Mental Health Australia

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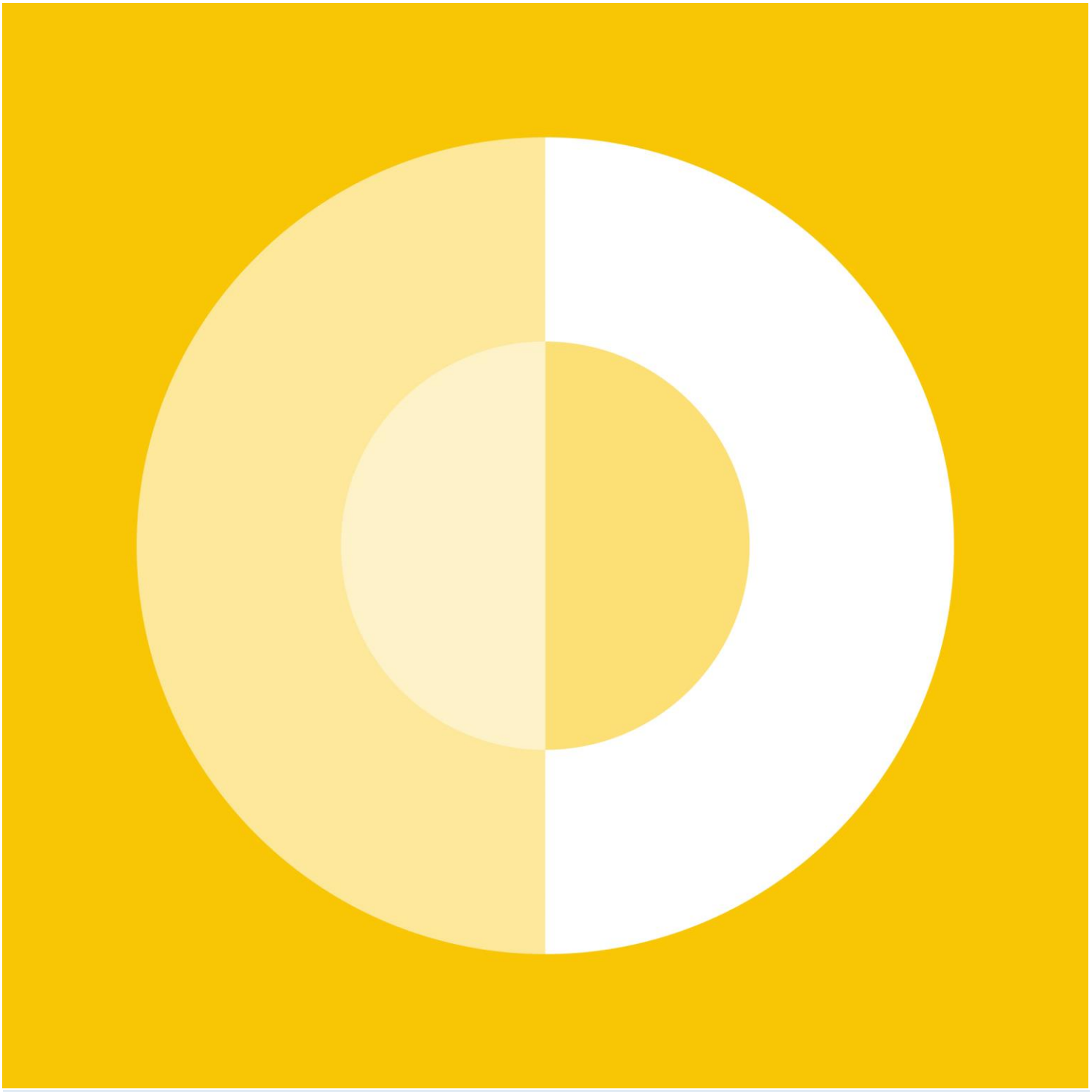

Discussion Paper: Options for commissioning and funding of mental health services

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Background

Throughout 2014, Mental Health Australia undertook substantial consultation with its members to identify the barriers to, and potential enablers of, a more effective and efficient Australian mental health system. One of the key issues identified through those consultations is the way in which funding arrangements can either help or hinder the delivery of services to support better mental health outcomes for clients.

Conditions placed on funding – from Commonwealth-State arrangements through contract design, management and reporting – have implications that flow through to services and to consumer and carer experiences. Many current approaches are inefficient, misaligned and increase red-tape for providers, restricting innovation, flexibility and coordination in the delivery of front line services. Further, mental health services are frequently subject to funding uncertainty, with negative impacts on service continuity for clients as well as operational and staffing costs associated with workforce instability and turnover.

There is broad agreement in the sector that a necessary (though not sufficient) condition for system change will be improved approaches to funding. One option that is gaining increasing attention across the social sector is funding mechanisms that emphasise the achievement of *outcomes*, rather than simply requiring delivery of specified activities and inputs.

In principle, a greater focus on outcomes would be a welcome development in mental health, as it aligns with central concepts of a contributing life, recovery and the importance of working towards holistic, whole-of-life outcomes through person-centred approaches. There are, however, various possible approaches to outcomes-based contracting, each of which may pose certain challenges for implementation in mental health.

To explore such issues further, Mental Health Australia has commissioned a study into how different approaches to funding might support better mental health outcomes. So far, the study has reviewed literature relating to outcomes-based commissioning and contracting, along with some other possible alternatives, and begun to consider the potential applicability of these to mental health. The next stage is to explore such matters through this discussion paper with Mental Health Australia members and with a panel of experts in commission/contracting processes.

Feedback on this Discussion Paper will help guide the finalisation of the study report, which will form an important platform for Mental Health Australia's advocacy following the 2015-16 Federal Budget and beyond. We anticipate that the findings of this research will be immediately relevant to how government responds to important policy processes, including the National Review of Mental Health Services and Programmes, the Competition Policy Review, and the White Paper on the Reform of the Federation.

Indeed, as this consultation paper was being prepared, the Australian Government released the National Mental Health Commission's Final Report from its Review of Mental Health Services and Programmes. In absorbing and interpreting the complex findings and recommendations of the Final Report – including its references to funding mechanisms, contract terms and contestability in commissioning – it is apparent how critical it is that government come to grips with the various issues raised in this discussion paper.

Beyond the immediate policy landscape, the project's findings may spur further, more detailed work to identify, trial and refine approaches to commissioning for improved mental health outcomes. From Mental Health Australia's perspective, future work would ideally take place through partnerships between the mental health sector and relevant government agencies, including central agencies mindful of the cross-portfolio dimensions of the issues discussed below.

1. Perceived problems

Current arrangements for government commissioning and funding of human services, including mental health services, are criticised on various grounds. For example:

- they frequently represent ad hoc decision-making by siloed government departments and fail to reflect a systematic or strategic approach (a trend exacerbated by the unpredictability of approvals by central agencies and committees of Cabinet);
- the services that result are fragmented, poorly coordinated and create overlaps and/or service gaps
- the typical tendering process requires potential providers to compete against one another, when partnerships or collaborative arrangements might well result in better services and better value for money
- current arrangements provide little if any opportunity for advance comment and advice from service or community organisations before being finalised
- government agencies waste resources on over-detailed contract administration, and use up provider resources on repeated competitive tendering and meeting compliance and reporting demands that may add little to the quality of services delivered
- competitive tendering that works largely on the basis of price tends to overlook key influences on service quality, such as the strength of existing community networks and relationships and a workforce that is constantly evolving and improving
- activity-based contracts are weak instruments for ensuring that basic policy goals are met; and in any event policy and program objectives are not always clearly identified
- contracts are often of shorter duration than service providers think appropriate; at the end of the funding period, providers can be left 'hanging' until the 11th hour without any certainty about ongoing funds to pay wages and other expenses, and without adequate arrangements for continuity of services if the contract is not renewed.

Many of these problems are also evident in Commonwealth/State funding arrangements (National Partnership Agreements, or NPAs). NPAs have also been criticised as imposing excessing reporting and administrative requirements on states and territories, and are frequently of very short duration. These problems can have flow-on effects on service providers that are contracted by state/territory governments.

Question 1: Are there other aspects of existing commissioning/funding arrangements that are unhelpful or counterproductive? Which of these might be amendable to change and which are more difficult to disrupt?

2. Improvements in existing approaches

A number of changes could be considered within the general commissioning and contracting frameworks that governments currently tend to use. For example:

- adoption by all governments of a suitable strategic framework to guide planning and funding decisions (in the case of mental health services such a framework is available in the National Targets and Indicators for Mental Health Reform, developed through extensive consultation by a COAG Expert Reference Group; another more advanced framework is the Close the Gap initiative)
- adherence to the outcomes-based principles within existing statements of policy, such as the Federal Financial Relations Framework for Commonwealth funding to States/Territories
- systematic and routine consultation with service providers and peak bodies in the course of developing policy, programs and projects
- tendering processes that allow more time for considered (possibly collaborative) responses, and that give more appropriate weight to organisations' community reputation, relationships, experience and on-the-ground knowledge
- more careful consideration of the desirable length of contracts in light of what they require of the service provider, and provision of appropriate time for renegotiation or transitional arrangements as the contract period comes to an end
- suitable indexation of funding levels and greater attention to how the commissioning body will respond to other changes in circumstances or policy
- changes to standard budget processes, such as:
  - » consideration of renewing programs in the Budget for the year before they expire, rather than only a few months before expiry.
  - » having programs expire on 31 December, rather than 30 June, so that there is more than 6 months between budget announcement and funding expiring.

Question 2: Which (combination of) changes to contracting/commissioning in relation to mental health are most important or most likely to be achievable?

3. Other possible approaches

3.1 Contracting for outcomes rather than for inputs or outputs

There is current interest in contracting that focuses as much as possible on outcomes, including the possibility of outcome-dependent payment. Several Australian jurisdictions appear to be moving towards outcome-based arrangements, illustrated for example by the Tasmanian Department of Health and Human Services' Funded Community Sector Outcomes Purchasing Framework. Arguments for outcomes-based contracting are usually based on governments getting better value for money and/or improving service effectiveness.

Significant points made in the literature include the following:

- Clarity of policy objectives is essential for outcome-based contracting.
- Specifying clear outcomes and targets may well be useful in itself, regardless of any use of 'extrinsic' incentives or sanctions.
- Where performance incentives or sanctions are used, these need not be large or 'high-intensity'.
- Payment for outcomes, in particular, requires being able to identify outcomes that:
  - » are relatively simple and few in number
  - » convincingly capture the essence of the underlying policy intention
  - » can be measured meaningfully, reliably, at reasonable cost and within a reasonable timeframe
  - » can with reasonable confidence be attributed to the service provider
  - » can be framed and priced in a way that avoids perverse incentives (such as the temptation to prioritise the least difficult or disadvantaged clients).
- It may be difficult or undesirable to use payment-for-outcomes in a 'pure' form; a program like Job Services Australia, for example, uses a combination of payment for outcomes and other types of payment.
- Introducing outcome-based contracting is likely to be a process of trial and error that will take time and require readiness to learn and adjust.
- Payment for outcomes may be contra-indicated where a long delay is likely between action and outcome, eg in early intervention programs. Given the complex and long-term nature of many social problems, this may be a significant limitation.

- Since it will not always be possible to design performance measures that directly drive key ('primary') outcomes, it may in some cases to be necessary to settle for specifying or incentivising secondary outcomes or high-order outputs.

For governments, one of the attractions of payment for outcomes is that it involves a transfer of risk to the service provider. Presumably the incentive offered for success has to be large enough to compensate for this. However, even waiting for payment until an outcome can be achieved will, on the face of it, be unattractive to not-for-profit organisations with limited resources and cashflow. If the pool of potential suppliers is not to be unduly narrowed, the financial issues need to be dealt with in some way; overseas literature suggests, for example, a system of loans to community organisations or the use of Social Impact Bonds. Another option may be to create incentives or sanctions that are fairly small relative to the scale of the contract overall.

It has been argued that payment-for-outcomes may work best in situations where we are reasonably confident about what kind of approach may be successful, but where there are uncertainties about the capacity of 'existing delivery chains' to produce strong results.

Outcome-based contracting has to date been most often used in employment programs and in corrections. An outcomes-focus was also an underpinning principle of the 2008 reforms to the Commonwealth-State funding arrangements, which sought to move away from inputs, such as widget specifications or requirements around particular service models, to outputs and outcomes measures, such as long-term measures of health, wellbeing, and social and economic participation. These reforms themselves became problematic as differences emerged between governments about what inputs would be deployed to achieve the outcomes that had already been agreed. This episode neatly demonstrates how the tensions that apply in relation to outcome-based contracting at the local or organisational level can also apply at a much broader level, including arrangements between governments.

As yet, outcome-based contracting has not been widely used in mental health services.

Question 3.1(a): How desirable and feasible is it to introduce outcome-based contracting or payment-for outcomes for mental health services in Australia? How readily could mental health policy goals be translated into contractual outcomes? What would be the risks or benefits in using second-order outcome measures or proxies?

Question 3.1(b): What financial arrangements might make outcome-based contracts attractive to/realistic for community-based organisations?

Question 3.1(c): How might approaches to outcome-based commissioning differ at national, state, regional or local levels? What principles might be shared across these different contexts?

3.2 Devolution of responsibilities to a third party

There has been some Australian experience in using a 'prime provider' model in which a large NGO (eg the Brotherhood of St Laurence in Victoria) is commissioned to coordinate and oversee implementation of a social program by itself and a number of subcontractors. The UK's welfare to work program works on a similar model.

The potential advantages are that government need not involve itself in hands-on management, which is arguably better put in the hands of a reputable organisation which

has practical experience in community services and is well placed to guide, support and share good practice information with subcontractors. A non-government 'prime provider' may also be in a good position to take a flexible approach to service improvement and innovation. Arguably this kind of approach can combine benefits of scale with the value of local knowledge and experience.

While use of a prime provider may be seen as a realistic response to the 'hollowing out' of public sector expertise that has resulted from successive governments' downsizing of the public service, it may also exacerbate this problem by distancing bureaucrats still further from practical experience of policy implementation.

In Western Australia the Mental Health Services Commission, rather than the Health Department, has responsibilities for determining mental health service needs and defining outcomes, identifying suitable service providers and purchasing services.

Another possible approach would involve the pooling, on a regional basis, of funds available from various sources, and the allocation of these through some suitable regional mechanism.

Question 3.2: Does devolution of commissioning or contracting responsibilities to a third party offer promise in the mental health field?

3.3 Cross-portfolio and cross-jurisdictional approaches

Complex and intractable social problems (sometimes called 'wicked problems') rarely respect conventional portfolio and jurisdictional boundaries; mental health issues are a clear example. Two current Australian examples of cross-portfolio planning or funding are:

- coordination of funding for Indigenous affairs within the Department of Prime Minister and Cabinet, with Closing the Gap initiatives considered across agencies and across jurisdictions
- the requirement at Commonwealth level that proposed new regulations be accompanied by a Regulatory Impact Statement.

One disincentive to inter-departmental thinking is the fact that an initiative in one portfolio may deliver some of its financial benefits in another portfolio or jurisdiction. Accordingly, Mental Health Australia's recent *Blueprint for Action on Mental Health* recommended that governments' budgeting rules be re-worked to allow Ministers to account for these sorts of savings, and also to better recognise downstream savings. Such savings might even occur for another level of government, making the cross-portfolio impacts of policy change even more important to track from an economic perspective.

The regional pooling of funds across portfolios is one possible approach, and consolidation of government agencies is another. In NSW, for instance, the former Department of Community Services, Housing NSW and the Department of Ageing, Disability and Home Care have been combined into a new Department of Family And Community Services. The new department recently adopted the 15 NSW Health regions as its own basis for delivery of coordinated service delivery.

In WA one of the perceived advantages of the role of the Mental Health Services Commission is that it is in a better position than the Health Department to promote cross-portfolio and cross- sector links and initiatives.

Question 3.3(a): What are the main barriers to stronger cross-portfolio and cross-jurisdictional action in mental health, and how might these be addressed?

Question 3.3(b): In what circumstances is cooperation across jurisdictions important in mental health, and how could this be promoted?

3.4 Service partnerships and collaboration

The prime provider approach mentioned above can be seen as an example of government supporting partnerships at service provider level. Another Australian example – and from the mental health field - is Partners in Recovery, which is funded by the Department of Health. For PiR the Commonwealth invited service providers within each Medicare Local area to assemble a suitable consortium to promote coordination of services and strengthen linkages among organisations serving mental health clients, with only one consortium permitted in each region. On a similar note, one of the explicit aims of the WA Mental Health Commission is to encourage appropriate partnerships and collaboration across the sector.

Question 3.4: What are the most important enablers of, and barriers to, collaboration among service providers and with mental health consumers and carers?

3.5 Relational or high trust contracting

In the private sector, working relationships and mutual interests are often more important than contractual provisions. Elaborate contracts, in fact, are sometimes seen as reflecting poor relationships and as inviting performance 'only to the letter' of the formal agreement. In their relationships with non-government service providers, however, government agencies have tended to rely on quite detailed contracts and to closely monitor compliance.

In New Zealand the Ministry of Social Development has in recent times made use of 'high trust contracts' which aim to simplify agreements and to reduce the reporting and other paperwork requirements on service providers. These are integrated agreements with groups of local providers, which bring together the contractual requirements of multiple funding agencies. They involve short, simple funding agreements, annual payment in advance and annual reporting on outcomes, and they aim to facilitate flexibility in service delivery. To be eligible for a high trust contract, community organisations need to have a proven relationship with government, a good performance record, a strong community base and a record of working well with other agencies.

For one 'high trust' program, Whanau Ora, which works with vulnerable extended families, the government has contracted three non-government commissioning agencies for a three-year period, offering an incentive payment for achievement of agreed measures - thus combining several of the possible techniques discussed in this paper.

Question 3.5(a): Is it feasible and desirable to trial the use of high trust contracting in the mental health field in Australia?

Question 3.5(b): How might the notion of high-trust contracting be extended to the development of policy and the identification of suitable service models – well before governments and providers enter a contractual relationship?

3.6 Competition and Contestability

A competitive framework has become a central feature of government grants and contracts for the provision of health and other human services. However there are sometimes departures from strict competition principles – for example by giving proven performers some advantage or preference around extensions and renewals of contracts, as happens with Job Services Australia.

The Council of Social Service (COSS) network has argued that the principles of competition do not sit easily with the work of community organisations, which may be much more accustomed to thinking and working collaboratively. One instance where the Commonwealth decided not to seek competitive tenders is Partners in Recovery where, as noted above, the Department of Health instead invited service providers in each Medicare Local region to put together a suitable consortium to take on the task of improving access to and coordination of mental health services

The term 'contestability' is used in various ways. Strictly speaking it means not actual competition but the credible possibility or threat of competition – 'latent but real'. A contestability framework may in principle offer several benefits – for example closer and more constructive relationships between commissioning agency and service provider, and avoidance of the churn, disruption or fragmentation that competition can entail, while still providing strong incentives for the provider to maintain or improve performance.

Question 3.6(a): Is there a case for reducing reliance on competitive tendering in the commissioning of mental health services? If so, in what circumstances?

Question 3.6(b): How can the principles of contestability be applied in the area of mental health without losing the benefits of high-trust dealings between funder and provider?

4. Identifying the right approaches

As New Zealand's Whanau Ora program indicates, there are potential links across many approaches outlined in this paper.

For example, a high trust, outcome-based agreement could involve several relevant portfolios, and use suitable prime providers to coordinate the work of a series of community agencies. Ideally this might occur in pursuit of an agreed national strategy for change, and after meaningful community and stakeholder consultation.

Whichever strategies for commissioning and funding are chosen to improve mental health outcomes, success will depend to a greater or lesser extent on whether those strategies are well matched to the political and institutional context in which they are introduced. Good policy can fail in the absence of the right conditions for its implementation; likewise, good outcomes can be achieved despite poor policy. With that in mind, new, outcome-driven approaches in mental health must be adapted to suit current practical realities.

Question 4(a): Are there combined approaches which seem worth pursuing in the commissioning and funding of mental health services?

Question 4(b): Are there other ways, not mentioned in this paper, of improving procurement arrangements, ensuring closer adherence to policy objectives and achieving better services?

Question 4(c): What real-world conditions do commissioning arrangements need to adapt to succeed? How might this happen?

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.

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