MENTAL HEALTH FINANCING IN SIX EASTERN EUROPEAN COUNTRIES

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Introduction

According to the World Health Organisation, mental illnesses affect more than 25 % of all people at some time during their lives. Mental illnesses are universal, affecting people of all countries and societies, individuals of all ages, women and men, the rich and the poor, from urban and rural environments. Mental illnesses have an economic impact on societies and on the quality of life of individuals and families. The global burden of neuropsychiatric disorders measured in disability-adjusted life years accounted for 13.1 % of the total global burden of disease in 2004. It is evident that governments have to allocate adequate financial, material and human resources to address a health problem on this scale. A well-designed system of mental health services financing is a mechanism whereby money is allocated to the right services which are subsequently provided to the right people.

Financing is a mechanism by which health policy plans are translated into action through the allocation of resources. Adequate financing is a critical factor in the creation of a viable mental health system. Financing is the mechanism by which plans and policies are translated into action through the allocation of resources. Without adequate financing, plans remain in the realm of rhetoric and good intentions. With adequate financing, a resource base can be created for the operation and delivery of services, the development and deployment of a trained workforce as well as the required infrastructure [10].

The objective of this study is to describe and compare the current status of mental health financing in six Eastern European countries: Bulgaria, the Czech Republic, the Republic of Moldova, Poland, Romania, and Slovakia. Since 1989, the Eastern European health systems have undergone many changes: health care financing out of taxation has been replaced by public health insurance, former state structures of health care delivery have been overtaken by health insurance agencies and independent public or private health care providers, many patient-oriented advocacy groups have come into being and the human rights of the mentally ill have become an important issue. In the case of mental health services, the countries share the inheritance of institutional-based mental health services, lack of community mental health services, and an underdeveloped protection of patient rights. In spite of many reforms in the past, a balance between community and hospital mental services has not yet been achieved in these countries [5], [8].

The social and cultural values are similar in some respects but in others they differ. The ultimate objectives of economic and health reforms may also differ. Nevertheless, within the transitional processes in Eastern European countries included in this study, some similar characteristics can be found.

1. Methods

A mental health care system can be defined as the structure of institutions and all activities whose primary purpose is to promote, maintain or restore mental health. This does not include institutions or resources outside the health system, although we know that care for the mentally-ill requires a comprehensive system of services and coordination of health and social services, all of which are essential for effective mental health care. In order to describe and compare mental healthcare systems, various methodologies can be applied. In particular we will draw attention to two methodologies for

which international experience is available. One successful approach for analyzing national health systems has been developed by the European Observatory on Health Systems and Policies. The European Observatory on Health Systems and Policies produces HiT health systems reviews (HiTs), which are country-based reports that provide a detailed description of a healthcare system as well as the reform and policy initiatives in progress. HiTs are prepared according to a template that is revised periodically and provides detailed guidelines, definitions, suggestion for data sources, together with examples. Although the template is rather comprehensive and detailed, it is intended to be used in a flexible way to allow the authors to adapt to their particular national context.

An example of an approach designed specifically for a mental health system has been developed by the World Health Organisation. The WHO Assessment Instrument for Mental Health Systems (WHO-AIMS) has been established as a tool for the comprehensive assessment of national mental health systems by a quite substantial set of input and process indicators. The idea behind the WHO-AIMS is that essential information for planning in order to strengthen mental health systems many countries has so far been lacking. WHO-AIMS consists of six domains of indicators: (1) policy and legislative framework, (2) mental health services, (3) mental health in primary care, (4) human resources, (5) public information and links with other sectors, and (6) monitoring and research.

In this study, we were inspired by both methodologies mentioned above. We made the decision to adhere more to the HiTs methodology for the specific reason that we are interested not only in numbers, but more importantly in the context and the story behind them. We have also found that in relation to our research objectives, the WHO-AIMS does not adequately deal with the issue of the purchase of healthcare services.

Country-specific information was obtained from a health policy questionnaire that was developed during the project Financing and Resource Allocation in Mental Health Care in Central and Eastern Europe, funded by the Czech Science Foundation. Four of the countries (Bulgaria, the Czech Republic, Romania, and Slovakia) participated in the project proposal, The Republic of Moldova and Poland joined the project later. During the course of the project, a health policy questionnaire was developed and the country-specific information was thereby obtained. The health policy questionnaire includes both qualitative and quantitative information and covers various aspects of mental health policy in five sections: (1) basic country information (demography, health, economic indicators), (2) health care financing, (3) mental health services (capacities and utilisation, ownership), (4) health service purchasing (purchasing organisations, contracting, reimbursement of services), and (5) mental health policy (policy documents, legislation, the role of civic society).

Some essential information for the realizing of the questionnaire for each selected country was gathered by experts from the individual countries in 2010 and 2011. Certain clarifications were needed in to avoid misunderstanding. In the years 2011–2012, national experts were asked for the last update of information. The data collected in the health policy questionnaires comes from the national health statistics, national health legislation, strategic policy documents and personal communications with local experts. The availability and reliability of the data on mental health services differ substantially between the countries.

2. Health Financing

Public health insurance is used in all six countries. Nevertheless there are also some important differences between the countries with respect to its implementation [2]. The main features of the country specific public health insurance models should thus be summed up as follows.

The financing of health care in Bulgaria is based on a compulsory health insurance model. The government has an important role in the financing of some strategic areas, such as emergency care, blood-transfusion, and inpatient psychiatric care among others. The state also contributes to the health insurance for some categories of citizens whose premiums are financed by the state or municipal budget. Health insurance is obligatory for all citizens. Bulgaria is confronted with the problem of the existence of a large number of non-insured persons (the self-employed, low income individuals, the Roma population) that do not

pay an insurance premium at all, or do not pay it regularly [1]. Most of these people receive services through the emergency care. For example, if a Roma person has to be hospitalized, the entire community comes up with the money to pay the insurance premiums for the previous six months in order to restore the insurance status of the person, whereupon he or she is subsequently admitted to hospital.

In the Czech Republic, public health insurance is the major source of health financing in the country. Direct health expenditures for the national and local governments are much lower. Altogether, public health financing, including health insurance and public budgets, adds up to 85 % of total health expenditures. The contribution arising from private funding, has been relatively low, but has been on the increase during the last few years. Public health insurance is administered by public health insurance funds that operate nationally and compete for members. The insurance system is dominated by the General Health Insurance Fund of the Czech Republic (Všeobecná zdravotní pojišťovna ČR). Participation in public health insurance is compulsory. Persons without incomes (children, unemployed, and pensioners) do not pay insurance, but the national government contribute a certain amount from the state budget to those health insurance funds where they are registered.

The Republic of Moldova has had to face some serious economic problems. During the period between the years 1993 and 1999, GDP fell by 60 %. Economic growth resumed only in 2000 after a decade of decline in the GDP. According to the GDP per capita, the Republic of Moldova is the poorest country in Europe. Public health insurance was introduced in 2004 to be provided by a single national health insurance fund. The other health financing sources are general tax revenues allocated to the health sector through central budgets and direct out-of-pocket payments. International donor and loan aid to the health care system has also been substantial. However, it is estimated that 20 % of the population is not covered by health insurance. The uninsured include self-employed farmers, part time employees or the unemployed. The relatively large number of people who are not covered by health insurance at all, combined with a relatively high level of informal payments and the cost of pharmaceuticals, all act as major barriers for large sections of society in accessing health services.

In Poland, a public health insurance system replaced the tax-financed system in 1997. Altogether, public financing covers approximately 72 % of total health expenditures (OECD Health Data 2011). The National Health Fund enrols the entire population. Private insurance companies compete with one another in the field of additional/optional health insurance. Participation in public health insurance is compulsory. The National Health Fund of Poland (Narodowy Fundusz Zdrowia) was established in 2003, replacing regional health insurance funds. Insurance contribution is 9 % of the gross salary. Persons without income (children, students, the unemployed, pensioners) do not pay insurance, but the government contributes to the national insurance fund. There is a yearly minimum and maximum for health insurance contribution.

Romania adopted a compulsory social health insurance system in 1998. According to the law, all Romanian citizens with Romanian permanent residence are insured, as well as foreign citizens and stateless persons who have applied for and obtained the right to temporary residence or who have their residence in Romania. Entitlement is based upon the payment of contributions. However, some population groups are automatically covered without having to pay a contribution. The National Health Insurance House is a public entity, which provides the administration for the public health insurance. The National Health Insurance House has 44 health insurance houses under its supervision. As from the first of December, 2008, the contributions have been 5.5 % for an employee, 5.2 % for an employer.

In Slovakia, a compulsory public health insurance system replaced the tax-financed system in 1994. Compulsory health insurance is administered by one public and two private health insurance companies. All of them are joint-stock companies. The health insurance system is dominated by the publicly owned General Health Insurance Company (Všeobecná zdravotná poisťovňa), which enrolled 66.5 % of the population in 2010. Persons without income do not pay insurance contributions, but the government contributes from the state

budget for each such person. Health services are generally free of charge but there are some exceptions e.g. supplementary payments for dental services, prescription drugs and emergency services. The health insurance companies collect premiums and purchase the services from the providers. The contribution rate is 14 % of the gross salary from which the employee pays 4 % and the employer 10 %. The self-employed pay 14 % of their income base with some additional specific arrangements, which in turn lower the amount paid by the self-employed significantly. Persons without income (children, students, the unemployed, pensioners) do not pay any insurance contributions.

In all of the selected countries, the tax-financed health system was transformed into a public health insurance system, though the implementation thereof differs from country to country. The Czech Republic and Slovakia established systems of competitive health insurance funds [7]. Romania introduced one national health insurance fund with regional insurance houses. Bulgaria, Moldova and Poland operate single national health insurance funds. In all countries, public health insurance is the main source of health care financing. The compulsory health insurance system ensures that the population has access to mental health services, irrespective of their ability to pay. Achieving such universal access appears to be a serious problem in Bulgaria and the Republic of Moldova. The Bulgarian health insurance system fails to generate sufficient resources to cover healthcare (including mental health) and to preserve a balance in health care delivery [1].

3. Health Services Purchasing

In Bulgaria, the financial relations between the National Health Insurance Fund and the health care providers are negotiated at two levels: (a) at the national level – by signing the National Framework Contract with the professional organisations of physicians and dentists; (b) at the individual level – by the signing of individual contracts with a given provider. If a provider of medical or dental care does not want to sign a contract with the NHIF, the services are not reimbursed. The financing of mental health services is not integrated into other health services. All the inpatient mental health services are financed by the government. The inpatient services financed by the government include psychiatric hospitals, psychiatric wards in general hospitals and inpatient units in the community-based mental health centres (dispensaries). On the other hand, the outpatient mental health services are financed by health insurance.

The Czech Republic does not have a separate budget for mental health services. Allocations are made from the overall health budget. At the national level, there is negotiation on the level of reimbursement between the providers and the insurance funds. If an agreement is reached, the Ministry of Health will issue a decree on the rules of reimbursement. In the event that providers and insurance funds cannot reach agreement, the Ministry itself will decide on the reimbursement levels, which has happened many times. When the national framework is agreed, a health insurance fund and a provider sign an individualized reimbursement contract which should be in line with the national agreement. Outpatient psychiatric services are paid by fee-for-service. General hospitals charge a combination of DRG, fee-for-service and budgetary payments. Inpatient services in psychiatric hospitals are paid by per day payment, but the total income is regulated. Dlouhý [3] estimated that the share of mental health expenditures was 4.1 % of total health expenditures in the Czech Republic in 2006 (Table 1). More than half of mental health expenditure (52.4 %) is allocated to long-term psychiatric hospitals. The financial power of mental health hospitals is surely a significant factor in resource allocation and in discussion on community mental health development in the country.

The Republic of Moldova does not have a separate budget for mental health services, which are financially integrated with other health services. Primary care is reimbursed by per capita payment. The National Health Insurance Fund agrees upon an annual contract with the hospital with pre-specified prices and a specific volume of services to be provided. Hospitals are reimbursed by a case-based rate. All patients are grouped into case-mix groups based on hospital structural departments. This is combined with a hospital-specific cap on allocations, which is fixed annually in their contracts. Outpatient and inpatient mental health services are officially free of charge and are financed from the central

Tab. 1: Mental Health Expenditures by the OECD Classification of Health Providers, Czech Republic, 2006.

Provider industry	Expenditure in %
1 Hospitals	59.4
1.1 General hospitals	6.6
1.2 Mental health and substance abuse hospitals	52.4
1.3 Speciality hospitals	0.4
2 Nursing and residential care facilities	0.0
3 Providers of ambulatory health care	12.6
4 Retail sale and other providers of medical goods	25.9
5 Public health programmes	0.0
6 General health administration and insurance	2.1
Total	100.0

Source: [3]

and local budgets, with the mental health care budget being allocated by the National Health Insurance Company. The cost of pharmaceuticals is a serious barrier for patients with mental health problems.

Poland also does not have any separate budget for mental health services. Allocations are made from the overall health budget. The National Health Fund defines rules of arrangements between the payer (the Fund) and the health providers. General practitioners are paid on a per capita payment basis in accordance with the age of the registered patients. Hospital services are reimbursed by the DRG system, which was introduced in July 2008. Highly specialized hospital services are financed by the Ministry of Health. The long-term mentally ill are cared for in regional psychiatric hospitals. The policy is that acute psychiatric care should be transferred to new psychiatric wards in general hospitals, rather than continuing the past practice of admitting patients to psychiatric hospitals, often located at some considerable distance from where they lived. The intention is also to increase the provision of community-based long-term psychiatric and social care, which remains the responsibility of the regional government [6].

In Romania, the government determines the spending level for each health care sector (primary health care, hospitals, drugs and ambulatory services). The fee-for-service system used for outpatient specialists is based on a list of services included in the framework contract, with defined reimbursement rates per service based on the number of points allocated to each service. Hospitals for the acute cases, receive prospective payments consisting of a combination of a case-based payment and a fee for service, while hospitals providing long-term care are paid for mostly through budgets. There are significant differences between acute care hospitals and institutions for chronic patients where conditions must be considered as inadequate and unacceptable. Almost all institutions are overcrowded, individual therapy and rehabilitation are absent and the staff is not sufficiently qualified.

In Slovakia, outpatient psychiatric services are paid for by means of a fee-for-service system. Inpatient services are paid for, using a case-based system. The health insurance company reimburses the hospital for an already completed period of the hospitalization of a patient and according to the specialization and type of health care facility. Prices for already completed hospitalizations are contracted on an individual basis between the health insurance companies and hospitals. In order to keep the costs under control, some health insurance companies negotiate a maximum volume of reimbursed services. The prices in chronic and psychiatric health care are determined on a one day of stay basis and are subject to negotiations between a health care provider and a health insurance company [9]. The Slovak Republic does not have any separate budget for mental health. Allocations are made from the overall

health budget and mental health care is financially integrated with other health services.

In all six countries, the purchase of mental health services is integrated with other health services. Bulgaria is an exception with inpatient services being funded by the national governments. This may be an opportunity for cost-shifting among inpatient and outpatient services, especially if both types of services are seriously underfinanced. The quality of mental health services is an important issue particularly for Romania. The availability of the data on mental health services differs substantially between the countries and we were not able to produce tables such as Table 1 for other countries in this study. National experts report insufficient cooperation between health providers serving to people with mental health problems. An intersectional cooperation is even worse because the social and health systems work without clearly defined relations. The frequent problem is a prevalence of biological model instead of social and psychological approach, although the technologies and know-how of modern mental health are known. A poor motivation among the professionals due to low salaries compared with other medical specialties also has to be taken into account.

4. Health Expenditures

According to economic performance, the economies of the Czech Republic, Poland, and Slovakia are relatively better than the economies of Bulgaria, Romania, and the Republic of Moldova. The Republic of Moldova is the country with a very low economic performance in comparison to other European countries. All six national economies perform below the EU average and from the year 2009, we can observe the impact of global economic crisis.

The national health expenditures are estimated by national statistical offices and published in health or national statistics year-books. International databases providing data on health expenditure include the WHO European Health for All Database, OECD Health Data, and Eurostat. The six Eastern European countries differ in the level of health care financing measured as a percentage of total health expenditure in the gross domestic product. According to the WHO data, Romania had the lowest relative expenditure on health (5.6 %) in comparison to the other four countries in this study in which only 6–8 % of their gross domestic product was spent on health care (Table 2). The Republic of Moldova must be categorized as an outlier in this respect, which is probably due to the extremely weak economic performance of the country in general. On average, Eastern European countries spend less from their GDP on healthcare than their Western European counterparts. There is also significant difference between the shares of public health expenditures on the total health expenditures. Public health expenditures are, at least officially, relatively high in the Czech Republic and Romania and relatively low in Bulgaria and the Republic of Moldova (Table 2).

In the European WHO region, the median value of mental health expenditure as a share of total health expenditure was estimated at around 6.3 % [4]. The estimates for six countries included in this study vary between 2.5 % for Bulgaria and 6.5 % for the Republic of Moldova. From this perspective, mental health is relatively underfinanced in comparison to physical health. Moreover, the effect is intensified by the fact that the Eastern European countries spend a lower percentage of their gross domestic product on total healthcare expenditure, whereby from this amount they spend an even lower percentage of the total healthcare expenditure on mental health services.

Although the financial resources devoted to healthcare and to mental health in Eastern Europe are lower in comparison to the levels in Western Europe, the countries of Eastern Europe finance relatively large numbers of institutional-based mental health services. For example in the Czech Republic, we have noticed a minimal change in the total number of psychiatric beds in spite of the fact that their number is one of the highest in Europe (Table 2). The numbers of other countries in the study are much lower.

Conclusions

After more than twenty years of healthcare reforms, a transition in the health system transition is still discernible. Eastern European countries are confronted with many problems in reforming their mental health services. The political, social and economic transition in the 1990s initiated the process of a new mental health policy formulation, the adoption of mental health legislation

Tab. 2: Psychiatric Hospital Beds, Total and Public Health Expenditure in Selected European Countries, 2010.

Countries	Psychiatric beds per 100 000 inhabitants	Total health expenditure as % of GDP	Public expenditure as % of total health expenditure
Bulgaria	64.88	6.88	54.50
Croatia	97.06	7.76	84.88
Cyprus	22.51	5.98	41.52
Czech Republic	101.66	7.88	83.68
Denmark	57.00	11.42	85.12
Estonia	54.47	6.04	78.68
Finland	75.06	8.96	75.06
France	91.18	11.88	77.86
Germany	49.28	11.64	77.08
Greece	...	10.26	59.40
Hungary	32.95	7.34	69.38
Iceland	...	9.40	80.70
Ireland	72.79	9.20	69.16
Italy	9.84	9.54	77.62
Kazakhstan	...	4.30	59.40
Kyrgyzstan	32.03	6.18	56.20
Latvia	119.47	6.68	61.14
Lithuania	100.49	7.04	73.50
Luxembourg	85.21	7.78	84.42
Malta	144.72	8.66	65.48
Monaco	162.86	4.30	88.06
Montenegro	50.38	9.12	67.18
Netherlands	...	11.92	79.24
Norway	82.30	9.48	83.90
Poland	63.10	7.46	72.62
Portugal	57.58	11.00	68.16
Republic of Moldova	71.87	11.68	45.80
Romania	77.14	5.58	78.10
Russian Federation	...	5.08	62.08
San Marino	...	7.14	85.36
Serbia	74.70	10.36	61.88
Slovakia	79.47	8.80	65.86
Slovenia	65.05	9.42	73.66
Spain	40.74	9.54	72.82
Sweden	47.53	9.64	81.10
Switzerland	96.55	11.52	59.02
Tajikistan	21.59	5.98	26.66
TFYR Macedonia	55.33	7.10	63.76
Turkey	6.36	6.74	75.20
Turkmenistan	58.01	2.50	59.38
Ukraine	...	7.72	56.64
United Kingdom	54.70	9.64	83.90
Uzbekistan	28.03	5.82	47.48
European Region	...	8.30	69.49

Source [11]

stressing the human rights of patients, and a call for a pragmatic balance between community and hospital services. However, not all of this has been fully and successfully realized. There is a tentative agreement among professionals about the direction of mental health policy. Professionals from psychiatric hospitals in all countries fear losing their jobs due to community-oriented reforms.

In all six Eastern European countries, the state financed and state organized health system was transformed into a public health insurance scheme, though the implementation thereof differs from country to country. The Czech Republic and Slovakia have established systems of competitive health insurance funds [7]. Romania has introduced one national health insurance fund with regional insurance houses. Bulgaria, the Republic of Moldova and Poland operate single national health insurance funds. In all countries, public health insurance is the main source of health care financing. It seems that there is a problem in achieving universal access to health services in both Bulgaria and the Republic of Moldova. In all six countries, the purchasing of mental health services is integrated with other health services. Bulgaria is an exception with inpatient services being funded by the national governments.

The countries in the study greatly differ in the numbers of psychiatric hospital beds, however the same difference in the number of beds can be found between Western European countries, so the interpretation of this fact is not clear. As national experts reported, there is an insufficient cooperation between health providers serving to people with mental health problems. The social and health systems work almost independently without clearly defined relations. The problem is a prevalence of traditional biological model, although the technologies and know-how of modern mental health are known. A poor consensus among the psychiatric profession about the direction of the mental health reforms is another obstacle for further development. A poor motivation among the professionals due to low salaries compared with other medical specialties also has to be taken into account. Bulgarian and Romanian mental health policy have substantially benefited from EU membership, because mental health has been an important issue during the accession process during which strong criticism against the poor conditions in the mental health institutions was expressed by a number of international NGOs, media and EU representatives. This has led to the improvement of human rights for the mentally impaired and the introduction of mental health care reforms with international help has taken place. In all counties, European funds have assisted the development of mental healthcare and social care by means of generating sources for the financing of NGOs.

The most significant hindrance to the general development is the fact that mental health services are underfinanced. In comparison to the Western European countries, the Eastern European countries (with specific exception of the Republic of Moldova) spend lower shares of their gross domestic product on total health expenditures, whereby from this amount an even lower share of total health expenditure is spent on mental health services. This is a long-term problem that will not be solved within a short period, because the relation between the total health expenditure and gross domestic product, i.e. an increasing share of total health expenditure on gross domestic product with growing gross domestic product, is well described in the literature. Insufficient financing of mental health services leads to absence of financial resources for mental health system development. There were poor investments in mental health services in the past, which led to the situation with a need of renovation of inpatient facilities, and need of improvement of the living conditions in the existing institutions. On the other hand, the national mental health systems need resources for strengthening weak community services. But such additional resources are not available.

It is still too early to evaluate the impact of the current economic crisis on healthcare systems. Although the present economic crisis can in no way be regarded as a positive trend, it can perhaps be regarded as a unique opportunity for the formulation and implementation of new and essential health care system reforms, including mental health care.

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Abstract

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We describe and compare the current status of mental health financing in Bulgaria, the Czech Republic, the Republic of Moldova, Poland, Romania, and Slovakia. In all six Eastern European countries, the state financed and state organized health system was transformed into a public health insurance scheme, though the implementation thereof differs from country to country. The country-specific information was obtained from a health policy questionnaire that includes both qualitative and quantitative information and covers health financing, purchasing, and provision of services. The compulsory health insurance secures that population has access to mental health services irrespective of their ability to pay. It seems that there is a problem to achieve such universal access in Bulgaria and the Republic of Moldova. The countries spend lower shares of GDP on total health expenditure and from this amount they spent lower shares of total health expenditure on mental health services than Western European countries. The political, social and economic transition in the 1990s initiated the process of mental health policy formulation, adoption of mental health legislation stressing human rights of patients, and a call for a pragmatic balance of community and hospital services. However, not all of this has been successfully realized. Mental health services are underfinanced. Insufficient financing of mental health services leads to absence of financial resources for mental health system development. There were poor investments in mental health services in the past, which led to the situation with a need of renovation of inpatient facilities, and need of improvement of the living conditions in the existing institutions. On the other hand, the national mental health systems need resources for strengthening weak community services. But such additional resources are not available.

Key Words: *Mental health financing, purchasing, Eastern Europe.*

JEL Classification: *I12, I18.*