Mental health and economics in Europe: Findings from the MHEEN group

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Summary: Mental health has become an increasingly important issue both at national and European levels. Working across thirty two countries, the Mental Health Economics European Network has been undertaking comparative analysis grouped around a number of themes including organisational structures and service provision, employment and the health/social care interface. In this article we highlight some of the findings in respect of funding, look at how economic incentives can influence the balance between institutional and community based care, and consider the merits of the economic case for promoting mental health and wellbeing.

Keywords: Mental Health; Economics; Financing; Prevention; Balance of Care

Mental health and economics in Europe

Mental health has moved up the political agenda in many European countries in recent years, whether in terms of promoting the general mental well being of the population, or addressing the needs of people who have a mental illness. The European Commission has added its weight to this trend with publication of its widely discussed Green Paper in 2005, while the World Health Organization brought together all 52 of Europe’s health ministries earlier that same year to endorse an ambitious plan for the region.

Common concerns

There are many common concerns across Europe. Among the most prevalent are: human rights abuses; the continued reliance in many countries on the old and discredited asylums; the difficulties of developing good community-based care to replace them; the perennial and controversial issue of compulsory treatment; the challenge of coordinating activity across health, social care, housing, criminal justice, employment and other systems; the search for effective treatments and support services; the question of how to prevent mental health problems arising in the first place; and the huge problems of stigma and discrimination.

None of these concerns is ‘economic’, but any actions taken to address them will have economic implications. Increasingly, therefore, politicians, managers and care professionals across Europe have been seeking economic evidence and insights to inform and support their decisions.

Demands for economics

What are they looking for? What are the ‘demands’ or needs for economics in the mental health field? Some needs relate to the costs – often following recognition that many mental health problems generate substantial and wide-ranging costs that fall on many agency budgets and also hit the pockets of individuals and families. Decision makers want to know if expenditure on treatment strategies might later be compensated by reductions in the future costs of inaction. New drugs invariably look more expensive than old drugs, and delivering psychological therapy to more people requires appointment of more staff, so questions are inevitably asked about whether such expenditure is ‘worth it’. Decision makers also want to know whether spending more money in the mental health area represents a better investment in health improvement and quality of life enhancement than, say, spending the same amount on cancer services. In other words, they are interested in cost-effectiveness.

There are other demands for economic information – for example, on how best to pay for mental health services to ensure fair access, which is an especially challenging topic given that long-term mental illness can impoverish someone, leaving them unable to afford to pay for their own treatment. There is the related question of equity, and how to design resource allocation arrangements to support the most vulnerable people in society. Economic
data can help to smooth the often-difficult process of agreeing joint action between different government departments or other bodies, given that mental health problems can have such wide-ranging impacts. Nowadays, there is better awareness of the interconnections between mental health problems, employment and social exclusion, and hence growing mutual interest among government ministries responsible for employment, social security and finance. Finally, there is the question of economic incentives and whether they can influence the behaviour of key individuals and organisations so as to encourage them to pay more attention to mental health needs.

Supplying the answers
These are just some of the questions posed by decision makers that have an economic flavour, but not many answers have been forthcoming. It was against this background that the Mental Health Economics European Network (MHEEN), established in 2002 with the support of the European Commission, has been collating information, initially across seventeen, but now thirty-two European countries. Jointly coordinated by the Personal Social Services Research Unit (www.pssru.ac.uk) at the London School of Economics and the Brussels-based non-governmental organisation, Mental Health Europe, the aim has been to develop a network of representatives, at least one from each country, with expertise and/or experience of health economics and with personal work or commitment to the economics of mental health (see www.mheen.org for MHEEN partners).

Activities in the first phase of work were grouped around a number of themes: financing; expenditure and costs; provision, services and workforce; employment; and the capacity for economic evaluation. In the second phase (2005–2007), and following expansion to a larger group of countries, the overarching aim remained the same, but the specific topics changed slightly (See Box 1). In this article we highlight some of the findings in respect of funding for mental health, look at how economic incentives can influence the balance between institutional and community based care and consider the merits of the economic case for promoting mental health and wellbeing (A series of policy briefs prepared by MHEEN dealing with these and other aspects of MHEEN work are available at www.mheen.org).

I. What public expenditure commitment is made to mental health?
Do services and initiatives that aim to meet mental health needs get their fair share of available health system funding? When we look across the countries of the Network, mental health care generally looks to be considerably under-funded. Despite the high prevalence, substantial contribution to the global burden of disability, strong association between deprivation and mental illness, and the growing body of cost-effectiveness evidence, the proportion of total public expenditure allocated to

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Box 1: Questions addressed in MHEEN Phase II

How are mental health systems financed, and how much public expenditure is committed to the area?

What are the barriers and incentives to improve mental health care, with particular focus on the balance of care (and especially the reliance on institutional models of care) and employment?

What mechanisms and strategies are in place for mental health promotion and to prevent the onset of mental health-related problems, and particularly what is known about the cost-effectiveness of such strategies?

Can the European Service Mapping Schedule be refined so as to assess mental health service utilisation and costs within small catchment areas?

Finally, is there a commitment to build capacity across Europe in mental health economics?

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Figure 1: Mental health expenditure as a percentage of GDP (latest available year)
mental health care is often modest. Only four countries have committed as much as 0.75 of 1% of Gross Domestic Product (See Figure 1), yet poor mental health may cost national economies four times this amount. We do, however, need to be a little cautious about these figures because it is difficult to make robust comparisons between countries when accounting procedures differ, and particularly when the boundaries around what is a ‘health service’ can be drawn in different ways.

This last point has added significance because it has been quite common across Europe for the boundaries between health, social care and other service systems to be fluid.3 This has been partly a response to the shifting balance of care away from institutions and towards systems that are more community-focused. Moving the locus of care to the community creates many new and welcome opportunities, but also raises challenges, including the difficulties of coordinating services across organisational and budgetary boundaries, and different eligibility criteria for support and for exemptions from payment.

How are mental health services funded?

The routes for funding mental health care, at first glance, do not appear to differ very much between countries. Funding relies largely on taxation or social insurance, respecting long-held principles of solidarity and universality. But this does not necessarily mean that such systems operate equitably. Systems where there is high reliance on out-of-pocket payments at the point of need (such as in Portugal) are likely to be inequitable. Out-of-pocket payments may be particularly inappropriate for people with mental health problems, who may already be unwilling to come into contact with services because of fears of being stigmatised, and who are already disadvantaged economically by the consequences of chronic illness.

Supplemental voluntary insurance (often called private insurance) continues to play a minimal role in providing coverage for mental health services in most western European countries, but its role is more significant in eastern Europe. Evidence from the US, where the private health insurance market is most well developed, illustrates the difficulty that mental health can have in achieving parity with physical health, leading to unequal access to insurance coverage for mental health treatment. Of course, as responsibilities shift out of the health system and into the social care system, for example, financing difficulties might arise because there might not be the same commitment to the principles of universality and solidarity; means testing is more common, for instance.

Resource allocation

With few exceptions, across MHEEN countries that employ tax-based financing systems annual budgets tend to be determined through some combination of historical precedent and political preference. Few report having an allocation mechanism objectively based on measures of population health need. One consequence is that resources are unlikely to be well targeted to areas where they have the greatest chance of being effective or where they can tackle inequities. Even when budgets are supposedly earmarked for mental health services, there are few safeguards in some countries to ensure that resources are not actually spent on non-mental health services.

One possible way to improve the allocation of resources is through the use of tariffs linked to specific procedures or needs, such as diagnosis-related groups (DRGs). These tariffs reimburse providers of mental health services — in both social insurance and tax-dominated countries — on the basis of some pre-set amount. But using DRGs has generated some difficulties: DRG tariffs have not always taken full account of the costs associated with chronic mental health problems and their use remains limited.

II. Shifting the balance of care from hospitals to the community

One of the greatest barriers to achieving social inclusion of people with mental health problems and improving the quality of care in a number of countries is the continued use of institutional care as exemplified by the old psychiatric asylums, dispensaries and ‘social care homes’ of many countries in central and Eastern Europe.

It is important to distinguish between the long, large, state social care homes in some of these countries, where provision is of a low standard, and human rights are often overlooked, and the social care facilities that accommodate many thousands of people in countries such as the UK, where standards are much higher. There are well-documented accounts of individuals admitted to institutions being kept in ‘caged beds’ or solitary confinement, experiencing physical or sexual abuse, or electro-convulsive therapy without anaesthesia or muscle relaxants. While these are undoubtedly exceptions, such practices are common enough to warrant urgent action.

Charting the exact balance of mental health care across thirty-two countries was obviously beyond the resources of MHEEN, but we were able to look at a number of important features. First, we asked Network partners to describe the general direction of movement, if indeed there had been any, in the provision of institution-based services. For example, we asked about increases in provision or admission rates. Second, we were interested in the economic barriers to changes in the balance of care, and in the economic incentives that had been found to support movement away from reliance on institutional services.

What is clear are that shifts in the balance of care away from institutions towards community-based support (where appropriate), vary markedly across Europe according to resources, financial incentives and national traditions. In western Europe, over a thirty-five year period, bed numbers have fallen sharply (Figure 2). Individuals have been transferred to other settings such as general hospitals or various forms of community-based supported living establishment. In central and eastern Europe the picture is more opaque — there appears to be significant progress in the Baltic States in particular; but little change in countries such as Romania, Slovakia and Slovenia (see Figure 3). These data may present a better picture than the situation merits as they do not take into account the number of people transferred to the large, isolated and poor quality social care homes operated outside the health system.

The MHEEN group identified a number of barriers to change. Funding may be locked in long stay institutions, so service providers may actually have incentives to maintain a high rate of occupancy in order to ensure that their budgets are not ratcheted down. Moreover, isolated large institutions may often be a major source of jobs in a locality, meaning that resistance to any reform may be substantial. The legal guardians of people with mental health problems may also have perverse incentives to place their relatives in long stay institutions, as they may be able to retain the disability pensions of these individuals.

There also remains a shortfall in the provision of community services in many countries, particularly in southern Europe.
(where family support is significant), central and eastern Europe. As countries continue to rebalance care they must be aware of the risks of closing beds before adequate community care is developed and funded. For a period of time there needs to be parallel funding of community and institution based services; in situations where resources are scarce this additional investment may be difficult to make. Thus there is a constant concern that bed reductions always precede the development of comprehensive and well-developed community-based services, leaving both hospitals and community services under-resourced. This can reduce public confidence in the appropriateness of community based care.

Flexible funding arrangements are one way of overcoming some of these barriers. For instance, joint budgeting arrangements, for example, between health, social care and employment departments in Sweden have been used to tackle the problem of fragmented funding, while in Flanders money notionally intended for the provision of beds can actually be used to foster independent living. Mergers between institutions and ambulatory services in the Netherlands were an important first step in rebalancing care. Effective planning for the alternative use of buildings, as well as retraining and economic regeneration of local communities dependent on institutions for jobs, can also help promote change. Another important development historically was increased access to social welfare benefits, giving individuals a safety net for supporting themselves in the community. More recently a growing number of countries in western Europe have begun introducing individual budgets, whereby people with mental health problems receive a budget which they can freely spend on services that best meet their needs.

III. The economic case for promotion and prevention
MHEEN has not just focused on those with mental health problems, but has examined many issues from a public health perspective. There are many reasons for promoting positive mental health and for seeking to prevent the emergence of problems in the first place. At the core of all of this is a desire to improve the quality of life of a population. But decision makers are also very aware of the costs of not acting appropriately or early enough.

For example, the total cost of depression
in Sweden in 2005 was estimated at €3.5 billion while the cost of schizophrenia in England in the same year was estimated at €10.4 billion. These cost estimates are indicative of a familiar pattern across Europe: the contribution of many different budgets. For instance, the total economic impact of depression in Sweden is absolutely dwarfed by the cost of lost productivity because so many people with depression experience absences from work or long-term unemployment. Similarly, the costs of schizophrenia in England fall to a host of budgets, and not just to the health care system. There have also been studies which have pointed to the average cost of a completed suicide: €2.04 million in Ireland and €1.88 million in Scotland. Each of these, and many other examples could be given, is a substantial amount. Again the costs of a completed suicide are not just for health or police or other agencies, but include lost productivity and the various intangible costs, including the pain and grief experienced by relatives and the lost opportunity for individuals who complete suicide to have future opportunities for life experiences.

While even the most optimistic of advocates would never imagine that all instances of depression could be prevented, or all psychoses avoided, or all suicides averted, it is surely possible for European societies to prevent some of these distressing and often devastating events occurring? Potentially this might be a highly cost effective use of resources. MHEEN partners have thus been trawling through electronic databases and the ‘grey’ literature of policy and advocacy bodies, as well as corporate documents, to find out just what is known about the cost-effectiveness of such initiatives. This has complemented a systematic literature review undertaken by MHEEN ranging over many areas, including schools, workplaces, primary health care settings and the community.

What do we know?

It remains the case that economic analysis is rare, but its use is increasing and some examples are given here. Perhaps most strikingly, most of this evidence focuses on preventive actions rather than on measures to improve mental well-being. This reflects current challenges being grappled with in Europe on how to accurately measure well-being.

The area where most work is available relates to children. This builds on the accumulation of evidence that behavioural and emotional problems in childhood, if not adequately addressed by mental health, education and social work services, can have enormous adverse consequences in adulthood. For instance, analyses of group based parenting interventions suggest that, even if only very modest quality of life benefits can be gained, these interventions have the potential to be highly cost effective. The majority of this work is though from the US, where a range of very long-term economic benefits from a variety of intervention programmes for children and young people have been identified. The extent to which these interventions can be adapted to differing contexts in Europe still needs careful consideration.

“suicide prevention strategies potentially are highly cost effective”

Remarkably, despite considerable attention given to suicide in policy discussions across Europe, evidence on the cost effectiveness of suicide prevention strategies is sparse. Yet potentially this may be highly cost effective: work in Scotland suggests that if just 1% of suicides could be avoided then the national programme would actually be cost saving. Looking at training interventions, economic analysis of STORM (Skills-based Training on Risk Management) in England indicated that a 2.5% decrease in the suicide rate would generate a cost per life year saved of just €5,500, a value considered to be highly cost effective. The use of taxation instruments to influence behaviours, for example, to reduce the over-consumption of alcohol, and subsequent alcohol related addictive behaviours, can also be much more cost effective than other alcohol control policies.

IV. Employment

Employment is a fundamental component of, or contributor to quality of life, the main source of income for most people, commonly a major influence on someone’s social network, and also a defining feature of social status. The interconnections between mental health problems and employment are many and various. As well as the link with individual well-being, employment is a major contributor to national and European productivity and competitiveness, and obviously also has implications for the sustainability of social welfare systems. Total disability benefit payments in England, Scotland and Wales alone in 2007 amounted to €3.9 billion, with the largest contribution (40%) attributed to ‘mental and behavioural disorders’.

Many national governments have now turned their attention to the employment difficulties experienced by people with common mental health problems, including stress and depression, and also encouraging greater awareness among employers as to their workplace responsibilities for promoting better mental well-being and reducing worker stress. Evidence on the effectiveness of various workplace based programmes, mental health problems is growing. There may well be substantial scope for economic benefits, such as increased productivity and a reduced need to pay disability benefits, through investment in the workplace. But there are major caveats on what we know: most evidence again comes from the US and is often generated by companies, and not subject to rigorous peer-review. Nevertheless, there are some tantalisingly interesting insights.

For example, evaluation of London Underground’s stress reduction programme suggests that in its first two years there was a reduction in absenteeism costs of €705,000. This is eight times greater than the cost of the scheme. In addition, improved productivity and some positive healthy lifestyle changes were observed.

One stress management programme in a Belgian pharmaceutical company achieved a reduction in absenteeism of just 1%, but still avoided costs of €600,000 because the economic impact of stress-related absenteeism was so substantial.

Mental health promoting interventions can also be cost effective in helping those who are out of work and thus at greater risk of developing mental health problems. One US programme, designed to help individuals take more control when seeking employment and cope with difficulties and disappointments, both increased re-employment and generated a positive return on investment. It has subsequently been implemented, with some success, elsewhere including Finland, the Netherlands and Ireland.

While the economic case is encouraging, there are a number of key challenges to
meet in strengthening the evidence base on workplace health promotion. Evaluation in the workplace is clearly a sensitive issue; both employers and employees may be reluctant to participate. Caution must also be exercised over the results of evaluations: interventions reported to have significant net benefits may be produced by organisations that stand to gain commercially from their use.

“The highest levels of workplace stress may well appear in public sector organisations”

Recognition of the economic impact of poor workplace mental health at national and EU levels does however provide an opportunity for action. Policy makers may wish to carefully consider providing financial support for the evaluation of workplace based mental health interventions. Already there are some positive signs: a number of ongoing and planned economic evaluations have already been identified by MHEEN. One pragmatic approach may be to retrospectively add an economic dimension to existing studies of the effectiveness of interventions. More partnership work between employers in the private and public sectors is also well merited; indeed the highest levels of workplace stress may well appear in public sector organisations.

Much of the work to date in this area has focused on large, often multi-national corporations. Demonstrating the economic case may also help persuade policy makers of the case for providing financial incentives to encourage small and medium sized enterprises, which otherwise might not have the resource, to invest in effective workplace mental health promoting interventions.

MHEEN: the way ahead

The personal, social and economic consequences of poor mental health can be profound: examples of the fundamental abuse of human rights in poor quality long stay institutions with EU Member States can still be found with regularity. All Member States of the WHO European Region, as well as the European Commission, in 2005 endorsed an action plan setting out a number of steps to be taken to meet these challenges. Transforming good intentions into actions on the ground is far from easy; activities like those undertaken by MHEEN can help strengthen the economic case for action and identify economic levers and incentives to promote change.

MHEEN members have also been active in raising awareness of the relevance of economics within mental health discourse in national, international and supranational contexts and have helped to develop local capacity and interest in economics and mental health. Because mental health has impacts on many different non-health sectors, a continuing challenge for MHEEN and others will be to engage with these sectors and provide economic evidence that encompasses both inputs from and impacts on the social care, housing, education employment and criminal justice systems.

In particular, a major gap in knowledge that MHEEN has addressed is the economic case for investment in promotion and prevention activities; this is vital to the better incorporation of mental health within public health policy. While the work of MHEEN indicates that this evidence is still modest, where evaluations have taken place the economic case often is very strong. To increase this knowledge one priority should be to incorporate economics into more prospective evaluations, but another complementary approach, which MHEEN members are taking forward, will be to retrospectively look at the economic implications of interventions already demonstrated to be effective.

REFERENCES