



**Submission in response to Productivity
Commission Inquiry into Mental Health
Intergovernmental arrangements**

JULY 2019

Contents

Executive summary	2
Overcoming the persistent lack of clarity about shared responsibilities	3
Collaborative, systems perspective mental health planning	3
Payment and funding models	3
Introduction	4
Overcoming the persistent lack of clarity about shared responsibilities	6
Current governance model	6
A National Mental Health Agreement	8
Collaborative, systems perspective mental health planning	10
Case study – Greater Manchester, UK – Whole of System Strategy	12
Payment and funding models	14
Activity Based Funding	14
Community mental health funding	15
Investment and insurance approaches	15
Future payment and funding models	16
Conclusion	19
Mental Health Australia	20



Executive summary

Understanding what governance and funding mechanisms are best suited to achieving national reform is key to addressing current shortcomings of the mental health system in Australia. Existing intergovernmental arrangements create cost shifting, gaps and do not encourage planning and coordination across government departments and between governments. These arrangements are contributing directly to the instability, overall quality and efficiency of the mental health system.¹ Immense pressure is put on governance frameworks to deliver clear roles and responsibilities for funders and providers of mental health care and services.

The most recent attempt to substantially recast the relationship between the Commonwealth and the States was through the Intergovernmental Agreement on Federal Financial Relations.² The national agreement defines the objectives, outcomes and performance indicators of particular areas, and seeks to clarify the roles and responsibilities of governments to guide them in delivering services in key sectors – including health, education, skills and workforce development, disability services, affordable housing and Indigenous reform.

Such an approach could become the basis for a new National Mental Health Agreement to underpin a future mental health system and should draw insight from the Productivity Commission's recent recommendations to strengthen a revised National Disability Agreement.

The provision of mental health services in Australia intersects across numerous Commonwealth, state and territory agencies and service providers. The lack of integration and complexity across the range, location and number of service providers restricts the ability of service providers to provide individualised person-centred services across a continuum of care. Focus should be directed toward providing person-centred holistic care and services and not directing them to fit into existing generalised programs. Investing in psychosocial supports, addressing the social determinants of health and co-designing services with consumers and carers are critical to consider in the development of a future system.

This submission, the third from Mental Health Australia, highlights the key levers and controls to be considered in the pursuit of constructing a sustainable system that continually builds upon capacity and capability. There is a need for strong feedback and monitoring

¹ National Health and Hospitals Reform Commission (2009) *A healthier future for all Australians. Final Report June 2009*. Retrieved from: <https://www.mja.com.au/journal/2009/191/7/healthier-future-all-australians-overview-final-report-national-health-and>

² Council of Australian Governments (2008) *Intergovernmental Agreement in Federal Financial Relations* Retrieved from: http://www.federalfinancialrelations.gov.au/content/intergovernmental_agreements/IGA_federal_financial_relations_aug11.pdf.

models to ensure continuous quality improvement and change is achieved. This submission also discusses how a strong governance framework is required to address the structural shortcomings of the current system and ensure the sustainability and success of a newly designed mental health system.

Key considerations are highlighted throughout the document to inform the recommendations the Productivity Commission will be developing.

Overcoming the persistent lack of clarity about shared responsibilities

The development of a National Mental Health Agreement would clarify relationships between all aspects of the mental health policy landscape, facilitate cooperation between governments and promote greater accountability. The current level of fragmentation has meant that mental health services and supports are provided through a complex mix of funders, services, programs and settings. Current approaches are inefficient, misaligned and restrict the innovation, flexibility and coordination in the delivery of services. By understanding where gaps are present within the current mental health system, clear lines of responsibility can be determined and service gaps addressed.

Collaborative, systems perspective mental health planning

The Australian mental health system lacks central policy governance, encourages fragmentation and offers poor integration and coordination of services between providers. Strategic management, accountability and governance require dedicated policy, legislation and decision-making to occur in a highly coordinated manner. A strengthened National Mental Health Commission should monitor and report on the human outcomes, system and financial performance of a national mental health system - outside of political influence and processes. The delivery of services and programs should always be examined through the consumer and carer lens and the National Mental Health Commission's 'whole of life indicators'.³

Payment and funding models

The current activity based funding model fails to deliver services for individuals living with mental illness and multifaceted needs in a holistic way. A revised national approach to funding mental health is required to meet the mental health care needs of Australians, with the development of a financial accountability framework and national oversight an important option for attention. Payment structures need to be blended around activities and populations with a focus on outcomes. Existing structures need to move beyond the current state to ensure they are able to redistribute services to high risk populations. This can be achieved by combining activity based funding with bundled payment models that focus on outcomes approaches across the continuum of care.

³ National Mental Health Commission (2013) *Expert Reference Group on Mental Health Reform*. Retrieved from: <https://www.mentalhealthcommission.gov.au/our-reports/expert-reference-group-on-mental-health-reform.aspx>



Introduction

The articulation of national mental health policy in Australia has been world leading, however, high quality implementation has failed to follow. Failure to adequately fund, implement and monitor reform has stunted progress in ensuring Australians are getting the support they require to maintain good mental health and recover from mental illness.

Numerous reviews, strategies to allocate funding and design approaches, including National Mental Health Commission reviews and multiple National Mental Health Plans, have resulted in little reform. The description the Productivity Commission used in its Disability Care and Support Report in 2011, where it concluded the disability system was “underfunded, fragmented, inefficient and giving people little choice” applies to the mental health system today. As a result, significant doubt must be placed on the merit of continued investment in current patterns of mental health service delivery and intergovernmental arrangements that continue to miss the mark.

This submission addresses three questions to support the Productivity Commission in forming recommendations to improve the mental health outcomes of all Australians.

- What are some effective ways of overcoming the perceived and persistent lack of clarity about shared responsibilities for mental health across tiers of government?
- How can we induce governments to approach mental health planning and program development from a collaborative, systems perspective, rather than from the perspective of an individual portfolio - possibly with aim of minimising gaps, duplication and confusion in service provision/availability and improving efficiency and effectiveness?
- Which payment/funding models are most appropriate for people/services at the various levels of stepped care?

In developing this submission, our third, Mental Health Australia started with a working hypothesis that the Productivity Commission must recommend that intergovernmental governance and finance arrangements need review and strengthening to ensure long term meaningful and sustainable change is achieved for the mental health system. Considering this hypothesis, Mental Health Australia undertook a desk based review of relevant literature and convened an Expert Forum to assist in identifying advice for the Productivity Commission on appropriate intergovernmental arrangements.

Attendees at the Expert Forum included stakeholders with significant experience in advocating for and delivering on major reforms across disability, Indigenous affairs and mental health service sectors, alongside significant experience both within and outside



government in relation to intergovernmental and cross sector negotiations on governance and financial arrangements.

The Expert Forum assisted in identifying key considerations for the Productivity Commission in relation to intergovernmental arrangements. The discussion at the Expert Forum has informed our internal deliberations in drafting this submission. Importantly, our submission does not specifically reflect any of the individual views of those present at the workshop.

This submission highlights improvements that need to be made to existing mental health intergovernmental governance and finance arrangements. These improvements would strengthen and leverage existing structures and agreements, build new funding models and governance structures and ensure long term holistic change is achieved for the mental health system.



Overcoming the persistent lack of clarity about shared responsibilities

Current governance model

Responsibility for planning, funding and regulating mental health services in Australia is shared between the Australian and state and territory governments. This intersection of policy and funding adds complexity and slows Australia's ability to adopt innovations that work well in other countries. Ultimately, it creates challenges in progressing towards a more fully integrated health system. The Reform of the Federation Discussion Paper⁴ outlined how the fragmented and complex web of government roles in different parts of the health system, particularly the lack of coordination in the mental health system, makes meaningful structural change difficult to achieve. The Paper also discussed how the mental health system is reactive and revolves around episodic care and treatment, making it extremely difficult for consumers with chronic and complex conditions to access the support and services they require.

Public policy development is a long process; elongated by layers of unclear government responsibilities, and the lack of sustained bilateral and multilateral cooperation. For mental health services to begin to meet the needs of the population and reduce and prevent the burden of illness, the roles and responsibilities of the Commonwealth and states and territories need to be clarified and agreed upfront. There remain critical questions to answer about who is responsible for which aspects of service delivery and whether these should be shared or exclusive areas of responsibility. Policy must be underpinned by robust research and balanced between early intervention, prevention, community care and acute services. This will support governments to bring fully developed and pragmatic policy in mental health to Council of Australian Governments (COAG) negotiations.

As highlighted in our previous submission, the current level of fragmentation has meant that mental health services and supports are provided through a complex mix of funders, services, programs and settings including government-funded health services, community allied health services, Primary Health Networks and Local Health Networks, non-government organisations and private donors. Fragmentation of funding and service

⁴ Prime Minister's Expert Advisory Panel (2015) *Reform of the Federation*. Retrieved from: <https://apo.org.au/sites/default/files/resource-files/2015/06/apo-nid55457-1192861.pdf>



regulation has created a complex, rapidly changing, and often impersonal mental health system that is increasingly difficult and frustrating to navigate.

Shared responsibility amongst tiers of government was mandated by the Fifth National Mental Health and Suicide Prevention Plan. The Plan was agreed by COAG in 2017 and sets out a high level approach to improving the delivery of mental health services across Australia. The failure to deliver on previous Plans is testimony to the intransigence of governments to invest in change and collaborate effectively under current governance arrangements.

Current approaches are inefficient, misaligned, restrict innovation, flexibility and coordination in the delivery of services. A world class mental health system would balance clinical and social care and support.⁵ In Australia, the mental health system has been shaped by our legacy health financing arrangements and as a result investment has focused primarily on a narrow biomedical model. The Australian Government is largely responsible for Medicare-subsidised mental health services provided by general practitioners (GPs), psychiatrists, and allied health professionals through programs such as the Better Access Initiative. The Australian Government is also responsible for primary care quality through Primary Health Networks (PHNs), including funding the PHN Primary Mental Health Care Flexible Funding Pool. State and territory governments have primary responsibility for ensuring public hospitals are managed appropriately and for managing community mental health services across their respective geographical jurisdictions.

The delivery of psychosocial supports in Australia is a key example of unclear responsibility and the implementation of ad hoc arrangements. Commonwealth programs which previously delivered psychosocial support were entirely transitioned into the National Disability Insurance Scheme (NDIS), leaving very little support for people with psychosocial disability outside the NDIS. Currently, psychosocial services and programs are delivered by the Australian Government and states and territories. The Australian Government's \$80 million commitment over four years to support the National Psychosocial Support (NPS) measure is intended to provide psychosocial support services to people with severe mental illness. The Commonwealth component of the NPS measure will be implemented through purpose specific funding to PHNs. This is a new area for PHNs and it will take time to evaluate if this has been successful.

The commissioning service model was intended to be developed in collaboration by the Australian Government, state and territory governments and PHNs in an attempt to ensure it is flexible and attributable to all involved parties. The approach to date has, however, followed a similar uncoordinated path, with the Commonwealth funding PHNs to address the diminishing Partners in Recovery (PIR) and Personal Helpers and Mentors Service (PHaMs) programs and some states and territory governments selecting programs that were already being delivered and committing some new and some already allocated funding through them. This is an example of an unintended consequence resulting from inadequate Commonwealth and state negotiations in relation to significant social services reform.

⁵ United Nations Human Rights Council (2017) *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standards of physical and mental health*. p6



A National Mental Health Agreement

Independent evaluations of the National Mental Health Plans have repeatedly pointed to the need to strengthen accountability. The failure to develop robust monitoring and reporting contributes to the failure to deliver mental health reform in Australia.⁶ Development of a National Mental Health Agreement could address issues around role clarification and accountability. Such an agreement would need to include clear governance arrangements, roles and responsibilities, objectives, target groups, outcomes and indicators, detailed funding arrangements and ensure transparent monitoring, reporting and accountability.

It is vital that a commitment is made to clarify what supports are to be provided through mainstream service systems and those that are to be provided through specialist services. To effectively drive change, a statement on governments' responsibility for improving mainstream services needs to be complemented by specific policy and funding commitments, with details about how governments intend to implement them. Indicators relating to the use of, and experiences with, mainstream services by people with mental illness could assist in identifying accessibility issues, and facilitate the assignment of responsibilities to improve these services.

An overarching agreement would ideally clarify the relationship between all aspects of the mental health policy landscape, facilitate cooperation between governments and promote greater accountability. The Productivity Commission's previous review of the National Disability Agreement highlighted a need to shift away from a centralised focus on service delivery toward a focus on the holistic needs of population groups.⁷

Roles and responsibilities must be clearly defined when attempting to achieve accountability within the community to ensure adequate supports are available for all people experiencing mental illness and their carers. As the landscape changes in regard to the way mental illness is managed as a policy issue, so too do the roles and responsibilities of governing bodies and authorities.

Such an agreement must reflect the intersection between mental health and broader services delivered through the NDIS, housing, employment, aged care and social security sectors. A ready and capable workforce, both within and outside the mental health system, is vital. Clear responsibilities for advancing the capabilities of the mental health and mainstream workforce to deliver accessible, inclusive and culturally responsive support must be established.

Almost as important as establishing clear roles and responsibilities between governments will be the manner in which transition to clearer roles occur. Existing policy frameworks and institutional mechanisms that have the support of national and state entities, and the sector should be the foundation for any system going forward. Mental health services have historically been subject to significant uncertainty, short term investment, and ad hoc decision making. Major reforms such as the implementation of the NDIS and the regionalisation of Commonwealth community mental health spending through PHNs have dramatically destabilised and undermined an already fragile sector.

⁶ Curie, C., Thornicroft, G. (2008). *Summative evaluation of the National Mental Health Plan 2003–2008*. Retrieved from: https://www.researchgate.net/publication/237459091_Summative_Evaluation_of_the_National_Mental_Health_Plan_2003-2008

⁷ Productivity Commission (2019) *Review of the National Disability Agreement*. Retrieved from: <https://www.pc.gov.au/inquiries/completed/disability-agreement/report/disability-agreement-overview.pdf>



For this reason, it is important that the Productivity Commission makes recommendations that acknowledge and build on services and system structures that are working. Although, it will be important to draw on lessons learned through creation of the Medicare Locals and PHNs. This issue is discussed in more detail in Mental Health Australia's second submission to the Productivity Commission's Inquiry into Mental Health.

Productivity Commission Key Considerations

- It is imperative that governments reach agreement at the outset of embarking on significant mental health reform to:
 - » confirm outcomes sought and provide a clear line of sight on responsibilities to deliver
 - » provide greater clarity and guidance to officials from all jurisdictions on strengthening accountability of all relevant Ministers to their Parliaments.
- A new National Mental Health Agreement should ensure coordination, accountability and clarify roles and responsibilities across tiers of Government. An agreement should encompass a long term care model that takes into consideration related industries such as disability support, aged care, housing, education and employment.
- The Productivity Commission's recent recommendations resulting from the review of the National Disability Agreement establish an important Framework, which can be drawn upon to inform development of a new National Mental Health Agreement.
- Wherever practical, existing policy frameworks and institutional mechanisms that have the support of national and state entities, and the sector should be used as the foundation for change.
- In this context, the Productivity Commission should consider lessons learned in creation of the Medicare Locals and Primary Health Networks and other relevant national strategies and reforms in health and social care.
- There is an opportunity to make greater use of strategic commissioning/purchasing across existing funding streams to drive integration and better outcomes, for example across housing, mental health, aged care and other relevant sectors.



Collaborative, systems perspective mental health planning

A lack of mental health system stewardship, funding arrangements that are unrelated to need and the consequent lack of effective governance arrangements have inhibited the systematic coordination of services for people with mental illness. Current policies related to mental health services discourage integrated care. Primary care functions are largely based on fee-for-service model. Consumers are moved from various emergency departments and hospitals when more comprehensive care is required. State-funded acute care has few current funding or governance levers to link with private or federal-funded care. Currently, Local Health Networks (LHNs) and PHNs don't have adequate resources to jointly manage the change required to work collectively across the interface.⁸

Evidence fails to illustrate organisational commitment and resourcing to deliver inter-professional training across the continuum or to develop training programs that align differing cultures and integrated ways of working in Australia.⁹ However, there are good examples that should be further promoted across the mental health sector, including the Mental Health Professionals' Network (MHPN), which enables multidisciplinary training and supports local networks, provides professional development and fosters communication between mental health practitioners. A comprehensive, multidisciplinary workforce is a valuable resource in meeting the mental health requirements of Australians and ensuring sustainability.

Better aligned systems focused on the development of appropriate governance and finance arrangements will enhance care delivery and simultaneously minimise spending and maximise mental health outcomes.¹⁰ Policy decisions and legislative change backed by long-term funding commitments are essential to ensure a reformed system focuses on wellbeing and the social determinants of health.

⁸ Nicholson, C., Jackson, C., Marley, J. (2014) *Best-practice integrated health care governance - applying evidence to Australia's health reform agenda*. Medical Journal Australia, 201(3), 64-66.

⁹ Nicholson, C., Jackson, C., Marley, J. (2014) *Best-practice integrated health care governance - applying evidence to Australia's health reform agenda*. Medical Journal Australia, 201(3), 64-66.

¹⁰ World Economic Forum (2016) *Misaligned Stakeholders and Health System Underperformance Industry Agenda Council on the Future of the Health Sector*. Retrieved from:

http://www3.weforum.org/docs/WEF_White_Paper_Misaligned_Stakeholders_Health_System_Underperformance_report_2016.pdf



The National Mental Health Commission could be refocused to support independent oversight that guides mental health reform away from political influence and process. Such a national oversight body with clear authority and monitoring boundaries will contribute to the accountability of the system. This oversight body should be responsible for collecting, tracking, monitoring and utilising data related to the delivery of mental health services in a transparent manner.

The delivery of services and programs should always be examined through a lens of consumers and carers, the National Mental Health Commission's 'whole of life' indicators, optimal functionality and suitability for the service user. Focus should be directed toward providing holistic care and services to people, not moulding them to fit into existing generalised programs. Investing in community mental health, psychosocial supports, addressing the social determinants of mental health and co-designing services with consumers and carers are critical to consider in the development of a future governance system.

Evidence illustrates data sharing amongst providers is essential to ensure continuous improvement within the mental health sector.¹¹ COAG has supported a need to invest in research that promotes evidence-based practice and innovation. They note establishing and investing in a culture of innovation is vital. Establishing integrated information communication technologies, using shared data as a measurement tool and sharing resources to support change remain ad hoc in Australia.¹²

Reform should focus on:

- Building integrated governance arrangements around joint planning, shared clinical priorities, consumer and carer involvement and population health service planning.
- Providing incentives for integrated care that currently fall predominantly into short-term programs, rather than robust governance arrangements at federal, state or local level.
- Leveraging existing agreements, arrangements and policies in the development of new mental health systems and structures.

In addition, the Productivity Commission's Inquiry into Mental Health Issues Paper rightly highlights the potential benefits for mental health of investments across the social determinants of health. In many contexts, less expensive, and potentially better fit-for-purpose, non-clinical supports should be preferentially favoured over expensive clinical supports. The mental health system would be well served by reconfiguring current budget processes to better recognise the longer-term and cross-portfolio impacts on mental health as a result of investment in other portfolios, and by other jurisdictions.

For example, prioritising housing for young people with mental health issues delivers substantial cross-portfolio and cross-jurisdictional savings. While the investment in housing is largely made by state and territory governments, and is not administered at the Commonwealth level, the greatest savings are realised by the Commonwealth. Decisions

¹¹ KPMG (2018) *Putting the pieces together: In search of the perfect mental health system*. Retrieved from: <https://assets.kpmg/content/dam/kpmg/ca/pdf/2018/12/ca-en-putting-the-pieces-together-volume-2.pdf>

¹² Nicholson, C., Jackson, C., Marley, J. (2014) Best-practice integrated health care governance - applying evidence to Australia's health reform agenda. *Medical Journal Australia*, 201(3), 64-66.



around housing must therefore be considered in the context of broad agreed national targets, with cohesive and unified systems.

Case study – Greater Manchester, UK – Whole of System Strategy

In 2016, the Greater Manchester Combined Authority developed a whole of system strategy in response to inconsistency in service provision and outcomes and unintegrated governance structures. The strategy untangled governance structures to enable streamlined decision making and reduce detrimental decision making at a system level.¹³ Developing a sustainable governance system involved a process of government stakeholders across all tiers agreeing upon common delivery outcomes and outputs.¹⁴ The governance structures put in place enable all parts of the system to have input into and influence over the overall vision for Greater Manchester. The structure creates a dispersed model of leadership and reflects the existing accountability arrangements and responsibilities held by local authorities, Clinical Commissioning Groups and National Health Service Providers.¹⁵ Relationships between public services and citizens and communities and businesses have enabled shared decision-making, democratic accountability and voice, genuine co-production and ultimately the joint delivery of services. Strategic partnership arrangements between the private, public, community, voluntary sector and social enterprises have supported collective working and thinking which has enabled more effective implementation of system reform.

Productivity Commission Key Considerations

- The National Mental Health Commission should be refocused and funded to support independent oversight and evaluation that guides mental health reform outside of political influence and process.
- There is a need for greater accountability to measure the progress of service delivery and outcomes at the regional level. All tiers of government would need to support the National Mental Health Commission in this essential role, including clarity and agreement regarding performance indicators and responsibilities and timelines.
- The delivery of services and programs should always be examined through the lens of consumers and carers and the National Mental Health Commission's 'whole of life indicators'.
- The Productivity Commission should explore the potential benefits of concrete, measurable arrangements between Primary Health Networks, Local Health Networks, state and Australian governments for joint commissioning of mental health funding at the regional level.
- Developing new service systems will require central policy development, local coordination of service delivery, system stewardship and a well trained workforce.

¹³ Manchester City Council (2018) *Report on health and social care budget update to resources and governance scrutiny*

¹⁴ Greater Manchester Combined Authority (2016) *Greater Manchester Mental Health and Wellbeing Strategy*. Retrieved from: <http://www.gmhsc.org.uk/wp-content/uploads/2018/04/GM-Mental-Health-Summary-Strategy.pdf>

¹⁵ Manchester City Council (2018) *Report on health and social care budget update to resources and governance scrutiny*.



- There must be robust infrastructure created within the Australian and state public services around policy implementation, including effective co-design and change management.
- There must be an increase and ongoing commitment to publicly available data to assist in building the case for continuous improvement and effectiveness.
- The Productivity Commission should recommend the establishment of Commonwealth and state Budget processes to identify and account for cross-portfolio and cross-jurisdictional return on investment.



Payment and funding models

Current methods of funding mental health services are not based on population need. The allocation of sufficient funds to provide accessible and high quality mental health services has been the subject of numerous investigations and reports, however, little reform has followed.¹⁶ The level of expenditure continues to be well below the level of investment required, despite some increased funding by the Australian, state and territory governments.¹⁷ A revised national approach to funding mental health is required to meet the mental health care needs of Australians.

Activity Based Funding

Activity based funding (ABF) is payment for the number and mix of patients treated, reflecting the workload and giving hospitals an incentive to provide services more efficiently.¹⁸ ABF models aim to increase transparency of how funds are allocated to services and to give hospitals incentives to more efficiently use those funds.¹⁹ The National Health Reform Agreement (NHRA), signed by the Australian Government and all states and territories in August 2011, committed to funding public hospitals using ABF where practicable. To an extent, ABF has enabled efficient comparison between hospitals, the identification of inefficient practices, management of costs and optimisation of resource allocation.²⁰ However, ABF struggles to deliver services for people with multifaceted and chronic conditions in a holistic way.

Any national mental health ABF framework with a focus on outcomes should identify the key elements of a fully operational system, develop a nationally consistent activity based funding regime and encompass consumer individuality by matching services to individual requirements.²¹

To set national efficient prices and costs that accurately reflect the reality faced by public hospitals, accurate activity, cost and expenditure data must be obtained.²² Ongoing

¹⁶ Australian Healthcare and Hospitals Association et al (2008) *Mental Health Funding Methodologies*. Retrieved from:

https://ahha.asn.au/sites/default/files/docs/policy-issue/final_ahha_mental_health_funding_and_governance.pdf

¹⁷ Australian Healthcare and Hospitals Association et al (2008) *Mental Health Funding Methodologies*. Retrieved from:

https://ahha.asn.au/sites/default/files/docs/policy-issue/final_ahha_mental_health_funding_and_governance.pdf

¹⁸ Solomon, S (2014) *Health reform and activity-based funding*. Medical Journal of Australia, 200(10): 564.

¹⁹ Busse R, Geissler A, Quentin W, Wiley M, editors (2011) *Diagnosis-related groups in Europe. Moving towards transparency, efficiency and quality in hospitals*. pp 10-11.

²⁰ Independent Hospital Pricing Authority (2018) *Annual Report 2017-18*. Retrieved from:

https://www.ihpa.gov.au/sites/default/files/publications/ihpa_annual_report_2017-18.pdf

²¹ Mental Health Council of Australia (2012) *Activity based funding and mental health issues paper*. Retrieved from:

https://mhaustralia.org/sites/default/files/docs/activity_based_funding_-_issues_paper_2012.pdf

²² Solomon, S. (2014) *Health reform and activity-based funding*. Medical Journal of Australia, 200(10): 564.



collaboration with service users and evidence-based evaluations will improve the pricing process and create a more accurate, transparent and sustainable funding system, which will drive efficiency and quality and provide better value for public money. Such a model needs to be complemented with payments for 'bundled services' to better integrate physical and mental health services and progressively adopt a stronger focus on payment for outcomes. Whether payment is for activity or block funded, there needs to be a stronger line of sight with outcomes.

Community mental health funding

As outlined in our first submission, current funding arrangements place community mental health organisations in a uniquely difficult position through requiring organisations to organise their business to accommodate multiple funding models (e.g. both block funding and individualised fee-for-service). In addition, organisational sustainability is undermined through unpredictable and short term contracting, sometimes from multiple sources, increasing unnecessary administrative burden.

Community mental health organisations' funding has been continually subjected to political decision making by successive governments without a long-term vision to stabilise and grow these essential services. In order to remove the politics from community mental health spending, the Productivity Commission should investigate permanent funding structures delivered through a clear delineation of payment sources. Decisions about what is funded should be delegated to experts (including consumers and carers) as is the case for other forms of health funding.

As a first step, the Productivity Commission could propose an appropriate mechanism for services delivered by the community mental health sector to be described and costed, by community mental health experts, consumers and carers. This would result in a common list of services and corresponding costs, which governments could agree and draw on in funding community services, regardless of the funding mechanism.

Investment and insurance approaches

A model that focuses solely on people who are living with a mental illness will not be adopted by all Australians. For any model to be adopted by all Australians it must be relevant to all Australians not just those it directly supports. National collaboration and subsequent 'buy in' is essential for the longevity of a future funding model. As a broad principle, adopting an investment approach to mental health that reflects the insurance principle of maximising lifetime opportunities and minimising lifetime costs to the country is desirable.

Ultimately, in reforming funding models, performance and quality based contracts with service providers and strong monitoring against these by PHNs is required to obtain meaningful data and demonstrate positive health and provider performance outcomes.



Future payment and funding models

Funding models need to enable collaboration across and between silos. Australia's mental health funding models need to be redesigned to improve integration or coordination of care and support.

Integrated funding model

An integrated funding model recognises effective mental health care requires a whole of government approach that acknowledges the social determinants of mental health and is underpinned by a commitment to key outcomes measures at the national and state level. An integrated approach must be underpinned by a robust platform and needs-based resource allocation methodology that covers the continuum of care. In Canada, integrated funding across both public and private sectors with aligned incentives has reduced length of stay, readmission and emergency department visits, while also improving patient and provider experience.²³ This model includes the use of a single payment for an episode of care across multiple settings.²⁴ An integrated model drives high-quality, efficient care and ultimately improves patient outcomes and experience.²⁵ In Australia, an integrated funding model could be used to distribute funds from state and territory governments and PHNs to service providers including the use of capitation, fee for service, case mix and outcomes based incentives.

Value-based payment model

Fee-for-service and output based funding models focus on short term episodic care and often force individuals to negotiate a chaotic system. The fee-for-service model funds inputs as opposed to successfully delivered outcomes. For example, an avoidable readmission is rewarded over successful transition to integrated home care. As highlighted in our previous submission, New York has moved from a fee-for-service approach to a value based payment (VBP) system, which offers a set of value-based options to service users. This funding reform has simultaneously improved population and individual health outcomes by creating a system where high value care delivery is rewarded.²⁶ Providers' margins go up when the value of care delivered increases. To be successful in a VBP environment, where providers are accountable for the health costs and outcomes of a defined population, attention must be given to the many factors that affect those costs and outcomes, including social factors. The funding reform in New York has highlighted increased accountability by providers and systems in relation to social factors for patient populations across the continuum of care.²⁷ The delivery system reform incentive payment (DSRIP) program based on the VBF principals has fundamentally restructured New York's health care delivery

²³ Ontario, Ministry of Health and Long-Term Care (2018) *Bundled Care (Integrated Funding Models)*. Retrieved from: <http://www.health.gov.on.ca/en/pro/programs/ecfa/funding/ifm/>

²⁴ Farrell, M., Scarth, F., Custers, T., Orchard, M., Soo, S., Whitham, L., Walker, K. (2018) *Impact of Bundled Care in Ontario*. International Journal of Integrated Care, 18(s2), 89.

²⁵ Australian Healthcare and Hospitals Association et al (2008) *Mental Health Funding Methodologies*. Retrieved from: https://ahha.asn.au/sites/default/files/docs/policy-issue/final_ahha_mental_health_funding_and_governance.pdf

²⁶ New York State (2014-2018) *NYS DSRIP Quarterly Reports*. Retrieved from: https://www.health.ny.gov/health_care/medicaid/redesign/dsrp/quarterly_reports.htm

²⁷ Bao, Y., et al. (2017) *Value-Based Payment in Implementing Evidence-Based Care: The Mental Health Integration Program in Washington State*, The American Journal of Managed Care, vol. 23:1, 48-53.



system to improve the financial sustainability for those who do not qualify for other public assistance programs.

Leading Better Value Care (LBVC)

Whilst activity based funding models have been effective in driving efficiency in the delivery of public hospital services, particularly for mental health services, it is important that pricing models support the delivery of services that prevent admissions, or allow for treatment in lower cost settings, such as the community. NSW has launched a large scale Value Based Healthcare (VBHC) program. The LBVC program works collaboratively with consumers and state health care systems to deliver a positive consumer experience throughout their journey through the health system.²⁸ Initial evaluation of the program is positive, with 1,200 fewer patients needing hospitalisation for re-fracture, 3,200 fewer patients with diabetes needing hospitalisation for high risk foot services and 390 fewer patients needing joint replacement operations.²⁹ However, this initiative does not yet encompass mental health care.

Demand management program

National Health Reform Agreements are usually broad and require Australian Government funded hospital services to meet criteria specified by the Independent Hospital Pricing Authority (IHPA). To be eligible for funding as a non-admitted patient service or non-medical specialist outpatient clinic, a service must be intended to substitute directly for an inpatient admission or emergency department service attendance.³⁰ Reallocation of activity based funding for mental health admissions to community based programs would need to demonstrate that services are a direct substitute for admissions. The Hospital Admission Risk Program (HARP), a demand management program in Victoria, aims to provide hospital substitution and diversion services by supporting people in the community, in ambulatory settings and in people's homes. The program has reduced hospital demand, provided savings and improved patient experience. Well run programs also produce an overall saving.³¹

Demand management programs can, however, be perceived negatively by states and territories with reductions in hospital demand resulting in reduced hospital funding and the Australian Government appearing to benefit without making a contribution. A process to operationalise mechanisms that equally distribute risks and benefits between jurisdictional governments is required.

Pooled, bilateral funding model

In the 1980s a bi-lateral, tripartite governance and funding model between all levels of government was developed to address the inadequacies of contemporary funding for small

²⁸ Independent Hospital Pricing Authority (2019) *Consultation Paper on the Pricing Framework for Australian Public Hospital Services*. Retrieved from: <https://www.ihoa.gov.au/consultation/past-consultations/consultation-paper-on-the-pricing-framework-australian-public-hospital-services-2019-20>

²⁹ Agency for Clinical Innovation (2018) *Evaluation of Leading Better Value Care*. Retrieved from: <https://www.aci.health.nsw.gov.au/search?q=Evaluation+of+Leading+Better+Value+Care>

³⁰ Independent Hospital Pricing Authority (2019) *General List of In-Scope Public Hospital Services Eligibility Policy*. Retrieved from: https://www.ihoa.gov.au/sites/default/files/publications/annual_review_of_the_general_list_of_in-scope_public_hospital_services_-_version_4.2_-_may_2018.pdf

³¹ Victoria State Government (2018) *Health Independence Program*. Retrieved from: <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/rehabilitation-complex-care/health-independence-program>



scale service provision. By pooling program funds from both state and federal governments an incorporated community body was able to redesign services to appropriately meet consumer needs. The removal of existing guidelines and program boundaries allowed the body to flexibly allocate and distribute workforce resources to where they were required. This model also enabled integrated and coordinated treatment, care and support. The model has been effective for communities with complex aged, disability and mental health needs and for communities with almost no base mental health services. The model enabled the commissioning of mental health services in sub-regional areas in several states and supported integrated care models that focused on prevention. The erosion of the model, however, due to the reintroduction of activity based funding for services provided under the model has redirected focus away from community directed care.

Productivity Commission Key Considerations

- Existing health funding arrangements should allow activity based funding to be changed, on agreement between the state and Australian governments, to allow funds to be distributed in different ways.
- Payment structures need to be blended around activities and populations. This can be achieved by combining ABF models with models that focus on outcome measures and collaborative approaches across the continuum of care (e.g. value based or integrated funding).
- A holistic approach to funding, that addresses the needs of the whole population, should be taken. Adopting an investment approach to mental health that reflects the insurance principle of maximising lifetime opportunities and minimising lifetime costs should be considered.
- Assurance and oversight mechanisms must be established to ensure the level of investment remains balanced between the community and acute sector.
- The Productivity Commission could propose an appropriate mechanism for services delivered by the community mental health sector to be described and costed by community mental health experts, consumers and carers.
- There is merit in progressing the notion of payments for 'bundled services' to better integrate physical and mental health services and progressively adopt a stronger focus on payment for outcomes. Whether payment is for activity or block funded, there needs to be a stronger line of sight with outcomes.
- Payment structures should enable the provision of multidisciplinary, integrated services (e.g. community health services and team-based care) through pooled and bi-lateral funding arrangements.
- Effective demand management programs are better for patients and reduce hospital demand and should be further explored.



Conclusion

A national whole of government approach is required to induce change. Poor links between sectors and a reluctance by all levels of government to co-operate in the delivery and funding of services has influenced a lack of progress in improving the mental health outcomes for Australians. Progress needs to be made in establishing integrated governance arrangements focused on service planning, shared priorities and resources. Engaging with consumers and carers and building a platform of accountability and independence is critical. There is no single agency, organisation or level of government with oversight of service delivery and financial accountability for mental health.

Current governance approaches are inefficient, misaligned, and restrict innovation, flexibility and coordination in the delivery of services. Through establishment of a National Mental Health Agreement clear lines of responsibility can be determined and services provided. The delivery of services and programs should always be examined through a consumer and carer lens and the National Mental Health Commission's 'whole of life indicators'.

A revised national approach to funding is required to meet the mental health care needs of Australians. Payment structures need to focus on outcomes, acknowledge the social determinants of health, and reinforce collaborative approaches across the continuum of care.

In delivering its recommendations, the Productivity Commission needs to outline the structural governance changes and financial arrangements required to support the implementation of its recommendations. Transitioning arrangements, stewardship responsibilities and funding must be outlined in order to support the successful transition from the old system to a new system. In support of an investment approach, the Productivity Commission should also detail the costs of inaction, i.e. the costs that will be borne by the community if no new investments are made, as well as the economic benefits of reform.

This submission has presented the case for change and reform to the intergovernmental arrangements currently in place for Australia's mental health system. The development and implementation of a National Mental Health Agreement and reformed funding system should provide the strong governance required to deliver consumer-centred models of care, based on population need, which covers the continuum of care and ensures clear functional roles for Government and service providers, both public and private.

Most importantly, people living with mental health issues and their families must lie at the heart of the new mental health system.



Mental Health Australia

Mental Health Australia is the peak, national non-government organisation representing and promoting the interests of the Australian mental health sector and committed to achieving better mental health for all Australians. It was established in 1997 as the first independent peak body in Australia to represent the full spectrum of mental health stakeholders and issues. Mental Health Australia members include national organisations representing consumers, carers, special needs groups, clinical service providers, public and private mental health service providers, researchers and state/territory community mental health peak bodies.



Mental Health Australia



Mentally healthy people,
mentally healthy communities

Mental Health Australia is the peak independent, national representative body of the mental health sector in Australia.

Mental Health Australia Ltd
9-11 Napier Close
Deakin ACT 2600
ABN 57 600 066 635

P 02 6285 3100
F 02 6285 2166
E info@mhaustralia.org
W mhaustralia.org