



**Report on the Mental
Health Policy
Project : Working
Group Meeting on
Financing and Mental
Health**

Geneva

4-5 December 2000



Mental Health Policy and Service Development
Department of Mental Health and Substance
Dependence
Noncommunicable Diseases and Mental Health
World Health Organization
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This document reports on the discussions and key recommendations made at a WHO meeting on mental health financing, organized by the Mental Health Policy and Service Development Team of the Department of Mental Health and Substance Dependence.



**Mental Health Policy and Service Development
Department of Mental Health and Substance Dependence
Noncommunicable Diseases and Mental Health
World Health Organization**

An initial draft of this report was prepared by Daniel Chisholm, EQC/GPE, WHO; and Florence Baingana, Mental Health Specialist, World Bank. Comments from meeting participants were included in revisions of the draft.

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1. Introduction

1.1 Background

This meeting on mental health financing is part of a broader project dealing with the development of an evidence-based guidance package for policy makers. WHO started thinking about the project well over one year ago, in response to a number of challenges:

- Countries rarely have mental health policies and plans, and when they do, they are often poorly implemented.
- Policy makers and planners are often frustrated with a lack of information for making wise choices concerning mental health policy and service strategies. Information, when available, is often overly theoretical, or does not address the needs of countries at different levels of development.

To help address this need, a **Mental Health Policy Project** has been created by WHO's Department of Mental Health and Substance Dependence. The goal of the project is to bring together the latest information on mental health policy, planning, and service development, compile it into a global, evidence-based guidance package, distribute it to member countries, and assist with its implementation. The project is expected to help countries to create policies and then put them into practice, which will lead to improved mental health care, treatment, and promotion.

1.2 Purpose of the Meeting

The subject of this meeting, economic and financial aspects of mental health policy development, is needed due to a shortage of knowledge in this area and the need to enhance the ability to respond to countries' needs in this domain of policy and service development. Accordingly, a background report was commissioned by WHO and prepared by Professor Martin Knapp and colleagues at the Personal Social Services Research Unit at the London School of Economics.

The main objectives of the current meeting were:

1. To validate the content of the background document on financing and mental health;
2. To formulate key practical recommendations for policy makers on financing and mental health;
3. To determine the main content areas to be covered by guidance documents;
4. To begin structuring an international network for the further development of the WHO Mental Health Policy Project.

2. Meeting Discussion

2.1 Opening

This meeting occurred at the advent of a series of WHO mental health activities scheduled for 2001. This includes including World Health Day, the World Health Assembly (highlighting mental health issues), and the release of the World Health Report (also devoted to mental health). The combination of these high profile events, along with the development of the Mental Health Policy Project, provides a unique opportunity to positively influence the global mental health agenda.

Dr Benedetto Saraceno, Director, Department of Mental Health and Substance Dependence (MSD) made opening remarks. He welcomed participants and provided an overview of the context within which the meeting was to be held.

Dr Michelle Funk, Coordinator, Mental Health Policy and Service Development, then introduced the background to and rationale for the Mental Health Policy Project as well as the meeting purpose.

Professor Harvey Whiteford reported on a recently convened meeting on the economics of mental health, sponsored by the World Bank and the WHO Commission on Macroeconomics and Health.

2.2 Presentation of Background Document

Following the meeting introduction, Professor Martin Knapp, from the London School of Economics and lead author of the mental health financing background document, made a presentation on the key concepts and recommendations that emerged from the background document. He highlighted salient points concerning:

- The economic impact of mental health problems
- Equity issues in mental health financing and services
- The mixed economy (or myriad ways to organize and fund mental health services)
- Revenue collection
- Purchasing
- Choosing interventions
- Financing at national and district levels

Throughout his presentation, Professor Knapp underscored the scarcity of robust empirical evidence in mental health financing, particularly with regard to developing countries. He pointed out that while a sizable body of literature is available about a) health financing, b) mental health, and c) developing countries, there is little known about the intersection of all three areas. Thus,

many of the recommendations in the document must be considered as preliminary.

2.3 Technical Review Of Background Document

The document was reviewed chapter by chapter. Meeting participants offered a range of comments and suggestions, which are summarized in Annex 3.

2.4 Key Recommendations on Financing and Mental Health

To provide further context on the discussion of mental health financing, Dr Shekhar Saxena, Coordinator, Mental Health Determinants and Populations, provided an overview of the ongoing WHO Country Resource Questionnaire, which is a survey of mental health resources in member states of the WHO. Preliminary results, based on a partial sample and interim analysis of the data, indicated that only approximately 60% of countries have a mental health budget. Among these, approximately 50% have mental health budgets that are less than one per cent of the total health budget. Tax-based revenue collection schemes are generally regarded as the most important source of financing.

Participants were divided into four small groups to discuss in more depth a number of key issues. Summarizing across the four groups, the following key points and recommendations emerged.

Question 1: What are the advantages and disadvantages of integrating mental health financing into health financing, generally? What are the acute and chronic care implications? Given this, should mental health financing be integrated into overall health financing schemes?

Integration brings numerous advantages, but also some disadvantages that are important to consider.

One key advantage of integration is that it is administratively simpler to manage. It might also encourage multi-professional decision-making and working, because mental health specialists and other health professionals are part of the same organization. While working in the same organization is no guarantee of collaboration, integration would make it easier to create incentives for other health professionals to work jointly with mental health specialists. There might also be the opportunity for general health care providers to learn skills in the treatment of common mental health disorders.

Integration has other potential advantages. It can help to reduce the stigma of mental disorders, and the associated discrimination. Within an organization, if budgets can be used flexibly, integration can encourage innovation, such as the integrated treatment of comorbid mental and physical health problems.

On the other hand, there is a widespread lack of awareness of mental disorders and their treatment among general health decision makers. Consequently, as part of an integrated system, mental health resources and priorities may be neither prioritized nor protected. There are instances where 'mental health resources' have been diverted to other medical specialties, even in health systems where mental health is known to be grossly underfunded. There is evidence from the USA that integrated financing can lead to under-detection of mental health problems by primary health care staff.

Two competing interests may be at play: to integrate health budgets so as to avoid the inefficiencies of isolated, unrelated allocation decisions, but at the same time, to protect funds dedicated to mental health services so they cannot easily be diverted to other uses. This problem becomes particularly acute when hospitals or other providers are given more autonomy to spend public resources. They should be relatively free to redirect funds among inputs, in pursuit of efficient provision, while being held responsible for a certain composition of output, including the share of mental health services in their total provision. In contractual or managerial terms, the goal is to protect [or "ring fence"] mental health resources, especially when they are only a small part of the budget, while still allowing flexibility in response to changing needs within that category and between it and other health services. Monitoring such arrangements requires a clear definition of what providers are expected to deliver, and some agreed-upon measures of their output in relation to the specified funds.

➤ **Recommendation:** If health planners accept mental health as an important area to address, and there is clear commitment to support mental health services, then there may be some advantage to integrate mental health financing into overall health financing mechanisms. On the other hand, countries without an identified mental health budget could benefit from protected start up funding for their mental health services.

Question 2: There is quite substantial reliance in some low income countries on donor subsidies. This raises concerns of control of the health agenda, and potentially a deprioritization of mental health care in favor of other medical conditions. How can we best ensure stable financing systems for mental health care in countries that are reliant on donor funding?

In Uganda, the government identified mental health as one of its priority areas. Mental health was included in the Uganda Minimum Health Care Package (UMHCP) both within the Health Policy and the Health Sector Strategic Plan. The presence of people within the government, who were committed to a mental health agenda, was important to achieve this goal. The donor community, which had initially been resistant, was convinced and mental health remains in the UMHCP hence it will receive funding through the SWAP.

➤ **Recommendation:** governments should formulate policies that include mental health as a priority; and donors should respond to country agendas rather than their own agendas. Prior experience suggests that this strategy is feasible.

Question 3: Revenue collection schemes might be unfairly biased against mental health, in that mental health care might be excluded from mainstream packages, and/or out-of-pocket/user charges might reduce access to those who are most in need. Given these and other issues, what is best way to ensure equity and funding stability via revenue collection systems?

Different systems of revenue collection have unique disadvantages. For example, user charges can discourage individuals from seeking treatment (shown to be especially true in the case of mental health problems), and generate fundamental issues with equity. Pre-payment is widely held to be preferable to out-of-pocket payments as the main way to finance health care. For this reason, some countries use pre-payment for general health care, but out-of-pocket charges for mental health services can still create inequities. One particular form of pre-payment, voluntary enrollment of individuals into health insurance schemes, can result in “adverse selection”, which occurs when a disproportionately large number of people with a high probability of using mental health services enroll in an insurance scheme. This can jeopardize a scheme’s financial viability over time.

➤ **Recommendations:** Given the market failures inherent within health care, it is not advisable to rely exclusively on user charges or out of pocket payments. Where possible, governments should attempt to achieve mandatory coverage for mental health, either through national, tax-based or social insurance. However, in many low income countries, no insurance schemes exist. In these cases, user charges may be an option, but they can create inequities, and therefore should be carefully regulated. Community-based insurance schemes also offer an option and should be promoted, although ideally they need to be complemented by government subsidies (i.e., limiting the coverage of a community scheme to a few, simple mental health interventions, with back-up from government-subsidized services for more complex, chronic cases).

Question 4: Provider reimbursement schemes can take several forms: fee for service, salary, population-based capitation, etc. What are the advantages and disadvantages of each scheme, specific to mental health care? What sort of provider reimbursement scheme(s) would maximize equity and mental health outcomes?

There are certain disadvantages inherent to each provider reimbursement scheme. The *fee-for-service* system tends to encourage overproduction, or “supplier induced demand.” There is no financial incentive on the part of the provider to contain health care utilization or costs. In a *salary* system, the

health care provider works on a time basis, and is not paid for the quantity of services provided. In this scheme, there might be an incentive to cut back on workload, thus potentially compromising the quality of services. In *capitation* systems, a fixed fee is paid to a nominated provider who has the responsibility to provide health care for the duration of the coverage period. When capitation systems are based on a unique caseload, there is a potential for providers to practice “cream-skimming”, which is taking only the healthiest (economically advantageous) cases, who are unlikely to use a high level of services. In capitation based on global budgeting, that is, local health services that are funded from the central government for total population coverage, there is a potential for overall limitation of mental health services to occur.

➤ **Recommendations:** Accreditation systems for providers should be introduced, and provider fees should be regulated. For capitation systems, risk-adjustment should occur at the population level, so that mental health risks more closely match reimbursement (thus reducing the incentive for cream-skimming). This could be accomplished by including a psychiatric weighting (e.g. in allocation formulae) to ensure that providers are not encouraged to 'exclude' these patients from their caseloads. Non-economic provider incentives also should be introduced (e.g., advocacy, training, education)

Question 5: What are the financing issues specific to mental health in allocating resources? How can funds be allocated most fairly and efficiently from the national to the district level?

➤ **Recommendations:** First, there needs to be an identified, defined mental health budget in the first place. Too frequently, countries have no mental health budget whatsoever. Second, the relation between general health care, mental health care and social services needs to be taken into account in determining and allocating budgets. Third, allocation of the budget to district levels via a needs-related formula is preferable where possible, otherwise per capita allocation more realistic. Fourth, concerning the purchase of services, governments are justified to prioritize services for the more severe, disabling mental disorders.

Question 6: How can financing be used as a tool for changing service delivery systems? For example:

- ***Moving the bulk of mental health care from institutions to community-based, primary care settings***
- ***Integrating mental health care with other sectors (e.g., criminal justice and education sectors)***
- ***Increasing evidence-based care***

Financing must be linked to the health sector reform process. Key elements for shifting the type of mental health care that is provided include: 1) transitional funding; 2) timely resources (e.g., community care put into place

before hospital beds are closed); 3) coordination across levels of care; 4) resource flexibility. There is a need to be aware of the potential for putting an economic burden on families without providing added support/resources, especially in low-income countries where welfare and social support systems are non-existent.

➤ **Recommendations:** To promote deinstitutionalization or institutional reform, partial hospital closure is a means of releasing new resources for development of community services (e.g., in Chile, the introduction of day hospital services served as a means of reducing inpatient hospital costs). In this case, it is important to provide transitional or 'hump' funding to facilitate this movement from hospital to community based services. Even after community care has been established, a certain level of parallel funding is needed to finance acute hospital care. Finally, it is important to engage with general health sector reform designers, with particular respect to decentralization efforts.

Question 7: Traditional healers are an important aspect of the mental health delivery system in many countries. Given this, should traditional healers be integrated into mainstream health financing schemes? If so, what are the most appropriate ways for doing so?

There was a recognition that, in certain cultural contexts, people with mental health needs may be likely to prefer traditional healers over health care providers who practice Western medicine. Financing issues related to traditional healers is complicated by the fact that payments are often "in kind" rather than based on local currency.

➤ **Recommendations:** A clear recommendation did not emerge regarding whether traditional healers should be integrated into mainstream financing schemes. However, it was generally agreed that registration and regulation of traditional healers is important (although enforcement may be difficult). This could include two types of action: monitoring of traditional healers' practice patterns, to protect patients from harmful intervention; and registration of traditional healers' businesses, to prevent financial exploitation.

2.5 Key Recommendations on Policy Project Guidance

Dr JoAnne Epping-Jordan led a discussion on how should the guidance package should be structured to maximize its relevance and effectiveness.

➤ **Recommendations**

- Merge the financing information with guidance on stewardship and service delivery.

- Consider two levels of guidance: a) for mental health advisors (more detailed and process oriented), and b) for general health policy makers (less detailed)
- Equip mental health policy makers with skills for advocating the mental health agenda (i.e., imparting skills not only in the area of economics, but also in the area of policy making).
- Use “good” and “bad” country case examples across the range of regions and levels of development.

Other recommendations for specific categories of policy makers included ...

Target group / audience	Key issues
Ministry of Health General policy makers	Important to present information concerning the “cost” of not acting to reduce the mental health burden, and information concerning whether it makes any difference to invest in mental health. Explicit links to general health sector reform efforts also would be useful.
Ministry of Health Mental health policy makers	This group would be interested in receiving skills to advocate mental health agenda with general health policy makers, practical information on the organizational structure of mental health care, and technical information.
Ministry of Finance / Planning	Important to show the <i>value</i> of mental health relative to other possible investments (e.g., transportation, military, etc.)
Private insurance companies	This group is concerned with making profits, therefore need to show link between improved mental health and reduced physical comorbidity/health care utilization
Service delivery institutions	This group want to know how to calculate the costs of services

2.6 World Health Report

Dr Srinivasa Murthy, Chief Editor, presented the outline to next year’s World Health Report, which is to be focused on mental health. A brief discussion about how financial aspects of mental health care could best be incorporated into the report was held.

3. Meeting Conclusion

The meeting was concluded by Dr Michelle Funk. Dr Funk discussed the conclusions of the meeting in relation to the meeting objectives. Summaries of issues raised were provided by the rapporteurs (Mr Chisholm, Dr Baingana) and Dr Funk.

ANNEX 1

Agenda

DAY 1: 4 DECEMBER 2000 (09:00 to 17:30)

General Introduction

09:00 – 09:15 Introductory remarks (Dr B. Saraceno)

09:15 – 10:00 Introduction to Mental Health Policy Project; meeting background, purpose, and structure; nomination of chair and rapporteur (Dr M. Funk)

10:00 – 10:15 Presentation of Los Angeles World Bank meeting (Dr H. Whiteford)

10:15 – 10:30 Presentation of financing background document (Professor M. Knapp)

Coffee Break: 10:30 to 10:45

Technical review of background document

10:45 – 12:30 Plenary: technical review of background document, chapter by chapter, and overall

Lunch: 12:30 – 14:00

14:00 – 15:00 *Continued* Plenary: technical review of background document

Moving from theory to practice

15:00 – 15:15 Presentation of WHO Country Resource Questionnaire results (Dr S. Saxena)

15:15 – 15:30 Presentation of Mozambique case study on mental health financing (Professor M. Knapp)

Coffee break: 15:30 to 15:45

15:45 – 16:00 Context setting for small group discussion

16:00 – 17:30 Small group discussion: Key practical recommendations for countries, based upon content of background document

DAY 2: 5 DECEMBER (09:00 to 17:30)

09:00 – 10:30 *Continued ...* Small group discussion: Key practical recommendations for countries, based upon content of background document

Coffee Break: 10:30 to 10:45

10:45 – 12:30 Small group report to plenary

Lunch: 12:30 to 14:00

Policy Project Guidance

14:00 – 14:30 *Continued ...* Small group report to plenary

14:30 – 15:30 Plenary: discussion of how to translate background document into guidance for policy makers and planners (Dr J. Epping-Jordan)

Coffee break: 15:30 to 15:45

World Health Report

15:45 – 16:15 *Continued ...* Plenary: discussion of how to translate background document into guidance for policy makers and planners

16:15 – 16:30 Presentation on the World Health Report (Professor S. Murthy)

16:30 – 17:15 Plenary: discussion and feedback on areas of mental health financing that might be most relevant for the WHR (led by Professor S. Murthy)

17:15 – 17:30 Meeting conclusion (Dr M. Funk)

ANNEX 2

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ANNEX 3

Summary Of Technical Review Of Background Document

Guiding Questions

Chapter by chapter questions ...

- 1) Is the reviewed literature accurately represented?
- 2) Is the literature review comprehensive? Has any body of literature been overlooked?
- 3) Is there additional information concerning developing countries that could be added?

Overall questions ...

- 4) Has any content area been overlooked that is outside the existing structure and scope of the background document?
- 5) Are there any other comments or suggestions on how to improve the technical content of the document?

Participant Comments

Chapter 1: Introduction

A series of general questions relating to the overall structure and content of the background document was raised. Participants wondered about the document's specific purpose, and suggested that it covered the economics of mental health, not simply financing, as its title implies. Other comments were made concerning the document's reliance on evidence and experiences from established market economies (as opposed to the current realities of mental health care in most low-income countries). Finally, it was suggested that points about mental health financing (as opposed to health financing, generally), tend to be obscured.

It was suggested that the report could be strengthened by a) shortening the document and focusing more on issues specific to mental health, b) where advantageous to do so, placing greater emphasis on issues specific to mental health (such as stigma and externality arguments leading to under-investment), c) incorporating a description of the broad changes that have occurred over the last decade with respect to health care reform in developing countries, such as decentralization and privatization, and d) explicitly recognizing the links between mental illness, disability and poverty.

Chapter 2: The Economic Impact of Mental Health Problems

The general limitations of 'cost of illness' studies were noted, due to the heterogeneity of the methods used and, in common with DALYs, the absence of decision rules for resource allocation and priority setting. As a result of this latter limitation, it was questioned whether the conclusion that mental health care expenditures were inadequate in most countries of the world was actually supported by the data presented in this chapter. Attention was drawn to the category of indirect costs that relate to lost employment of women, who may be engaged in the agrarian economy, and to the medical poverty trap that can occur with those suffering from mental disorders. The World Mental Health Survey 2000 that is currently being undertaken in over 20 countries worldwide was referred to as a new important source of up-to-date information on both the epidemiological and economic burden of mental disorders.

Chapter 3: Equity and Mental Health

It was suggested that the concepts of horizontal and vertical equity (introduced in Chapter 5) be added to the set of definitions given at the outset of this chapter. The related concepts of ability to pay and willingness to pay (vis a vis user charges) could also be usefully introduced in this context. Reference was made to the work of Lucy Gilson and others at the London School of Hygiene and Tropical Medicine on equity issues as they relate to health care financing in developing (mainly sub-Saharan African) countries. Finally, the availability of additional data in the Latin American context was referred to (by Dr Minoletti, Chile).

Chapter 4: The mixed economy of mental health care

Whilst the mixed economy framework was widely acknowledged as a useful tool for considering or mapping the various stakeholders involved in the financing and provision of mental health care, it was also considered important to acknowledge the limited scope of services in many developing countries, hence service entities such as insurance schemes, social support and housing have limited relevance in these contexts. A wide-ranging discussion was held in relation to the potential role of the informal care sector and traditional healers in particular. Potential benefits included their accessibility, their role as case-finding and referral agents, family counseling and health promotion. The complementary role of traditional healers or the informal sector was identified as a special issue for further research. Returning to the issue of general health sector reform in developing countries, it was suggested that this chapter include an expanded discussion of the dynamic changes occurring in the health sector, such as: a) decentralization; b) growth of the private sector; c) SWAPs – sector wide approaches – by which external resources are channeled through a basket approach.

Chapter 5: Funding mental health services

A number of issues were brought up in relation to user fees, including the very limited extent to which they generate resources (2-15%), equity problems that

are raised by their use, and operational problems associated with creating user fee exemption systems for the poor. More generally, it was felt that there was a need to explicitly tackle in this chapter a) a vertical versus an integrated approach to resource allocation/financing and b) the relative merits of mandatory versus voluntary insurance systems, and in particular the issue of adverse selection as a key constraint of private insurance.

Chapter 6: Purchasing mental health care

It was acknowledged that this chapter is quite dense and could benefit from some further editing. More mental-health specific information is needed, and an increased emphasis could be placed upon the advantages and disadvantages of different methods of payment to providers. One key question to be addressed is whether supplier-induced demand in fee for service arrangements is greater in mental health services, as opposed to general health services. Other issues that could be given greater attention included the distinction between sole source versus multiple source contracting, and the trade-off between competition versus non-competitive practice. The issues of need assessment, contestability (as opposed to competition) and contracting were also raised as discussion points, which needed further consideration.

Chapter 7: Choosing interventions

In terms of the ordering of economic questions, it was argued that cost-offset should follow rather than precede cost-effectiveness. Prioritization should be made according to the availability of effective / cost-effective interventions and the presence of significant negative externalities. However, demonstration of the consequences of doing nothing was emphasized as an important corollary to studies of the relative cost-effectiveness of interventions. An important issue raised with respect to priority-setting was the level at which an intervention is considered cost-effective; this differs by country/region according to affordability (e.g. in the US the threshold level might be \$20,000 per DALY, but in low-income countries might be only \$200 per DALY). More intensive / higher cost mental health care interventions may not be viewed as a cost-effective use of resources in this competitive priority-setting context. Participants were given a brief outline of the generalized cost-effectiveness initiative that WHO is currently undertaking which holds out the prospect of a standardized methods for comparative sectoral assessment of cost-effectiveness.

Chapter 8: National and district-level resource allocation

Many of the comments for this chapter focused upon the relevance of this information to countries with limited mental health resources. In this context, the need to demonstrate the economic costs of doing nothing was emphasized, as was the need for models that could have relevance to low-income countries in determining the levels of resources required for a given size of population.