Review of mental health financing arrangements in EU

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Introduction
Financing of mental health care services varies between EU countries. These differences arise most often with demographic conditions, socioeconomic contexts, macroeconomic capabilities, societal attitudes, cultural and religious orientation, and the political commitment and policy priorities. The aim of this article is to review currently used methods of mental health financing in EU member countries.

Methods
Non-systematic review, WHO resources.

Results
The dominant form of mental health financing system in Europe is social health insurance, for example this form is represented in Austria, Belgium, the Czech Republic, France, Germany, the Netherlands and Romania. Although most countries finance their health care through more than one source, European countries rely principally on publicly financed systems, typically through some form of taxation or contribution to social health insurance. Voluntary health insurance (private health insurance), out-of-pocket payments and international aid play smaller role. Although mental health financing systems are diverse they have many common features.

The prevalent form of financing hospital services in mental health is the pay per day reimbursement (Finland, Switzerland, Estonia, Poland), the payment per case (Austria, England, Czech Republic,) and sometimes a combination of them with global budget. Visits to the primary care is financed based on capitation or fee-for-service whereas specialist doctors are accounted as FFS in most countries i.e. Finland, , Denmark, Belgium or Switzerland. Financing long-term care often is determined on a separate basis, which takes into account patient characteristics.

In some European countries (England, Netherlands, Germany, Denmark,) a mental health financing systems are based on grouping benefits of the psychiatric care into homogeneous clusters. In England DRG classification units patients based on their health needs rather than the cost amount carried for curing them though the preliminary assessment is pointing at the large variability of costs within individual groups. Instead Dutch DRG are based on classification system of diagnostic and therapeutic clusters. Hence the amount of the rate depends on the diagnosis, the treatment, the type of therapy and the length of stay and is determined based on information about the real workload, the material consumption and the amount of costs of capital. In Germany for clearing and grouping of patients classified on the basis of the diagnosis, clinical status, and the uniformity of treatment cost is used PEEP system. Differentiating factors in the system PEEP is the degree of severity, drug therapy, intensity of therapy in terms of used resources involved in the treatment of the case (number of physicians, psychotherapists, psychologists).

Now, in UE countries a trend of implementing the community-based mental health care is developing. The main purpose of community-based care is to enable a person with mental illness to function in the society and have the opportunity to study and work. Implementation of community model can be observed in Italy, England and Germany. It is observed that community care model is more expensive than the institutional model however is much more cost-effective. International experience shows that the incentive to implement community-based care is to finance medical services under capitation rates, thus "the money will go behind the patient" regardless of the provision place of health care services. Funding source of community care services can vary from budget of the Ministry of Health, to social care budgets and the other Labor Departments. Moreover, in Italy and in the UK personal budgets were introduced, where patients are given a pool of money which is then spent on the implementation of the necessary services in their everyday functioning.

At the end it is worth mentioning how look like the share of spending on mental health care in different countries. Percentage share of spending on psychiatric care in relation to the total budget for healthcare services in developed countries ranges from about 3-5% (Czech Republic, Finland, Greece) to about 10-
20% (England, France, Netherlands, Germany, Norway, Sweden).

Conclusions
In determining the optimal method of financing health care you can wonder what type of financing system is best placed into adaptation to changing priorities. Financing psychiatric care can be based on many factors: Mental Health Legislation and Human Rights; Mental Health Policy, Plans and Programmes; Planning and Budgeting to Deliver Services for Mental Health; and Advocacy for Mental Health. However, every planning associated with financing the psychiatric care require financial underpinning so it is important to determine exactly the resources and the appropriate allocation of resources.

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