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Policy brief

Mental health III
Funding mental health in Europe

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Policy brief

Funding mental health in Europe[1]

Introduction

Although prevalence rates for the majority of psychiatric disorders vary very little across Europe, different health systems identify different levels of need for mental health services, devote different levels of funding and choose different ways to deliver them. These variations in need, funding and response arise for many reasons, including differences in demography, socioeconomic structure, political structure, societal context, culture and priorities. What is undoubtedly clear, however, is that in many countries in Europe mental health care is grossly underfunded. Despite the high prevalence of psychiatric disorders, their substantial contribution to the global burden of disability, the strong association between deprivation and mental illness, and the growing body of cost-effectiveness evidence, the proportion of total health-system expenditure devoted to mental health care is often very small. Many countries still lack an explicit mental health policy, have acute shortages of specialist mental health staff and demonstrate little political commitment to improving the situation. The stigma of mental illness is an enormous barrier to action in some cultures.

This lack of funding is both inefficient – because of the substantial benefits that interventions would bring – and inequitable, given the significant burden of mental health problems, and the disproportionate impact they have on the poor. It can also hamper the ongoing reform of mental health systems across Europe, as this often requires the injection of additional resources. Systems that have been starved of funding and skilled human resources for decades will be in no shape to support major changes to the delivery setting, organization or processing of care (Knapp et al., 2004).

This policy brief provides an overview of the level of funding for mental health in Europe. It looks at the way in which mental health care is financed, and

1. This policy brief builds, in part, on ongoing work by the authors, in particular papers by Knapp et al. (2005), Knapp et al. (2004), and McDaid et al. (2004). The policy brief is one of a series on health care issues by the European Observatory on Health Systems and Policies; this series is available online at: www.observatory.dk

how available funds are distributed within countries in order to facilitate access to a range of services, often provided across a number of sectors such as social care, housing, criminal justice and education. Barriers to increased funding for mental health and to the improved allocation of existing resources are discussed, and solutions provided.

The costs and consequences of poor mental health

Mental health problems account for nearly 20% of the total burden of ill health in Europe, coming second only to cardiovascular disease. This is, in fact, a conservative estimate and does not take into account many other negative effects of mental health on other aspects of health. Poor mental health has an impact on an individual's physical health; levels of co-morbidity and (non-suicide-related) mortality are significantly higher than in the general population. There may also be adverse effects on the health of other family members, because of the rigours of caring, or (for vulnerable family members such as children and the aged) because of neglect.

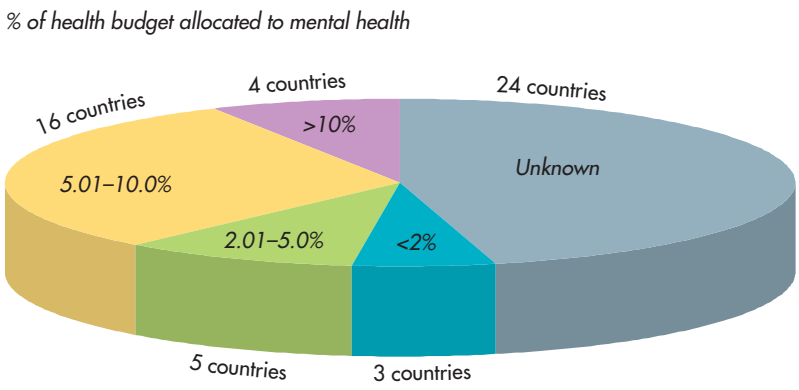
The economic costs for the 15 countries that were members of the European Union (EU) before 1 May 2004 are conservatively estimated to be at least 3–4% of gross national product (Gabriel & Liimatainen, 2000). In fact, most of the quantifiable costs occur outside the health sector, being due to lost employment, absenteeism, poor performance within the workplace and premature retirement. Typically, they account for between 60% and 80% of the total economic impact/consequences of major mental health problems. Other important consequences, such as stigmatization, social exclusion and fundamental abuses of human rights, are rarely included in economic analyses – because they are not measurable in cost terms – but should not be ignored.

Funding for mental health

The historically low level of funding for mental health in many European systems appears to be both inefficient – as there would be substantial benefits from prevention and promotion strategies, treatments and rehabilitation approaches that are known to be effective and cost–effective – and inequitable, given that mental health problems account for at least one in five of all health problems in Europe, yet a great many people remain untreated.

Project Atlas, the 2001 World Health Organization (WHO) study on mental health was the first attempt at systematic collection of information on mental health expenditure across Europe, indeed across the world. Overall, only 23 of the 52 European countries provided information, a primary reason for this

Figure 1: Specified mental health budget as a % of total health care expenditure in 52 European countries



Sources: WHO, Project Atlas, 2001/Mental Health Economics European Network, 2004

being the fragmented structure of funding systems, especially where social-insurance systems operate; political imperatives can also prevent transparency of budget data. Another complication is that many services are often provided outside the health care sector and are subject to different funding structures.

Combining data from Project Atlas with more recent work undertaken by the Mental Health Economics European Network (MHEEN) – an initiative funded by the European Commission and coordinated by Mental Health Europe and the London School of Economics – means that statistics on mental health expenditure in 28 countries are now available (McDaid et al., 2004). These figures show that mental health expenditure, as a proportion of total health spending, ranges from <2% (Albania and Azerbaijan) to approximately 13% (Luxembourg and England). As Figure 1 illustrates, only 4 countries (8%) allocate more than 10% of their health budgets to mental health, 16 (31%) spend between 5% and 10%, while the remaining 8 (16%) all spend less than 5%. The lowest reported budgets are mostly in countries of the former Soviet Union, where, historically, mental health services were a low priority, even though they have been treated as separate health care structures receiving their own funding. However, it would be a mistake to think that all the countries with the lowest levels of mental health funding are in eastern Europe, since at least two of the fifteen countries that were members of the EU before 1 May 2004 are estimated to allocate <5% of their health care budgets to mental health, and a new EU Member State, Slovakia, was reported to spend only 2% on mental health.

To put these figures into a global context, Project Atlas reported that 11% of the health care budget in New Zealand and in Canada was devoted to mental health, the figure was 6% in Australia and the USA, and an average of 2.8% of the health care budget was allocated to mental health in middle-income countries worldwide (WHO, 2003). Problems in reporting are not confined to Europe. For instance, Japan, also a country with a social health insurance system, does not make data on mental health expenditure available.

Methods of financing mental health in Europe

Although the level of resources available for mental health vary considerably, financing mechanisms for mental health care do not differ much from those for health care in general. All countries rely largely on some form of income- or sales-related taxation and/or social insurance. However, for countries in the former Soviet Union in particular, the transition to social health insurance systems has not always been effective, increasing still further the significant proportion of health expenditure incurred through out-of-pocket payments and private insurance (for example, in Armenia and Georgia, respectively, only 41% and 38% of health care expenditure is from public sources). The limited evidence available suggests that private expenditure on mental health is limited, owing in part to the association of mental health problems with poverty, so that many individuals have to rely on state-funded services where these are available.

What role is played by voluntary health insurance?

Voluntary (for-profit or not-for-profit) insurance schemes provide minimal coverage for mental health in the European Economic Area. One reason for this is the chronic nature and high cost of mental health treatments and interventions. Where these treatments are covered, premiums are likely to be higher. Evidence from the US, where the private health-insurance market is most well-developed, illustrates the difficulty in achieving parity between mental and physical health insurance coverage, leading to unequal access to mental health treatment.

The importance of voluntary (private) insurance is growing in many parts of central and eastern Europe (Dixon et al., 2004); the challenge will be to ensure that where countries shift towards more reliance on private insurance, rather than social insurance or tax, mental health disorders are fully covered in the same way as other conditions. At present, premiums are usually risk-rated (based on an assessment of individual risk) rather than being community-rated like social health insurance. One consequence of this is that the greatest financial burden is imposed on people with mental health disorders or on those

with a family history of mental health disorders (where this information is used to calculate premiums).

Out-of-pocket payments and utilization of mental health services

User charges continue to provide a significant contribution to overall health expenditure in many European countries; this is the case not only in many countries of central and eastern Europe, but also elsewhere, such as Portugal, for example, where approximately one-third of costs are incurred out of pocket. Given the strong correlation between mental health problems, unemployment and deprivation, user charges for mental health services can be highly inequitable: those people needing services will often be the least able to pay. This could compound the documented poor utilization of services that is attributed, in part, to the stigma associated with mental health problems. Even when there are no financial barriers obstructing access, as many as two-thirds of individuals with mental health problems with capacity to benefit do not come into contact with formal services. The poor rate of diagnosis of mental health problems in primary care is not likely to be improved if those with mental health problems are discouraged from coming into contact because of the application of user charges. Moreover, people with mental health problems have poorer physical health than the general population, so, again, inappropriate use of user charges could adversely impact upon them.

How are resources allocated?

Even when the level of funding collected (either through taxation or through insurance for mental health) is commensurate with the level of need and the availability of effective interventions, there could still be a need for action. The allocation of services and payments may not be appropriate. Understanding how these resources are allocated can help provide information as to whether the distribution of funds to mental health and other sectors of the health system is undertaken on the same basis, and also whether this takes into account any planning or assessment of population needs. These issues may be of particular concern given the high degree of decentralization in many countries, something which can lead to wide variations in funding for, and availability of, services. (Box 1 illustrates the challenges facing policy-makers deciding on resource allocation for mental health in Norway.)

The MHEEN group recently looked at resource allocation methods for mental health funding in 17 western European countries (McDaid et al., 2004). With few exceptions (where local budgets are provided) these were based on historical precedents or political judgements rather than objective measures of

Box 1: The challenge of resource allocation in Norway

In Norway, the provision of mental health services is the responsibility both of five regional health authorities (RHAs) controlled by the central government and of municipalities governed by locally elected assemblies. RHAs are responsible for specialized services in hospitals and specialized services in the community. Municipalities are responsible for primary health care and social services, including general practitioners, nursing care and housing. Financing is through national and local taxation, with out-of-pocket payments playing only a minor role.

The overall level of financial resources available for RHAs and municipalities is determined annually by the central government. However, the decision on how to allocate these resources is taken at a more local level. RHAs decide on the distribution of resources for somatic versus mental health care, while municipalities decide on how much money to spend on primary health care and social health care (versus primary education, care for elderly and other public services). There has been a general fear that block grants to municipalities lead to mental health care receiving a lower share of resources than desired. One reason for this is that primary education, for instance, has the support of a strong pressure group able to influence local political decisions, while users of mental health services do not.

General hospitals run by RHAs are partly financed through a cost-per-case reimbursement from the central government. The reimbursement only covers somatic inpatients (60% of average costs in 2003) and is based on DRGs. While block grants leave RHAs with a fixed budget, per-case reimbursement gives RHAs the possibility of increased income. The fear among both mental health service professionals and central government staff has been that these incentives will lead to inappropriate reallocation of budgets and resources away from mental health services towards somatic care.

Source: V. Halsteinli (personal communication, 2003).

population health needs. The methods used are unlikely to target resources to areas where they are most likely to be effective; they may also allow inequities to persist. For instance, if resources continue to be concentrated in major cities, rural areas within a country may be neglected. The stigma associated with mental illness is likely to mean that, in such a system, services for those with mental health problems are particularly unlikely to receive a fair share of the

budget, and there may also be prejudice against the funding of non-institutional programmes.

Methods of resource allocation can be even more complex in countries dominated by social health insurance systems. Some funding, such as that for public health and health promotion services, will be provided through taxation, but the majority of funding may be in the form of direct reimbursements from sickness funds to service providers for the provision of services. The MHEEN group reported increasing use of diagnosis-related group (DRG) tariffs for reimbursing service providers for mental health-related services in both social insurance and tax dominated countries. The use of such DRG tariffs in some countries has led to underfunding for mental health, as reimbursement rates have not always fully taken into account all of the costs associated with chronic mental health problems.

Are there particular challenges in shifting resources from institutions to community-based services?

An issue of fundamental concern – indeed, often generating heated debate – in some European countries, particularly those in central and eastern Europe, is the challenge of moving away from continued heavy reliance on inappropriate institutional care either in psychiatric hospitals or in social care homes (*internats*). Mental health in eastern Europe is influenced heavily by the historical legacy of large institutions, in which conditions are poor and there is a custodial (rather than therapeutic) attitude to patient care, leading to concerns about the protection of human rights (Tomov et al., 2005; Mossialos, Murthy & McDaid, 2003).

Financial resource allocation systems in many countries in central and eastern Europe still link funding for mental health services directly to bed occupancy, allowing little flexibility and providing little incentive for local planners to develop community-based alternative services. This can be exacerbated by perverse funding formulae: in the Russian Federation, for instance, psychiatric hospitals with more than 1000 beds occupied can be more generously financed than smaller hospitals (Samyshkin et al., 2004).

Even where deinstitutionalization is taking place, there remains a danger that funds will not be transferred to the provision of community-based services: leakage of mental health funds into other areas of the health care system seems to be all too common. For instance, Hungary has seen a 50% decline in the number of beds in mental hospitals, apparently with little development of community services (Harangozò & Kristòf, 2000). Moreover, the economic

climate in some countries has meant that where deinstitutionalization does take place there are perverse incentives for discharging the most costly individuals first (without transferring funds to community-based care) and for keeping low-cost (and therefore the least appropriate) individuals within institutions. This is done to increase the level of resources available – from unpaid or low-paid work of the residents of the institutions – to cover staff wages.

Should health care systems be considered in isolation?

Many of the services used by people with mental health problems are also funded and provided outside the health sector. Few countries provide services within the health care system to meet the full set of needs. Increasingly, community-based services are being shifted out of the health sector and into the social care sector, potentially having significant implications both for entitlement, and access, to services. Access to services within social care systems may be restricted, being affected, perhaps, by means testing, significant co-payments and or other criteria such as assessment of disability. Here, the challenge is to ensure that any continuing shift of funding out of the health sector does not increase inequity in access to, or provision of, services.

Access to housing and long-term care services in high-income countries in Europe is subject to assessment of financial means, so that before an individual qualifies for assistance their ability to pay (or, in some cases, the ability of family members to pay as well) is first assessed. The individual may be expected to contribute most of his/her own income, as well as run down any capital, savings and other assets before – as a last resort – he/she can become eligible for public assistance. Of the fifteen countries that were members of the EU prior to 1 May 2004, only Sweden currently appears to fund all social care services entirely through taxation, subject to assessment of need and regardless of patient income.

What are the key challenges for funding and allocating resources to mental health?

There are a number of resource-related challenges facing mental health systems in Europe over and above a simple lack of funds. Inefficiency and/or inequity could follow from each of them. Some of the key barriers are summarized below (see the full discussion in Knapp et al., 2004).

Resource insufficiency: not enough financial resources are made available for mental health.

Resource distribution: services are poorly distributed, being available in the

wrong place and at the wrong time relative to need.

Resource inappropriateness: services do not match what is needed or preferred. A clear example of this is the dominance, in many systems, of large psychiatric asylums. In cost terms, such hospitals account for high proportions of available mental health budgets while supporting only small proportions of the total populations in need.

Resource inflexibility: care or support arrangements may be too rigidly organized, leaving them unable to respond to differences in individual needs or community circumstances. This is a common problem when there is scant information on population or local needs, or when patients and their families have few opportunities to participate in decision-making as to how resources are to be used in their own individual circumstances.

Resource dislocation: services may be potentially available to meet the multiple needs of individuals or families, but they are poorly coordinated.

Resource timing: improvements in practices may take a long time to work their way through to cost savings or improved health outcomes.

What can be done to tackle these resource barriers?

Identifying whether these barriers are applicable to individual countries or regions is a first step in improving the use of scarce resources. Left unchecked, these barriers could both worsen problems of inequity in access to services and also increase allocative and productive inefficiencies, making it harder for services to respond to the preferences of service users. Possible steps to address these challenges are outlined below. Not all will be applicable or appropriate for every country. Each solution needs to be assessed in terms of its local relevance and its potential for improving the levels, distribution, appropriateness, flexibility, coordination and ready availability of resources for meeting the mental health needs of the population.

Improving mental health literacy

Fundamental to any action is the need to improve awareness of mental health issues and to address the stigma associated with mental health problems. Some members of the general public may believe that mental illness is self-inflicted and therefore less deserving of attention. They may believe that such problems are difficult to treat. They may be ignorant of the high prevalence of problems, and they may believe that it is more important to invest resources in life-saving treatments. Improving the mental health literacy of the general population may lead to a greater willingness to support mental health and develop national

mental health policies and action plans. National anti-stigma programmes have been introduced and are being evaluated in several countries in Europe and elsewhere.

Building the case for increased investment in mental health

The contribution of mental health problems to the overall disease burden, as well as the availability of effective and cost–effective interventions for prevention and for the treatment and/or rehabilitation of affected individuals appear to justify considering a significant increases in funding for mental health in most countries. This makes sense from the perspectives of both social justice and efficiency. Of course, many considerations must be taken on board before funding decisions are taken, but the case for expanding mental health funding appears strong.

Another argument for increased investment is in the support of implementation of a mental health reform process. There have been dramatic shifts in the approaches used in mental health care over recent decades, with many countries moving from an era dominated by the old asylums to one that is much more actively focused on community-based arrangements for support. Such shifts require additional resources, at least in the short term. There is obviously a need to invest in new physical (and human) capital resources in the community prior to the closure of a hospital, to ensure the smooth and effective movement from one system to another. In addition, community and hospital systems will need to run in parallel for some time, resulting in double running costs. Consequently, mental health reformers will almost certainly need to invest in order to save. Many countries will definitely need injections of additional resources in order to promote improvements in quality of life. Reforms that are introduced in a cost-neutral way – or, worse, are intended to save money – could result in many people being denied care, at least in the short term. This case needs to be made forcefully.

The role of economics in supporting the case for investment in mental health

Resource allocation decisions are notoriously difficult, and decision-makers will generally look for evidence as to the consequences of alternative courses of action in terms of effectiveness and cost–effectiveness. Although it is still limited, the economics evidence base in the mental health field continues to grow. Economic evidence can be used to demonstrate that greater investment in mental health produces many benefits that occur outside the health care system, such as increased productivity, reduced contact with the criminal-justice system and improved rates of social inclusion. In some areas of mental health, there are relatively large amounts of evidence: for example, many of the most frequently used treatments for schizophrenia and depression have been the

Box 2: The Mental Health Economics European Network

With partners in 31 European countries the new MHEEN initiative – from 2005 – will aim to:

- map funding structures and availability of resources for mental health;
- synthesize information on the costs of mental health problems;
- analyse links between employment and mental health;
- assess the cost–effectiveness of mental health promotion and employment interventions;
- explore how economic incentives can be used to encourage system reform;
- share economic evidence and look at how it can be adapted across countries and settings; and
- build mental health economics capacity and facilitate greater use of mental health economics in the decision-making process.

subject of cost–effectiveness evaluations. On the other hand, there have been relatively few economic evaluations of mental health promotion strategies, treatments or service arrangements for people with anxiety disorders, child and adolescent mental health problems, personality disorders or mental health problems in old age.

Given the general finding that economic evidence, unlike most of the evidence coming from clinical studies, does not generalize well from one health system or country to another, there needs to be encouragement for research endeavours that can generate robust cost–effectiveness (and related) evidence on the range of therapeutic and service options available within a mental health care system and can demonstrate how these results might be adapted to another setting or country. This is one of a number of tasks now being explored by MHEEN (see Box 2).

The current CHOICE (CHOosing Interventions that are cost–effective) programme of WHO includes a database on the cost–effectiveness of many interventions for mental health in Europe. This information, while not at country-specific level, is provided for three European subregions in a transparent manner so that data potentially can be adapted to take account of local costs and the availability of resources. This database confirms that cost–effective treatments are available for all of Europe, even where resources for health are very limited.

Strengthening the information base

It is also important to strengthen further our information base on how mental health services are currently funded, to better identify their costs, and to map what is available. Information of this kind would help decision-makers allocate resources and identify gaps in access to essential services. Such action should focus not only on health care systems, but also on other sectors such as social care.

Moving to needs-based resource allocation

Where information is available on the level of psychiatric need within countries, this can be used in allocating resources from central to local level, as in England (see Box 3). Local purchasers or service providers would then receive a share of the national health budget, based not only on the age and gender composition of their local populations but also on mental health needs. With regular surveys, particular areas of concern might be addressed and budgets adjusted to reflect changes.

Earmarking/protecting funds

Given that mental health may be seen as a low priority by decision-makers, it may be necessary to "ring-fence" budgets for mental health. In very decentralized systems this can also be used to ensure that there is some uniformity in the funding of mental health. In Sweden, for instance, responsibility for delivering health services rests with county councils, who allocate resources from global health budgets on the basis of a mixture of historical precedent and capitation formulae. Specialist mental health services, however, operate with protected fixed budgets whose levels are set by the national government.

Protection of funds may also be critical to the process of deinstitutionalization and movement towards more community-based systems. Decision-makers may see the closure of institutions as an opportunity to reduce the budget for mental health and to spend the released funds in quite different areas. Protection of the mental health budget can help ensure that resources are transferred to alternative community services. The closure of long-stay institutions and social care homes might also be encouraged by moving to a per-capita funding system whereby funding follows an individual regardless of where he/she receives services. Wherever protected funds are used, the levels at which they are set would need to be reviewed regularly to ensure that the allocations are consistent with the levels of need within that country.

Using DRGs to improve financial flows

If there are sufficient data on resource utilization and costs in both tax and social insurance-financed systems, DRG unit costs can be used. Well-constructed

Box 3: Funding mental health care in England

The annual budgets of local purchasers (primary care trusts) for health care are determined on the basis of weighted populations and assignment of recurrent resources together with some special allocations and redistributions. Weightings are based on age profiles and measures of health care need; this includes use of a specially developed mental health need index. This index combines a number of indicators of population needs used to allocate funding to local government, together with evidence on patterns of mental health care need from the annual Health Survey for England.

Mental health as a proportion of total local purchaser allocations in 2003/2004 varied from 22.48% to 8.12%, the average being 11.56% (Glover, 2004). Some of this variation is due to the additional finance provided for remaining long-stay institutions.

Local purchasers are free to spend more or less on mental health than is determined by the mental health needs allocation, but, in providing services, local planners must ensure that services facilities are available that meet the needs of the National Service Framework for Mental Health, ensuring that resources are targeted in evidence-based ways to mental health. Small amounts of additional money for mental health can be earmarked through special allocations: in recent years these have included funds for mentally disordered offenders and for helping to implement mental health aspects of the National Health Service plan.

DRGs can be an effective way of ensuring that sufficient resources are transferred to secondary and specialist mental health-related services. When a retrospective DRG payment system was introduced in Austria in 1997, the complexity of the mental health problems meant that costs were initially underestimated, which led to considerable financial deficits for hospital care-providers. After considerable pressure from leading psychiatrists, the DRG system was reformed to take account of the complexities and to allow length of stay to be adjusted to take account of needs. This now means that psychiatric wards in Austrian hospitals receive full reimbursement of their costs (Zechmeister et al., 2002).

Coordinating funding and responsiveness across sectors

Multiple costs, not just to different agencies within the public or private sectors, but also to individual service users and their families, raise a number of challenges. In particular, unless the full cost implications of mental health problems, and of changes to mental health systems, are recognized, multiple

costs raise the risk of the reform process being seriously underfunded. They also give rise to the potentially very constraining problem of "silo budgets" (that is, resources held in one budget, which cannot be allocated to other uses – to the general detriment of the pursuit of effectiveness). There is also a risk that key opportunities for promoting service user well-being will be missed, for example by denying individuals the opportunity to secure paid employment.

Some of these problems may be addressed through the creation of joint budgets for mental health across sectors, as seen in England, so that resource implications and benefits are shared by sectors, increasing flexibility in delivering services that best address needs. The issue of resource inflexibility may also be addressed by implementing a greater degree of partnership-working with the not-for-profit non-governmental organizations. Non-governmental organizations can be commissioned to deliver services, and there is evidence that they can respond more flexibly than the statutory sector when adapting to changing local circumstances.

Another possibility is to create what is known as a "one-stop shop" – a central agency responsible for coordinating services across a number of sectors. Case managers working at such an agency could have responsibility for devolved funding, thus helping to improve the services' responsiveness to needs, and provide opportunities for service users to express their preferences.

Direct payments to service users

Another way of helping to ensure that funds are allocated to meet needs particularly within the community is by encouraging "direct payments" (consumer-directed care). Individuals are given cash with which to purchase some, or all, of their services. This helps to empower individuals, promoting independence and inclusion, and offers opportunities for rehabilitation, education, leisure and employment. This system has been introduced only in a few countries, such as England, Scotland and the Netherlands. If experience is similar to that when such payments were used for people with physical or sensory disabilities, this system (though not yet fully evaluated) may avoid some of the problems of funding services across different sectors.

Looking forward

The last five years have seen a significant increase in the attention given to mental health by WHO, the European Commission and many European governments. There is now substantial evidence that greater investment in many areas of mental health is justified not only for tackling inequalities, the high levels of social exclusion and adverse consequences, but also because it

represents a more efficient use of health (and other) sector resources. Efficiency gains can be both immediate and long-term. There remain gaps in our knowledge, however. International initiatives aimed at improving awareness of, and looking at the transferability of, the results of cost–effectiveness studies (such as the work of the WHO-CHOICE programme globally and the MHEEN network in Europe) can help build capacity and fill some of these gaps. These initiatives may serve to strengthen the case further for investment.

Of course, on their own, these positive developments will not lead to a level of funding of mental health consistent with the impact of mental health problems. Effective communication and engagement is needed for stakeholders in all sectors – not only for policy-makers, service users and families, but also for others, such as employers, trade unions and schools. Any discussion of funding, therefore, must also take account of other sectors in which, in comparison with European health care systems, there may be even greater barriers to access, higher levels of co-payments and the use of income-related means testing. Non-governmental organizations and international donors will also need to continue to play important roles in both funding and delivery of services. The long-term sustainability of effective initiatives should be an important goal.

It is crucial to recognize that it is not just a question of the levels of funding allocated to mental health, but also the way in which these funds are used. Movement towards greater reliance on community care requires that resources be shifted away from institutional care. But, as we have seen, there can be many barriers to achieving this. Financial incentives can be a very powerful tool for improving the flow of funds to, and within, any mental health system (including all relevant agencies and not just those within the health care sector) and for creating incentives and disincentives to enhance action and performance. Making decision-makers aware of the cost implications of their decisions can be quite illuminating; making them financially responsible in a direct way can be quite influential in changing behaviour. These incentives can also be used to empower service users, through consumer-directed payment schemes, so that they can make their own decisions about their service needs.[2]

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Useful web sites

Mental Health Economics European Network
http://www.mentalhealth-econ.org, accessed 25 December 2004.

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More information on mental health in Europe can be found in:

Mental health policy and practice across Europe

Edited by Martin Knapp, David McDaid, Elias Mossialos and Graham Thornicroft

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Contents

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This policy brief is intended for policy-makers and those addressing the issues of mental health and health care systems.