et al., 2021) These are often unique perspectives within the context of the care delivered, organisational structures, and imbedded regulations. Special considerations for mental healthcare common across countries include broader service use outside the healthcare sector that impacts health outcomes, open-ended 'episodes' of care, and the existence of comorbid substance abuse disorders. (Ettner et al., 2000)

Our study sought to collect and theme stakeholder perspectives on shifting mental healthcare funding from a fee for service payment model to a payment model that rewards providers for delivering better care quality and health outcomes. It uses the Australian healthcare system to frame research questions. The Australian healthcare system has characteristics similar to those of the US, UK, Canadia and some European systems. It is characterised by a mix of public and private healthcare provision and financing. Like the US, Canada, and Germany, healthcare governance is divided between the federal government and state and territory governments.

We present a parsimonious collection of stakeholder views from national consultation within Australia collated into themes and schemas. Our study identifies potential blind spots among respondents when considering implementing payment model reform and clear knowledge gaps where further research should be concentrated. It highlights conflicting perspectives from respondents on how value based payments should be implemented, and highlights differences in the importance placed on themes by government and non-government respondents.

Our study identifies the importance of 'laying the groundwork' for value based payment reform by addressing broader issues within the mental healthcare system, such as limited collection and use of quality data and evidence, workforce challenges such as gaps and burnout, and political complexity between state, territory and federal governments.

Our results extend the stakeholder analysis undertaken by the Australian Productivity Commission (an independent federal government agency) in their landmark "Inquiry into Mental Health", (Productivity Commission, 2020) and provides insights for future negotiations between state, territory and federal governments in Australia on the National Mental Health and Suicide Prevention Agreement. It also provides insights for negotiations on value based funding within the next Australian National Health Reform Agreement.

While we evaluate Australian stakeholder perspectives, insights can equally be applied to other countries that seek to shift mental healthcare funding from fee for service to value based payments. Many countries face the same shift towards paying for value as Australia. Examples include the United States, where the government is seeking to address the 'national mental health crisis' by embedding more outcome based payment models. (Hughs et al., 2022) The United Kingdom also seeks to introduce a new Mental Health Act, (House of Commons and House of Lords, 2022) and payment incentives to improve care quality. (National Health Service (NHS), 2019) Our paper contributes to the ongoing debate on how to shift from a fee for service funding model to a payment model that incentivises providers to deliver better quality care and health outcomes.

The principle-agent problem

Agency theory suggests mental health consumers and providers maximise their own utility functions when seeking and delivering care, but some consumer objectives are incorporated into the provider's utility function. (Mooney and Ryan, 1993) Consumer and provider utility functions are therefore interdependent. Provider actions are constrained by the need to meet minimum standards established by colleges and accreditation processes. Intrinsic provider values also constrain their activities. These incentive compatibility constraints create imperfections in the principal-agent relationship, potentially leading to worse care and increased costs. (Conrad, 2015)

To minimise imperfections, payers can create compensation rules to incentivise providers to deliver better mental health care. These rules must be acceptable to providers. (Arrow, 1986) Payers must also monitor the behaviour of providers, for example through the application of minimum quality standards and quality management frameworks. In some sectors, payers publicise provider performance using star ratings, anticipating that providers will improve their care quality to attract more informed consumers. (Gaynor and Town, 2011)

While characteristic of most mental health care payment models in developed countries, a simplistic fee-for-service model is likely to be inappropriate for mental healthcare. An optimal payment model when large asymmetric information on appropriate services exists, like within some types of mental health care, should be based on outcomes with shared financial risk. (Shavell, 1979) However, providers should not assume all financial risks associated with delivering outcomes given they are risk averse. (Mooney and Ryan, 1993)

Payers must have some understanding of the consumer and provider utility functions to operate a successful payment model. The success of a principal-agent relationship depends on the payer or consumer knowing when the provider has delivered good care. Uncertain health outcomes, particularly prevalent in mental healthcare, means establishing whether a provider has delivered good care is

difficult. Other challenges include defining and measuring mental health outcomes that matter to consumers and attributing provider actions to those outcomes. (Ettner et al., 2000)

Study setting

In Australia, community based mental health care services delivered by general practitioners, psychologists, psychiatrists and other mental healthcare providers are funded using a public universal insurance program called Medicare. Providers receive a fee per service, based on a listed fee within the Medicare Benefits Schedule. Some providers bulk bill their services to some consumers, which means the provider only receives the entire scheduled fee and the consumer is not required to pay. Most providers do no bulk bill, instead choosing to receive 85 per cent of the scheduled fee with some copayment from the consumer, as determined by the provider.

The Australian federal government also funds psychosocial services for people with psychosocial disability, through the National Disability Insurance Scheme. (National Disability Insurance Agency, 2021) The Scheme provides block funding to eligible recipients based on assessed need, who pay providers for each service delivered, although the fee is agreed between the provider and the consumer.

Other community mental health care services delivered through public and private mental health organisations, Local Health Networks, and online providers are block funded through a combination of state, territory and federal government funding. Primary Health Networks, which are commissioning groups funded by the federal government, also purchase private mental health care services in the community based on local planning needs.

State, territory and federal governments are responsible for funding public hospital mental health care services and residential mental health care services, which are managed by Local Health Networks. Payments for mental health care are made using block payments, although the federal government is seeking to introduce activity based funding for public hospital services and community services to align with the way physical services are funded.

Private hospital mental health care services and private residential services, which provide around 33 per cent of specialised mental health hospital services and 31 per cent of residential mental health services, (Australian Institute of Health and Welfare (AIHW), 2024) are funded by a combination of private health insurers and consumers based on the number of days receiving care and the types of services received. Mental health specialists within private hospitals also receive fees for each service delivered based on the Medicare Benefits Schedule.

Method

A rapid literature review was undertaken in 2022 to explore the international funding landscape in mental healthcare, focusing on payment models that sought to incentivise providers to deliver better care quality and improved health outcomes. This informed the development and public release of a consultation paper, (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 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 mental healthcare funding framework that could embed value based payment alongside fee-for-service payment, to ensure payment depends in part on outcomes achieved by providers. It proposed that payment model trials be orchestrated by a newly established Independent Value Based Payment Authority, to develop and trial new healthcare payment models. The consultation paper discussed potential 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)

A national consultation process was conducted between August and November 2023 that included semi-structured interviews with senior executives within state, territory and federal health departments, The Treasury, and mental health commissioner offices. Three national online workshops were also conducted with non-government mental health respondents, including providers, peak bodies, consumers, carers and academics. One online workshop was devoted to consumers and carers only.

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) Non-government stakeholder perspectives from the three online workshops were analysed using schema analysis, a systematic way of summarising, and then offering a clear and succinct presentation of the essential elements within an original text. (Rapport et al., 2018b) The Schema analysis employed group-working activities within a 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.

Data collection

Interviews

Targeted emails were sent to every Australian state, territory, and federal health department and mental health commission to recruit respondents for the interviews. Initial emails were sent to 53 contacts at the relevant agencies on 28th June 2023 to ascertain appropriate individuals for the interview. These

contacts were identified through web-based searches. Formal invitations were sent to 45 individuals between 3rd and 14th of August 2023, and follow up emails were sent on 17th August and 12th October 2023.

Interviewees mostly held Director, Executive Director, or Commissioner level roles at their respective departments and agencies, and provided general responses and views based on their experience and expertise. 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.

Thirteen semi-structured interviews were undertaken between September and November 2023. The purpose was to understand stakeholder perspectives on the funding framework presented in the consultation paper, with each respondent having been sent the consultation paper and a list of potential questions prior to their interview. An iterative approach was adopted for conducting the interview schedule, with questions from the first interview refined for the second and subsequent interviews to maximise information gathering. Some questions were also adapted within the interview process in response to answers from respondents on prior questions.

All interviews were conducted and recorded online via Zoom. Each interview was led by one senior researcher (HC, JF) and lasted between 45 to 60 minutes. Other members of the research team (AN, AB) attended interviews as observers to take notes. The interviews commenced with questions regarding the case for exploring value-based payments within the context of recent mental health care agreements between state and territory governments and the Australian federal government. The remainder of the interview asked questions related to perspectives on introducing a value based payment framework in the Australian mental health care system (see Appendix A).

Workshops

Three national online workshops were held between September and November 2023 to collect non-government stakeholder views on funding reform in mental health care. Emails were sent to potentially interested individuals identified through academic mailing lists, mental health commission contact lists, four large research and consumer organisation contact lists; five provider contact lists; and 442 individually identified points of contact that included consumers organisations, provider organisations, academics, regional health care organisations, and others. These contacts were identified from the publicly available list of respondents that submitted to the Productivity Commission Inquiry into Mental Health. (Productivity Commission, 2020)

Following these invitations, 38 respondents registered for workshop 1 and 36 registered for workshop 2. From the individuals registered, 25 respondents (i.e., 66% of those who had initially registered) attended

workshop 1 and 24 respondents (67% of those who had initially registered) attended workshop 2. Respondents self-identified as being part of an advocacy, consumer and support group (16), provider (18), peak body or other stakeholder (5), or academic researcher (10).

Online workshops lasted two hours and were chaired by a senior researcher (HC or JF). The workshops were delivered in three parts. The first delivered a short presentation derived from the consultation paper on the current mental health care funding policy environment, the purpose of our research, and how the research outcomes would fit into the current funding policy debate. The second delivered a short presentation on different ways to define and measure value. This was proceeded by a set of three questions presented to the group for discussion.

The third part of the workshop delivered a short presentation on the proposed mental health care funding framework derived from the consultation paper and then presented eight questions for discussion (see Appendix B). Respondents discussed each set of questions within breakout rooms curated by researchers (JF, AB, AN, MA) first meeting in smaller groups of 5-7 respondents and then joining a full group discussion in the plenum hosted by a senior researcher, while other researchers took field notes. A third workshop was conducted that focussed exclusively on consumers and carers.

The decision to add a third workshop was based on the observation that perspectives of lived experience groups were described as central in workshops 1 and 2; however, consumers and carers often did not manage to substantially contribute to the relevant group discussions.

Recruitment for workshop 3 was mainly undertaken through public advertising. An advertising campaign via Facebook and Instagram was conducted for 11 days, which reached 46,878 individuals, of whom 811 clicked on the advertisement, and 8 registered for the workshop. Lived experience organisations were also recruited to advertise the workshop to their members. Other channels mentioned by individuals who registered were LinkedIn (8), direct email (18), word of mouth (4) and other forms of direct referral (5). Of the 43 individuals who registered, 21 individuals (49%) participated in the workshop.

Thematic analysis

All interviews were electronically recorded in Zoom and transcribed verbatim, with meanings drawn from thematic analysis using a phased approach. (Braun and Clarke, 2006, Braun et al., 2019, Terry et al., 2017).

1. Familiarisation: After transcription, four researchers (AN, JF, AB, FR) individually analysed the first three interview transcripts before discussing their initial coding ideas. The senior researcher (FR) advised that coding may cease before the full dataset was analysed if the research team was confident that data saturation had been achieved and no new codes were arising.

2. Generating codes: One member of the research team (AN) combined the four individual analyses of the pilot data following groupwork and consensus opinion had been attained on the key codes. These were compiled as an initial list of codes.
3. Constructing themes: Three members of the research team (AN, JF, FR) grouped the codes into a thematic framework. The remaining ten interview transcripts were analysed by two researchers (AN, JF) with reference to the framework, with additional codes added when required. Data saturation was monitored through regular discussions between three members of the research team (AN, JF, FR). Data saturation appeared to be reached on the tenth interview, however coding continued for all 13 interviews to ensure all perspectives from respondents were captured.
4. Reviewing themes: After all interviews were analysed, the thematic framework was reviewed and refined through discussion and debate at a further thematic analysis groupwork session attended by all team members (AN, JF, AB, FR, MA, HC).
5. Defining themes: After the two frameworks were finalised the themes were defined, named, and illustrated by salient, concomitant categories and verbatim quotations. Each quotation was attributed to one of the 25 government employees interviewed across the 13 semi-structured interviews.

Themes were subsequently mapped to the Consolidated Framework for Implementation Research (CIFR). The CFIR is a common 'meta-theoretical' framework developed from a synthesis of nearly 500 published sources across 13 fields of research on diffusion of innovations in service industries, (Greenhalgh et al., 2004) 18 existing theories and consensus among the implementation science community. (Damschroder et al., 2009) It consists of five domains (Intervention characteristics; Outer setting; Inner setting; Individuals; Implementation process) which hold 26 constructs that can impact implementation of a complex and multifaceted healthcare program.

Assessing the alignment between the thematic analysis and the CFIR framework allowed stakeholder views to be categorised within commonly established taxonomy, terminology, and definitions. This provided a deeper understanding of potential facilitators and barriers to implementing a value based payment model in mental health care.

Schema analysis

All workshop discussions were electronically recorded in Zoom, transcribed verbatim and used in the Schema analysis. Schema analysis lends itself to workshops or other group events where more than one person is involved in answering questions. It captures the overarching 'flavour' of respondent views, by deriving a schema across respondent's opinions. Three primary stages were used within the Schema analysis undertaken with these workshop transcripts, including constructing individual researcher schemas (one from each researcher) that are brief and succinct, undertaking group work to develop

longer group or 'Meta-Schemas' (one for each workshop), and interpretation, discussion and, finally, group approval of the final Meta Schemas. (Rapport et al., 2018b)

Four researchers (AB, FR, JF, MA) first individually summarised the discussion of workshop questions into individual Schemas for each workshop. A synthesis of individual Schemas was subsequently created in three Meta-Schemas that focussed on defining value and value-based payment models. The Meta-Schemas were drafted by one member of the research team (AB) and refined through discussion and debate that led to consensus among all researchers. Following both thematic and Schema analyses, results were triangulated into a composite whole to bring together key issues arising across all datasets, while ensuring datasets were aligned with one another. (Rapport et al., 2018a)

Results

Thematic analysis

The thematic analysis resulted in six core themes with various subthemes (see Table 1). These 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; and 6. Circumventing barriers to payment reform. Themes related to developing a payment model (Themes 1, 2, and 3) and to the broader system context within which a payment model would operate (Themes 4, 5 and 6).

Table 1: Themes resulting from the thematic analysis

Themes related to payment model	Themes related to broader system context
1. Clear payment model definitions and place • Value in mental health • Roles and responsibilities • Payment models and care pathways • Target cohort • Identifying and measuring outcomes	4. Ensuring patient focused care • Holistic care • Social determinants of health and wellbeing • Individual perspective and need • Patient relevant outcomes • Patient autonomy
2. Payment model characteristics • Existing payment models • System and service fragmentation • Flexibility and adaptability • Stakeholder equity and inclusion • Collecting evidence • Attributing outcomes to care • Risk management • Transitional funding	5. Addressing workforce challenges • Existing shortages • Reform fatigue • Provider perspective and buy-in • Aligning incentives with objectives • Behaviour change

Themes related to payment model	Themes related to broader system context
3. Circumventing barriers to payment reform • The necessity for change • Past failures • Real-world complexity • Funding as the way forward • Administrative burden • Where to start • Competing priorities • Evidence deficit	6.Imbedding appropriate governance structures • System level approach • Governance tiers • Independent agency • Expertise • Capability • Resourcing • Timeframes

Theme 1: Clear payment model definitions and place

This theme highlighted consensus towards embedding greater value into mental health care funding. Respondents noted the need to ensure that there is a common language and clear understanding of the perspective taken when defining and measuring value, given different views held by respondents on what value means, and because these can conflict with value defined by providers or government.

It was recognised that value must be measured through outcomes, which are currently not standardised and not easily identified due to the unique preferences for outcomes held by consumers. Value was considered a concept that would prioritise individual consumers. There was some consensus that health outcomes measured by standard clinical surveys were not sufficient to capture outcomes that represent value.

> *It's so fragmented, [there's a] lack of consistency in definitions. There's no standardisation, outcomes are really hard to define and measure.* [Government Employee (GE) 3]

> *Views of what is a positive outcome from the consumers' perspective may differ to the outcome that a clinician may see as being a positive outcome… [the] consumer is separate from the clinical, government, other perspectives.* [GE 10]

This theme also highlighted concern about how a value based payment model would fit into the current healthcare system. There was some concern that overlapping roles and responsibilities across system governance and service funders, from a public and private perspective, federated governance structure perspective, and inter-departmental perspective, could inhibit the success of any value based payment model to appropriately support the delivery of patient centred care across multiple services. Respondents expressed some uncertainty around what characteristics a value based payment model would have, who it would target, and how value based funding would fit within a system where the best model of care is often unknown.

> *The starting point needs to be, who's responsible for what? Who's going to define that? And then how are we going to ensure that if the agency or level of government that is responsible for that, is responsible? How are we going to ensure that it funds it adequately?* [GE 1]

> *What proportion of people would that be relevant for? And whose decision would it be? … And who would then administer that? What's the eligibility criteria?* [GE 4]

Theme 2: Payment model characteristics

This theme recognised the inadequacies of current payment models for mental health care, with respondents noting limited flexibility in the use of funds leading to underfunded services. There was consensus that current payment models such as Medicare have created perverse incentives, such as overuse of inpatient care, limiting the ability of government and service providers to innovate care pathways, and have created inequitable access to care. Respondents noted that diversity in funding streams has limited the ability to coordinate care.

> *There's a disincentive to make changes, and to grow a system or change a system design, because the existing funding approaches, with our relationship with the Commonwealth in particular, means there's a tendency for the status quo*. [GE 3]

> *Mental health doesn't neatly fit into any of the existing funding parameters available to us.* [GE 2]

> *The current arrangements, I believe, are not incentivising the right sort of work across a range of different providers*. [GE 20]

This theme highlighted that introducing a value based payment model into the current mental health care system would be challenging and take some years, but nonetheless respondents supported funding system reform. Investment to improve data collection, data infrastructure and data sharing was recognised as a necessary condition for successful payment reform. Many respondents noted that agreement on what outcomes to measure and ensuring measured outcomes were attributable to services, was pivotal to success. There was strong consensus for an evidence based approach to measuring and attributing health outcomes that account for different consumer characteristics and circumstances, along with the variable nature of mental health outcomes regardless of treatment.

> *In terms of moving to these more values-based payment models, a complementary piece would have to be an investment in making sure that we are clearly measuring outcomes for patients. And collecting that data, you know, more, probably more than we are at the moment in order to understand the effects that funding is actually having*. [GE 8]

This theme also highlighted the need to ensure any new payment model promoted equitable access to care and included funding for psychosocial support services. Respondents wanted to ensure any new payment model was flexible, beyond what Medicare currently provides. Respondents felt that payment models must allow services to respond to local and ever changing needs and allow funds to be spent on support services that prevent consumers from slipping into poor mental health.

> *It's always that narrative of equity. So I think that these are really important conversations, and we want to get value for healthcare. But also appreciating the nuance of some of these really specific groups [in rural and remote areas]. I think we need it to work, but it needs to be a balance between where it's a bit different.* [GE 16]

> *We support flexible funding arrangements in mental health, a lot, like we think that activity-based funding is quite limiting to a certain degree.* [GE 2]

Inadequate methods to attribute services to outcomes were identified as a primary risk to successfully implementing and embedding a payment model based on outcomes, given that societal and situational factors often impact outcomes regardless of treatment. There was some uncertainty from respondents on what types of risks a value based payment model would introduce for providers and whether respondents define risks differently.

> *How do you minimise risk? Where does the risk sit, or how is the risk shared in all this will also be important.* [GE 3]

> *The issue of risk is raised significantly, continuously. But when you ask risk of what, and to whom, there are very different answers to that question.* [GE 10]

This theme recognised that providers would need some investment from government to help reduce the risk associated with providing services under a value based payment model, with respondents suggesting there would be a limited desire from providers to participate otherwise.

<u>Theme 3: Circumventing barriers to payment reform</u>

This theme reiterated the consensus among respondents that payment models for mental health care must change given Medicare and activity based funding provides no incentive for providers to integrate their services within a care pathway. However, it questioned whether there was support for changing governance structures.

Respondents voiced concern about the impact of past reform failures on the willingness of government and the sector to shift towards a value based payment model. There was particular concern among respondents regarding embedding non health portfolios into payment model reforms, highlighting past failures in doing so within prior national mental health plans. Some respondents were frustrated, noting

their efforts to better integrate mental healthcare have made little progress, with reform failures costing political capital.

> *There was all of the long term reforms that were put into the addendum to last National Health Reform Agreement. I feel like you referenced a lot of those in your paper. To my knowledge, there's not a lot of work that has happened in that space… we worked very hard to agree all of those very ambitious reforms. We had all the Ministers sign it off. And then it's been quite silent. So what would this, apart from that level of agreement, to get through?* [GE 2]

Complexity was identified as a primary barrier to implementing a value based payment model. Respondents noted a divided sector with vested and competing interests that have derailed prior reform attempts. Respondents also noted complex service delivery structures and complex payment models in past attempts to reform mental healthcare. Many respondents thought there was a complex relationship between state, territory and federal governments, derived from current funding structures. Specific issues included challenging political narratives, and the potential perception of cost shifting from federal to state and territory governments within payment reform. Some respondents questioned whether mental health care is the right sector to start introducing value based payment models in Australia.

> *When you bring state and Commonwealth funding together… the politics around that is often a significant challenge, I think, for the system… when you try and bring the two together there's often opposing views… I think we spend too long then in the politics or the mechanics around it rather than actually dealing with the issue.* [GE 21]

Some respondents noted that a value based payment model that brought state, territory and federal government spending together could provide an opportunity to stop these governments from blaming each other for current gaps in mental health care services. Others questioned whether payment model reform can deliver better outcomes, instead noting the importance of system and service design, with payment models an enabler, rather than a driver, of change.

> *It feels like overloading what the ambition of what funding can do, like obviously funding is an important lever, and provides the incentives. But where does system design and service design sit in all of this, would be probably the main thing I'm thinking about.* [GE 3]

This theme also highlighted the potential additional administrative burden of a value based payment model compared to Medicare, including the need to bring people together and to manage additional complexity. One respondent noted that care quality could potentially be improved by measuring outcomes better and using them within a performance management framework, without the need to attach funding to those outcomes.

Respondents also noted competing reform priorities that may reduce the potential success of payment reform, including broader healthcare workforce pressures, increasing elective surgery and emergency department waiting times, and a lack of health care system funds. They also highlighted the potential deficit in current evidence that value based payment models work, noting this would act as a barrier to motivating change, particularly among providers.

Theme 4: Ensuring patient focused care

This theme highlighted the strong consensus that any value based payment model should facilitate a mental health care system that is patient focused, enabling some flexibility to capture the unique preferences for care held by consumers. This included enabling a potential shift in funding from a treatment focus to one that reduces the risk of mental ill health by improving social circumstances. Respondents suggested that reducing the prevalence of social determinants of mental ill health would help improve the value of treatment, given the strong relationships between social determinates and outcomes. Respondents also noted that a whole of person approach requires more investment in prevention and community care.

> *What are the contributants when you're measuring value based payments… that the value of an investment into the health dollar will only be optimised if someone has a safe, stable place to live and all those other elements*. [GE 19]
>
> *We've got quite a tension between [a] medical model versus a social determinant, so community, a social model. And it's not that one needs to win over the other, there needs to be consideration given to all.* [GE 22]

There was no consensus from respondents on what type of consumer a value based payment model should target, but there was some consensus that targeting the 'missing middle', as defined by the Productivity Commission, (Productivity Commission, 2020) was not meaningful. It was considered difficult to understand who belonged to the missing middle, with some concerns expressed by respondents on developing eligibility criteria.

Respondents highlighted the need for a value based payment model to target the treatment pathway, potentially related to a specific diagnosis, where greater integration and care continuity are needed. Respondents noted that a consumer's right to choose their service provider should be maintained, even if it does not deliver the best outcomes or the most cost effective care. This view recognised that consumers value autonomy and value service attributes beyond health outcomes.

Theme 5: Addressing workforce challenges

This theme highlighted the current concern among respondents that the Australian mental health care system suffers from crucial workforce gaps, has been going through a period of consolidation, and those working in the system were fatigued. Respondents cautioned moving too quickly towards a value based payment model, noting that workforce challenges are a function of the funding environment, so they must also be addressed within any value based payment model.

> *We just have to be careful in a sector that is significantly stressed, significantly under-resourced in terms of workforce… if we reform but we don't have the workforce to deliver it, it's not going to help.* [GE 10]

Respondents highlighted the importance of ensuring the provider perspective is incorporated into the development of a value based payment model to encourage buy-in. Respondents highlighted the risk in alienating providers if some conditions were not met. These included ensuring providers remain viable, such as not being financially worse off and having funding certainty to attract and retain a workforce.

> *Providers won't accept a model where they're worse off.* [GE 8]

> *Everybody needs to see the benefit of this, both at a system level, at a service delivery level, at a frontline consumer care, a family level.* [GE 17]

Respondents suggested that all respondents needed to perceive some benefit from a value based payment model and model complexity should be minimised. Respondents highlighted that prices should be based on provider cost structures, which would require government to collect additional data on provider costs.

This theme also highlighted the importance of governments aligning funding incentives with system objectives. This including incentivising providers to deliver better outcomes and incentivising providers to share more data with government. Respondents cautioned the potential to introduce unintended perverse incentives and providers gaming the incentive program for financial gain to the detriment of clinical outcomes.

> *I'm a believer of governments being able to use their funding levers in a stronger way than they have.* [GE 1]

> *It's more about having the right incentives, but not incentivising bad things, is usually where funding comes in.* [GE 5]

This theme also highlighted that for incentives to work, there needs to be some understanding of which behaviour needs to change and what competing non-financial motivations providers and clinicians may have. Respondents noted the need to consider clinical risks and the need for clinicians to further develop

capabilities to realign care and manage their practice within a more financially risky environment. Respondents noted that some clinicians may be more amenable to payment model change than others.

Theme 6: Imbedding appropriate governance structures

This theme recognised that a change in governance structures was necessary for a value based payment model to be successful in mental health care. There was consensus among respondents that the current system was fragmented, delivered ad hoc care that led to inequities in access to care, which lends support to reforming the mental health care system and payment models.

While respondents noted the National Health Reform Agreement (Australian Government, 2020) and the National Mental Health and Suicide Prevention Agreement (Commonwealth of Australia, 2022) provided a good start, respondents suggested they did not provide enough guidance on funding reform nor generate enough political will for change. There was consensus that a system wide approach to embedding mental health into government portfolios was necessary, and consensus that funding was an enabler of system redesign, helping services integrate to form continuous and connected care.

> *How do we deliver a value based system, not just value based services? Because if you have really good value based services, but they're still ad hoc, there's still gaps between them, there's no consistency across the service system?* [GE 24]

> *You can fund services but if services aren't funded in a connected, joined up way then you're going to have inefficiencies through lack of accessibility, or lack of communication, or poor referral.* [GE 19]

This theme highlighted the potential complexities associated with implementing mental health care funding reform within a federated political structure, in particular getting state, territory and federal governments on the 'same page'. There was some disagreement among respondents on whether an independent agency tasked with developing, implementing, and evaluating vale based payment models, as presented in the consultation paper, was required. Opponents noted that an independent agency might duplicate government functions and it would be challenging to incorporate a value based payment model into current state, territory and federal government structures, unless they were convinced it was required.

> *If you think about having a national authority, which will then tell the states or whatever, I think that's going to be problematic in some, unless the states are embracing this from the start and want to do it.* [GE 17]

> *Creating a structure that sits outside of existing mechanisms to create payment models, I think, would be very hard to manage, for us as a jurisdiction, and I think the state and*

> *federal relationship when it comes to funding… I just don't know how we would manage that complexity.* [GE 4]

Proponents noted that an independent agency would ensure a clear allocation of responsibility, allow concentrated development of expertise and ensure disciplined use of evidence. One respondent noted that the Independent Health and Aged Care Pricing Authority's role could include the development and testing of value based payment models. Some respondents noted most government health departments do not have the necessary expertise to legitimise their attempt to introduce value based payment models, although others suggested that having academia, think tanks and other experts provide advice would suffice.

> *It's the missing agency in all the national bodies that we have. And, to me, it could change the conversation that we have around efficient pricing and efficient cost … [to] how to improve quality and efficiency, and potentially equity as well, through improved models of care.* [GE 25]

This theme highlighted further potential gaps in civil service capability to implement a value based payment model. This included the need to ensure one organisation undertakes data collection and analysis, develops capability and evidence, and promotes innovation. Respondents suggested that organisation also help develop the workforce, recognising that providers may lack the capability to appropriately manage their services under a value based payment model.

This theme reiterated the need to ensure additional resources and supportive structure were allocated to help providers implement a value based payment model. Respondents noted the complexity of aligning state, territory and government objectives and the need to provide enough time for change within a new payment model. It was suggested that two years to trial a payment model was not enough, while others believed that five years would be more appropriate.

> *Two years is not enough. People are just beginning to find their feet, understand a model, and the carpet is pulled out from everyone, the rug is pulled out from under everyone's feet. And all of that work is put aside, and we start again. So it needs a long time for people to understand the model, implement it, refine it, etc.* [GE 2]

Themes mapped to the CFIR

The six themes were mapped to constructs within the Consolidated Framework for Integration Research (CFIR) (see Table 2) to further understand the potential facilitators and barriers to embedding value based payments in mental healthcare. The CFIR provided common taxonomy, terminology, and definitions associated with implementing complex interventions within healthcare.

Table 2: Summary of mapping themes to CFIR constructs

CFIR constructs	Number of links	Barrier or Enabler	Comment
Characteristics of the Intervention			
Intervention source	8	N/A	Intervention does not yet exist. Thematic analysis elements suggest what components to consider to ensure the source (most likely external) is acceptable to respondents.
Evidence Strength and Quality	4	Barrier	Current lack of evidence to support value based funding is a key barrier to implementation
Relative Advantage	3	N/A	Intervention does not yet exist. Communicating the merits of value based funding in terms of relative advantage to providers and consumers would enable implementation.
Adaptability	2	N/A	Intervention does not yet exist. An adaptable framework that can accommodate real world complexity would enable implementation.
Trialability	0	N/A	
Complexity	3	Barrier	Complexity of current system, assigning outcomes to care, integration with existing payment models is a barrier to implementation.
Design Quality	9	N/A	Intervention does not yet exist. Thematic analysis elements suggest what components to consider to ensure the intervention design is acceptable to respondents.
Cost	2	Barrier	Cost of change and resources required for ongoing support of new payment models are barriers to change, particularly given competing priorities/opportunity costs.
Outer Setting			
Patient Needs and Resources	5	Barrier & Enabler	Thematic analysis elements suggest what components to consider to ensure intervention meets consumer needs. Barriers linked to complexity of eliciting needs, particularly given individualised nature of mental health and impact of social determinants on mental health. If consumer needs can be identified and met, consumer support would be an enabler of implementation.
Cosmopolitanism	3	Barrier	System fragmentation, in part driven by current lack of incentives to create strong provider networks is a barrier to implementation.
Peer Pressure	3	Barrier & Enabler	Currently no peer pressure to implement. Linked to relative advantage, if the benefits of value based funding to respondents were clearly communicated, peer pressure could become an enabler.
External Policy and Incentives	9	Barrier	Current external policy environment is a key barrier to implementation.
Inner Setting			

CFIR constructs	Number of links	Barrier or Enabler	Comment
Structural characteristics	2	Barrier	Workforce shortages and reform fatigue are barriers to the implementation of further reform.
Networks and communication	1	Barrier & Enabler	Existing networks (formal and informal) within and between organisations should be leveraged to build support for an intervention. There is a risk that the same organisations could resist change.
Culture	1	Barrier	Multiple provider organisations involved – the culture at each is currently unknown. Managing multiple unknown but likely different cultures will be a barrier to implementation.
Implementation climate	8	Barrier & Enabler	Conflicting responses: some agencies questioned need/priority for change; others strongly felt that change was needed. Convincing everyone of the need for change would be a key enabler.
Readiness for Implementation	5	Barrier & Enabler	Limited resources available for the shift to value based funding is a barrier implementation. Different levels of engagement and knowledge across agencies. Increasing engagement and knowledge would be an important enabler.
Individuals involved in implementation			
Knowledge and Beliefs about Intervention	2	N/A	Intervention does not yet exist. Thematic analysis suggests provider buy-in (engagement) is an enabler for implementation, behaviour change is linked to provider knowledge & beliefs about value based funding.
Self-efficacy	2	N/A	Intervention does not yet exist. Thematic analysis suggests behaviour change requires support beyond financial incentives - e.g., support for data collection, infrastructure, reporting.
Individual State of Change	0	N/A	
Individual Identification with Organisation	0	N/A	
Other Personal Attributes	2	Enabler	Accommodating provider perspectives and aligning incentives would enable implementation.
Process of implementation			
Planning	17	Enabler	Defining value based funding and creating payment models that address barriers identified in this research prior to implementation would enable effective implementation.
Engaging	3	Enabler	Engaging respondents would enable implementation.
Executing	0	N/A	
Reflecting and Evaluating	5	Enabler	Adaptable models with ongoing evaluation and stakeholder input would support long term success of the intervention.

Note: More detail on mapping themes to CFIR constructs is presented in Appendix C.

There was a high degree of overlap between constructs in the ‘intervention characteristics’ domain and categories derived from the thematic analysis of interview data. Barriers to implementation included the lack of evidence to support value-based funding, the complexity of implementing funding reforms in a multi-payer healthcare system, and the costs of implementing complex reform.

‘Adaptability’ was revealed as a potential enabler to implementing a value based payment model. Communicating the merits of a new model, in terms of ‘relative advantage’ to providers and consumers, may enable implementation. However, results linked to the ‘adaptability’ construct will only become relevant when such an intervention is designed, and only then can the potential for adaptability as an enabler be fully assessed.

Constructs in the ‘outer setting’ domain overlapped with multiple themes in the thematic analysis. The external policy environment was seen as a key barrier to implementation. System fragmentation and a lack of ‘cosmopolitanism’, driven in part by a lack of incentives to create strong provider networks, was also a barrier to implementation. Patient needs, workforce needs and incentives were raised as potential barriers to implementation but, if addressed, could become enablers of implementation.

There was a strong overlap between the ‘implementation climate’ and ‘readiness for implementation’ constructs and the thematic analysis for the development of value based payment models. Some agencies interviewed questioned the need and relative priority for mental health funding reform, while others strongly felt a change was needed. Inertia could be a barrier to change, but demonstrating the need and potential impact of value based funding compared to Medicare could be an important implementation enabler.

Organisations differed in their levels of engagement with, and knowledge of, value-based payment models, and multiple respondents noted the limited resources in government available for large scale reform. Additional barriers in the 'inner setting’ domain were ‘structural characteristics’ (workforce shortages and reform fatigue) and the number of respondents involved, each with their own unique culture. Existing networks (formal and informal) could resist change but could also be leveraged to build support for an intervention.

There was limited overlap between themes emerging from the thematic analysis and constructs in the ‘characteristics of individuals’ domain. Accommodating provider perspectives and aligning incentives would help implement a value based payment model, while knowledge, beliefs, and individual self-efficacy cannot be fully appreciated until the payment model is developed.

Defining value-based funding and payment model development was linked with the ‘planning’ construct of the ‘implementation process’ domain. Defining value based funding, (including what is meant by value, who are the respondents, and what outcomes are to be measured), and creating a payment model

that interacts with existing governance structures and intended service delivery was seen as vital. A value based payment model would need to be flexible, adaptable, and equitable, and government would be required to collect high quality data to support faithful attribution of outcomes to care. Such key concepts should be considered when planning the rollout of a value-based payment model. Respondents noted the need to engage respondents across the healthcare system to enable payment model implementation. Consequently, adaptable models with ongoing evaluation and stakeholder input may support the long-term success of such an intervention, if aligned with the 'reflecting and evaluating' construct of the implementation process domain.

'Trialability' in the 'intervention characteristics' domain did not emerge as a theme in the analysis of interviews. This may be because the proposed funding framework within the consultation paper did not include a post-market evaluation loop to prompt discussion. Alternatively, the idea of trialling a value based funding model was not at the forefront of respondent's minds because the intervention does not yet exist. 'Individual state of change' and 'individual identification with the organisation' in the 'individuals' domain did not emerge as a theme. Similarly, the 'executing' construct in the 'implementation process' domain did not emerge as a theme. It is likely that the intervention is currently too immature to elicit responses relevant to these constructs.

Schema – Value

There was some uncertainty within the interviews of non-government stakeholders regarding how value should be defined and measured. Value was therefore explicitly explored within the workshops to better understand non-government stakeholder views, with responses transcribed and then assessed using Schema analysis.

Workshop respondents all agreed to the inherent complexity of implementing a value based payment model within mental healthcare. While surveys and clinical measures may be helpful for assessing specific diagnoses and progression, respondents felt these do not '*hit the mark*' in fully capturing what consumers, carers and families value from services, including holistic wellbeing and the ability to '*function*' in society ('*capabilities*').

Respondents note that existing outcome measures have limited utility in enabling comparisons of outcomes across diagnoses and between mental health and other sectors. Outcome measures would need improving for system level priority-setting and resource allocation. Mapping some outcomes to health utilities would be challenging, with utilities desirable for comparing across policy domains. Respondents recognised that surveys may support deriving utilities based on a subjective wellbeing paradigm. However, respondents noted that consumers often do not consider their condition from a wellbeing

perspective and may not even have 'wellbeing outcomes' depending on condition. Instead, some may value '*capabilities'*.

Consumers, carers and lived experience groups queried the ability of existing survey instruments to collect meaningful data not '*skewed'* towards finding positive outcomes. Some respondents perceived these measures as being '*created by clinicians'* and not giving adequate weight to sustained, long-term outcome improvement. Surveys were said to also be frequently completed by providers or carers, not consumers, leading to '*an evaluative funnel, whereby the raw data and the real experience is not captured*'.

That said, some respondents noted that consumers and carers may themselves require support to provide useful data, and some may be incapable of doing so. Individual coping styles influence self-reporting, mental health is dynamic, diagnoses are often chronic and subject to '*treatment resistance*' and what is '*valued*' by consumers, carers and providers may conflict, adding further complexity to outcome measurement.

Some respondents saw merit in partial reliance on '*raw'* administrative outcomes, unaffected by a specific stakeholder lens (*'waiting lists', 'referrals'*). Some respondents noted the potential usefulness of process outcomes, including: *'keeping people engaged in care'* and implementing *'clinical guidelines',* due to the challenges associated with attributing specific changes in mental health and wellbeing to provider care.

Respondents strongly felt that many valued outcomes fall outside clinical domains including *'social connection', 'getting or maintaining work', 'educational outcomes', 'housing'*, *'safety and hope', 'dignity and respect', 'spiritual and physical'* wellbeing, and '*partnerships with families, supporters and carers'*. It was suggested that current measures overlook *'social determinants of health'* and the multifaceted nature of life experience, including pathways through care, and may not be tailored to the needs of specific groups. Cultural, housing and social needs are often missed, ultimately resulting in ineffective individual-level care. Respondents noted that evidence-based measures need to be designed considering factors such as rural residence, gender, disabilities, comorbidities, and cultural background.

Workshop respondents acknowledged challenges in developing a standardised set of consumer-centred outcome measures, due to preference heterogeneity: '*mental health is an incredibly unique journey'*. Respondents were contradictory, arguing both for a wider range of outcomes ('*flexibility*') but also a '*targeted and minimal subset'* that could be realistically collected in the face of existing access issues. Ultimately, co-design of outcome measurement tools was emphasised, incorporating lived experience insights on what truly matters on mental health journeys: *'the consumer suffers because they usually have the weakest voice'*. Respondents noted that processes for finding consensus on value across

stakeholder groups are needed, potentially through better embedding of regular provider-consumer interactions to find *'appropriate'* and *'valued'* outcomes that consider individual contexts.

Schema – Value based payment models

Workshop respondents were asked to consider the vision of a framework for developing and implementing value-based payment models in mental health, as outlined within the consultation paper. 'In-principle' agreement with the need for reform resulted, with respondents recognising current system flaws, including payment and service fragmentation, limited innovation in care, and limited encouragement of holistic, consumer-centric approaches beyond purely clinical.

The 'appetite for change' was underpinned by respondents' awareness of failures to achieve sustained outcome improvement in mental healthcare. Respondents noted these would continue without greater integration of healthcare and non-healthcare services. Merit was also seen in shifting the focus away from clinical inputs (e.g., 'beds') to encouraging greater innovation and creativity in producing outcomes.

Many respondents described substantial 'real-world' barriers and system complexity that must be navigated to implement value-based payments in mental health care: 'the devil's in the detail'. Consumer groups were critical of models that pay for outcomes at the provider level. The difficulty of defining specific outcomes to measure was recognised, as was the low predictability of outcomes in mental health care. Respondents noted that treatment may vary for 'people with similar presentations', due to heterogeneity in individual preferences and circumstances.

Respondents noted that perverse incentives created by focussing on specific outcomes may skew treatment towards 'box-ticking' activities rather than holistic, humane, consumer-centric care, a concern particularly voiced by consumers, but also highlighted by other respondents. A strict outcome focus may inadvertently result in provider selection of consumers with lower need, but easily modifiable outcomes. It may also ignore the reality of treatment resistance and the chronic nature of many mental health conditions.

Respondents noted that value-based payment models might be perceived 'as offensive' and 'role-devaluing' by providers if they put 'the onus of change entirely on the clinician, rather than seeing it as a partnership between clinician, patient and the broader system'.

A tension was said to exist between extrinsic and intrinsic motivation and providers feared value-based payments would shift significant financial risk to them or be vehicles for cost-cutting. Some consumers argued for greater empowerment through consumer 'budgets' to support a range of services, 'not just typical mental health care'. Others raised concerns about those in acute stages of illness not being able to gauge their care needs or care availability.

Existing workforce shortages and regional access issues were significant themes across all workshops. Respondents felt a value based payment model should encourage innovation, support a sustainable workforce and enable a 'healthy and diverse sector'. Equity and access, recognising condition and disability, cultural background, socioeconomic status and geography, was mentioned as a crucial design consideration.

Respondents noted that models of value-based care need to be coordinated and integrated across sectors, to create multi-dimensional services in line with the impact of mental health problems and outcomes. Tailored and flexible value based payment models may also be necessary, depending on patient populations and local and community need.

Block or activity-based funding for groups with treatment resistance was suggested by respondents, alongside value-based payments for conditions with measurable, modifiable outcomes. Individuals with acute conditions such as schizophrenia might be a promising first target group for value-based payments due to their high service use and care outcomes falling across health and non-health sectors.

Respondents noted that payment models should be carefully piloted and evaluated over a sufficiently long period of time to accommodate adjustment and thorough assessment. Any independent 'value-based payment authority' should mesh with existing governance structures and stakeholder partnerships and be clear on accountability. Consumers and carers wanted their lived experience inputs to be strongly embedded within any model development, implementation, and evaluation, with 'iterative' approaches and 'feedback loops'. Respondents suggested that policy should strive towards consumer-centricity, while political discussions should be more empathetic, shifting away from perceiving individuals with mental health problems as exclusively a 'societal burden'.

Discussion

Summary of findings

This study explored stakeholder perspectives on hypothetical system wide reform towards value based payments in mental health care. Presenting a parsimonious collection of stakeholder views collated into themes and schemas, our study identified potential implementation blind spots and clear knowledge gaps where further research should be concentrated. It highlighted the importance of '*laying the groundwork'* by addressing broader issues within the mental healthcare system, such as limited collection and use of data and evidence, workforce challenges, and political will.

Research was conducted by undertaking extensive interviews and national workshops with government and non-government respondents, with responses recorded and transcribed verbatim. Thematic analysis, the Consolidated Framework for Implementation Research and Schema analysis were employed to synthesise, organise and analyse data in a transparent, systematic and collective way.

Six themes were identified that were categorised into two groups, including themes specifically on value based payment model; and themes related to the broader context within which funding models operate. The former group's themes included clear payment model definitions and place; payment model characteristics; and circumventing barriers to payment reform. The latter group's themes included ensuring patient focused care; addressing workforce challenges; and embedding appropriate governance structures.

Mapping the six themes to five domains and 26 constructs within the Consolidated Framework for Implementation Research highlighted potential barriers and enablers to implement a value based payment model in mental health care. Government respondents considered the external policy and economic environment as major barriers to payment reform. Planning was also a focal point, most likely reflecting government respondent experience in implementing healthcare system change.

Less commentary from government respondents was mapped to the domain 'Individuals involved in implementation'. This could represent a blind spot in government thinking around implementation from taking a more systems level focus, particularly given the high importance of understanding individual behaviour affected by policy change prevalent in the non-government workshops.

This suggests less consideration was given by government respondents to the interplay between individual behaviours and organisational change, despite the potential for individual behaviours to impact implementation through their knowledge and beliefs, self-efficacy and relationship with the organisation. (Damschroder et al., 2009) Little commentary was received from all respondents on the importance of 'networks and communication' and 'culture' within organisations when implementing payment model reforms.

Schema analysis conducted within this study allowed complex information collected from disparate stakeholder perspectives to be interpreted using a consensus team based approach, drawing out the essence of meaning from those perspectives, and adding substance to the thematic analysis. (Rapport et al., 2018b)

The *'value'* Schema revealed important concepts on the notion of equity. While the debate on defining equity in health care is ongoing, particularly within the context of mental health, (Mangalore and Knapp, 2006, Knapp and Wong, 2020) responses suggested non-government respondents views align with the concept of freedoms and capabilities, and the understanding of social justice. (Sen, 2002) Respondents emphasised the goal of addressing population need by considering condition and disability, cultural background, socioeconomic status and geography. This reflects a departure from common proxies used in healthcare systems to represent equity, which focus on utilisation. (Raine et al., 2016)

Non-government respondents noted the importance of ensuring that consumers can *'function'* in society and the potential for consumers to value *'capabilities'* over wellbeing outcomes, revealing their distaste for using clinical measures to reflect these concepts. A component of Sen's capability approach was also reflected in the thematic analysis, to the extent that government respondents valued the ability of consumers to choose their services, (Sen, 1988) although government respondents were quiet on ensuring capabilities among consumers.

Non-government respondents also concluded that employing outcome measures within a funding model should be undertaken with care. While this aligned with government stakeholder views, the conclusion was borne from different concerns. Government respondents took a more technical view, highlighting the potential difficulty in selecting and measuring outcomes that matter to consumers and the challenges in attributing outcomes to services.

It was suggested that data collected by governments are not sufficient to enable attribution without great uncertainty for people receiving multiple health and non-health services. Non-government respondents took a broader view, although somewhat contradictory, noting the need to employ a wide range of outcomes to capture consumer heterogeneity, but also a 'targeted and minimal subset' of outcomes for payment.

Non-government respondents identified examples of valued outcomes that are non-clinical, the need to capture preference heterogeneity given the '*unique journey'* towards better mental health for each consumer, and the need to capture outcomes that reflect the circumstances of consumers with chronic, treatment resistant conditions. There were concerns that a strict focus on outcomes would lead to providers selecting consumers with lesser needs and lesser complexity, potentially creating further inequities in access to care.

There was no consensus among respondents on what outcomes should be measured. While non-government respondents noted that outcomes must reflect individual circumstances and preferences, a payment model should not employ outcomes if they cannot be attributed with confidence to services received. This is likely within the current mental health care environment, where the ability to efficiently collate data on factors that impact outcomes in a timely manner, such as consumer characteristics, health related behaviours, services received, and the receipt of informal care, is lacking. Attributing provider service to outcomes is also fraught with errors and complexity, and some providers may not have a locus of control. (Smith et al., 2008)

Contrasting themes and Schemas highlighted similarities and differences in the weights government and non-government respondents placed on dimensions and constructs. There was consensus that payment reform should be pursued in mental health care, but implementation barriers were large, given the lack

of data and evidence, implementation complexity, and challenging political and economic environments. Both groups highlighted workforce gaps and inequity in access to care for consumers in regional and remote areas that need to be addressed.

The thematic analysis revealed that government respondents took a more macro view of implementation. Government respondents highlighted the inadequacies associated with current governance structures, the complexities of embedding an independent agency within a federated structure, and potential difficulties in creating political will among competing challenges, such as workforce gaps and budget pressure.

The Schemas revealed that non-government respondents had a greater focus on gaining consensus on defining value and on identifying outcomes that matter to consumers. They took a more individualistic perspective, highlighting potential power imbalance between government and consumers when deciding on outcomes, suggesting lived experience insights were essential, but consumer voices were weak within current governance structures. Some concern was expressed by providers that value based payment models would shift financial risk onto themselves or be used by governments to cut costs. This view seems common among providers facing value based payment reform in health care. (Werner et al., 2021)

Insights into outcomes based payment reform in mental health care

Barriers to implementing a value based payment model identified in our study are not unique to the Australian mental health care system. Evidence gaps, workforce challenges, silo budgeting, budget limitations and inequalities are endemic and persistent throughout developed country mental health care systems. (Knapp and Wong, 2020)

Most research has focused on what services should be provided in mental healthcare rather than how responsibilities of delivering and funding care should be allocated, or how payment models should be structured. Recommendations on how to better integrate physical and mental health highlight the importance of also reforming payment models in the United States. (O'Donnell et al., 2013, Miller et al., 2017)

No studies were found within our study that collected stakeholder perspectives on increasing the proportion of payment for mental health care based on outcomes. One study provided a framework for value based payment reform but did not specifically relate to mental health care. (Conrad et al., 2016) Perelman et al. (2018) recommended funding models that incentivise delivering best practice care in the Portuguese mental health care system but focused on four specific treatment types using the perspectives of 22 ‘experts’. The narrow focus of that study limits how recommendations can be transferrable to other mental health care systems.

The results presented in this paper contribute to the existing literature by providing parsimonious, collective meaning to disparate stakeholder perspectives, and to identifying the potential barriers and enablers to implementing value based payment models in mental health care.

Funding model reform towards paying for outcomes in healthcare is on the agenda in several other developed countries besides Australia, such as the United States and the United Kingdom. The United States is starting to incorporate mental health care into physical health care funding models, known as behavioural health integration, and the CMS Innovation Centre has indicated its intent to expand these types of models. (Hughs et al., 2022) Value based funding model trials in the United States have mostly related to physical health, with some applied to chronic conditions. Bundled payments have had a mixed impact on reducing costs. Success has come from changing care models, shortening hospital stays and renegotiating supplier prices, (Yee et al., 2020) but most only preserve outcomes. (Agarwal et al., 2020)

Accountable care organisations have generated small improvements in quality and patient experience scores, (Peiris et al., 2018) and reduced costs by reducing hospital admission rates and emergency department presentations, (Werner et al., 2021) but have had limited success in improving mental health outcomes. (Counts et al., 2019) Of more than 50 models tested by the CMS Innovation Centre across all health conditions, only four have been expanded in duration and scope. (Center for Medicare and Medicaid Innovation, 2021)

The limited success of value based payment models suggests more learning is required. Some suggest more patience is also needed, given the United States seeks to transform payment models and the organisation of health care simultaneously. (Burns and Pauly, 2018) This is likely the case in mental health care, where value based funding models are embryonic compared to physical health funding models. Characteristics of mental health, differ from physical health, which makes implementing value based payment models in mental healthcare unique.

One difference is greater complexity in measuring a broader set of outcomes valued by consumers and attributing those outcomes to services. If not adequately addressed, providers may focus on attracting less ill and less costly consumers, (McGuire, 2020) potentially exacerbating inequities in access to care. This was demonstrated in the United States, where risk adjustment for compensating health plans to enrol consumers with more severe depression and substance use disorders incentivised plans to restrict access. (Montz et al., 2016).

Limitations

This is the first study to explore stakeholder perspectives on system wide reform towards value based payments in mental health care that originates from an economics perspective, which is critical when

aiming to change service provision and behaviour through financial incentives. However, this study has limitations.

While stakeholder views from all relevant state, territory and federal government departments and agencies were sought, our analysis does not include views from the federal Department of Health and Aged Care and one state health department. It is possible that some perspectives were missed that would have impacted the thematic framework. However, given the wide range of government perspectives elicited, this effect is expected to be negligible. Furthermore, the analysis and coding undertaken achieved thematic saturation after 10 interviews, with a further three interviews undertaken with government respondents.

Additionally, our consultation paper proposed one framework for implementing value based payment models. The framework was considered by all respondents within the context of the Australian mental health care system and Australia's economic, political and social contexts. This may limit the transferability of stakeholder views to other value based payment model frameworks and other mental health care systems.

We believe that limited transferability would most likely be contained within views related to embedding appropriate governance structures given they were formed within the context of the Australian federated system. Many developed countries' mental health care systems face problems similar to those identified in this study. These include workforce gaps, budget pressures and reform complexity, suggesting less concern for the transferability of our results to other settings. (Knapp and Wong, 2020) The Australian health care system also holds similar structural characteristics to other countries, often being considered a hybrid of the United States and United Kingdom health care systems.

Conclusion

Respondents agreed the Australian mental health care system needs funding reform and they supported a shift away from Medicare towards a value based payment model. There were contrasting views held by government respondents on whether developing an independent value based payment authority was appropriate. Government respondents were mostly concerned with whether an independent agency would fit within the political and economic complexity of a federated structure. While having an independent agency would provide a clear allocation of responsibility and help concentrate necessary multidisciplinary skills for model development and implementation, respondents suggested more consultation is required.

Seeking stakeholder views to co-design, implement and evaluate complex health care interventions is considered essential for achieving equitable outcomes. This is particularly the case for mental health

care, where the perspectives of consumers with lived experience have mostly been excluded from policy formulation. (World Health Organization (WHO), 2023)

Attempts to reform mental health care systems have focused on reorganising service delivery. Developed countries have shifted care from institutionalised settings to community settings, from treatment to prevention, and on to stepped care and community support services for people disabled by mental ill health. (Goldman and Morrissey, 2020) Given the desire to better integrate mental health care, and that payment models fundamentally impact how providers choose to allocate their resources, it is essential to understand stakeholder perspectives on value based payment model reform, to enable and promote better mental health care systems.

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Appendix A: Interview guide

ID:
Date: 31 August 2023
Interview start time: 4pm
Interview finish time: 5pm

Introduction, thanks for participation, consent

My name is *[insert name]* and I am *[insert position]* at the Macquarie University Centre for Health Economy (MUCHE). I will be conducting the interview with you today.

Also present with me are *[insert names],* who are researchers at MUCHE. Their role is to observe the interview as part of our qualitative research methodology and will therefore not ask questions.

Thank you for agreeing to be interviewed.

I will now run through some information related to this interview.

Your participation is completely voluntary. Acceptance of our interview invitation suggests written consent to take part in the study. If you change your mind, you can withdraw at any time, and you do not have to give a reason.

We will now turn on Zoom recording and ask you a series of questions to gain your views on the mental healthcare funding and investment environment in Australia. I will also share my screen at times to show the tables and figures that some of the questions refer to, which were included in the Consultation Paper we provided.

Prior to commencing recording, we would like to emphasize that strict confidentiality is to be maintained by all individuals present here. No information regarding the discussions here is to be disclosed to anyone outside of this group. We would also like to emphasize that we expect general responses and views to the questions we pose based on your experiences, but there is no need to identify individuals or other identifiable sensitive information within your responses.

Do you consent to us turning on Zoom recording?

Please feel free to ask any of us questions at any time during the interview. You may also contact MUCHE following the interview if you have any questions related to the study.

[Start recording]

We have written a consultation paper that I hope you have seen as these interview questions are based on that paper.

We will mostly focus on two frameworks presented in the paper, the first on value based funding and the second on making investment decisions in mental health care.

I would like to start with some questions that seek your views on recent mental healthcare funding and investment reform ideas and progress.

Chapter 2

1. Do you think there is a case for exploring value based payments and alternative investment approaches in mental healthcare?
2. Do you believe the National Mental Health and Suicide Prevention Agreement sets an appropriate agenda for funding and investment reform within state and territories?

Chapter 3

As part of our research, we have developed a proposed approach for introducing value based payments in mental healthcare, as illustrated in Figure 1 of the Executive Summary.

We are interested on your views on this approach. Let me share the figure on the screen and walk you through it. *[Interviewer note: Walk through Figure 1].*

1. What are your views on the proposed governance structure for value based payments in mental healthcare presented in **Error! Reference source not found.** of the Executive Summary?
2. Do you agree that the development of value based payment models should be governed by a federal independent value based payment authority?
3. What are the potential barriers to implementing this structure within states and territories?
4. What are the special characteristics we should consider within mental healthcare when thinking about value based payments?
5. Is there a specific patient population you believe value based payments should first target to improve outcomes and service delivery efficiency?

Final Question

1. Is there anything you want to add that we haven't covered in the interview today?

We would now like to offer you the opportunity to provide any feedback or concerns regarding the conduct of this interview or any of the discussions. You are also welcome to contact us with any concerns or questions via email following the interview.

Thank you very much for your time today.

[End recording]

Appendix B: Workshop guide

ID:
Date: 26 September
Workshop start time: 10:30am
Workshop finish time: 12:30pm

Introduction, thanks for participation, consent

My name is *[Insert name]*. I am a *[Insert title]* at the Macquarie University Centre for Health Economy (MUCHE). I will be facilitating the workshop proceedings today. Also present with me are *[Insert team member names],* who are health economics researchers at MUCHE, and who will be helping with running the group sessions.

Thank you for agreeing to participate in this workshop. We would like to emphasize that your participation is completely voluntary. Acceptance of our workshop invitation suggests written consent to take part in the study. If you change your mind, you can withdraw at any time, and you do not have to give a reason.

Our purpose here is to gain your views on the mental healthcare funding and investment environment in Australia, and how we could better embed value over the longer term to improve mental health outcomes and promote quality and evidence-based care. Ultimately, your insights will contribute to the to the development of a policy recommendations and a proposed framework to embed more value into Australia's mental healthcare funding and investment environment.

Prior to commencing, we would like to emphasize that strict confidentiality is to be maintained by all respondents present here. No information regarding the discussions here is to be disclosed to anyone outside of this group. We would also like to emphasize that we expect general responses and views to the questions we pose based on your experiences, but there is no need to identify individuals or disclose other sensitive information within your discussions with the group.

We will be anonymising all the responses collected here and no individual will be identified in the qualitative analyses we will conduct following this workshop, although we may use general quotes summarising key themes. But these will not be attributed to any specific individual or organisation.

We have allocated all the respondents present here to one of four groups with mixed stakeholder types. Over this workshop, we will present you with some questions to discuss within your breakout rooms.

You will then reconvene with the broader group, with one 'speaker' from each group to present the group's responses to the questions they were presented. The broader group will then also have the opportunity to participate in a group discussion and offer any comments or views.

There will be an observer and guide from MUCHE within each breakout room to facilitate the group activities and share the screen to show the questions and any diagrams or notes related to the questions. One group member will need to be a scribe or speaker. This person will take notes on the views and responses to each question presented, and summarise the views and responses of the group in the notes when reconvening with the broader group here.

Please feel free to ask the MUCHE research team member in your breakout room any questions at any time during the workshop. You may also contact MUCHE following the workshop if you have any question related to the study.

[Start recording]

[Start first presentation on current payment model reform environment and how our research fits into the policy debate]

[Start second presentation on defining and measuring value in mental health care]

[Start first breakout room activities. Researcher to identify a group leader to scribe and present summary of discussion. Group to discuss the following questions]

What does value in mental healthcare mean to you?

Should summary clinical surveys be used to measure changes in mental health outcomes from service delivery?

What other outcomes are valued by people with mental ill health?

What are some challenges when measuring outcomes and costs?

[End first breakout room activities]

[Reconvene with broader group to discuss responses to questions. Host to ask each group leader to present summary of group discussion. Open the discussion to all once all group leaders have presented]

[Start third presentation on proposed payment model framework]

[Start second breakout room activities. Respondents allocated to the same group. Group to discuss the following questions]

Group 1

1. Should value based payment models be used to fund mental healthcare?

2. What principles are most important to underpin mental healthcare investment?

Group 2

1. What principles are most important to underpin mental healthcare value based payment models?
2. Should there be a unified approach to investment decisions in mental healthcare?

Group 3

1. Do you agree with the proposed governance structure for implementing value based payment models in mental healthcare?
2. Do you believe investments should be implemented on a conditional basis before a final recommendation is made?

Group 4

1. Is there a specific patient population value based payment models should target to improve outcomes?
2. Do you agree with the proposed process for considering investments and making recommendations?

[End second breakout room activities]

[Reconvene with broader group to discuss responses to questions. Host to ask each group leader to present summary of group discussion. Open the discussion to all once all group leaders have presented]

Workshop close

Thank you all for sharing your valuable insights and views today, which will help us in preparing recommendations on how to shift funding and investment in mental health care towards greater value over the longer term. Our hope is that this consultation process will help guide the Commonwealth Government and states and territories as they approach and consider new payment, commissioning and funding approaches in mental health care to help meet the needs of local populations, while promoting care quality, health outcomes valued by patients and adherence to best-practice care.

We would now like to offer you the opportunity to provide any feedback or concerns with regards to the conduct of this workshop or any of the discussions that have taken place. Please unmute yourself to share any concerns you would like to voice. Or if you prefer, you are also welcome to contact us with any concerns or questions via email following the workshop.

[End recording]

Appendix C: Thematic analysis themes mapped to the Consolidated Framework for Implementation Research (CFIR)

Table B.1: Clearly defining value based funding (Theme 1)

CFIR constructs	Value in mental health	Roles and responsibilities	Payment models and pathways	Target cohort	Outcomes
Characteristics of the Intervention					
Intervention source					
Evidence Strength and Quality					
Relative Advantage					
Adaptability					
Trialability					
Complexity					
Design Quality	Y	Y	Y	Y	Y
Cost					
Outer Setting					
Patient Needs and Resources					
Cosmopolitanism					
Peer Pressure					
External Policy and Incentives					
Inner Setting					
Structural characteristics					
Networks and Communication					
Culture					
Implementation climate					
Readiness for Implementation					
Individuals involved in implementation					
Knowledge and Beliefs about Intervention					
Self-efficacy					
Individual State of Change					
Individual Identification with Organisation					
Other Personal Attributes					
Process of implementation					
Planning	Y	Y	Y	Y	Y
Engaging					
Executing					
Reflecting and Evaluating					

CFIR constructs	Value in mental health	Roles and responsibilities	Payment models and pathways	Target cohort	Outcomes
Total	2	2	2	2	2

Table B.2: Patient focused care (Theme 2)

CFIR constructs	Holistic care	Social determinants of health and wellbeing	Individual perspective and need	Patient relevant outcomes	Patient autonomy
Characteristics of the Intervention					
Intervention source					
Evidence Strength and Quality					
Relative Advantage			Y		
Adaptability					
Trialability					
Complexity					
Design Quality			Y		
Cost					
Outer Setting					
Patient Needs and Resources	Y	Y	Y	Y	Y
Cosmopolitanism					
Peer Pressure					
External Policy and Incentives					
Inner Setting					
Structural characteristics					
Networks and Communication					
Culture					
Implementation climate					
Readiness for Implementation					
Individuals involved in implementation					
Knowledge and Beliefs about Intervention					
Self-efficacy					
Individual State of Change					
Individual Identification with Organisation					
Other Personal Attributes					
Process of implementation					
Planning			Y		
Engaging			Y		
Executing					

CFIR constructs	Holistic care	Social determinants of health and wellbeing	Individual perspective and need	Patient relevant outcomes	Patient autonomy
Reflecting and Evaluating			Y		
Total	1	1	6	1	1

Table B.3: Payment model development (Theme 3)

CFIR constructs	Existing payment models	System and service fragmentation	Flexibility and adaptability	Stakeholder equity and inclusion	Collecting evidence	Attributing outcomes to care	Risk management	Transitional funding
Characteristics of the Intervention								
Intervention source			Y	Y	Y		Y	
Evidence Strength and Quality					Y			
Relative Advantage								
Adaptability			Y					
Trialability								
Complexity	Y					Y		
Design Quality								
Cost								
Outer Setting								
Patient Needs and Resources								
Cosmopolitanism		Y						
Peer Pressure								
External Policy and Incentives								
Inner Setting								
Structural characteristics								
Networks and communication								
Culture								
Implementation climate								

CFIR constructs	Existing payment models	System and service fragmentation	Flexibility and adaptability	Stakeholder equity and inclusion	Collecting evidence	Attributing outcomes to care	Risk management	Transitional funding
Readiness for Implementation								
Individuals involved in implementation								
Knowledge and Beliefs about Intervention								
Self-efficacy								
Individual State of Change								
Individual Identification with Organisation								
Other Personal Attributes								
Process of implementation								
Planning	Y		Y	Y	Y	Y	Y	Y
Engaging								
Executing								
Reflecting and Evaluating			Y		Y			
Total	2	1	4	2	4	2	2	1

Table B.4: Workforce needs and challenges (Theme 4)

CFIR constructs	Existing shortages	Reform fatigue	Provider perspective and buy-in	Aligning incentives with objectives	Behaviour change
Characteristics of the Intervention					
Intervention source					
Evidence Strength and Quality			Y		
Relative Advantage			Y		Y
Adaptability					
Trialability					
Complexity					
Design Quality			Y		
Cost					
Outer Setting					
Patient Needs and Resources					
Cosmopolitanism				Y	
Peer Pressure			Y	Y	Y
External Policy and Incentives					
Inner Setting					
Structural characteristics	Y	Y			
Networks and Communication				Y	
Culture			Y		
Implementation climate		Y			
Readiness for Implementation	Y	Y			
Individuals involved in implementation					
Knowledge and Beliefs about Intervention			Y		Y
Self-efficacy			Y		Y
Individual State of Change					
Individual Identification with Organisation					
Other Personal Attributes			Y	Y	
Process of implementation					
Planning			Y		
Engaging			Y		
Executing					
Reflecting and Evaluating			Y		
Total	2	3	11	4	4

Table B.5: Governance structures (Theme 5)

CFIR constructs	System level approach	Governance tiers	Independent agency	Expertise	Capability	Resourcing	Timeframes
Characteristics of the Intervention							
Intervention source	Y	Y	Y	Y			
Evidence Strength and Quality				Y			
Relative Advantage							
Adaptability							
Trialability							
Complexity							
Design Quality				Y	Y		
Cost						Y	
Outer Setting							
Patient Needs and Resources							
Cosmopolitanism	Y						
Peer Pressure							
External Policy and Incentives	Y	Y	Y				
Inner Setting							
Structural characteristics							
Networks and communication							
Culture							
Implementation climate							

CFIR constructs	System level approach	Governance tiers	Independent agency	Expertise	Capability	Resourcing	Timeframes
Readiness for Implementation							
Individuals involved in implementation							
Knowledge and Beliefs about Intervention							
Self-efficacy							
Individual State of Change							
Individual Identification with Organisation							
Other Personal Attributes							
Process of implementation							
Planning				Y	Y	Y	
Engaging	Y						
Executing							
Reflecting and Evaluating	Y						
Total	5	2	2	4	2	2	0

Table B.6: Barriers to change (Theme 6)

CFIR constructs	The necessity for change	Past failures	Real-world complexity	Funding as the way forward?	Administrative burden	Where to start	Competing priorities	Evidence deficit
Characteristics of the Intervention								
Intervention source								
Evidence Strength and Quality								Y
Relative Advantage								
Adaptability			Y					
Trialability								
Complexity			Y					
Design Quality								
Cost							Y	
Outer Setting								
Patient Needs and Resources								
Cosmopolitanism								
Peer Pressure								
External Policy and Incentives	Y	Y	Y	Y		Y	Y	
Inner Setting								
Structural characteristics								
Networks and communication								
Culture								

CFIR constructs	The necessity for change	Past failures	Real-world complexity	Funding as the way forward?	Administrative burden	Where to start	Competing priorities	Evidence deficit
Implementation climate	Y	Y	Y	Y	Y		Y	Y
Readiness for Implementation				Y	Y		Y	
Individuals involved in implementation								
Knowledge and Beliefs about Intervention								
Self-efficacy								
Individual State of Change								
Individual Identification with Organisation								
Other Personal Attributes								
Process of implementation								
Planning								
Engaging								
Executing								
Reflecting and Evaluating								
Total	2	2	4	3	2	1	4	2