

ECONOMIC CONSIDERATIONS FOR MENTAL HEALTH POLICY DEVELOPMENT IN LITHUANIA

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Key words: mental health, financing, costs of illness, deinstitutionalization, Lithuania

INTRODUCTION

Lithuanian mental health care system is structured to serve mental health care needs of children and adolescents, as well as of adults. The provision of mental health care is based on equity, solidarity assuring accessibility of mental health services of those in need. The structure of mental health care system is based on a primary level (family physicians, outpatient mental health centres), secondary level (outpatient specialist care, inpatient specialized care in hospitals or day care centres) and tertiary level (this is specialized mental health care, outpatient or inpatient in university clinics). Mental patients are eligible for social care under both institutional and non-institutional arrangements.

Throughout the last decade Lithuanian mental health care system has undergone changes applied to the improved accessibility of care and assurance of the quality of care in the framework of deinstitutionalization. Due to the absence of periodic assessments, a study of public funding for mental health was undertaken at the end of 2009. Data on health system financing and spending, including certain time and structure dimensions, could be considered as significant input into health policy.

The main aim of the study was to look at Lithuanian mental health sector development in the financing of mental health dimension, thus to provide evidences on implementation of the national mental health strategy. Correspondingly, two main fields of research were a) an estimation of government costs and societal economic burden related to poor mental health in Lithuania by assessing 2008 data; and b) an assessment the changes in public mental health financing in the country during 2000-2008.

MATERIAL AND METHODS

The study sources are Lithuanian Statistics Department surveys and routine statistics, the Statutory Health Insurance Fund (hereinafter SHIF) database, other secondary sources. The study employs descriptive statistics and economic simulation methods.

Financing of healthcare services rendered to the patients with mental disorders (ICD-X F00-F99 diagnosis) provided and paid under the contracts with the State Health Insurance Fund (hereinafter SHIF) was the major focus of the study. In data collection a top down approach was applied, so registered total costs on a national level were distributed to mental disorders. For 2000, 2002, 2003, 2005 and 2008 the data from the SHIF were extracted according to mental health disorders. The money spent by the SHIF on reimbursement of medicines prescribed to the patients with I00-I99 diagnosis was additionally took into account.

Both public and private expenditures were estimated for mental health care services on a primary, outpatient specialist care, hospital inpatient care levels as well as expenditures on medications. In absence of routine statistics, private costs were estimated under clear assumptions. Costs of the social services for mentally ill were extracted from administrative data sources

Besides, particular public mental health and social expenditure are analysed seeking to get evidences on the structural reforms progress in mental health field.

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RESULTS AND DISCUSSION

Direct costs of poor mental health in the country

Direct costs of the diseases through analysis of used resources present costs in the formal health care and social service sectors.

Direct costs of treatment include those of outpatient and inpatient care as well as medications.

*Primary health care (herei*nafter as PHC) covers activities of family physicians (hereinafter FP including teams of internists and paediatricians working as FP), of community-based mental health centres (hereinafter MHCs), and nursing provided both for outpatient patients (including home visits and particular procedures rendered by the nurses over those delivered by the nurses from the mental health centres) and inpatient patients (in nursing hospitals). Both FPs and MHCs are mostly paid per capita of registered local population. A share of financing for mental health care provided by FPs is estimated by using the proportion of FP visits by patients with ICD-X F00-F99 diagnosis within a total number of FP visits. Nursing services are paid either on fee-for-service basis or as a number of patient days multiple by reference prices.

O*utpatient specialist care* is covered by the SHIF as fees for consultations and particular services.

Inpatient care allocation is a total of reimbursed inpatient treatment cases.

Medical rehabilitation costs were estimated as a share of the total medical rehabilitation costs according to the latest available data of 2000-2003.

- Day and other care provided by NGOs under the programme addressed at disabled persons and supported by the state funding.

Table1. Direct costs of poor mental health in Lithuania in 2008 (Million Litas)

Health sector				Social care sector	
PHC		Public	Private	Public	Private
	FP	0.3		x	
	MHC	36.6		x	
	Nursing	1.2		x	
Outpatient specialist care		7.1	1.9	x	
Inpatient care		158.4	1.2	121.4	27.5
Medical rehabilitation		2.1	0.6	x	
Other care (programmes)		2.2		6.1	
Medications		67.6	10.5	x	
Total		**275.5**	**14.2**	**127.5**	**27.5**

Under the costs of *medications* a total amount for the medicines prescribed for outpatient treatment is presented.
Private costs of mental health services were estimated as a share of monetary out-pocket household expenditures (in ration of mental health and total health expenditure in public sector). Private costs for medicines present extra billing for prescribed medications (about 15%).
So the total direct costs for mental disorders treatment could reach 289.7 million Litas in 2008.

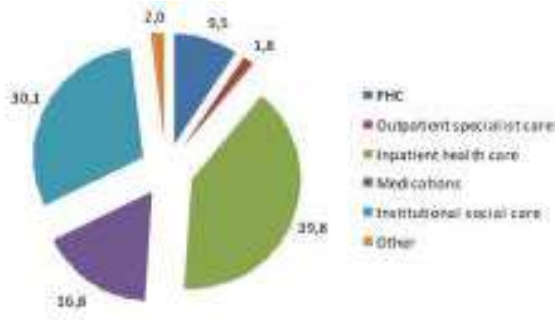

Figure 1. Structure of the public expenditure for mental health care in 2008 (in percent)

Social care costs present expenditure on:

- Institutional care – maintenance of 25 specialised settings mostly paid form the national budget, and co-financed by the patients after the assets testing.

The total direct costs in social sector were not less than 155 million Litas in 2008 (taking into account that the data on some costs like social care at home is not available).
In total in 2008 direct costs of poor mental health were about 445 million Litas.
In 2008, a minimum estimation of the share for institutional care was 70 percent of the total costs.

Changes in the public mental health care funding in 2000-2008

In 2008 276 million Litas[1] was spent on mental health care by the SHIF. It is 2 times more than in 2000 and eventually

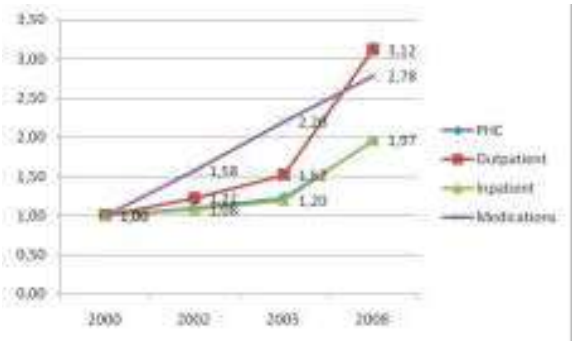

Figure 2. Changes in public mental health expenditure in 2000-2008 (expenditure in 2000 = 1)

the increase was very similar to that of the total health care expenditure.

1 Exchange rate is 3.45 Litas=1 EUR

Mental health care expenditure as a share of the total expenditure increased from 8.2 percent in 2000 to 9.0 percent in 2002, and subsequently decreased to 8.8 percent in 2005 and 8.1 percent in 2008.

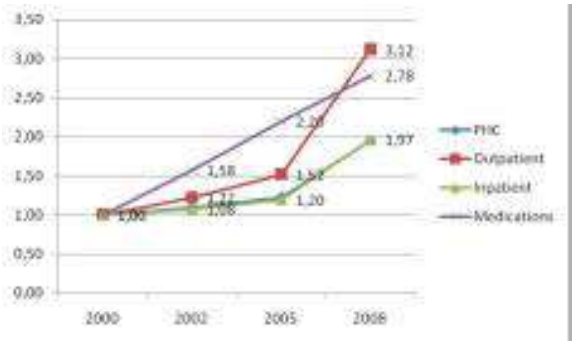

Figure 2. Changes in public mental health expenditure in 2000-2008 (expenditure in 2000 = 1)

The allocation for mental health services as a share of the total expenditure for the services, increased from 8.3 percent to 11.6 percent in 2000-2001, and in 2000-2008 decreased from 9.0 percent to 7.7 percent.

Since 2000, outrunning increase of medications costs (2.8 times) and the costs for inpatient care (1.97 times) for patients with mental disorders in comparison for those for the total medications (2.1 times) and inpatient care (1.85 times) could be observed; the total expenditure increased by 4.3 times and the reimbursement for those provided for patients with mental disorders – 3.1 times.

As a result, in 2008 the shares of specific mental health care costs within the total respective groups of expenditure were:

- One percent regarding outpatient specialist care expenditure;
- 6 percent of PHC expenditure;
- 11 percent for inpatient care and 10 percent for reimbursement of medications.

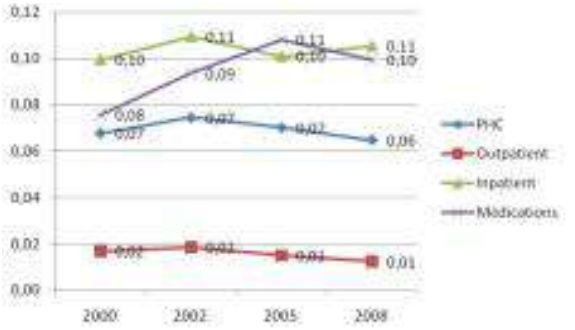

Figure 3. The main mental health care expenditure as a share of the corresponding total expenditure groups in 2000 – 2008 (in percent)

An average mental health care spending per capita increased from 34 Litas in 2000 to 52 Litas in 2005 and reached 81 Litas in 2008. Within this total average expenditure those for the services changed from 27 Litas to 36

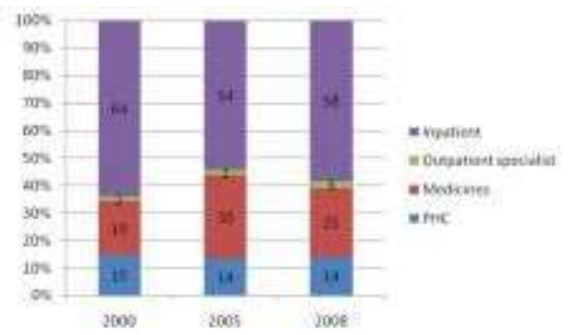

Figure 4. The SHIF expenditure for mental health care in 2000, 2005, and 2008 (in percent).

Litas and to 61 Litas accordingly, and those for reimbursement of medicines - from 7 Litas to 16 Litas and to 20 Litas, respectively.

In 2000 – 2008 all types of the SHIF allocations for mental health care increased, however, they proportions were changed (with exception of PHC).

The key aims of mental health care reforms (systematic changes) in Lithuania were targeted at *deinstitutionalization* of mental health care. Therefore considering deinstitutionalisation concept specifically, several more trends are of interest:

- The inpatient and outpatient mental health care public funding.

The allocation for outpatient care increased 2.5 times in 2000-2008. I n the meantime the allocation for inpatient health care increased twice and reached 158 million Litas. A share of outpatient care expenditure enlarged from 36 percent in 2000 to 45 percent in 2005, whereas in 2008 it was 41 percent.

- Particular inpatient mental healthcare services, like involuntary treatment, long-term inpatient treatment and admissions due to re-hospitalisation in order to observe any possible signs of re-institutionalisation.

Involuntary treatment is provided for patients referred due to decision of forensic medicine service. A number of mentally ill persons because of their criminal behaviour and in-

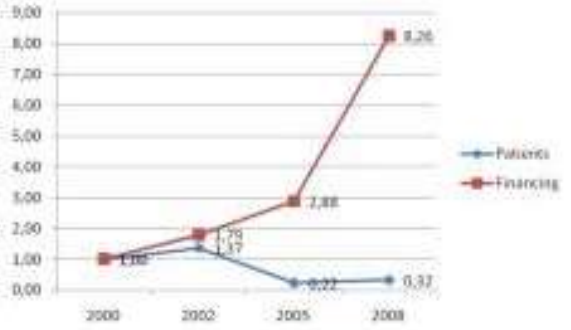

Figure 5.Changes in involuntary treatment provision and funding in 2000-2008 (2000=1).

voluntary treated in hospitals[2] considerably decreased by 68 percent in 2000-2008. Throughout the same period, the financing of such treatment increased by 8 times.

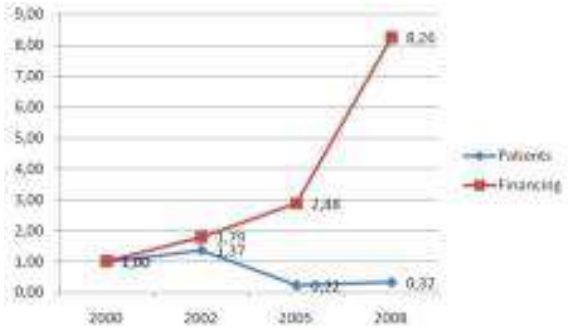

Figure 5.Changes in involuntary treatment provision and funding in 2000-2008 (2000=1).

A number of patients getting *long-term inpatient treatment* in 2000-2008 decreased almost twice.

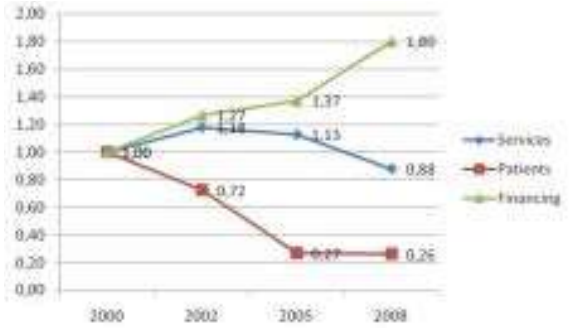

Figure 6. Changes in long-term treatment provision and funding in 2000-2008 (2000=1).

In 2005-2008, only an increase in financing could be noted.

Inpatient re-hospitalisations due to mental disorders decreased significantly regarding all three dimensions.

- Public funding of specialised long-term care institutions in the social sector

In 2000-2008 the public financing of the social care institutions for mentally ill persons increased more than by half mostly due to increase of funding for institutional long-term care for adults.

However, in 2005-2008 an increase of the public funding was the most obvious (by 1.45 times), and regarding the social care financing for children the enlargement was even bigger (by 1.51 times) than for institutions for adults (1.43 times).

DISCUSSION

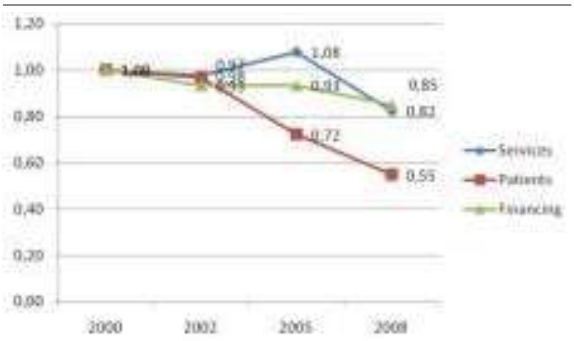

Figure 7. Changes in re-hospitalisations' provision and funding in 2000-2008 (2000=1)

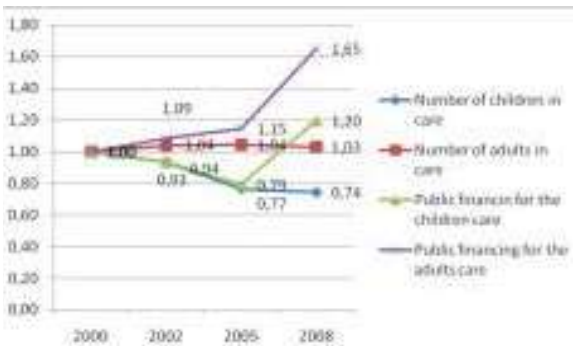

Figure 8. Changes in specialised long-term social care provision and financing in 2000-2008 (2000=1)

Information on mental health care financing might serve as one of the tools to evaluate mental health policies or practices. There is a numerous amount of national and regional policies and programmes developed in order to improve public mental health in Lithuania, yet their funding is very limited. One of the most significant documents approved in the last years is national Mental Health Strategy (2007), highlighting modern mental health care and promotion development guidelines. Provision of mental health care services is more often driven by stakeholder groups (e.g. professional societies of psychiatrists) or other factors rather than policy documents. Therefore, as mental health care financing peculiarities reflected, there is no obvious linkage between mental health policy documents and mental health care financing.

Accessibility and quality of mental health care services are mainly considered in national Mental Health Strategy (2007), Law on Mental health care (1995). Eventually mental health policy and financing of mental health care tend to "live" separate lives, therefore no obvious changes in the quality of provided care due to changes of financing

2 The practice of the involuntary treatment delivery in any specialized mental hospital has been steadily changed to provision it at a single specialized hospital in the country.

might also be observed. Reliable evidences for the changed quality and accessibility of care with regard to financing trends are still badly in need.

The outcomes of Lithuanian mental health care are also rather poor – very high suicide rate (33.1/100 000 in 2008; 38.6/100 000 in 2005). Existing morbidity statistics reflects need for treatment more than real epidemiological prevalence of mental disorders. In 2005, 20 percent of Lithuanian population identified that during the last 12 months they presumed being ill with chronic anxiety or depression, while 5 percent indicated that disorder is clinically diagnosed. In 2000-2008 a number of children recognised as disabled increased considerably from 184 to 766. A number of working-age persons recognised as disabled due to mental illnesses are more than 1700 per year.

CONCLUSIONS

The most significant Lithuanian mental health policy developments were oriented at deinstitutionalization of mental health care, quality and accessibility improvement. Poor public mental health condition is still observed in the country.

- In 2008 minimum overall direct costs of poor mental health in Lithuania were about 445 million Litas (66 percent of this sum was for health care sector and 34 percent for social care sector).
- Institutional care expenditure could be estimate as at least 70 percent of the total costs.
- Public health care expenditure for mental disorders increased twice in 2000-2008, and constituted about 8 percent of the total health care expenditure.
- In despite of the outrunning increase of the allocation for the specialist outpatient services, these costs present less than 3 percent of the total costs.
- In the context of the overall increase of all types of mental health care expenditure in 2000-2008, in the period of 2005-2008 certain signs of reverse trend could be noted, for example such as decreasing share of outpatient care expenditure from 45 to 41 percent. Moreover, if in 2000-2005 the structural changes in public funding could bring some evidences for deinstitutionalisation process; in 2005-2008 more signs of institutionalisation are coming.
- Considering few indicators, no clear evidences of re-institutionalisation were found in the country. General trend is that in inpatient sector a significant increase of public funding in parallel to declined number of patients commonly could be observed. The same could be said about social sector where financing for almost the same number of the clients getting institutional care significantly increased.