ANNEX XII – Paper B - Financing in Mental Health in Western Europe

PAPER B

FINANCING ARRANGEMENTS FOR MENTAL HEALTH CARE IN WESTERN EUROPE

1. Introduction

One challenge in Europe is to ensure that mental health receives a fair share of available health funding. The historical low level of funding for mental health within many European systems appears both to be inefficient, because of the substantial benefits that interventions would bring, and inequitable given that mental health problems account for nearly 20% of all health problems in Europe.

In order to build an investment case for greater investment in mental health, an important first key step is to look at the ways in which services are made available and how they are financed across Europe. Attention should be paid to the extent to which financing methods impact upon potential access to services because many people with mental health problems (as many as two-thirds in the US; Zuvekas 1999) may not come into contact with services. While much has been written in the literature on the ways in which general health care systems are financed in Europe, little has been written on this in relation to mental health promotion and treatment services (Knapp et al 2003). Looking at mental health is also of importance given the unique degree to which services, particularly those for the promotion and maintenance of good mental health and for the provision of community care, are provided outside the health care sector in different countries, with attendant equity implications.

2. Methods

One of the first tasks undertaken by the MHEEN group was a detailed review of health financing systems across all 17 MHEEN countries. A structured questionnaire was developed iteratively by the group to examine, firstly, the extent to which mental health services may be funded in a different fashion to other health care services, and to consider whether the approaches are efficient and equitable. A second purpose was to review the extent to which services are provided outside the health care sector, for instance by social care services, and identify the implications for entitlement and access to services. A third key concern was to identify gaps in the availability of such information across countries.

This paper therefore begins by briefly outlining the main methods of health care financing in Europe, and entitlements to services in section 3. The following section then considers whether there are any specific distinctions between the methods of financing of general health and mental health care, and report on the role of voluntary health insurance. The overall level of funding within the health care system for mental health is then reported. However even if this level of funding for mental health is fair, this in itself is insufficient to ensure that resources are invested in mental health. Another key issue is the way in which resources collected through taxation or insurance are allocated to mental health and distributed to fund services according to

need across countries. A second questionnaire was developed by the MHEEN network in order to obtain some insight on the process by which the resources that are collected through taxation, social insurance (etc.) are allocated to health services in general and mental health services in particular. Results from this questionnaire also reported. Finally we also look at entitlements to mental health services in the social care sector, and provides an overview of financing mechanisms for social care services.

3. An overview of health care financing in western Europe

This overview begins by briefly setting out the characteristics of the principle methods of funding health care systems in Europe. Although there are many differences and variations between individual systems, there are four primary mechanisms for collecting funds for European health care systems: some form of direct or indirect taxation, social health insurance, optional private insurance (which may be complementary or a substitute for public services and also known as voluntary insurance) and out-of-pocket payments/user charges. In all 17 MHEEN countries taxation and social health insurance systems dominate as can be seen in Table 1, but voluntary insurance and out-of-pocket payments will also play a role. The current role of for profit voluntary insurance in funding mental health service remains very limited in most countries.

Table 1. Health Care Funding Models in Western Europe

Tax Based Systems	Social Health Insurance	Mixed Systems
Denmark	Austria	Greece
Iceland	Belgium	
Ireland	France	
Italy	Germany	
Norway	Luxembourg	
Portugal	Netherlands	
Spain		
Sweden		
United Kingdom		

3.1 Taxation

All countries, even those that rely heavily on social health insurance, will use some tax based funding for health services, and in particular in order to fund public health and health promotion activities. Taxes come in many forms. They might be imposed directly on the whole population through some combination of income, savings, investment, profits and household taxes. They might also be raised indirectly, perhaps by imposing a sales tax on goods and services purchased. Tax revenues can be earmarked or hypothecated for specific causes such as health or collected into one central fund, and distributed according to government priorities. The recent introduction of an additional 1% national insurance contribution in the UK specifically to fund the NHS is an example of such a hypothecated tax.[1]

[1] National Insurance revenues in the UK are pooled with general taxation, and do not impact on entitlements to services; thus they are assumed in this paper effectively to be taxation rather than a form of social health insurance.

Similarly, taxes on cigarettes and alcohol may be earmarked for health care. In France the tax contribution to funding health care has been broadened recently, making contributions more akin to general taxation, with unearned income savings, pensions and capital gains now taxable assets. Employees now pay 7.5% of their total income via the general social contribution (CSG). 79% of the CSG is hypothecated for health, reducing the reliance solely on payroll contributions to compulsory social health insurance schemes.

Taxes can be levied by authorities other than central government, most notably in Denmark, Finland, Italy, Norway, Spain and Sweden, where high proportions of health care expenditure are raised through taxes levied locally by either regional governments, county councils and/or municipalities. In Spain for instance the autonomous communities can raise petrol taxes to provide additional funding for healthcare, and from August 2004 a levy of 2.4 cents per litre is being charged in Catalonia for this purpose, anticipated to raise an additional €65 to €80 million per annum. To differing extents these countries will also rely on additional funds from national taxes.

Reform of the health care system in Finland in 1993 extended the already considerable responsibility of the 455 municipalities yet further by allowing them the freedom to determine the allocation of funding to different health care priorities. Municipal taxation now raises more than 40% of funds for health and they receive a lump sum from central government for all welfare services they provide rather than a proportion of the costs of delivering these services. Since 1993, the government's proportion in funding health care has declined markedly: in 1995 this was 28.4 % of the total health care expenditure, whereas by 2000 it was only 17.6%.

3.2 Social health insurance

Social health insurance (SHI), which can be traced back to the system introduced by Bismarck in Germany in the late 19th century, remains the dominant method for funding health care in several European countries including Germany, the Netherlands, France, Belgium and Austria. Although the characteristics of social health insurance differ markedly across countries, SHI systems are typically characterised by a number of features including:

- Insured individuals pay a regular, usually wage-based contribution, which may be a flat rate or variable.
- Employers may also pay a contribution.
- SHI is compulsory for the overwhelming majority or total population.
- There may be one or more independent ‘sickness funds’ or social insurers.
- Individuals may or may not be able to choose which sickness fund they join.
- Transfers are made from general taxation to cover the premiums of the unemployed, retired and other disadvantaged, vulnerable groups (Normand and Buse 2002).

3.3 Voluntary health insurance

Voluntary health insurance has been defined as 'health insurance that is taken up and paid for at the discretion of individuals or employers on behalf of individuals. Voluntary health insurance can be offered by public or quasi-public bodies and by for-profit and not-for-profit private organizations (Mossialos and Thomson 2002). It takes three principle forms: a substitute for the statutory social health insurance scheme (as in Germany for higher paid workers), or a complement to public entitlement (as in Belgium or France , where complementary private health insurance is purchased to cover co-payments within the public health system). Insurance can also be a mixture of complementary and supplemental insurance such as that in Ireland to cover the costs of primary care for citizens not entitled to free care, as well as increasing individual patient choice allowing the receipt of services privately in a shorter time period within inpatient hospital care.

Unlike social health insurance, voluntary health insurance may be risk-rated, i.e. offer lower premiums to low risk individuals, hence being more likely to 'cream skim' low risk individuals into funds and exclude other groups in society. In addition to traditional insurance plans, voluntary health insurance can also include schemes such as hospital cash plans, which pay out predetermined cash benefits when individuals use health care services. Schemes may also provide benefits in kind, accident insurance, critical illness cover and cover for long-term care.

While there are opportunities to purchase voluntary health insurance in addition to contributions to tax or social health insurance schemes in all countries, with the exceptions of the Netherlands (17.1%), France (13.2%), and Germany (8.6%), it accounts for well under 10% of expenditure, and in some countries is virtually non existent e.g. in Iceland, Denmark, Finland and Norway. It also accounts for less than 25% of all private health care expenditure in most countries, (the exceptions being France and the Netherlands); the majority of private expenditure remains user charges and other out-of-pocket payments.

3.4 Voluntary insurance and mental health

In most countries the majority of voluntary health insurance policies are bought at the discretion of an employer on behalf of the individual. Premiums are usually risk-rated based on an assessment of individual risk. Individual risk rating would impose the greatest financial burden on people with mental health disorders or with a family history of mental health disorders (where this information is used to calculate premia). Most private insurers in Europe will refuse cover if there are pre-existing mental health problems or high probabilities of mental illness. Anyone with a family history of mental health problems or with a proven genetic pre-disposition to mental illness (e.g. early onset dementia) will find enrolment prohibitively expensive (if available at all).

Where supplemental insurance is available, coverage for mental health-related services is therefore often very limited. Due to the chronic nature and high cost of mental health treatments and interventions, private insurers are likely to exclude mental health interventions from the benefits offered to enrolees. Psychiatric care and mental health problems are explicitly excluded in some European Union member states (Mossialos and Thomson, 2002). For instance the sole provider of voluntary

health insurance in Luxembourg does not cover mental health. Where treatments are covered, premia are likely to be higher.

In Germany while 9% of population have additional supplemental insurance only 6% of this in 2001 was spent on mental health care. (PKV Zahlenbericht 2001/2002). In the Netherlands access to out patient psychologists (not covered by the AWBZ) is reimbursable under 60% of private health insurance schemes, but this is not a significant factor in choosing insurance policies (Mesman and Verhaak 2001). A small number of health insurers in Portugal have offered coverage for domiciliary care (Oliveira 2001b).

Only in Austria are insurers prohibited from refusing to insure someone with a chronic illness. Although there are no differences in reimbursements for services of private psychiatrists, they are, however, permitted to charge higher premia or impose cost-sharing for hospital care, given the disproportional lengths of stay and types of treatment received which, from the insurers point of view, do not necessarily require hospital stay (e.g. certain forms of psychotherapy).

In the UK while the number of individuals purchasing private insurance remains very small, a recent market report suggests that mental health is the fastest growing independent private health care insurance sector. As more mental health services are provided by the independent healthcare sector as the NHS increasingly outsources actue psychiatric care, opportunities to also provide this service through private insurance also increase. Independent psychiatric hopsital revenues grew strongly in 2001 to £336 million, up 17% on the previous year (Laing & Buisson 2003)

However psychiatric care is more likely to be an optional extra, and heavily restricted, rather than a core element of private insurance packages in the UK, so coverage will depend on the contract negotiated between the employer and insurance company. For individuals buying insurance direct from the market, the variety of products and packages is daunting. For example of a sample of 203 policies available to a 50-year old , provided by seven insurance companies, 101 offered some inpatient psychiatric cover and 80 some outpatient psychiatric cover. Inpatient care ranged from 28 days inpatient care to ‘full’ psychiatric care. Various conditions might be applied depending on the policy, for example psychiatric care may only available if there is a waiting list of 6 weeks or more in the NHS in some schemes, while the UK’s largest private insurer British United Providential Association (BUPA) offers up to 45 days of inpatient or outpatient psychiatric care to policy holders only after they have had at least 2 years on a policy with psychiatric cover included. (BUPA Ireland, the second largest insurance provider there, operates a similar scheme.) Spending caps might also be imposed, and three other companies had limits per annum of £600, £750 and £1200.

Overall the role of private health insurance in the area of mental health remains extremely limited; but there is some evidence of increasing access to services in some countries as enrolment in employer related schemes increases. A new phenomena for which only limited information is available, are insurance schemes providing employment protection. While these may not directly pay for mental health care, they can provide a cash benefit should an individual have to give up work because of a mental health related problem. In the UK such insurance schemes have funded

counselling and other treatment for workers who have stress related disorders such as teachers.

Access to private health insurance is likely to be inequitable, in the UK Family Earning Survey 40% of those in the richest decile have private insurance compared to just under 5% of the poorest 4 deciles. The likelihood of the insurance being paid for by an employer also increases as income increases (Emmerson et al 2002). Another issue to be considered is the impact private insurance might have on equity of access to services, particularly if this means faster access to mental health related services provided in the public sector on the basis of financial incentives for health care professionals rather than on the basis of clinical need.

3.5 Out-of-pocket payments/user charges

User charges, either as a percentage of cost or a fixed amount, are often levied on certain health care services, such as pharmaceuticals, dentistry or primary care consultations. These charges may be in place in part to raise revenue, but also to discourage excessive or inappropriate utilisation. However, user charges can be costly to administer and may deter patients from accessing the care that they need. In the case of mental health disorders, this may exacerbate the issue of low service utilisation.

User charges it has been argued could ultimately increase the costs to the health care system, for instance the recent introduction of user charges for previously exempt vulnerable groups in Quebec (Tamblyn et al 2001) demonstrated that charges lead to a reduction in the use of services by low-income groups. Tamblyn's study also found that although there was initially a reduction in costs to the healthcare system, in the medium term costs increased as individuals who did not buy medication more frequently presented themselves at secondary and emergency care facilities.

User charges are of particular significance when considering mental health. Given the strong correlation between mental health problems and unemployment and low socio-economic status, user charges for mental health services will be highly inequitable: those needing services will often be the least able to pay. This could compound the documented low utilisation of services attributed in part to the stigma associated with mental health problems. Another difficulty is the poor rate of diagnosis of mental health problems in primary care, something that is more likely to be improved if those with mental health problems are not discouraged from coming into contact with services by 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 on this population subgroup (Lawrence et al 2001).

Table 2 illustrates the significant contribution that out-of-pocket payments can make to overall health expenditure. Portugal is the most extreme example, where more than one third of all health care expenditure is through out-of-pocket payments

Table2. Out-of-pocket payments for all health care service 2002

Out-of-pocket payments - % total exp. on health 2002	
Austria	17.5
Belgium	
Denmark	15.3
Finland	20
France	9.8
Germany	10.4
Greece	
Iceland	16
Ireland	13.2
Italy*	20.6
Luxembourg	11.9
Netherlands	10.1
Norway*	14
Portugal	
Spain	23.6
Sweden	
United Kingdom	

Source OECD Health Database 2004
* Data from 2003

The MHEEN group reviewed the role played by user charges across all 17 countries, looking not only at their use in relation to primary, secondary and tertiary health care services, but also in relation to community care and rehabilitation. Types of charges, whether they were administered retrospectively or prospectively, and exemptions from charging were all examined.

The use of user charges like other types of funding instrument again varies considerably across Europe, (see Table 4) although all countries impose some user charge on prescription charges, (although these are being phased out in Wales over the next four years.) Countries where user charges appear to play a minimal role include Denmark, Greece, Germany, Italy, the Netherlands and Spain, while in Austria, Belgium and France user charges occur for all of these different health and social care services. The situation in Ireland is slightly more complex, individuals with incomes below a specified level and all those over the age of 70 (just under one third of the population) qualify for full cover under the GMS General Medical Services scheme and are exempt from all charges including those for prescriptions. The remaining two thirds typically purchase complementary insurance to cover the costs of fee for service charges for primary care, and inpatient service costs. 25 % of the Irish population do not have an exemption from charges nor do they purchase private health insurance and may face significant financial costs should they require medical care. Significant costs may also be incurred for long term care which is typically not covered by voluntary insurance schemes in Ireland. Another important equity dimension in Ireland is that unusually those under the age of 18 are not automatically exempt from charges. In the UK most health care costs are provided free of charge, (other than dental and ophthalmic services) but significant costs may be incurred for long term and community care under the means tested subsidiarity principle. Where user charges are incurred across Europe the majority are flat fees rather than a proportion of the costs of care.

Exemptions from charges

Exemptions on the basis of age, income, disease or functional status are common. For example in Austria within some insurance bodies, people with a net income below €643.54 are exempted from prescription fees. Additionally, people with low income whose expenditures due to illness are 'exceptionally' high are exempted from prescription fees. For many services there may also be an upper ceiling on the amount of personal contributions. Similarly in Belgium there is a maximum upper ceiling dependent on income. In Iceland no groups are fully exempt although those over the age of 67 can make use of the same reduced charge rates as those with disabilities, while in Italy people with mental health problems are exempt from charges for using outpatient services. In Portugal exemptions to user charges have applied for those with : low family incomes, individuals with exceptional need for health care consumption such as the disabled and those with certain chronic conditions, and range of special patient groups (e.g. pregnant women, children, drug addicts on recovery programs, chronic mental patients, etc) (Pereira et al. 1999). Chronic service users in both Ireland and the UK may be able to participate in schemes exempting or limiting total payment for access to prescription based medications. Means testing on the basis of income also limits some co-payments. Complementary insurance may be taken out in France to cover the costs of co-payments, and since 2000 individuals with an income of less than €550 per month have been enrolled in the fund by the government.

4. Entitlements to health care services

Overall, public funding of health care through some combination of taxation and SHI remains the dominant approach in western Europe. The principle of social solidarity in respect of health care has long been accepted in nearly all these 17 countries, so it is not surprising that there is near universal coverage by public health care systems in most countries, provided usually on the basis of residency rather than citizenship. The only apparent exceptions to this are Germany where 10% of the population were not covered in 2002 and the Netherlands where in 2001 25% were not covered under the public system (OECD 2004). However in Germany, individuals have an opportunity to opt out of the social insurance system and purchase private insurance if their income exceeds a certain level, while in the Netherlands public social insurance is not available above a certain income threshold, and instead nearly all individuals voluntarily purchase private insurance instead. In the case of the Netherlands an additional compulsory social health insurance covers long term illness including mental health problems.

The latest data available from the OECD indicate that in nearly all countries in western Europe, public health expenditure accounts for over 70% of total health care expenditure, with the highest levels of public coverage being reported in Luxembourg, Denmark, Norway and Sweden (Table 2). These figures are somewhat deceptive, however, as they do not distinguish user charges and co-payments levied in public health care systems from voluntary health insurance and direct payments for other services.

Total expenditure on health as a percentage of GDP is in excess of 6% in all countries, ranging from 6.2% in Luxembourg to 10.9% in Germany. The contribution of public financing to expenditure varies markedly. This contribution ranges from

lows of 53.9% in Greece and 69.9% in Austria to a high of 85.5% in Norway (see Table 3). Thus while there may be universal access to health care services, private financing through out-of-pocket payments, private insurance and other charges such as for prescriptions accounts for at least 15% of all funding.

Table 3. Total Expenditure on Health as a % of GDP and % Public Expenditure 2002

	% of GDP on health	% as public expenditure
Austria	7.7	69.9
Belgium	9.1	71.2
Denmark	8.8	83.1
Finland	7.3	75.7
France	9.7	76
Germany	10.9	78.5
Greece	9.5	52.9
Iceland	9.9	84
Ireland	7.3	75.2
Italy*	8.5	75.3
Luxembourg	6.2	85.4
Netherlands	9.1	
Norway*	9.1	85.5
Portugal	9.3	70.5
Spain	7.6	71.4
Sweden	9.2	85.3
United Kingdom	7.7	83.4

Source: OECD 2004 *Data for Italy and Norway from 2003

5. Does mental health financing differ from general health care financing?

In general, mental health care is financed in the same fashion as other health care services, using either national, regional or local budgets from taxation or the pooled funds of social insurers. As we have seen the role for voluntary private health insurance in covering mental health services remains extremely limited. The Netherlands is somewhat unusual in having a separate mandatory insurance scheme (The Exceptional Medical Expenses Scheme AWBZ) for all citizens, regardless of income, to cover the costs of long-term illness. (see Box 1).

Box 1. Funding Mental Health in The Netherlands

The AWBZ exceptional medical expenses insurance scheme is obligatory, even for those with high incomes enrolled in private health insurance. Long-term mental health problems are thus funded under this scheme and about 85% of the costs of mental health care facilities are paid through the AWBZ, with an additional 11% coming directly from taxation out of the national budget. There are also out-of-pocket contributions towards in-patient treatment, sheltered accommodation and psychotherapy, covering 4% of all the costs of mental health care (Ministry of Health Welfare and Sport; Ministry of Health Welfare and Sport (VWS) and Institute 2000). About 75% of the funding is spent on mental health care for adults and older people, 15% on children and adolescents, 7% on addiction care and 5% on forensic psychiatry. Two-thirds are spent on inpatient care and part-time treatment. (Evers 2003) Coverage includes admission and stay in general hospitals, psychiatric hospitals, and rehabilitation centres after the first 365 days, as well as funding nursing home care, home care, sheltered accommodation, counselling and outpatient psychiatric care. Outpatient treatment for addictive disorders are paid for from a different budget (Welfare Act).

6. The level of funding for mental health in Europe

The 2001 WHO Atlas on Mental Health was the first attempt to systematically collect information on expenditure on mental health across Europe. Overall only 23 of the 52 WHO European region countries provided information, a primary reason for this being the fragmented structure of funding systems, especially where social insurance systems operate. Another complication is that many services are often provided outside the health care sector, and are subject to different funding structures. MHEEN network updated this information on funding, and also looked further at the reasons for non availability of data in all countries.

Table 6 provides estimates of expenditure on mental health services across all MHEEN countries. In four of the 17 MHEEN countries – Austria, Finland, Greece, and Norway – no estimates on funding are reported. This is a reflection in part of the difficulties of collecting or aggregating information in systems where healthcare is devolved to local governments as well as because of the fragmentation of systems providing mental health related services.

Table 6: Estimates of mental health expenditure as a proportion of total expenditure on health

Country	% of health budget
Austria	N/A
Belgium*	6
Denmark	8
Finland	N/A
France*	5
Germany	10
Greece	N/A
Iceland	6.3
Ireland	6.8
Italy	5.0
Luxembourg*	13.4
Netherlands	8
Norway	N/A
Portugal	5
Spain	4.6 - 5.3
Sweden*	11
UK	12

* Estimates taken from the WHO Atlas on Mental Health 2001. All other estimates reported by MHEEN group.

The highest estimates of expenditure on mental health are to be found in Luxembourg and the UK (England) with the lowest estimates of under 5% reported from Portugal and Spain. Extreme caution must be exercised with these findings, the estimate from Portugal represents a best guess at calculating these costs using a bottom up approach, aggregating together services that are targeted at people with mental health problems, while data from Spain is taken from two regions, Catalonia and Navarra, and cannot even be directly compared with each other because of different methodologies used in their estimation, and the different extent to which they include social care services within their budgets.

Drawing any firm conclusions from these estimates therefore is not be a useful exercise, as without also estimating the costs related to mental health across sectors a meaningful comparison across countries is not possible. Nevertheless any estimates of funding below 5% of total health expenditure may indicate an unfair allocation of resources to mental health given that the mental health problems contribute to more than 20% of disease burden in Europe. Published estimates of levels of funding can also be unhelpful, the level of ring fenced funding for mental health reported in the Atlas in Norway was just 0.01% of the health budget, and this was interpreted erroneously by some as meaning that funding in mental health was virtually non existent. It should also be recognised that countries may in fact not wish to fully make public the share of expenditure going to mental health, if political pressure and negative attitudes towards mental health may then force decision makers to cut budgets.

However to put these figures in some context, looking beyond these 17 countries to the whole of Europe, MHEEN obtained estimates for 28 European countries. These range between just over 13% and less than 2%, of which only 4 allocate more than 10% of their health budgets to mental health, 16 spend between 5% and 10%, with the remainder under 5%. The lowest reported budgets of less than 2% are all found in former soviet bloc states, which may in part be a legacy of the low political value of mental health politically. Elsewhere the Atlas reported that 11% of the health care budget in New Zealand and Canada respectively were devoted to mental health, with 6.% spent in Australia and the USA. Problems in reporting are not confined to Europe, Japan a country with a Bismarck-style social health insurance system does not make available data on mental health expenditure.

7. The allocation of funds to mental health

It is not enough that the level of funding collected either through taxation or insurance for mental health is commensurate with the level of need and the availability of effective interventions. The MHEEN group developed a questionnaire to identify information on the way in which funds for health care that are collected by a third-party payer (e.g. government, insurer, etc.) are distributed to local health care purchasers/plans. The purchaser might be a local government, a local administrative board, a provider group or a social health insurance fund.

Purchasers are charged with organising specified types of health care for a designated population, whether defined by geography, employment type, or voluntary enrolment, over a given time period. In some systems the revenue collection and purchasing function are integrated and there is no resource allocation mechanism to purchasers. Understanding how resources are allocated can help provide contextual information as to whether the distribution of funds for mental health and other sectors of the health system is firstly undertaken on the same basis, and secondly whether this takes in account any planning or assessment of needs. These issues may be of particular concern given the high level of devolution in many countries, which can potentially lead to wide variations in funding for and availability of services within countries. Network members provided information on the processes used for setting global budgets, e.g. according to size of bids from purchasers, political negotiation, historical precedent or an independent measure of health need (e.g. risk adjusted capitation).

The MHEEN group also sought to identify whether budgets for mental health were protected.

If budgets for health are set on a historical basis or because of political pressure rather than on the basis of health needs, then this is unlikely to target resources to areas where they are most likely to be effective and may also allow inequities to persist, for instance if resources continue to be concentrated in major cities, neglecting rural areas within a country. The stigma associated with funding mental health is likely to mean that it is unlikely to receive a share of the budget merited by its contribution to ill health, and this may also mean that it is more difficult to invest resources in new community based services. Existing institutions may receive funding on the basis of the number of beds they have, and there may be greater reluctance to provide additional funding during any transitional period of deinsitutionalisation to also support alternative services. Deinsitutionalisation may be perceived also as a way of containing or even reducing costs, so protection or ring fencing of budgets for mental health may therefore be one approach to ensure that resources do follow individuals into the community.

Budgets may also be fixed at a global level for institutions providing services or may be varied to be a mixture of a fixed element plus payments based on activity rates. The rate of payment in both tax and social insurance based systems may be the subject of competition or as is increasingly the case in some countries be set at a national or local rate, using Diagnosis Related Groups (DRGs) costs which are based on the average costs associated with a condition or procedure.

Resource allocation decisions may reflect local concerns, as for instance is seen in Norway where the municipalities must decide on the balance between mental and physical health, and on promotion versus treatment and long term care. (See Box 2)

Box 2: Resource allocation in Norway

In Norway the provision of mental health services are the responsibility of five regional health authorities (RHAs) controlled by the central government and the responsibility of the municipalities who are governed by a locally elected assembly. RHAs are responsible for specialised services at the hospital level and specialised services at the community level. Municipalities are responsible for primary health care and social services, which includes general practitioners (GPs), nursing care and housing.

An important feature of the Norwegian health care system is the predominance of tax-financed public provision. For both RHAs and municipalities taxes are the major financial source. Out-of-pocket payments exist, but play a minor role. RHAs are financed through grants from the central government. Municipalities are financed through grants from the central government and local taxes.

The central government has the overall responsibility for laws and regulations, including regulating local taxes. The overall level of financial recourses available for RHAs and municipalities is a yearly decision made by the central government. As a principle the decision how much resources to spend on mental health services on the other hand is a local decision. RHAs decide how much resources to spend on somatic versus mental health care, and municipalities decide how much money to spend on primary health care and social health care versus primary education, care for elderly and basic infrastructure.

In Sweden responsibility for health rests with county councils who allocate resources from global budgets on the basis of a mix of historical precedent and capitation formula. Specialist mental health services operate with fixed budgets, not being

subject to the capitation formula. Budgets for psychiatric services are protected and have recently been increased by the national government.[2] In Finland decisions on how to distibute health budget resources are taken by 274 municipalities. In Denmark resource allocation decisions are made at several levels. The most significant resource allocation mechanism is the national budget negotiation that takes place once a year between the Ministry of Health, the Ministry of Finance and the county and municipal councils, represented by the Association of County Councils and the National Association of Local Authorities. At this annual negotiation the recommended level of county and municipal taxes are set, together with state subsidies and the level of redistribution and financial equalisation between the counties and municipalities to compensate for variations in tax take. In Iceland budgets are set through negotiation between health service providers, the national health insurance company and the ministry of health. This is based very much on political and historical precedents and there is no formal protection for mental health resources within the budget. In Spain budgets are set by each of the autonomous regions and will be influenced in part by the extent to which additional local taxation for health is raised. In Portugal a mixed system is used combining a morbidity adjusted per capita formula and historical budgeting to transfer of funds to regional health authorities who are responsible for primary care services. Hospital funding is determined centrally using global budgets. In Italy while the national government determines the share of the health care budgets going to the regions, where these resources are allocated rests with the regions, leading to much variation in the level of expenditure on mental health.

In England although prospective allocations of health care resources using a made to local primary care trusts include a specific adjustment to take account of mental health problems these funds are not ring fenced for mental health. They may be used for other non mental health related services meaning that the funds available for mental health may in some cases be much lower (or indeed higher) than that intended by the formula (Bindman et al 2000). In practice though PCTs have to ensure that they are purchasing services to meet National Service Frameworks established in a number of key health areas including mental health. This in practice does provide some protection for mental health.

In Greece budgets for health care resources are determined on the basis of political negotiation and historical precedent, and there is no protection for the mental health budget. In Ireland budget determinations for health for each of the 8 health boards are set out annually by the Minister of Health and Children and the Minister of Finance. These are based largely on historical precedent although they do to some extent take demographic changes into account.

Methods of resource allocation can be even more complex in countries dominated by social health insurance systems. Some funding, e.g. for public health and health promotion services will be provided through general taxation, but the majority of funding will be in the form of direct reimbursements from sickness funds to service providers for the provision of services. A set of national or local tariffs may be set to add in this reimbursement process, while some funding may be transferred on a per capita basis e.g. to primary care service providers.

---

[2] This was in part due to the tragic killing of foreign minister Anna Lind by a psychiatric patient in 2003.

Germany does not have one budget but 17 tax-based budgets (one at federal level and 16 at *Länder* level) and currently 453 sickness fund budgets (not counting other social insurance budgets, reimbursement through private health insurance companies etc). These sickness funds do not have fixed pre-determined budgets, but have to cover all the expenses of their insured members. This means that the contribution rate has to be adjusted if income does not match expenditure. To provide all sickness funds with an equal starting position or a level playing field for competition, a risk structure compensation scheme to equalize difference in contribution rates (due to varying income levels) and expenditure (due to age and sex) was introduced in two steps (1994 and 1995 – the latter included retired insurees and thereby replaced the former sharing of actual expenses for retired persons between funds). The compensatory mechanism requires all sickness funds to provide or receive compensation for the differences in their contributory incomes as well as in averaged expenditures. Budgets set by the Lander are largely determined by historical precedent and again there is no protection for mental health budgets.

In Austria budgets for primary care providers are determined through negotiation between the sickness funds and the Austrian Medical Association, which allocations made on a fixed budget plus fee for service basis. Since 1997 in each of the nine provinces a provincial fund has been established which receives funding from health insurance, as well as through central and local government contributions. Hospitals are then reimbursed using a modified DRG system, the Performance Oriented Hospital Financing System' (LKF).

A similar system mixing capitation payments, fee for services, DRG-system, and price setting by negotiation between different parties is used in the Netherlands. Primary care physicians are paid by capitation for treatment of patients who participate in sickness funds and by fee-for-service for treatment of those with private insurance. Patients may see a specialist only after referral from a primary care physician. Specialist practices are predominantly small, hospital based, and fee-for-service. The capitation rate and the fee-for-service schedule are set nationally each year by a complicated negotiation process among members of the sickness funds, the LHV (the National General Practitioners Association), and the LSV (the National Specialists Association); the results of negotiation require government approval. In secondary health care (specialist and outpatient care), the introduction of a new funding system has the highest priority, which in some aspects resembles a DRG-system. The system will give hospitals more autonomy and make people more cost-conscious. Hospitals have already undergone change. The number of beds and the duration of admissions have both been cut drastically, while one-day admissions and outpatient treatment have increased.

8. Challenges in the use of DRGs to allocate resources to services

Well constructed DRGs can be a very effective way of ensuring the sufficient resources are transferred to mental health related services. A particular challenge for mental health is however capturing all costs, and in Norway there have been fears that widespread use of DRGs may lead to a lower share of resources being spent on mental health. Similarly when a retrospective DRG payment system was introduced in Austria in 1997, the complexity of mental health problems meant that costs were

underestimated, leading to considerable financial deficits for hospital care providers. Only after significant pressure from leading psychiatrists was the DRG system reformed to take account of the additional problems associated with psychiatry, and to allow length of stay to be adjusted to take account of needs, and to provide additional 'points' for psychiatric cases. This now means that psychiatric wards in hospitals do now at least cover their costs or even generate a surplus, helping to maintain smaller general hospitals (Zechmeister 2003).

In Spain specific DRGs have been used for mental health problems within the national health system since the royal decree of 1995, but these are largely inaccurate and outdated. In future a DRG system for allocating resources to mental health may be introduced in France given that there is an ongoing comprehensive collection of information taking place (PMSI - *Program de Médicalisation du Système d'Information*") on mental health service utilisation and psychiatric consultations in order to help define case mix and adjust funding accordingly.

9. The role of direct payments

Another way of facilitating the equitable use of funds to meet needs particularly within the community is by providing so called 'direct payments' to those with mental health problems, empowering them to purchase services best meeting their needs. This system has been introduced in some countries, e.g. UK and the Netherlands, and while not fully evaluated yet may avoid some of the problems of funding services across different sectors, as payments can be used to purchase services in any sectors.

10. The balance between health and non-health sectors

A more important immediate concern for equitable access arises where mental health services are funded and provided *outside* the health sector. Few countries provide a fully complete comprehensive range of services within the health care system. Increasingly community based services are shifted out of health and into the social care sector, potentially having significant implications both for entitlement and access to services. In contrast to universality and solidarity found in health care systems, access to services within social care systems may be restricted, subject perhaps to 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 inequities in access to or provision of services.

Access to housing and long-term care services in particular are subject to means assessment, so before an individual qualifies for assistance their ability to pay (or in some cases that of family members as well) must be first assessed, and they may be expected to contribute most of their own income, as well as run down any capital, savings and other assets before as a last resort they becoming eligible for assistance. Out of pocket payments for non-health sector services can form a very high proportion of total costs impacting on ability to access services.

10.1 Overview and implications for entitlement to non-health sector services

As with the financing of health care systems there is much variation in the range of services covered within or outside the health care sector, but in many countries key

services such as long-term residential care, supported housing, day care services, sheltered workshops and vocational rehabilitation are funded and delivered outside the health care sector. In some though they remain within health care systems.

While the coverage of these areas of support is relatively clear in countries with social insurance systems because of the publication of lists of reimbursable services, the situation in tax funded countries is more opaque. Overall though few countries provide a fully complete comprehensive range of services within the health care system, and even where they do the boundaries of responsibility and financing between the health and other sectors most notably social care may be blurred.

This shift of services out of the health care sector to other sectors can have significant implications both for entitlement to services and also affect the ability to access services. In contrast to health care systems that are universal or nearly universally available to all, access to social care systems may be more restricted, subject perhaps to means testing and/or other criteria. A focus on disability is one feature of social care provision identified by the MHEEN group that seems to influence the types of services and entitlements for people with mental health problems, gearing these towards people with more severe mental health problems rather than supporting people with common but less severe mental health problems. For instance in Germany individuals are assessed for level of disability and may be assigned one of two categories, one where disability reduces functioning by 30% and a second where disability reduces functioning by 50%. Most relevant social care services are limited to people deemed to be at least 30% disabled. Similar provision exists in Spain where a certificate of disability, determined by official assessment teams (Equipo de Valoración y Orientación- EVO) and graded according to severity is required to gain access to relevant social services.

Table 5 provides an overview of funding and entitlements to mental health related social care and housing services provided outside the health care sector. In all cases some form of taxation at either national, regional or local level is the principle method of funding services, however access to most services in nearly all countries cases is subject to some form of means testing and/or assessment of disability.

Only Sweden appears to fund all services 100% through taxation subject to assessment of need and regardless of patient income (see Box 3). In several other countries including Denmark, Finland and Norway most services with the exception of the 'hotel' costs of housing are available without charge, funded through taxation. A more recent development in some social insurance system countries has been the creation of long term care insurance packages separate to those for health care. While this arrangement has been longstanding and compulsory in the Netherlands, policies are now available in Germany and the Flanders region of Belgium.

Box 3. Non health care sector services available in Sweden

Specially adapted apartments with support facilities, such as home help services or personal assistance.

Group accommodation or an apartment in a special housing complex, for individuals who want and need to have staff available 24 hours a day.

Home help services or home-based assistance

Practical assistance or personal care

A companion to assist with recreational activities and outings, shopping or social contacts

Support/ part-time assistance in the home or in temporary accommodation, for functionally disabled individuals cared for by relatives

Occupational or other activities for individuals who are free in the daytime due to functional disability

Regardless of means testing or disability assessment, the availability of services through social care systems may be difficult to gauge as funded may be very limited, and many services may be provided solely on a discretionary basis, leading to widespread variation in access. In Spain for example less than 1% of the national budget is allocated to social services, far below the EU average.

This different development of social care services, where the principle of universal access and a basic package of entitlements may not apply, has contributed to charitable and religious groups funding and delivering services to fill in gaps in some countries. Other funding sources can include international aid and lottery funds. In Greece EU co-funding through the PsychoArgos programme has been used to extend the range of community mental health centres, day centres, services for children and workplace rehabilitation programmes, while in Iceland the Housing Fund of the National Organisation for Disabled People, partly funded by the National Lottery owns about 600 apartments which disabled people can rent at a low price covering the operating costs. About one quarter are rented by people classified as being disabled due to mental health problems.

For access to housing and long-term care services in particular the principle of subsidiarity applies in several countries including Austria, Greece, Portugal and the United Kingdom. Subsidiarity implies that before an individual qualifies for public assistance their own ability to pay is first assessed, and they may be expected to contribute most of their own income, as well as run down any capital, savings and other assets before as a last resort they become eligible for public assistance. The principle of subsidiarity can even extend beyond the individual with mental health problems, in Austria (See Box 4). In the UK there are increasingly variations in the use of the subsidiarity principle following devolution in 1999, the most striking example of which is the full funding of both nursing and personal care costs of long term care in Scotland compared with just nursing care only in England, where the subsidiarity principle applies for personal care.

Box 4. Subsidiarity in funding of social care services in Austria

Under the provincial Social Assistance Acts (*Sozialhilfegesetze*) differences between private contributions and the full costs of care may be retrospectively recovered from the private savings of close relatives. The loose interpretation of this law leads to considerable variability concerning the implications for individual patients even within one province. Flat daily rates are charged for social services, nursing home and other types of help with accommodation. Full public funding is, available for specific ambulatory and mobile psychiatric social services (Psychoszoziale Dienste). They are financed via annual budgets from tax money. There are also publicly financed services for promoting employment and labour market integration funded via a combination of annual budgets and subsidies

from the federal and provincial governments as well as the Labour Market Service (*Arbeitsmarktservice*). Overall, it is estimated that one third of the Austrian social care expenditure for social services and living arrangements is privately financed whilst public money accounts for two thirds (Statistische Nachrichten 2000). Accordingly social service provision for people with mental health problems is patchy, as this group are among those least likely to be able to contribute towards the cost of care.

10.2 Balance of provision of services between health and other sectors

On paper, the Irish and Greek systems provide a full range of services within the health care system. Continuing reforms of the mental health system in Greece since 1985 have seen the establishment of a network of community mental health services and a reduction of 60% in psychiatric inpatient beds. Different types of housing facilities are also provided, while vocational training and workshops are also funded by the health care system.

In Ireland the health boards and the Eastern Regional Health Authority[*] are responsible for funding not only medical-related care services, but also long-term care, day centres, vocational rehabilitation and other ancillary services for people with mental health problems. Other government departments, voluntary and church organisations also fund services in these areas, and the boundaries between sectors are blurred. There may be shared funding arrangements or contracting out of work by the health boards to voluntary agencies or the health boards may work in partnership with a voluntary agency (see Box 5).

The Western Health Board, for example, provided over €1m in funding to voluntary agencies in 2003 for the provision of mental health services, and has service agreements with voluntary agencies. The amount paid depends on the level of service provided and some health boards have more developed services than others. This reflects a general trend of uneven geographical distribution of health services throughout the country. This is because state provision of such services was lacking for a long time. Voluntary groups began to provide the services in response to observed need and then applied for funding which the state is now providing but in a somewhat ad-hoc rather than a comprehensive well-planned fashion. The provision of services is discretionary at present rather than a statutory obligation.

Box 5. Funding arrangements for supported housing in Ireland

In the case of housing for people who are recovering from mental illnesses and who need such forms of sheltered accommodation the Department of the Environment are responsible for funding the physical provision of housing (they provide 90% grants towards accommodation) and the Health Boards are responsible for staffing. In practice, they often contract this work out to voluntary agencies. The application for funding is made by a local group. This group may be simply a group of concerned local people who come together to form a voluntary Housing association, or it may be a local branch of a national association, for example, a branch of Mental Health Ireland.

As in Ireland, the boundaries between health and other sectors in the UK are blurred. Funding for personal social services in England, Wales and Scotland rests with local authorities who also raise additional revenue through local taxation. In Northern

[*] From January 2005 the ERHA and Health Boards will be replaced by a National Health Executive divided into four regions.

Ireland, however, health and social care services are located in the same governmental department. Local authorities are responsible for funding services such as supported housing, day care, home care, help for carers etc and may also help with employment programmes. These may be delivered by the NHS, social services or other statutory/voluntary agencies. A person with a mental health problem who is 'in the system' is assigned a care coordinator, whose role it is to help the individual access services appropriate to their need. The balance for funding services in Italy is similar, with responsibility shared between the Italian health and social care systems. However, once again, questions of access to services are important as the system has been criticised for having patchy community mental health services and support, and relying heavily on families.

There are many similarities between the UK, Irish and Greek systems and the countries of northern Europe, although a key difference is a long-standing commitment in the latter to high levels of social welfare support and community solidarity. Social care and housing services are funded mainly by county and/or municipal authorities in Denmark, Finland, Norway and Sweden. In Finland sheltered day centres (working and rehabilitation) are also run by the municipalities, and funded through the social care budget. The situation in Iceland is similar, with funding for housing services provided by the Ministry of Social Affairs, while social services may provide means-tested support for outpatient psychology services. Sheltered work schemes and vocational rehabilitation are funded in part by the health care system and partly by the social care system, while schools may cover the costs of some diagnostic services provided by psychologists.

Portugal and Spain have in recent years shifted the responsibility for mental health services to other sectors (mainly social welfare agencies). As in Italy, the approach to social support and care implicitly places great importance on the family. In Portugal community mental health services are mostly provided outside the health care system. In the case of long-term care they are delivered entirely by the private sector, the health system being responsible for medical care costs, but all other services being the responsibility of the Ministry of Labour and Social Care. Although the state is responsible for ensuring universal access to social care, the principle of subsidiary means that access firstly depends on family and user status, secondly on voluntary sector activities and resources, before the state may intervene. In Portugal no information is currently published on the levels of entitlement to social care services.

In Spain services for people with mental health problems (and also those with learning disabilities) have been transferred away from the health care sector to discretionary social services. Services transferred include non-hospital residential care, as well as occupational care and other intermediate facilities. The long-term implications for financing and access to these services have not yet been studied. The Ministry of Health and IMSERSO (an office of the Ministry of Labour) are currently trying to develop guidance on a definition and package of benefits for conditions that overlap health and social care needs (*ambito sociosanitario*) and a number of the autonomous communities have created offices of health and social care or co-ordination commissions at the regional level.

In France the health insurance system covers community care services, and is also the channel for the distribution of social security benefits which include disability,

educational and housing allowances. However, special schooling for children and sheltered workshops/vocational rehabilitation are not covered by health insurance. Similarly in the Netherlands a key sector not covered by health insurance or the AWBZ is social rehabilitation. Assistance with housing, education, leisure activities and employment are provided in an integrated fashion by local municipalities. Funding comes from several sources, predominantly central government grants. In both Germany and Luxembourg day care services, housing support, vocational rehabilitation and sheltered workshops are not covered by social health insurance. There is a separate long-term care insurance in Germany which also includes payment of an allowance to informal carers and cash for direct payment for services. Some long-term care costs are covered under social health insurance in Belgium, and in the Flanders region of Belgium a separate care insurance is also provided. This is intended largely, but not exclusively, to help with the costs of home and residential care. The insurance makes direct payments of between €75 and €125 per month for different services.

By contrast, coverage of mental health problems under the Austrian social health insurance system seems quite different to the other social health insurance countries, as access to insurance is strictly determined by necessary length of treatment. If the length of treatment exceeds a certain time period, people are excluded from the insurance system and are financed via the social care system. In this respect people with mental health problems are more likely than those with many physical health problems to be excluded from coverage under health insurance. The differing method of financing social care can lead to considerable disadvantages. (See next section). Specific psychiatric social services, such as community and ambulatory psychiatric social services (Psychosoziale Dienste) or psychiatric day care centres[3] are not covered by social health insurance. Additionally, accommodation such as nursing homes, sheltered housing or independent living arrangements and employment-related services are not covered.

11. Discussion

11.1 Methods of funding

Methods of funding public health care systems in all 17 countries are broadly progressive, relying on some combination of taxation and/or social insurance, and barring some minor variations no significant differences can be seen in the ways in which funding is raised for mental health. The reliance on social health insurance rather than private health insurance broadly has meant that mental health care is on a level playing field with other areas of health care. Some countries, most notably the Netherlands, have specific long term care insurance systems which may cover much of the costs associated with mental health problems. Private insurance currently only plays a small role in the provision of mental health services, but there is some evidence that it is growing. If this helps provide supplemental coverage for instance for workplace mental health promotion and treatment then this would help address a gap in current service provision, and it may be highly appropriate that employers and employees contribute directly to this. Most mental health problems though remain excluded from private health insurance packages or benefits are severely curtailed,

[3] These have to be distinguished from psychiatric *outpatient day clinic* which has been financed within health care since 2002.

and as experience from the United States indicates without adequate regulation, protection and use of community rather than risk rating this would be unlikely to change. This has important implications for any systems which are trying to encourage greater use of private health insurance, as for instance are a number of countries in central and eastern Europe.

Although there is near universal coverage for Europeans under public health systems, this does not mean that such systems operate equitably. Systems where there is a high reliance on out of pocket payments at the point of need are a cause of inequity in the system, and may particularly be inappropriate for targets groups such as those with mental health problems, who may already be unwilling to come into contact with services because of fears of being stigmatised and labelled by the community. Research has shown that as many as two thirds of those with mental health problems do not come into contact with services, yet primary care service providers should be a key area for the early identification of mental health problems, and allow for the subsequent prevention of more serious consequences. More work needs to be done to determine the extent to which current systems of health financing in Europe are equitable, and ideally this needs to also take into account services provided in other sectors such as social care.

11.2 Level of funding

It remains difficult to ascertain the level of health expenditure targeted to mental health across Europe, although estimates were obtained by the MHEEN group from 12 of the 17 countries. This is a reflection of the fragmentation of budgets for mental health, and in particular the provision of services across a number of sectors. One area where knowledge is extremely limited in all countries, is the area of mental health promotion. Analysis of the way in which resources are used for mental health needs to be able to distinguish between preventative, treatment and rehabilitative interventions. While this was not the specific focus of the MHEEN study it is striking that virtually no breakdown between these three areas could be provided by any country, and merits future attention.

Although we must be extremely cautious in making conclusions about the level of funding reported for mental health, given it's high contribution to overall burden of ill health in Europe, estimated to be approximately 20% of Disability Adjusted Life Years (WHO 2004), it can be argued that mental health is somewhat neglected. Only three countries have levels of mental health expenditure in excess of 10% of the health budget, despite the availability of cost effective interventions with the potential to not only improve health but also reduce the adverse external consequences of poor mental health on society, including the loss of economic productivity, increased physical morbidity, increased family strain and contact with the criminal justice system. However the differences in methodologies used to calculate mental health expenditure in countries (e.g. in some this includes social care and addiction services) implies that using mental health expenditure as a key indicator for mental health in Europe is extremely problematic and potentially highly misleading.

11.3 Fairly allocating resources

Furthermore a fair share of the health budget for mental health is not enough to ensure that resources are fairly allocated to mental health. This will depend also on the way in which pooled funds raised through social insurance or taxation are allocated directly to mental health or indirectly to those who role at a local level is to purchase health services.

Where information is available on the level of psychiatric need within countries, for instance through regular surveys of psychiatric morbidity, this can be used in allocating resources from central to the local level, as for instance is the case in England where local purchasers receive an share of the national health budget, based not only on the age and gender composition of their local populations but also using a measure of psychiatric need. The reimbursement process for service providers might also be improved by the use of tariffs that fully cover the costs of providing mental health services. With sufficient data on resource utilisation and costs in both tax and social insurance financed systems diagnosis related group (DRG) unit costs that estimate the average costs for treating a mental health problem, can be used to ensure that mental health related services provided in secondary and specialist care facilities receive a level of reimbursement fully covering the typical costs of providing services.

However DRG payments systems used in several countries such as Austria and Spain have had problems in ensuring sufficient funding is received for mental health services. This is of particular importance given moves in several other European countries including France, the UK, and the Netherlands to implement their own versions of DRG based payment mechanisms. Further exploration of incentives to encourage the efficient flow of funds for mental health is also required, for instance might performance related target payments to health and social care professionals help to promote greater investment and uptake of mental health services, as has been observed in some other areas?

Most MHEEN countries still determine budgetary allocations for health on the basis of long standing historical allocations and political pressure alone. This is likely to be both inefficient and inequitable as resources may not be targeted to the most effective interventions, nor targeted at those groups with greatest capacity to benefit. The development of sophisticated resource utilisation and epidemiological surveillance systems are a pre-requisite to the introduction of a needs adjusted formula for geographically allocating resources across a country. In systems where such data is not currently available, it may be necessary to protect mental health budgets, given the low priority otherwise received within health care systems. This would need to be regularly reviewed to ensure that such an allocation is consistent with the level of need within a country.

11.4 Entitlement and access to services outside the health sector

No analysis of funding for, and access to services to promote and maintain good mental health can be restricted to the health system alone. At the very minimum analysis must also look at the role of social care systems within countries. One striking example of this is the coverage of mental health within the social insurance system in Austria. Conditions not cured after thirty days are considered chronic and treated within and funded through local social care systems. The risk of incurring

catastrophic costs may be much higher as as much as one third of the total cost of care are met through means tested out of pocket contributions by individuals and their families.

The Austrian example highlights a key issue that is overlooked in most studies of health care financing across Europe, the balance between health, social care and other sectors. In the case of mental health this issue is absolutely critical, as many services that can be classified as being part of a health care system, can just as easily be classified as being part of a social care system, and this is no more evident than in the case of community based care and support services and long term care/housing support. The shift to community-based services has been accompanied by a shifting of responsibilities outside the health care sector, which in part may have been driven by concerns for cost containment.

While access to services within European health care systems is usually not dependent on ability to pay (although out of pocket payments we have seen in some countries can be substantial, e.g. in Portugal), the rules governing social care systems can be very different. Entitlements to services may not be universal, they may be the subject of means testing and needs assessment, while there are also fewer legal obligations to fund services. Services vary significantly across and within countries, but are likely to involve much higher degrees of user co-payments and other private payments than those observed within the health care sector in most countries. These contributions can even require an individual to dispose of their assets in order to meet costs. The most equitable access to social care systems, unsurprisingly given their historical support of social welfare systems seems to be in the Scandinavian countries, where many services are available free and are not means tested. Elsewhere however means testing and the need to provide co-payments for services are commonplace. The principle of subsidiarity may apply, whereby the state is the funder of last resort for some social care services, particularly long term care. Individuals (and in some countries their families) must exhaust income, assets and savings before the state will intervene. Some of the most vulnerable members of society, who may find it difficult to maintain or regain work, living with chronic mental health problems may therefore find themselves in a poverty trap.

Reforming social care systems to improve equity for the vulnerable is needed in many European countries so as not to increase barriers to the uptake of cost effective services among a population who can be characterised by their high level of unmet need and reluctance to come into contact with formal service providers. Of course improving the equity and efficiency of health and social care systems are of little use if mental health services are not available. Co-ordination between sectors is also of paramount importance, and ways of increasing flexibility in budgets so as not to penalise sectors which invest more in mental health promotion and services, but do not see financial and other benefits realised in their own sector. If the economy is boosted by having a workforce with better mental health, then there needs to be scope for transferring additional resources for instance from Ministries of Finance to health and social care sectors. These problems of so called ‘silo budgeting’ may be addressed through creation of joint budgets for mental health across sectors, so that resource costs and benefits are shared.

12. Limitations of analysis and ongoing work

While this synthesis and comparative analysis of information on the financing of mental health is perhaps the most comprehensive yet undertaken because of the focus on non health care as well as health care financing the reader should be aware of a number of important limitations in methods of data collection and interpretation. This analysis is based largely on analysis of secondary sources, published and grey literature and the personal expertise of MHEEN members. Comparable data collection systems providing extensive information related to mental health service availability, methods of financing and utilisation are largely non-existent across Europe. In some instances data is almost completely absent (particularly for non health care services), while in other instances e.g. in Spain different data collection methods may be used within the same country.

Moreover the analysis does not look at the ways in which mental health promotion interventions such as suicide prevention programmes are funded, although we have assumed that these will most likely be funded through public health programmes, typically funded through taxation and consumable without the need to 'purchase' a service. Although we have identified the important role that may be played by religious and voluntary organisations in financing mental health care services, no systematic attempt has been made to elicit their contribution to overall expenditure on mental health, which in some countries may be very significant.

Furthermore only very limited consideration has been paid to the notion of services financed by private enterprises rather than the individual or society. The paper notes that employers in some countries are increasingly willing to support workplace programmes to identify mental health problems such as stress and anxiety disorders and also modify the working environment to improve mental health. Future analysis needs to consider the extent to which company financed programmes are available, and whether incentives to encourage greater development of these services might be considered. (Employment related issues are discussed in more detail in the next chapter).

Finally even if financing systems are progressive and access to services is dependent on need rather than ability to pay, equity of access will depend on the availability of services within and across countries. This requires a significant degree of political will and co-ordination between agencies and development of specific mental health policies and targets. For instance in Ireland the National Health Strategy 2001 called for fairer and more equitable access to quality services; mental health was highlighted as a key priority, and it was recognised that the provision of services across regions was patchy. A new national strategy for mental health was introduced, along with a watchdog body to help monitor quality and protect human right, the Mental Health Commission. An expert group on Mental Health was also set up to help ensure a more consistent and appropriate level of mental health services, including promotion and prevention across the country. It still however remains too early to see how successful this approach has been in improving services and increasing the focus on promotion.

It is crucial therefore to map the availability of resources for mental health promotion, prevention, treatment and rehabilitation services. The challenge of this task should not

be underestimated because of difficulties not only in collecting data but also collating this information in a comparable form. Instruments such as the European Service Mapping Schedule (ESMS) (Johnson & Kuhlman, 2000) or tools used in mapping resource use in the ESEMeD (European Study of the Epidemiology of Mental Disorders) (Alonso et al 2004) need to be used to help build up a picture of resource use.

The fundamental issue is the extent to which services have been transferred out of the health care sector into the social care sector across many of these countries. This has not received sufficient attention in the health policy literature but has profound implications for equity given that unlike the health care system entitlements and access to services may be more restricted and significant co-payments required. Policy makers should consider addressing these inequities in non health sectors and develop a guaranteed set of appropriate services rather than leaving this solely to local discretion.

Table 5: Provision and financing arrangements for services used by people with mental health problems provided outside the health care sector

	Method of Public Funding	Means Testing	OOP	National/Regional/Local	Other
Austria	Taxation	Subsidiarity Principle	Yes for most services	Regional	May be retrospectively recovered from clients and close relatives. Approx one third of costs private contributions
Belgium	Taxation	Yes	For some services including long term care	National	Social care insurance available in Flanders
Denmark	Municipal/County Taxation	No	Only hotel costs of LTC	Local	Other than hotel costs 100% financed by taxation
Finland	National/Municipal Taxation	Yes/Also Flat Rate Contributions	Flat income related housing cost contribution in municipal provided accommodation; subsidy for private accommodation	Local	
France	National/Local Taxation/Donations	?	?	?	Large part of housing costs financed by social health insurance

Germany	Unemployment Funds/Taxation/Long Term Care Insurance/Donations	Access dependent on assessment of level of impairment	Yes for some services		5% quota on employers for impaired people
Greece	Taxation/Insurance/EU Support	Subsidiarity Principle	No	National	All mental health relevant services including housing funded through health care system
Iceland	Taxation/Donations/Nation al Lottery	?	?	National	Private charity subsidises costs of housing for people with mental health problems
Ireland	Taxation/Donations/	Yes	Yes for most services (exemptions for Category I people)	Regional	
Italy	Taxation	?	?	Local	Services largely provided in partnership with health care system
Luxembourg	Taxation	Housing requires referral from medical sector	?	?	Specialist housing provided through general taxation
Netherlands	National Taxation/Other Sources	?	?	Local	Long Term Care is funded through the
Norway	Taxation	?	Yes	?	
Portugal	Taxation/Donations	Subsidiarity Principle	Yes	National	Attempts to standardise payments for service providers; health related aspects of long term care

					covered by health system
Spain	Regional taxation	Certificate of disability required to access services/Discretionary provision	?	Regional	2% quota on employers not enforced Part of oil taxes
Sweden	Local Taxation/National Equalisation	No	No	Local	National system to equalise revenues received from municipalities
United Kingdom	Taxation/Donations	Subsidiarity Principle	Yes for some services	Devolved Administrations/ Local	Wide variation in access to services; personal and nursing costs of LTC free in Scotland

Table 4: Overview of user charges in MHEEN countries

	Primary Care Consultation	Specialist Inpatient Care	Specialist Outpatient Care	Community Care	Nursing Care	Rehabilitation Services	Diagnostic Interventions	Prescriptions	Special mental health therapies
Austria	Y (variable)	Y (variable)	Y €10.90 with referral; otherwise €18.17	Y/N	Y/N	Y (variable)	Y (variable)	€ 4.25	Y (Variable)
Belgium	Fixed fee	Fixed fee	Fixed fee	Fixed fee	Fixed fee	Fixed fee	Fixed fee	Y (upper ceiling)	Fixed Fee
Denmark	No	No	No	No	No	No	No	Y (upper ceiling)	No
Finland	Fixed fee or %	Fixed fee	Fixed fee or %	Fixed fee	%	No	No (in public sector)	Y (upper ceiling)	No
France	Fixed fee	Fixed fee	Fixed fee (in private sector)	Fixed fee	Fixed fee (private sector)	Fixed fee	N/A	% total cost	Fixed Fee 100% in private sector
Germany	No	€9 per day; max 14 days	No	No	No	€9 per day; max 14 days	No	Fixed fee; upper limit of 2% of gross annual income	No
Greece	No	No	Fixed fee €3	No	No	No	No	25% co-payment No ceiling	No where available
Iceland	Fixed fee (reduced for disabled)	No	Fixed fee (reduced for disabled)	Yes	No	No	Fixed fee (reduced for disabled)	Co-payment reduced for some drugs e.g. anti-depressants; neuroleptics no charge	Fixed fee (reduced for disabled)
Ireland	Variable fees for non GMS	Fixed fee for non GMS	Variable for non GMS	Yes	Yes for non GMS	No for GMS	No for GMS	Monthly ceiling for non GMS	Yes for non GMS
Italy	No	No	Yes (exemptions for mental illness)	No	No	No	Yes	Flat fees	No
Luxembourg	%	Fixed fee	Variable	Fixed fee	Fixed fee	%	Fixed Fee	%'s	Possible
Netherlands	No	No	No	No	Flat rate		No	Possible	Fixed fees
Norway	Yes	No	Yes	?	No	?		Fixed fee; upper ceiling	No
Portugal	Fixed fee	No	Fixed fee	Variable	Variable	Variable	Fixed fee	Fixed fee	Variable
Spain	No	No	No	No	No	No	No	Yes	
Sweden	Fixed fee	Fixed fee	Fixed fee	No	No	No	No	Variable fee; upper ceiling	
United Kingdom	No	No	No	Variable	No	Variable	No	Fixed fee (free in Wales)	

This report was produced by a contractor for Health & Consumer Protection Directorate General and represents the views of the contractor or author. These views have not been adopted or in any way approved by the Commission and do not necessarily represent the view of the Commission or the Directorate General for Health and Consumer Protection. The European Commission does not guarantee the accuracy of the data included in this study, nor does it accept responsibility for any use made thereof.