

New and old challenges in the reform of mental health systems in Spain

Joan Costa-Font, Juan Cabases Hita, Jordi Alonso,
Luis Salvador-Carulla and David McDaid

Summary: This article provides an overview of the state of mental health reform in Spain. It describes the motivation and the process of different reforms, briefly brings to the fore the most relevant evidence on their consequences, and ends by identifying key areas of policy reform.

Keywords: Mental Health, Reform, Spain

While mental health seldom occupies a significant space within political debates, increasingly it has featured high on health policy priorities across Europe.¹ However, mental health systems are very much country-specific and influenced heavily by prevailing societal attitudes towards poor mental health. Rapid economic, political and social changes in Spain have meant a move away from the conservative society that existed in 1979 to a liberal democracy over the course of three decades. As a result, the principles underpinning the organisation of mental health systems have shifted away from a reliance on long stay institutional care in asylums, where the overarching concern had been to protect society from potential ‘harm’, to a system where the bulk of care is being provided through the development of a network of community based centres to help support people with mental health problems.

One continuing challenge in looking at mental health reform is obtaining data on the structure of mental health systems. Such data is of highly variable quality

across Europe, making cross-country comparisons difficult. One comparative study (the ESEMED study) looked at services in six European countries – Spain, Italy, Belgium, Germany, France and the Netherlands. This study indicated that the provision of services for people with mental health needs was low in Spain (as well as in Belgium and Italy).² Expenditure on public mental health services in Spain remains modest at around 5% of total health care expenditure,³ although there is some significant variation between the seventeen Autonomous Communities (ACs); expenditure in Catalonia, for instance, has recently been estimated to be closer to 9%.⁴ No wonder mental health care is regarded as the Cinderella of the Spanish health system, namely a second order priority and generally among the last to be reformed.

This article provides an overview of the state of mental health reform in Spain. It describes the motivation and the process of different reforms, briefly brings to the fore the most relevant evidence on their conse-

quences, and ends by identifying key areas of policy reform.

A chronology of mental health reform

The 1986 General Health Care Act, charged the National Health System with working towards both the promotion of good health and the prevention of disease. The aim was to achieve equity of access and help overcome social and geographical differences across the country. Access to health care became free at the point of use to all residents of the country (including undocumented immigrants) and user co-payments were restricted to pharmaceuticals. Benefits remain comprehensive, although coverage for some services such as long-term care and dental services is limited and varies according to region-specific demands.

Today, mental health services, like the rest of the health care system, are the responsibility of the seventeen ACs. There are therefore at least seventeen different mental health plans, each one tackling AC specific problems, with cross-regional learning taking place. However historically mental health had been somewhat neglected; the system relied on the willingness of the non-governmental sector, typically religious organisations, to fill the gaps left by the limited, fragmented and poorly coordinated public services managed by different administrative bodies.⁵

*Joan Costa-Font is Senior Research Fellow and Lecturer, LSE, UK. Juan Cabases Hita is Professor of Applied Economics, Universidad Pública de Navarra, Spain. Jordi Alonso is based at the Health Services Research Unit, Institut Municipal d'Investigació Mèdica (IMIM-Hospital del Mar), Barcelona, Spain. Luis Salvador-Carulla is Professor in the Department of Psychiatry, University of Cadiz, Spain. David McDaid is Senior Research Fellow, LSE Health and Social Care and European Observatory on Health Systems and Policies, London School of Economics and Political Science, UK.
Email: J.Costa-Font@lse.ac.uk*

A 1983 Ministerial Commission on Psychiatric Reform, followed by the Psychiatric Reform Act of 1985, gave rise to what can be regarded as a modern model of mental health care. The Act aimed to guarantee access for people with mental health problems to services within the general network of health care, and specifically within primary care. It also redefined the therapeutic meaning of psychiatric hospitalisation, which lost its central role in psychiatric care. This was coupled with the objective of providing adequate community services and social supports for the rehabilitation and reintegration of people with mental health problems into the community. Actions were also envisaged in the community to tackle discrimination and protect human and civil rights. The reforms however only focused on people with psychoses who had been living in institutions; in fact they only make up a fraction of the total population of people with mental health problems at risk of being social excluded.⁶

Meantime, broad health system reforms introduced under the General Health Act of 1986 integrated mental health care into the mainstream health network. Mental health services, with the exceptions of hypnosis and psychoanalysis, were included within the package of general health services. Moreover a set of specific Diagnostic Related Groups (DRG) were defined so as to measure activity alongside other information system improvements.

The reforms helped in the completion of the de-institutionalisation process initiated in the late 1970s, which implied a shift away from a system based on old asylums to one centred on community care, as in some other western countries. Figure 1 illustrates the decline in the number of beds in psychiatric hospitals over the last quarter century, being just 39.6 beds per 100,000 population by 2006.⁷

This decline in beds implied the integration of the mental health system to follow a similar structure as the rest of the health system, namely an organisation that would rely on outpatient, inpatient and residential facilities, as well as multidisciplinary teams of health and social care resources. Workforce regulation and accreditation criteria were completely reformed to include doctors, as well as a new cadre of new mental health professionals, such as social workers and other health professionals, that only recently have been considered of equal value to other professionals within the health

system. Indeed these reforms led to the creation of a national training programme for psychiatrists, a network of mental health units to assist outpatient provision following GP referral, and the addition of psychiatric beds to several general hospitals. Psychiatrist activity rates expanded from 3.9 per 100,000 population in 1982 to 5.12 in 1994. There have been other newly emerging mental health care professionals in the last decade. As of 2005 these included: psychiatric nurses (4.2 per 100,000 population), neurologists (2.5 per 100,000 population) and psychologists (1.9 per 100,000 population).

A network of mental health centres each covering population catchments of between 200,000 and 250,000 people developed rapidly. By 1994 there were 550 such centres; however, given the devolved nature of the Spanish health care system, the implementation of the reform has been geographically uneven and there appear to be marked differences between the different ACs in the availability of services due to differences in regional priorities.

In 1994, a national essential drug therapy catalogue, including treatments for mental health problems was established. A further reform under Royal Decree 63/1995 defined mental health as a type of 'specialised care' made of diagnosis and follow up, drug treatment and individual (group or family) psychotherapy, and possibly hospitalisation.

Unlike other areas of health care policy, the voluntary sector plays a crucial role in the provision of community care, to say nothing of the informal contribution of family carers. When the mental health

service package was updated in 2006 (Royal Decree 1030/2006) it made particular reference to the role of primary care in identifying mental health problems, thus further emphasising the community care-led model. One of the key challenges that Spain faces, common to the situation in many other countries, is the lack of coordination between different levels of primary, secondary and specialist care, as well as between health and other sectors including social care, in assessing and meeting the needs of people with mental health problems.

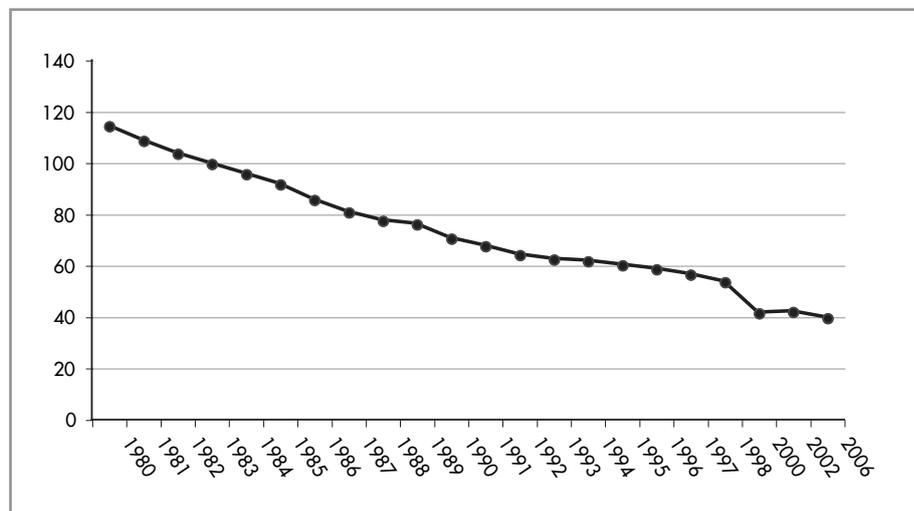
However, it was not until 2007 that the Ministry of Health put forward a working document, the so called 'Strategy to Tackle Mental Health' which contained new clinical guidelines for general practitioners and specialists on the identification and prevention of mental health problems. Similar strategic actions had long been set up for related problems such as the prevention of substance abuse.

The utilisation of services within primary care remains low in comparison, at approximately 17% of all those with mental health problems compared with 40-50% in most European countries.⁸ This does not simply reflect a lack of demand for such services, but also is a consequence of the restrictions in their availability.

Financing and coordination

Mental health is financed in the same way as other health care services in Spain, through taxation supplemented by out-of-pocket expenditure by service users and their families. Private insurance does not play a prominent role. We have noted that expenditure on public mental health

Figure 1: Psychiatric beds per 100,000 population, Spain



Source: Spanish Ministry of Health and Consumer Affairs, 2006

services in Spain remains modest at around 5% of total health care expenditure³ but that there can be significant variation in expenditure rates between the ACs, reflecting the differing levels of priority given to mental health.

Indeed, Salvador-Carulla et al,⁵ report higher mental health expenditure relative to total expenditure in Catalonia and a higher absolute expenditure in Navarra compared to Andalucía.

In terms of service mix, as we have already noted, community care services are still developing, which may explain the greater reliance on pharmacotherapy relative to other high income countries. While there has been a significant volume growth in the use of antidepressants in seven European Union countries, growth in Spain is almost three times that of France.⁹ Moreover some non-pharmacological services are not well covered within the public system, the most notable being psychotherapy which, unlike the situation in Germany and the Netherlands, may only be covered for very short periods of time.

We have noted challenges in administrative co-ordination. Across Spain arrangements for managing mental health services can vary considerably, with different degrees of responsibility resting with the AC governments, provincial governments and municipal authorities. Coordination within and across the health service is thus complex and rarely takes place.

Services provided within the health care system are also often not well coordinated with social care and other relevant sectors in social policy. The transfer of social services to the ACs was completed in 1997 but it was only with the completion of the health care decentralisation process in 2002 that the need for functional coordination came to the fore. The shift away from institutional to community based care has been markedly uncoordinated with asylum closures before community services have been fully developed.⁶ Although roughly half of the ACs have set up some mechanism for coordination, the absence of well run coordination between social and primary care remains the norm rather than the exception.

Empirical Evidence

Need for mental health services

Between 5–10% of Spaniards will experience an episode of depression at some point during their lifetimes.¹⁰ Rates are

much higher in women than in men, with urban residence not seen as a significant risk factor.¹¹ Rates are lower for people aged between thirty and forty-four. Other protective factors include being single, employment and a good level of educational attainment.¹² Similarly, the results of the ESEMED project³ indicate that 19.5% of Spaniards (23% of women and 16% of men) experience some mental health problem during their lifetimes, with 8.5% experiencing such an event in any one year (11.4% women and 5.3% of men).

Utilisation of services

Spain lags behind Italy, France, Germany, Belgium and the Netherlands in psychiatrists per 100,000 population (only one-third that of Italy and 15% of that France). It has around 50% of the psychiatric beds per capita available in France.¹³ About 6.4% of adults make use of the health care system because of a mental health disorder, of which 21.2% do not receive any specific treatment.² Alonso and Haro³ reveal that roughly one-third of the population have contacted a mental health professional; the lifetime rate of consultation is about 15% higher than Italy, and similar to that seen in the Netherlands (30%) and France (28%).¹³ Estimates of service utilisation were relatively high among those with mental health problems resulting from alcohol disorders.

Data from a 2006 Eurobarometer survey allow the comparison of mental health service utilisation in Spain with that of the EU average.¹⁴ Table 1 reveals that Spaniards have lower contact rates with their general practitioners to discuss mental health problems. However, if comparing just those who have diagnosed mental health problems, then rates are comparable to the EU average. Whilst they are on average less likely to use a pharmacist's advice, they appear to be more likely to visit a psychiatrist, especially when experiencing a mental health problem. Rates of therapist and psychoanalyst utilisation are similar to those in the EU as a whole, psychotherapy rates are lower, while contact rates for nursing for those known to have mental health problems are above the EU average.

Appropriateness of care

Another major problem that mental health systems must contend with concerns the appropriateness of care, and more broadly quality. In Spain about 13% of visits to formal care services are made by individuals who do not meet any diagnostic criteria for mental health problems.¹⁵ However, in practice, matching service utilisation with need can be complex as the presence of a mental health disorder does not always imply the need for mental health care. In fact, Spain has low service

Table 1. Percentage of mental health care use in Spain compared to EU average, 2006

Question: In the last twelve months did you seek help from a professional in respect to a psychological or emotional health problem?

	EU		Spain	
	All	Mental health problems	All	Mental health problems
GP	10.4	17.5	6.3	16.7
Pharmacist	2.0	3.2	0.7	2.1
Physiatrist	1.9	3.3	1.9	5.0
Therapist	1.6	2.7	3.4	2.4
Psychoanalyst	0.1	0.2	0	0.3
Nurse	0.6	1.0	0.1	1.6
Social worker	0.5	1.0	0.1	1.8
Psychotherapist	0.4	0.75	0.2	0.5
Any other professional	2.3	3.83	1.4	3.1

Source: Commission of the European Communities, 2006.¹⁴

consultation rates by those without mental health disorders, which on one hand might be taken as a measure of appropriateness of care, but on the other might well indicate little investment in prevention.¹⁵

Key policy challenges

One of the main problems in regulating mental health services is the greater level of information asymmetries between service providers and those with mental health needs. This is in part due to the high level of prejudice and stigmatisation that continues to surround mental health, particularly in a country like Spain which has only begun to modernise relatively recently. Furthermore, the important role of partners and family members in providing support for people with mental health problems is widely acknowledged. The need to tackle stigma, as well as prevent mental health problems occurring, are key priorities, particularly for those who already may be at greater risk of marginalisation, including immigrants and the unemployed. In Spain one survey suggests that poor physical and mental health can impact on the social activities of just over 30% of the population, a rate much lower than that observed across the EU as a whole. However, it is complex to disentangle the extent to which this evidence responds to a lower prevalence of mental health disorders or, a higher under-reporting of mental health disorders due to stigma.

Of particular importance are population sub-groups such as children and older people. Children who have parents with enduring mental health problems may experience lower quality parenting which is likely to affect their future life and working opportunities. Equally, mental health problems observed at school might have adverse impacts for crime and increase the risk of social exclusion. Young people, who may find it difficult to break into the employment market due to a lack of experience and qualifications, are another key group. Young people identified as having psychosis require both early health and social care interventions to prevent and treat potential conditions that can result in more severe symptoms and disorders. Another important group are older people; this is especially relevant in Spain given rapid population ageing. For older people poor mental health may compound existing physical health problems and disabilities; it may often go untreated, increasing the risk of dependency.

Another source of increasing demand for mental health services is work-related stress. Spain has all of a sudden become 'Europeanised', leading to a significant change in lifestyles, especially in working conditions, some of which might have transitional costs in terms of stress and adaptation. Another source of increasing demand for mental health services is unemployment, and Spain has traditionally been a country with high unemployment rates. Finally, another important consequence of the westernisation of Spanish habits lies in the adoption of western lifestyles and identities, which can be responsible in some circumstances and in some social groups for increased illegal drug consumption, as well as an increasing risk of eating disorders.

As with physical health, there is an income gradient that explains the influence of social hierarchy in explaining the prevalence of mental health disorders. This especially is the case for depression.¹⁶ Indeed, depression in Spain appears to be more prevalent among the poorest, even when income related inequalities are decomposed into education and a set of other relevant determinants. Among potential explanations for this feature is the fact that the quality of child care is found not to be independent of income, and the absence of an efficient health care network for prevention, diagnosis and appropriate treatment of mental health problems among the less affluent.

Concluding remarks

This article provides a brief overview of the organisation and reform of mental health care in Spain, focusing on recent reforms and current challenges. Given that mental health care does not come cheap and it is far from obvious how mental health programmes are prioritised vis-à-vis other health related programmes, reforms should veer more towards increasing the integration and coordination of mental health care within health and social care services. From the existing evidence, further coordination between specialised and primary care is required and targets for prevention might be set inter-sectorally given the existing spillover effects of mental health problems on other sectors, as well as their impact on physical health.

Ignorance, along with the irrational fear and stigmatisation of mental health problems that is common across the globe, goes some way to explaining limited public sector actions. Mental health services have

paid a high price for not being adequately funded, as the authorities (albeit to a lesser extent after decentralisation), rather than organising strong mental health policies themselves, have opted instead to shift care to the social arena where it is the subject of means testing.⁵ Arguably this can be seen as an implicit means of privatisation. Given that the priorities for social care differ across the ACs, there is a need for more robust coordination of health and social care. After all, better support for people with mental health problems, it is acknowledged, can in turn reduce the likelihood of common co-morbid chronic physical health problems.

REFERENCES

1. McDaid D. Mental health reform: Europe at the crossroads. *Health Economics, Policy and Law* 2008;3:212–28.
2. Alonso J, Angermeyer MC, Bernert S. Use of mental health services in Europe: results from the European Study of the Epidemiology of Mental Disorders (ESEMED) project. *Acta Psychiatrica Scandinavica* 2004;109(Suppl. 420):47–54.
3. Alonso J, Haro JM. *La epidemiología de los trastornos mentales en España: estudio ESEMED* [The epidemiology of mental disorders in Spain: the ESEMED study]. Barcelona: ESEMED Project, 2000.
4. Gisbert R, Brosa M, Bohigas L. Distribución del presupuesto sanitario público de Cataluña del año 2005 entre las 17 categorías CIE-9-MC [Distribution of the public healthcare budget of Catalonia (Spain) for 2005 among the 17 ICD-9-CM categories]. *Gaceta Sanitaria* 2007;21(2):124–31.
5. Salvador-Carulla L, Garrido M, McDaid D, Haro JM. Financing mental health care in Spain: context and critical issues. *European Journal of Psychiatry* 2006;20(1):29–44.
6. Salvador-Carulla L, Tibaldi G, Johnson S, Scala E, Romero C, Munizza C. Patterns of mental health service utilisation in Italy and Spain. An investigation using the European Service Mapping Schedule. *Social Psychiatry and Psychiatric Epidemiology* 2005;40(2):149–59.
7. World Health Organization. *Mental Health Atlas 2005*. Geneva: WHO, 2005.
8. Siras Mainar A, Rejas Gitiérrez J, Navarro Artieda R, Serrat Tarrés J, Blanca Tamayo B, Días Crespo S. Costes y Patrón de uso de Servicios en pacientes que demandan Atención por problemas mentales en Asistencia Primaria [Costs and patterns of use of primary care services by

patients seeking help for mental health problems]. *Gaceta Sanitaria* 2007;21(4):306–13.

9. IMS. *Antidepressants in the European Union*. London: IMS, 2002

10. Ayuso Mateos JL. Depresión: una prioridad en salud pública [Depression: a priority in public health]. *Medicina Clinica* 2004;123:181–86.

11. Kovess-Masfety V, Alonso J, de Graff R, Demyttenaere K. A European approach to rural-urban differences in mental health: The ESMED 2000 Comparative Study.

Canadian Journal of Psychiatry 2005;50(14):926–36.

12. ESEMeD/MHEDEA2000 Investigators. Prevalence of mental disorders in Europe: results from the European Study of the Epidemiology of Mental Disorders (ESEMeD) project. *Acta Psychiatrica Scandinavica* 2004;109(Suppl. 1):21–27.

13. Kovess-Masfety V, Alonson J, Brugha TS, Angermeyer M C, Haro J M, Sevilla-Dedieu. Differences in lifetime use of services for mental health problems in six european countries. *Psychiatric Services* 2007;58(2):1–7.

14. Commission of the European Communities. *Mental Well-being. Special Eurobarometer 248. Wave 64.4*. Brussels: Commission of the European Communities, 2006.

15. Alonso J, Codony M, Kovess V, *et al.* Population level of unmet need for mental health care in Europe. *British Journal of Psychiatry* 2007;190:299–306

16. Costa-Font J, Gil J. Would Socio-Economic Inequalities in Depression fade away with Income Transfers? *Journal of Happiness Studies* 2008 9(4):539–58.

Liberalisation of health care in the Netherlands:

The case of mental health care

Frank van Hoof, Ineke Kok and Joost Vijselaar

Summary: A process of liberalisation is taking place in health care in the Netherlands. The impact of this process varies over the various health care domains. Mental health care is a domain for which the impact seems to be relatively large. Dutch mental health care is in the process of being transformed from a homogeneous, regionally organised, integrated mental health care system, financed by a single social insurance, to a more heterogeneous working field, financed through several sources and subject to market forces. Stakeholders in Dutch mental health care welcome new possibilities this presents for providers, but concerns are expressed about the consequences of these changes for the quality and comprehensiveness of long term (community) care and for the sustainability of the mental health care system as a whole.

Keywords: Mental Health Care; Financing; Health Insurance System; Deinstitutionalisation Policy; the Netherlands

Recent studies, including those of the Mental Health Economics European Network, have shown that there are two dominant trends in mental health care financing in Europe. The first is a partial shift of funding to the social care and housing sectors. The second is a liberalisation of the health care sector and of health care financing as a whole.^{1,2,3}

Specific to the current changes in Dutch mental health care is that the first trend – the transfer of mental health care funds to non-health care domains – only takes place at a very limited level. To a much greater extent, Dutch mental health has become subject to a broader liberalisation process taking place within the health care sector.

Health and social care financing

Since 2007 health and social care in the Netherlands have been funded through three financing systems (Box 1). The first, the Health Insurance Act (ZVW or Zorgverzekeringswet) covers basic, essential health care. The ZVW was introduced in 2006 and replaced several previous health care insurance systems. The ZVW is the main vehicle for the liberalisation of health care in the Netherlands. It places a strong emphasis on market competition between insurers, and between health care providers. Under the new legislation all citizens are obliged to

Frank van Hoof is Senior Research Associate, and Ineke Kok is Head of the Department of Mental Health Care Policy and Management at the Trimbos Institute, the Netherlands Institute of Mental Health and Addiction. Joost Vijselaar is Senior Research Associate at the Trimbos Institute and Professor of the History of Psychiatry at the University of Utrecht, the Netherlands. Email: fhoof@trimbos.nl.