

**Mental Health Policy and
Service Guidance Package**

MENTAL HEALTH FINANCING



World Health Organization, 2003

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“Mental health financing is a powerful tool with which policy-makers can develop and shape quality mental health systems. Without adequate financing, mental health policies and plans remain in the realm of rhetoric and good intentions.”

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This module is part of the WHO Mental Health Policy and Service guidance package, which provides practical information to assist countries to improve the mental health of their populations.

What is the purpose of the guidance package?

The purpose of the guidance package is to assist policy-makers and planners to:

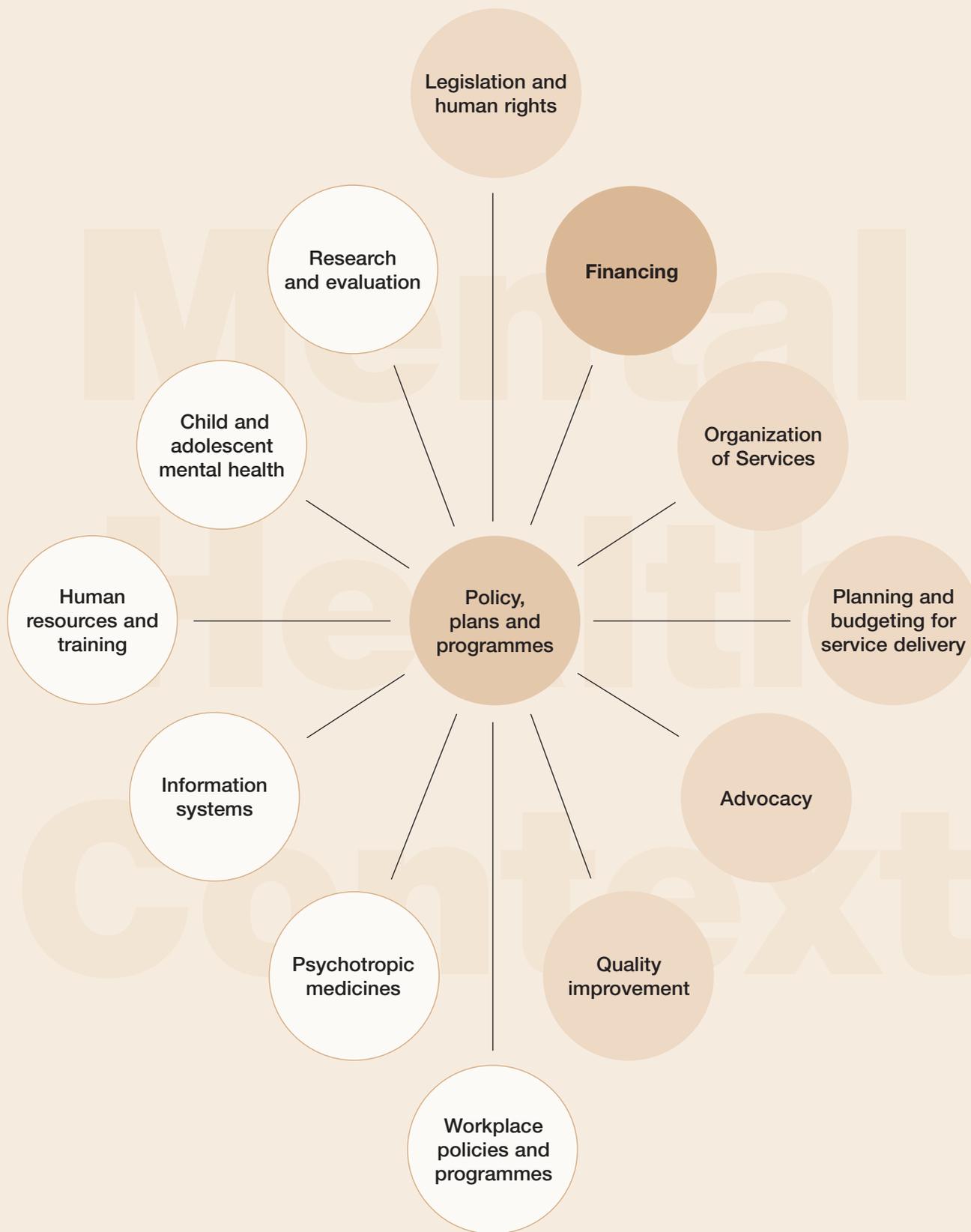
- develop policies and comprehensive strategies for improving the mental health of populations;
- use existing resources to achieve the greatest possible benefits;
- provide effective services to those in need;
- assist the reintegration of persons with mental disorders into all aspects of community life, thus improving their overall quality of life.

What is in the package?

The package consists of a series of interrelated user-friendly modules that are designed to address the wide variety of needs and priorities in policy development and service planning. The topic of each module represents a core aspect of mental health. The starting point is the module entitled The Mental Health Context, which outlines the global context of mental health and summarizes the content of all the modules. This module should give readers an understanding of the global context of mental health, and should enable them to select specific modules that will be useful to them in their own situations. Mental Health Policy, Plans and Programmes is a central module, providing detailed information about the process of developing policy and implementing it through plans and programmes. Following a reading of this module, countries may wish to focus on specific aspects of mental health covered in other modules.

The guidance package includes the following modules:

- > The Mental Health Context
- > Mental Health Policy, Plans and Programmes
- > Mental Health Financing
- > Mental Health Legislation and Human Rights
- > Advocacy for Mental Health
- > Organization of Services for Mental Health
- > Quality Improvement for Mental Health
- > Planning and Budgeting to Deliver Services for Mental Health



● still to be developed

The following modules are not yet available but will be included in the final guidance package:

- > Improving Access and Use of Psychotropic Medicines
- > Mental Health Information Systems
- > Human Resources and Training for Mental Health
- > Child and Adolescent Mental Health
- > Research and Evaluation of Mental Health Policy and Services
- > Workplace Mental Health Policies and Programmes

Who is the guidance package for?

The modules will be of interest to:

- policy-makers and health planners;
- government departments at federal, state/regional and local levels;
- mental health professionals;
- groups representing people with mental disorders;
- representatives or associations of families and carers of people with mental disorders;
- advocacy organizations representing the interests of people with mental disorders and their relatives and families;
- nongovernmental organizations involved or interested in the provision of mental health services.

How to use the modules

- They can be used **individually or as a package**. They are cross-referenced with each other for ease of use. Countries may wish to go through each of the modules systematically or may use a specific module when the emphasis is on a particular area of mental health. For example, countries wishing to address mental health legislation may find the module entitled Mental Health Legislation and Human Rights useful for this purpose.
- They can be used as a **training package** for mental health policy-makers, planners and others involved in organizing, delivering and funding mental health services. They can be used as educational materials in university or college courses. Professional organizations may choose to use the package as an aid to training for persons working in mental health.
- They can be used as a framework for **technical consultancy** by a wide range of international and national organizations that provide support to countries wishing to reform their mental health policy and/or services.
- They can be used as **advocacy tools** by consumer, family and advocacy organizations. The modules contain useful information for public education and for increasing awareness among politicians, opinion-makers, other health professionals and the general public about mental disorders and mental health services.

Format of the modules

Each module clearly outlines its aims and the target audience for which it is intended. The modules are presented in a step-by-step format so as to assist countries in using and implementing the guidance provided. The guidance is not intended to be prescriptive or to be interpreted in a rigid way: countries are encouraged to adapt the material in accordance with their own needs and circumstances. Practical examples are given throughout.

There is extensive cross-referencing between the modules. Readers of one module may need to consult another (as indicated in the text) should they wish further guidance.

All the modules should be read in the light of WHO's policy of providing most mental health care through general health services and community settings. Mental health is necessarily an intersectoral issue involving the education, employment, housing, social services and criminal justice sectors. It is important to engage in serious consultation with consumer and family organizations in the development of policy and the delivery of services.

Dr Michelle Funk

Dr Benedetto Saraceno

MENTAL HEALTH FINANCING



Introduction

Financing is a critical factor in the realization of a viable mental health system. It 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 financing, a resource base is created for operations and the delivery of services, for the development and deployment of a trained workforce, and for the required infrastructure and technology.

In order to finance a mental health system, policy-makers and planners have to address the following key questions.

- > How can sufficient funds be mobilized to finance the mental health plan, including mental health services and the required infrastructure?
- > How can those funds be allocated and how can the delivery of mental health care be organized so that defined needs and priorities are addressed?
- > How can the cost of care be controlled?

This module provides practical guidance to assist countries with the financing of mental health care. Such financing is not an isolated activity but occurs in widely disparate political and economic contexts and, often, within the context of more general health care financing. In many countries, mental health financing is subsumed under more general health financing and is often not distinct. In many cases it is shaped, if not determined, by the objectives of general health care financing.

In the sense that mental health financing occurs within a larger context the present module fits in with the other modules in the package. Activities and steps described in those modules are intimately tied to financing.

The objectives of this module are:

- (1) to provide a conceptual introduction to key issues related to the financing of mental health care;
- (2) to describe a step-by-step approach to these issues, recognizing that it may be necessary to adapt and tailor the steps to the circumstances in each country;
- (3) to link the steps to activities defined in other modules.

The following steps represent a systematic approach to the financing of mental health systems.

Step 1. Understand the broad health care financing context.

The first step is to understand the health care financing context in which mental health financing is embedded.

- > Governments have many mechanisms for raising revenues: taxes, user charges, mandates, grant assistance, and borrowing. Health care can also be jointly financed by federal and state (or provincial) governments. Some countries use the general tax approach but decentralize responsibility to the local government.
- > There are three ways to finance individual health care: private individual payments, private collective payments, and public finance.

- Common methods of financing mental health care are tax-based funding, social insurance and out-of-pocket payments.
- Individuals with mental disorders are commonly poorer than the rest of the population and less able or willing to seek care because of stigma or previous negative experiences of services. As a result, payment out of their own pockets or their families' pockets is more of an obstacle to care compared to payment for many acute physical health problems. Finding ways to increase the share of prepayment, particularly for expensive or repeated procedures, can therefore benefit mental health spending preferentially if enough of the additional prepayment is dedicated to mental and behavioural problems.
- Where possible, governments should attempt to achieve mandatory coverage for mental health, either through national, tax-based or social insurance. In many systems, however, not necessarily only in poor countries, such mandatory coverage is difficult to achieve. In high-income countries, even where there is coverage, limits may exist. In many low-income countries, insurance schemes are not generally available or are non-existent.

Step 2. Map the mental health system to understand the level of current resources and how they are used.

The mapping of existing services and the resources available for them is a critical step in understanding the mental health financing system.

- The mapping exercise should include infrastructure and administrative support costs, especially the costs of implementing policy, services and the needed infrastructure.
- The broad categories for this mapping process should be identified and listed, e.g. hospitals, residential care, outpatient services, information systems and policy/administrative support.
- Sources of funding for these various categories should be identified from the available information. Intersectoral sources may be needed.
- The sources of funding should be identified by the type of funding and the type of sector or organization providing it.
- Understanding the relationships between the sources of funding and the resources identified with the various mental health functions may provide opportunities for and indicate limitations on the development of additional resources.

Step 3. Develop the resource base for mental health services.

Understanding the reasons for underfunding is an important starting point for developing the resource base for mental health.

- Among the many factors that can give rise to underfunding are: poor economic conditions in the countries concerned; inadequate recognition of mental health problems and their consequences; unwillingness or inability of individuals with mental health problems (or their families) to pay for treatment; and failure by policy-makers to understand what can be done to prevent or treat mental disorders, resulting in a belief that funding for other services is more beneficial to society.
- The resource base may be developed through policy initiatives as outlined in other modules in the guidance package.
- The resource base may also be developed through financial mechanisms such as seed funding for innovative projects and the inclusion of resource development for mental health within that for general health.

Step 4. Allocate funds to address planning priorities.

- The allocation of funds must be tied to policy and planning priorities.
- Allocation to regions can be based on per capita funding but this does not take account of differences in the prevalences of mental disorders (persons in low-income groups have higher prevalences than those in high-income groups), existing resources mental health resources are better developed in some areas than in others), and accessibility factors (remote and rural areas may have more difficulty than urban areas in providing access to services). As part of the planning process these factors should be considered in the development of strategies for allocation from the national level to the local level.
- Allocations to regions must also be coordinated with any strategies for decentralizing or devolving authority to the local level. It is important to consider the development of local management skills and commitment to mental health so as to achieve a positive impact with increased local ownership and control.
- Allocations to different components and interventions should be based on target populations and types of service. Identified through the planning process, a knowledge base of the most cost-effective services for special problems in different subpopulations can inform this process.
- One approach proposed for building community-based systems involves transferring resources from hospital-based systems. However, this needs careful evaluation and should be based on an assessment of the number of hospital beds needed as community systems grow. Double funding may be needed initially in order to ensure that a community system can accommodate people discharged from hospital. Furthermore, transfers of funds cannot be gradual because resources can only be moved from hospitals once units have been closed and staff reductions have taken effect.

Step 5. Build budgets for management and accountability.

- A budget is a plan for achieving objectives stated in monetary terms. Planning should drive the budgetary process. Too often, however, plans and budgets are developed independently, with the result that objectives are not explicitly reflected in the budgets.
- A budget serves four functions: policy, planning, control and accountability.
- There are four types of budgets: global budgets, line budgets, performance-based budgets and zero-based budgets. Mental health planners may not have the option of defining the type of budget to be used but it is important to understand the main advantages and disadvantages of each.
- A budget should be tied to priorities in plans and policies and should not be limited to services. The priorities include policy development, planning and advocacy.
- One approach to innovation is to create a special mental health innovation fund. This could seed demonstration and evaluation projects, even on a small scale, so as to promote change and quality improvement.
- Thus a budget is much more than a projection of the costs of a service delivery system. It is an instrument for communicating standards of performance expected by the organizations concerned, a tool for motivating employees to achieve objectives, and a mechanism for monitoring and assessing the performance of various sub-organizational components.

Step 6. Purchase mental health services so as to optimize effectiveness and efficiency.

- There are essentially three broad types of relationships between funders and providers: reimbursement, contract and integrated. Integrated models, in which the funder is the provider and there is no dichotomy between funder

and provider, are widespread, but most countries have a mixture of models. Moreover, models are changing within countries.

- Purchasing may be based on a global budget (i.e. services are purchased for a defined population), capitation (i.e. a defined subset of a population is eligible for services), the case rate (i.e. the recipients of services) or fee-for-service (i.e. fees for services provided).
- Each of these purchasing arrangements has different incentives associated with it, allowing the government (or purchaser) to decide which mechanism is the most appropriate.

Step 7. Develop the infrastructure for mental health financing.

The adequacy of financing processes and activities depends largely on the management structures in which they are embedded and the quality of the information on which they are based. The critical areas include:

- management/purchasing structures;
- information systems;
- evaluation and cost-effectiveness analysis;
- information-sharing and the involvement of key stakeholders.

Step 8. Use financing as a tool to change mental health service delivery systems.

Financing mechanisms can be used to facilitate change and introduce innovations in systems. Financial and budgetary factors that can encourage the shifting of the balance between hospital and community services include:

- budget flexibility;
- explicit funding for community services;
- financial incentives;
- the coordination of funding between ministries or agencies.

In respect of the integration of mental health care with primary care it is necessary to ensure adequate funding for mental health services. Mental health services may not receive sufficient attention, and funding may remain static or diminish. This can be prevented by:

- tracking funds expended on mental health services;
- developing line items for specialized services for mental health populations;
- establishing and protecting levels of funding for mental health services.

It is important to maintain some financing capacity for introducing innovation through demonstrations and pilot projects.

Conclusions and recommendations for action

1. Build and broaden consensus on mental health as a priority.

Many of the actions related to financing mental health are based on steps defined in other modules, e.g. *Mental Health Legislation and Human Rights; Advocacy for Mental Health; Mental Health Policy, Plans and Programmes; and Planning and Budgeting to Deliver Services for Mental Health*. These create a broad consensus that mental health needs are a social priority. But even these activities require financial underpinnings.

The first action related to financing is the building of a coalition with consensus on key needs. This creates a foundation for advocacy that can move forward simultaneously on **legislation, policy development and financing** as a coherent set of activities rather than as independent, single-track initiatives. Financing ultimately depends on politics, advocacy and broader societal expectations.

2. Identify priorities for financing.

Each country has its own starting point in the development of its mental health system and its own priorities and barriers to tackling priorities. This is true of both developed and developing countries. For example, affluent countries may be confronted with heavily institutionalized systems in which the major financing issues relate to the transfer of existing resources from hospitals to community services. On the other hand, in some developing countries there may be virtually no mental health system and the major issues may relate to seed funding for demonstration projects.

For a country that is just beginning to develop its mental health system a major focus is the development of a mental health infrastructure that includes legislation, the development of a plan and the budget associated with the proposed initial activities. For such activities, initial funding may be obtainable from the World Bank or other donor organizations. The objective of initial financing is the articulation of the laws, policies, rights of individuals and broad structural arrangements intended to be part of the long-term infrastructure of the mental health system. Once this foundation is laid the financing of mental health services can be addressed more specifically.

3. Tie mental health financing to general health financing.

A major aspect of mental health financing, especially in countries that have not had a well-articulated mental health system, is to ensure that mental health financing is an integral component of general health financing and that specific allocations are made for mental health financing associated with other health initiatives. The case for such resource allocations has been strengthened by data on disability-adjusted life-years and by the association of mental health problems with physical health problems such as heart disease, diabetes and other conditions.

4. Identify the steps in this module that are the most relevant for your country's situation.

Each step in this document is a recommendation for action. The action that is considered most pertinent will depend on the specific objectives defined in policies and plans and the specific issues that each country faces. In general, each country has to address issues defined in each of the steps. But the details and the degree of elaboration in each step should be tailored to the specific circumstances in each country.

Aims and target audience

Aims

This module provides practical guidance to assist countries with the financing of mental health care. The aims of the module are to:

- (1) provide a conceptual introduction to key issues related to the financing of mental health care;
- (2) set out a step-by-step approach addressing these key financing issues, recognizing that the steps may need to be adapted and tailored to the circumstances of each country;
- (3) link the steps to activities defined in other modules.

The Introduction emphasizes financing as a major driver of the system and indicates the need to integrate this function with policy-making and planning. Steps are then presented to assist countries in their financing efforts.

These steps are not intended to be prescriptive or rigid. Instead they identify critical activities related to financing which should be addressed in order to build and sustain a mental health system that meets priority needs and produces desired outcomes. Barriers to mental health financing are also reviewed.

Target audiences

This module is intended for the following audiences:

- > mental health administrators and planners who are directly responsible for planning and developing mental health systems;
- > policy-makers who wish to understand critical issues related to the financing of mental health services and infrastructures;
- > people with mental disorders, their families and advocates so that they can build their knowledge base regarding financing issues;
- > providers, mental health staff and other stakeholders so that they have a better understanding of issues related to the financing of the systems of which they are a part.

Ultimately, financing involves policy formulation, planning, economics and accounting. The information in this module provides broad guidance and is not intended to substitute for expertise in these areas.

1. Introduction

Adequate and sustained 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 operations and delivery of services, the development and deployment of a trained workforce and the required infrastructure and technology. Financing is a fundamental building block on which the other critical aspects of the system rest.

As such, financing is not only a major driver of the system but is also a powerful tool with which policy-makers can develop and shape mental health services and their impact. There is an inherent parallel danger in that if this tool is not used in a planned and thoughtful fashion the expected results and goals may not be achieved. Indeed, if financing issues are not adequately addressed there may be unintended consequences that are harmful and undermine the stated objectives.

In order to finance mental health systems, policy-makers and planners have to address the following key questions.

- How can sufficient funds be mobilized to finance mental health plans, including services and the necessary infrastructure?
- How can those funds be allocated and how can the delivery of mental health care be organized so that defined needs and priorities are addressed?
- How can the cost of care be controlled?

This module outlines ways in which these questions can be addressed in a systematic step-by-step process. Firstly, however, it is important to understand some of the central challenges that face mental health financing, some of the main themes of this module, and the way in which financing is related to policy formulation and planning.

Financing challenges

Among the broad challenges faced by the financing of mental health care systems are: the diversity of resources among countries; the lack of financial data; the varying control and influence of mental health policy-makers and planners over mental health care financing; the varying levels of development of mental health systems between countries.

With regard to the diversity of resources between countries, estimates suggest that almost 90% of global health expenditures occur in high-income countries (per capita income above US\$ 8500) whose populations account for only 16% of the world population (Schieber & Maeda, 1997). The extreme disparity between the amount of resources dedicated by low-income and middle-income countries to health care reflects the widely varying capacities of these countries to provide mental health services.

A second challenge is presented by the incompleteness or unavailability of data on mental health expenditure. Despite efforts to develop systems of national health accounts, many countries lack the basic information needed to assess how mental health system resources are being raised and used. Without such information it is difficult for policy-makers and planners to understand the effects of their policies and to determine which decisions are likely to ensure equity or efficiency or to increase the returns on resources being developed.

Financing translates plans and policies into action.

Financing must be integrated with planning and policy-making.

Several challenges face policy-makers and planners when addressing these questions.

The challenge of resource diversity.

The challenge of a lack of data.

Mental health financing is often subsumed under general health financing. Broad decisions about such financing may not come under the purview of the mental health policy-maker or planner, i.e. mental health financing is intimately tied to the funding of general health care and may be largely determined by it. A corollary is that it is rare to find models of mental health financing that are independent of the financing of general health care.

Mental health financing is often subsumed under general health financing.

A further challenge, linked to the first, is presented by the diversity of mental health systems themselves, which may be in different stages of development. These systems may be in their initial stages of development in some countries while in others they may be more developed yet may still encounter issues related to a lack of funds or a fragmentation of funding streams.

There is a diversity of mental health systems.

Finally, health spending is frequently directed to curative services. In developing countries, a large proportion of spending is on hospitals and salaries. Spending on curative hospitals cannot easily be redirected. There is a scarcity of models for spending on quality improvement and infrastructure, especially where benefits are difficult to quantify.

Much current resource expenditure is on curative services.

Despite these challenges, mental health planners and policy-makers can take various actions related to financing which can support the development and implementation of mental health policies and plans. Such actions are outlined in this module.

Themes

Throughout the module there are recurring themes that provide a framework for the proposed steps.

Several broad themes run through this module.

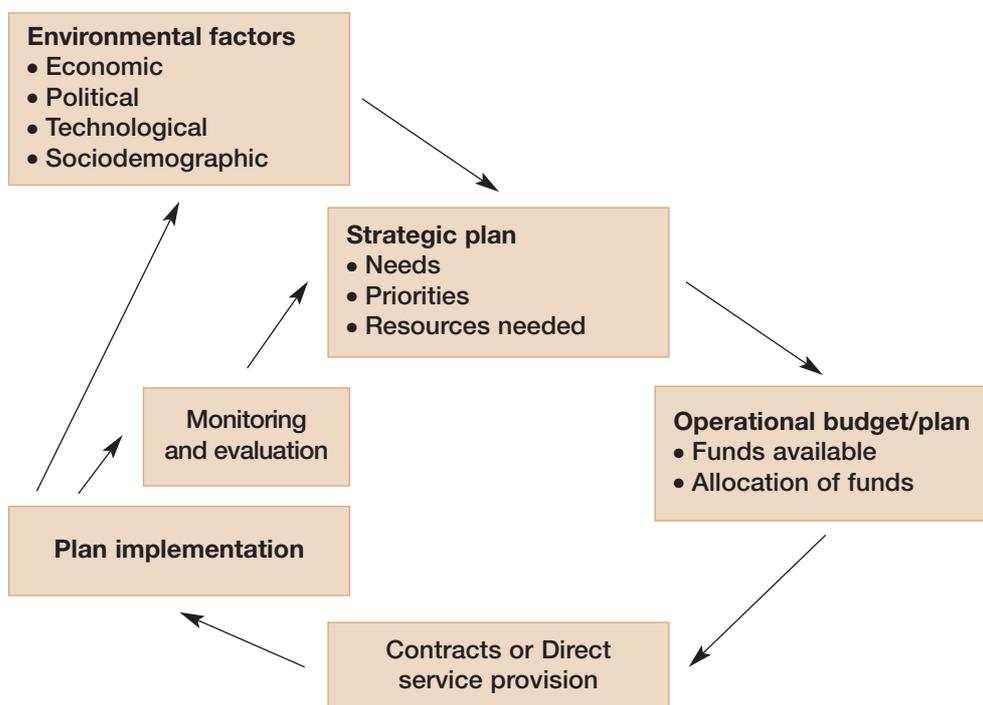
- *Financing policy can have little impact unless there is political commitment to build the mental health sector or make it more effective.*
Financing is a *tool*, not an end in itself.
- *Financing is not an isolated independent activity.* Financing reforms are related and must be undertaken in combination with other mechanisms. Financing is intimately related to policy and planning functions and many of its goals are achieved through processes described in other modules, e.g. *Mental Health Legislation and Human Rights; Advocacy for Mental Health; Planning and Budgeting to Deliver Services for Mental Health; Mental Health Policy, Plans and Programmes.*
- *Financing should focus on the development and implementation of policies and plans, not only on services.* Many of the activities proposed in this module are related to developing and improving mental health systems that provide the infrastructure for services. These activities include policy development, planning, quality improvement, legislation, advocacy, and the provision of information systems. Financing for these activities must be explicit and transparent.
- *Financing incentives should be aligned with policy and planning priorities and with opportunities for quality improvement.* A guideline for decisions related to financing and financial incentives should be guided by the extent to which they promote planning priorities and quality improvement. This does not necessarily refer to the national level of reform but could refer to smaller applied projects that move the system in the desired direction. In this connection, the opportunities that financing can foster apply as much to developed as to developing countries.

How does financing relate to policy and planning?

Financing is integrated and intimately tied to the policy-making and planning processes described in the other modules. The financing of services is the operationalization of those processes: the operational budget should be the mechanism whereby plans are promulgated. It is useful to think of these different activities as part of an integrated cycle of planning, budgeting and implementation at the systems level.

Thus the development of a strategic plan reflects the major goals and objectives of a policy. The plan is an essential vehicle for building and articulating consensus across a broad spectrum of stakeholders regarding the vision and goals of the policy and the manner of their achievement. On the basis of the needs and priorities reflected in the plan a budget request is generated which is generally reviewed by key decision-makers. It often happens that the appropriated budget is not the same as the budget request. Consequently, modifications may have to be made to priorities and targets. The operational budget, which usually covers a specified period, becomes the resource base for the overall system. In order to achieve stated targets it is necessary to make allocations to different regions, service sectors and providers. Monitoring the performance of the entities receiving allocations is necessary in order to evaluate the implementation of the plan. This, together with other factors that may have emerged in the environment, becomes the basis of the next cycle of activity. The cycle is shown in Fig.1.

**Figure 1: Financing the mental health system:
the cycle of planning, budgeting and implementation**



Although Figure 1 may not reflect the actual budget formulation process in a particular country, it does illustrate relationships that should exist between budget processes, policies and planning. Financing is a logical and operational extension of policy-making and planning. It represents the administrative will and commitment to implement and achieve the objectives developed in policies and plans.

Financing is a logical extension and operational arm of policy.

If these different processes are not aligned and coordinated, mixed signals are provided to the system regarding policy and future direction. If this happens, financing becomes the major determinant of the evolution of the mental health system rather than a means of obtaining policy and planning objectives. This is a critical point: the total amount of available resources, the allocation strategies and the incentive systems, whether explicit or implicit, would ultimately shape the system. Financing mechanisms should support plans and priorities and should not, in themselves, become de facto policy.

Financing translates plans and policies into action.

For example, in many cases mental health financing is shaped, if not determined, by the objectives of general health care financing. These objectives can vary greatly. A primary objective may be to control the costs of health care rather than to build the funding base for it. Over the last 20 years this has occurred in some of the more affluent countries. Even where it is recognized that funding for mental health is insufficient, such an objective can have a negative effect on overall mental health financing.

Implementing policy through financing: key principles

Given that financing is a vehicle for policy and planning rather than the reverse being true, it is essential to outline the key principles on which mental health financing is based. In many countries, mental health advocates and stakeholders are concerned about four areas: access, quality, outcomes and efficiency. These translate into the following key questions.

- Are people who need services receiving them? (ACCESS)
- Are people receiving appropriate services of high quality? (QUALITY)
- Is their mental health improving? (OUTCOMES)
- Are services being provided efficiently? (EFFICIENCY)

Access normally refers to the ease and convenience with which people obtain services. It also includes a consideration of whether there are people with unmet needs who are not receiving any services.

Quality refers to whether the level of care for a person receiving services is appropriate for the person's level of need and whether the services provided are consistent with current knowledge. Policy-makers often have to decide between financial allocations for serving more people, i.e. increasing access, or for increasing the quality of services for people who are already receiving them. A minimum threshold of quality clearly has to be met, otherwise services would be ineffective and the resources invested would be wasted. As pointed out in the module on Quality Improvement for Mental Health, there are no global standards of care. Each country should define the minimum threshold in relation to its specific conditions and context. However, policy-makers have to decide how much to enhance the quality of services beyond the minimum threshold while improving access to them.

Policy-makers have to make financial decisions so as to create a balance between serving more people and providing better services.

The balance that is achieved largely depends on the **outcomes** that are targeted. For most policy-makers, optimizing productive capacity at work, school or in the home is an important goal. The adequacy and appropriateness of services depends on the goals that have been established: each will have particular implications for programmes and services and consequently for the finances that are needed.

Services should be organized and managed so that the use of resources is maximized (**efficiency**). This optimization should be approached at two levels: firstly the societal level and secondly the level of the mental health system itself. Too often the focus is on the latter. The larger perspective is necessary because costs are incurred when financing for appropriate access and quality is not available. An important aspect of such

Services should be organized and managed so as to optimize resources.

maximization is the reduction of misuse and overuse of services that do not produce desired outcomes. Maximization includes the appropriate targeting of cost-effective services to people who are assessed as needing them in order to produce outcomes desirable from the perspective of the individual, the mental health system and society. Indeed, ensuring that these perspectives are aligned is a key function of planning.

It is becoming evident that when mental health services are available there may be reductions in the costs of physical health care, increases in productivity and reduced demands on other social services and the criminal justice system (e.g. Conti & Burton, 1994; Smith et al., 1996; von Korff et al., 1998). Some of these offsets may not be observed for a considerable time. In respect of interventions for children, for example, the payoffs are associated with the avoidance of mental, social and legal problems in adulthood.

The total amount of resources available for mental health is critical, but equally important is their allocation between regions, segments of populations, services and programmes. Major problems are presented by disparities of resources between urban and rural areas and between income groups. Policy-makers also have to guide and make decisions on the distribution of funding within the mental health system, defining which services are covered and which receive priority.

The concepts of **equity**, **effectiveness** and **efficiency** can help policy-makers to make decisions on allocation.

- > **Equity** means that no particular segment of the population is unduly favoured and that other possible inequities are taken into account. For most policy-makers the improvement of equity involves working towards greater equality in outcomes or status among individuals, regardless of the income group to which they belong or the region in which they reside. However, there is no consensus on whether equity should be measured in terms of health status, utilization of services, resources or access.
- > **Effectiveness** relates to the achievement of desired or expected outcomes. The degree of effectiveness is a measure of how well results are produced.
- > **Efficiency** is related to the resources required for effectiveness. For a given result, efficiency increases as the resources used decrease.

Financing can affect equity, effectiveness and efficiency. For example, if a mental health system depends on user charges as a source of revenue, these could be a barrier for the poor (EQUITY). If adequate funding is not available and yet the objective is to meet demand, subclinical levels of care or inappropriate services could result and outcomes would not meet expectations (EFFECTIVENESS). If appropriate interventions are not funded, outcomes may take longer to attain, resulting in higher costs to both the mental health system and society as a whole (EFFICIENCY).

This module aims to provide policy-makers with tools ensuring that financing helps to achieve the objectives of mental health systems and increase equity, effectiveness and efficiency.

Total resources are critical but allocation strategies are equally important.

Financing can affect equity, effectiveness and efficiency.

2. Steps to mental health financing

Following is a series of steps that policy-makers and planners can take in order to build a financing infrastructure that develops and sustains the mental health system in a country.

Step 1. Understand the broad health care financing context

The first step is to understand the health care financing context in which mental health financing is embedded. Certain problems in the mental health sector exist in parallel with problems in the general health sector. These can be summarized as insufficient funding for cost-effective programmes, waste, and inequitable distribution. Poor approaches to financing are a fundamental cause of these problems.

Governments have many mechanisms for raising revenues: taxes, user charges, mandates, grant assistance and borrowing (see Definitions).

- *Taxes* can be direct (e.g. personal income taxes, corporate taxes, payroll taxes, social security taxes, property taxes, wealth taxes) or indirect (e.g. sales taxes, value-added taxes, import taxes). Financing through general taxation means that the government allocates a portion of its annual budget to health care. Each year the health budget competes directly for funds with education, transportation, defence, agriculture and other programmes or departments.
- *User charges* are fees paid by patients or consumers when they receive health services.
- *Mandates*, e.g. employer mandates, require the provision of health care benefits.
- *Grant assistance* from foreign donors are a major source of health care financing in low-income and some middle-income countries. In Africa (excluding South Africa), donor assistance accounts for an average of almost 20% of health spending; the figure exceeds 50% in several countries. *Borrowing* from domestic or foreign sources can be used to finance public health spending. Foreign sources include international development organizations, bilateral donor assistance agencies, private institutions and foreign medical suppliers.

In Step 2 the focus is on understanding how these sources relate to mental health resources both in importance and in terms of potential sources that could be explored.

Health care can also be jointly financed by federal and state (or provincial) governments. In Canada, for example, the federal government provides each province with a fixed sum for health care, indexed to the gross national product. The provincial governments have to use their own tax revenues to finance the balance of health care costs, and consequently have a strong interest in controlling costs. Some countries use the general tax approach but decentralize responsibility to local government. Under this system, decision-making usually rests with the local area, which provides funds and assures the delivery of services to its residents.

There are three ways of financing individual health care: private individual payments, private collective payments, and public finance (Jönsson & Musgrove, 1997). *Private individual payments* are also called out-of-pocket payments. The problem with these is that medical expenses are sometimes so large that even people with higher than average incomes cannot afford them. The situation is exacerbated because health problems may result in reduced incomes. Moreover, the people with the lowest incomes, who are often those in greatest need of care, may be excluded from it.

Governments have many mechanisms for raising revenues.

Health services have to compete with other social and health priorities.

Health care can be jointly financed by different levels of government.

For these reasons, insurance becomes central to any discussion of health care finance. Insurance involves prepayment for services that are paid for by a third party, i.e. the insurer, should the need arise. Insurance is a substitute for, or in some cases is complementary to, direct out-of-pocket payment. The pooling of a large number of people allows average outlays to be predicted fairly well and this reduces the financial risk for consumers.

People with health insurance tend to see doctors more often and to use costlier treatments than other people, even when the benefits are small. In the case of private collective payments (or private insurance), insurance companies have incentives for excluding high-risk consumers or at least for identifying them so they can be charged more. On the other hand, persons who are aware that their health problems represent a high risk can be expected to seek the highest possible coverage.

These problems with private insurance represent some of the main arguments in favour of *public insurance*, which can more easily be made universal so that everyone is obliged to share the risks. Universal coverage ensures that everyone has access to health care and avoids the problems of exclusion associated with high risk.

There are essentially two types of social insurance programmes which can provide universal health insurance coverage: government plans with standardized benefit and rate structures, and various public and private plans that offer consumers a choice even though insurance is still compulsory. In the latter case, governments specify the benefits, rules and standards with which private plans have to comply.

What is the relevance of this brief review of general health care financing to mental health care financing? Box 1 shows that the sources of mental health care financing correspond to those of general health care financing, and indicates the sources used by some countries. All countries use combinations of these methods to finance their health systems.

There are several problems with private health insurance.

Box 1. Mental health budget as a proportion of the general health budget, and sources of mental health financing in various countries

Country	Specific budget for mental health	Mental health budget as proportion of general health budget	Sources of mental health financing (in descending order)
Australia	Yes	6.5%	Tax-based, private insurance and out-of-pocket
Chile	Yes	4.1%	Social insurance, tax-based, out-of-pocket and private insurance
Egypt	Yes	9.0%	Tax-based, out-of-pocket, social insurance and private insurance
Fiji	Yes	1.7%	Tax based and private insurance
France	Yes	5.0%	Tax-based and social insurance
Italy	Yes	Not available	Tax-based, out-of-pocket and private insurance
Kenya	Yes	0.01%	Tax-based, out-of-pocket, private insurance and social insurance
Lao People's Democratic Republic	No	Not available	Out-of-pocket and tax-based
Republic of Korea	No	3.0%	Social insurance, tax-based and out-of-pocket
Romania	Yes	3.0%	Out-of-pocket and social insurance
South Africa	Yes	2.7%	Tax-based, private insurance, out-of-pocket and social insurance
USA	Yes	6.0%	Private insurance, tax-based, out-of-pocket and social insurance

Source: World Health Organization, *Atlas*, 2001.

Characteristics of good mental health financing

The characteristics of good financing for mental health are the same as those of good financing for general health services (World Health Organization, 2000). There are three principal considerations.

- > First, people should be **protected from catastrophic financial risk**. This means minimizing out-of-pocket payments and, in particular, requiring such payments only for small expenses on affordable goods or services. All forms of prepayment, whether via general taxation, mandatory social insurance or voluntary private insurance, are preferable in this respect, because they pool risks and allow the use of services to be at least partly separated from payment for them. Because mental health problems are sometimes chronic it is important to consider not only the cost of individual treatments or services but also the likelihood of their being repeated over long periods. What an individual or a household can afford once, in a crisis, may be unaffordable in the long term, as is the case with certain chronic noncommunicable physical conditions, e.g. diabetes.
- > Second, the **healthy should subsidize the sick**. In general any prepayment mechanism does this (whereas out-of-pocket payment does not) but the flow of subsidies in the right direction for mental health depends on whether prepayment covers the specific needs of people with mental disorders. A financing system might be adequate in this respect for many services but may not transfer resources from the healthy to the sick in instances of mental or behavioural problems, simply because these are not covered. The effect of a particular financing arrangement on mental health provision therefore depends on the interventions that have been selected for financing.
- > Finally, in a good financing system the **well-off subsidize the poor**, at least to some extent. This is the hardest characteristic to ensure, because it depends on the coverage and progressivity of the taxation system and on who is covered by social or private insurance. The well-off are obliged to subsidize the poor only if both groups, and not only the well-off, are included in the insurance system, and if contributions are at least partly income-related rather than uniform or related only to risks. As always, the magnitude and direction of subsidy depend on the services that are covered.

Typically, prepayment accounts for a larger share of total health spending in rich countries than in poor ones, and this has consequences for mental health financing. If a government provides 70-80% of expenditure on health, as occurs in many Member States of the Organization of Economic Cooperation and Development (OECD), decisions about the priority to be given to mental health can be directly implemented through the budget, probably with only minor offsetting effects on private spending. If, however, a government provides only 20-30% of total financing, as in China, Cyprus, India, Lebanon, Myanmar, Nigeria, Pakistan and Sudan, and if there is also little insurance coverage, mental health care is likely to be neglected in comparison with other aspects of health care because out-of-pocket spending predominates.

Currently, the most common methods of financing mental health care are tax-based funding, social insurance and out-of-pocket payments. The latter place an excessive and unplanned burden on families, especially in low-income countries. Private insurance plays a relatively minor role in mental health care financing in all WHO Regions (World Health Organization, 2001b). Box 1 gave examples of countries with different sources of funding. Box 2 on the following page contains some statistics on funding methods.

There are three principal characteristics of good mental health financing.

People should be protected from catastrophic financial risk.

The healthy should subsidize the sick.

The well-off should subsidize the poor.

Box 2. Methods of financing mental health: some statistics

- Taxes are the primary method of mental health financing for 60.2% of countries worldwide, followed by social insurance (18.7%) and out-of-pocket payments (16.4%). This percentage varies when examined by WHO regions, but taxes remain the dominant mode of mental health financing in all regions. Private insurance and external grants account for 1.8% and 2.9% respectively.
- Out-of-pocket payment is the second most common method of financing mental health care in 35.9% of countries in the African Region, 30% of those in the South-East Asia Region, 22.2% in the Eastern Mediterranean, 13.3% in the Americas and 11.5% in the Western Pacific Region. No countries in the European Region use this method as the secondary means of expenditure on mental health care.
- Social insurance is the second most common method of financing in 50% of countries in the European Region and only 7.7% of countries in the Western Pacific Region use it as the third most common method of financing mental health care. No countries in the African Region nor the South-East Asia Region use insurance as the second or third most common method of mental health financing.
- Private insurance is used as a method of financing in very few countries world wide (in Africa and the Americas).
- External grants support mental health care in 7.7% of countries in the Western Pacific Region, in 5.6% of countries in the Eastern Mediterranean Region and in 5.1% of countries in the African Region.
- If countries are examined according to income groups (low, lower middle, higher middle and High), tax is the most common primary method of financing.
- Out-of-pocket payment is the second most common method of financing in 39.6% of low-income countries but in none of the higher middle income countries and only 2.9% in high income countries.
- Social insurance is the second most common method of financing in 38.3% of high income countries and in 29.4% of higher middle-income countries. No low-income country uses social insurance as a primary method of financing mental health.

Source: *Atlas*: World Health Organization, 2001.

Persons with mental disorders are commonly poorer than the rest of the population and are often less able or willing to seek care because of stigma or previous negative experiences of services. As a result, payment out of their own or their families' pockets is even more of an obstacle than it is in relation to many acute physical conditions. This is not just a problem in developing countries. In many of the more affluent countries, persons with serious mental illness are often marginalized economically. Finding ways to increase the share of prepayment, particularly for expensive or repeated procedures, can therefore benefit mental health spending preferentially, if enough of the additional prepayment is dedicated to mental and behavioural disorders (World Health Organization, 2000). Movement in the other direction, i.e. from prepayment to more out-of-pocket spending, as has occurred during the economic transition in several countries of Eastern Europe, is likely to diminish the resources available for mental health care.

In countries with a low share of prepayment and difficulties in raising tax revenues or extending social insurance because much of the population is rural and has no formal employment, community financing schemes may seem an attractive way to reduce the out-of-pocket burden. Evidence on their success is scanty and mixed. However, it should be noted that unless such schemes receive substantial subsidies from governments, nongovernmental organizations or external donors, they are not likely to solve the chronic problems of an easily identified part of the beneficiary population. The implication is that community-based services should not depend on community-based finance.

Individuals with mental disorders are often poorer than the rest of the population.

Community-based services should not depend on community-based finance.

These same poor countries are sometimes heavily dependent on external donors to pay for health care. Potentially, these donors are a valuable source of funds for mental health care. However, their priorities may not coincide with those of the governments in question. In particular, they seldom give mental health a high priority over communicable disease. In this event, it is necessary for governments to decide whether they should try to persuade the donors to align their aid more closely with the priorities of the countries concerned. The alternative is for the governments to use their own limited funds in areas neglected by the donors, in particular by dedicating an increased proportion of domestic resources to national priorities.

Where possible, governments should attempt to achieve mandatory coverage for mental health, either through national, tax-based or social insurance. In many systems, however, and not necessarily just in poor countries, such mandatory coverage is difficult to achieve. In high-income countries, even where there is coverage, limits may exist. In many low-income countries, insurance schemes are generally not available, or are non-existent.

External donors are a valuable resource, although their priorities do not always coincide with those of governments.

Key points: Step 1. Understand the broad context of health care finance.

- Governments have many mechanisms for raising revenues: taxes, user charges, mandates, grant assistance, borrowing. Health care can also be jointly financed by federal and state (or provincial) governments. Some countries use the general tax approach but decentralize responsibility to local government.
- There are three ways to finance individual health care: private individual payments, private collective payments and public finance.
- The most common methods of financing mental health care are tax-based funding, social insurance and out-of-pocket payments.
- Individuals with mental disorders are commonly poorer than the rest of the population, and often less able or willing to seek care because of stigma or previous negative experiences of services. As a result, payment out of their own or their families' pockets is even more of an obstacle than it is in relation to many acute physical health problems. Finding ways to increase the share of prepayment, particularly for expensive or repeated procedures, can therefore benefit mental health spending preferentially, provided that enough of the additional prepayment is dedicated to mental and behavioural problems.
- Where possible, governments should attempt to achieve mandatory coverage for mental health, either through national, tax-based or social insurance. In many systems, not necessarily just in poor countries, such mandatory coverage is difficult to achieve. In high-income countries, even where there is coverage, limits may exist. In many low-income countries, insurance schemes are generally not available, or are non-existent.

Step 2. Map the mental health system to understand the level of current resources and how they are used

Having gained some understanding of the broad context of health care financing, the next step is to focus more specifically on the financing of mental health systems within countries. This step mainly addresses the mapping of mental health services, as opposed to the wider mental health system, including the non-health sector, e.g. housing, education, criminal justice, etc. The narrower focus is adopted because of the potential complexity of the funding base of all sectors involved in mental health.

In many countries, mental health services have not received the attention they deserve. More recently, however, there has been an improvement in the understanding of the social and economic consequences of this state of affairs, and new effective medications and treatment regimens have emerged. As a result, policy-makers are giving increased attention to mental health services. Nevertheless, these services still have to compete with other social and health priorities. Humanistic arguments are no longer sufficient. The case for mental health services must be made on the basis of research and information indicating a clear expectation of a return on investment in this field.

In order to achieve credibility and accountability, it is necessary to understand what resources are available, which regions and services they are allocated to, and what difference this makes not only to individuals with mental disorders but also to society in general. Planners and policy-makers often do not know what resources are available because mental health services are fragmented and various ministries are responsible for different streams of funding for mental health services.

In order to understand what resources are available it is therefore necessary to map mental health financing systems. This defines the resources that are currently available for mental health services and how they are allocated. Exercises of this kind reveal gaps in needed information.

The purpose of this step is to give policy-makers a tool with which to obtain a better understanding of funding sources, purchasing mechanisms, target populations, services and their effects in the countries or regions concerned. This tool is not intended to provide a static picture but to identify issues that may affect the allocation of resources. This has implications for regions, different service populations and different services. Ultimately, two perspectives have to be related, viz. how the money flows and how and where consumers gain access to services. An understanding of these two flows is needed in order to move mental health systems in a desired rational direction.

Figure 2 illustrates the flows of money and consumers' access to services. The purpose of mapping these flows is to gain an understanding of where people go for services and what services they receive. The complexity of such mapping is related to the detail desired. Countries may need to adapt the diagram to their specific circumstances. Variations can occur between regions, between sociodemographic characteristics and between the types of problem for which help is sought. Ideally, a map of this kind indicates the numbers of persons receiving services and shows who is paying for the services. If this information is unavailable, estimates and best guesses can be usefully employed in developing a financial schema for the system of mental health care in a given country or region.

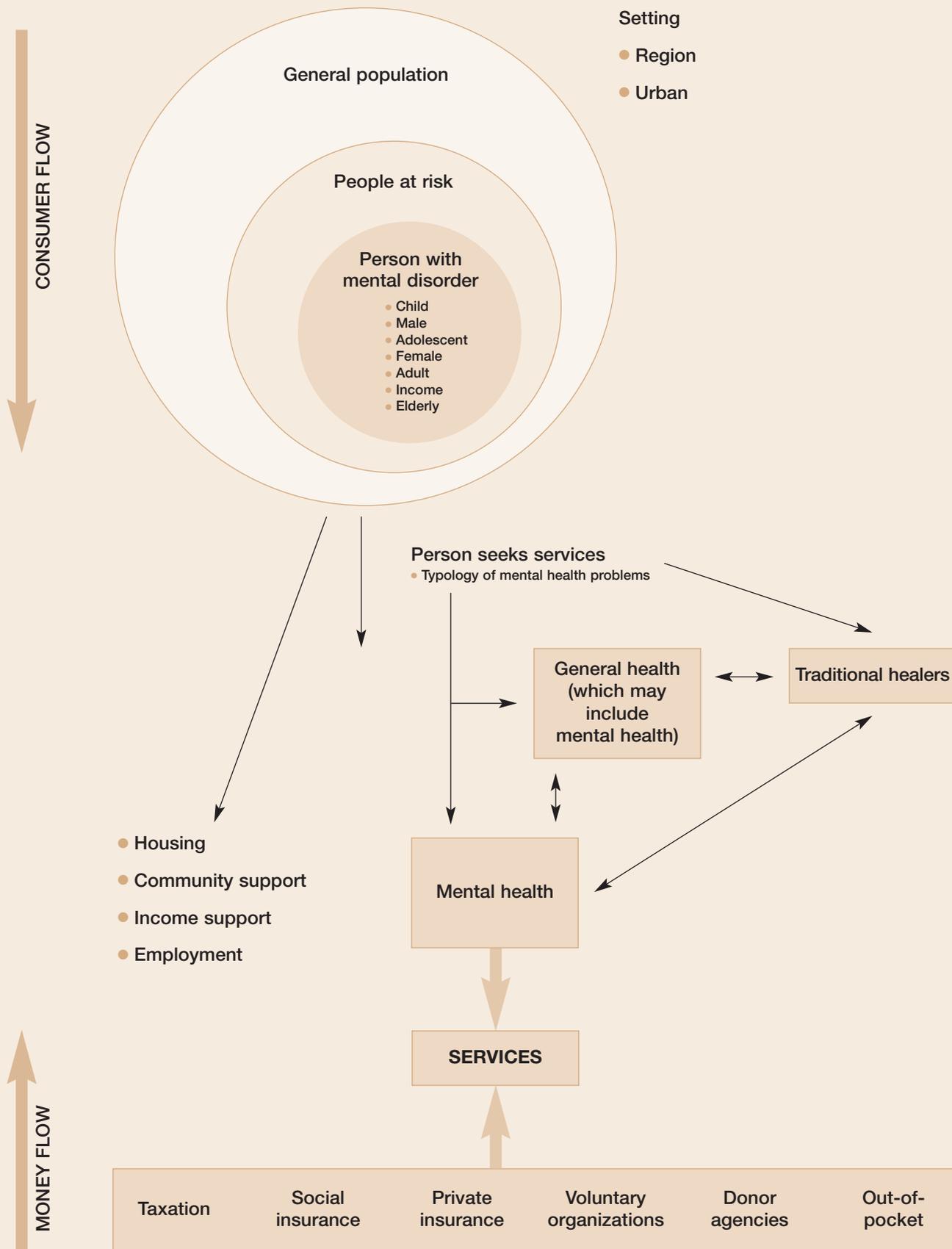
Mental health services have to compete with other social and health priorities.

It is vital to understand what resources are available.

This requires mapping the mental health finance system.

The purpose of this step is to provide a tool for mapping mental health finance within a country or region.

Figure 2: Mapping the mental health financing system



Guiding questions for policy-makers in the development of this map are as follows.

- What are the sources of funding for mental health services?
What amount is available from each?
- How are the resources allocated to different regions? Is the allocation equitable?
- How are resources allocated to different service provision sectors?
Are there regional differences?
- Who is receiving services with available funding?
- How much of the funding is going to direct service provision
(vs. administrative costs)?
- Who should be receiving services but is not?
- How much will it cost to provide needed services?

Clearly, the key elements associated with each of these questions varies between countries as does the capacity to develop the needed information. Even in relatively developed countries these questions are not easily addressed. Without answers to them, however, it is more difficult to make the case for mental health services.

This step may not be simple, especially if mental health expenditures are not routinely disaggregated from general health expenditures. As Fig. 1 shows, mental health services may be provided by both the general health sector and a specialized mental health sector. The point here is to start with the current capacity and data that are available in the system.

The following separate tasks may be identified.

Task 1: List the mental health resources and the budget for each.

Depending on the detail desired it is possible to start by listing the mental health resources that exist and identifying the budget of each. This may not be easy and may involve examining various sources and documents, including records of hospital expenditures and staffing data and, in some cases, making educated estimates and guesses. For example, if a hospital's budget is available this will be the starting point. In other situations the total budget may not be available but there may be information about personnel costs. As an alternative this may be the place to start.

Depending on the particular country's situation, information may be needed from other units, sectors or ministries. For example, the budget for housing and residential services for adults or children with mental disorders may be part of the budget of the ministry of social welfare or the ministry of housing. Information on this matter would have to be obtained or estimated from the sources available.

When calculating or estimating the budgets for services it is essential to include the administrative and infrastructural costs that make the services possible, including the cost of key functions for the development and ongoing maintenance of the system. Among these functions are capital items, the implementation of policy functions, planning, information systems, quality improvement and advocacy support. These are often unfunded mandates or expectations that should be identified as costs. As is pointed out in other modules the viability of the system depends on these functions and they must be included in any resource-mapping initiative.

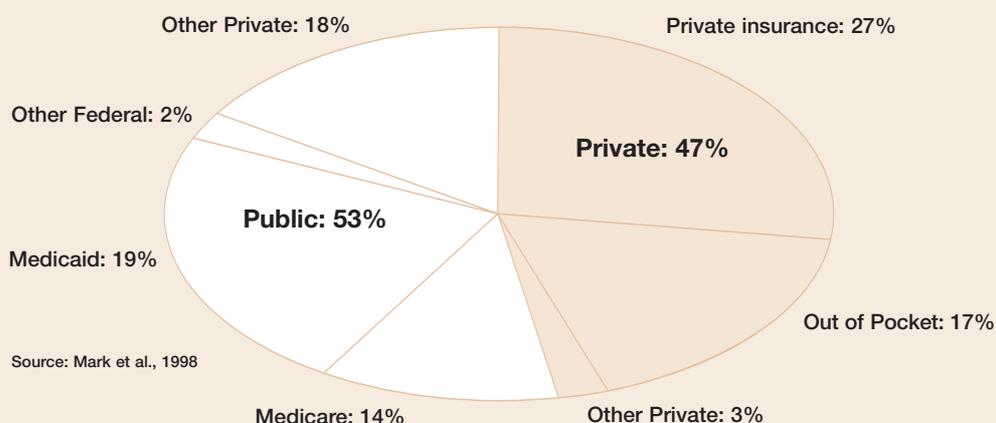
Several questions are useful for guiding the mapping process

The development of such a map is neither straightforward nor simple, even in countries with sophisticated information systems. In developing countries the problems are exacerbated: there may be little information on who uses the private or traditional sectors, how much they are used and what users pay. It is often difficult to distinguish patterns of use by different population groups. However, this exercise is a starting point that can be developed over time. Initial work can identify gaps and areas in respect of which special efforts may be needed in order to obtain information.

This exercise should ultimately produce a list of the available mental health services and of the budgets or expenditures associated with them. The list can be subdivided in accordance with the regions or groups served.

This permits the identification of the key components of the existing mental health system and the funding associated with each component on the basis of the available information. An overview is thus obtained of the current state of mental health financing in the country or region concerned, in preparation for the next step. Figure 3 is an example of the mapping of mental health financing in the USA, with expenditure listed by payer.

Figure 3: Mental health expenditures in the USA by payer, 1996
(Total = US\$ 69 billion)



Population, spending and per capita mental health costs by insurance status, USA, 1996

Insurance status	Number (millions)	Spending (US\$ billions)	Annual per capita (US\$)
Private	167.5	32.3	193
Insurance payment		18.4	
Out-of-pocket payment		11.7	
Other private		2.2	
Medicare	30.6	9.8	320
Medicaid	27.0	13.0	481
Other and uninsured	41.7	13.9	333
SPMI*	5.1	12.4	2431
Other	36.6	1.5	41
Total	266.8	69.0	259

*Severe and persistent mental illness.

Source Mark et al., 1998; and calculations by D. Regier, personal communication, 1999

Mental health expenditures in relation to national health expenditures by source of payer, USA, 1996

	Expenditures, US\$ billions, 1996		
	Mental health care	All health care	%
Private			
Client out-of-pocket	11	171	6
Private insurance	17	292	6
Other private	2	32	5
Total private	30	495	6
Public			
Medicare	10	198	5
Medicaid	13	140	9
Other federal government	1	41	3
State/local government	12	69	18
Total public	36	447	8
Total expenditures	66	943	7

Source: Mark et al., 1998 (revised)

Source: Department of Health and Human Services, U.S. Public Health Service, 1999

Task 2: Plot the existing mental health services on a matrix

As a complement to the previous task, a second useful tool for mapping the financing of a mental health system and its component services is a simple matrix relating revenue sources to service provision sectors (Knapp, 1995) (Box 3).

Box 3. Matrix of revenue sources and service provision sectors

REVENUE COLLECTION (FUNDING)	MODE OR SECTOR OF PROVISION			
	Public/state sector	Voluntary /NGO	Private (for-profit)	Informal sector
General taxation				
Social insurance				
Private insurance				
Charitable				
Foreign governments				
Out-of-pocket				

NGO = nongovernmental organization.

What would go into such a matrix? The matrix can be completed by listing a range of different aspects of the mental health system (inpatient facilities, community services, vocational training units) in the appropriate cells, thus providing an overview of the range of services or organizations currently available and their corresponding funding sources. This could be done for each region of a country or for the entire country.

The purpose of developing such a matrix is to link the sources of funding to the mode of service provision. The matrix can be related to Task 1 by linking the revenue sources and amounts to the various mental health services depicted in the previous mapping exercise. An understanding of these sources throws light not only on the resource structure but also on the implications for the ongoing sustained funding of the system.

This mapping process can be illustrated with examples of diverse funding sources for mental health. In Argentina, funding for mental health comes from the federal government, the provinces, the cities, the social security administration, the trade unions and private organizations. In India, government-sponsored mental health services are funded by the central government, the state governments or the University Grants Commission, which receives funds from central government and finances some of the country's psychiatric teaching units. In situations such as these, increases in funding depend on allocations made for mental health services in national or state health plans or in the budgets of other funding sources.

Box 4 shows how these diverse funding sources may be mapped in a matrix. When conducting this exercise, countries should adapt the data to their own circumstances.

Information from the mapping exercise may prove useful when the case is being made for additional resources

Box 4. Matrix for mental health services in a hypothetical country*

REVENUE COLLECTION (FUNDING)	MODE OR SECTOR OF PROVISION			
	Public/state sector	Voluntary /NGO	Private (for-profit)	Informal sector
General taxation	(1) State psychiatric hospital (2) Psychiatric outpatient clinics (3) Percentage of primary health care budget used for mental health care (4) Percentage of health promotion budget used for mental health promotion	Pledged state contribution (5%) to an international NGO providing trauma services	Commissioning (contracting out) of specific services, e.g. trauma counsellors in primary care clinics	Grants to identified chronic service users
Social insurance	-	-	-	-
Private insurance	-	-	Voluntary contributions (annual contributions to private insurance agencies)	-
Charitable	NGO funding of sheltered employment in state-owned facility	(1) NGO providing trauma services (95% of annual budget) (2) Advocacy organization campaigning for rights in psychiatric hospitals	-	Grants to epilepsy sufferers from international epilepsy fund
Foreign governments	Foreign government-subsidies to mental health service providers		-	-
Out-of-pocket	Sliding scale service charges for public services	Sliding scale service charges for trauma counselling (NGO)	Fee-for-service payments to private providers and traditional healers	-
No exchange	NA	NA	NA	Family care; neighbourhood support

* This is an illustration, not a recommendation as to how mental health financing should be structured. NA = not applicable. / NGO = nongovernmental organization.

The mapping exercise can help to clearly identify limitations and potential sources of expansion. This is essential for addressing the goals of policy and planning and for expanding the funding base for the identified needs and priorities. However, this alone cannot result in the expansion of the required resources. In many countries, such expansion may, in fact, be outside the purview of the mental health policy-maker or planner. But the information derived through this step may prove useful in making the case for additional resources and even drawing attention to potential sources of funding. Mapping the current state of affairs can help to establish the rationale, credibility and accountability needed to justify the growth of resources. As such, this analysis is a useful tool for informing policy-making and planning.

Key points: Step 2. Map the mental health system.

- Mapping existing services and the resources available for them is a critical step in understanding the mental health financing system.
- This mapping exercise should include infrastructure and administrative support costs, especially the costs of implementing the key functions identified in the various modules of the guidance package.
- The broad categories for this mapping process should be identified and listed e.g. hospitals, residential care, outpatient services, information systems, advocacy organizations and policy/administrative support.
- Sources of funding for these categories should be identified and available information should be obtained. Intersectoral sources may be needed.
- The sources of funding should be identified by type of funding and by type of sector or organization providing the funding.
- Understanding the relationship between these sources of funding and the resources identified with the various mental health functions may provide opportunities for and indicate limitations to the development of additional resources.

Step 3. Develop the resource base for mental health services

Once an overview of the current status of mental health financing has been gained by mapping the system, the next step is to develop the resource base for mental health services. This needs to be done in accordance with the priorities identified by the mental health policy.

At this stage, policy-makers and planners inevitably face the reality of underfunding for mental health. Understanding the reasons for underfunding is an important starting point for developing the resource base for mental health.

Underfunding can arise for various reasons (M. Knapp and D. McDaid, personal communication, 2001):

- Countries in dire economic circumstances or facing complex emergencies are unlikely to be able or indeed to want to give priority to health expenditure. Furthermore, within the area of health expenditure they are unlikely to prioritize expenditure on mental health services.
- Low recognition of mental health problems and their consequences.
- In systems that are heavily reliant on user charges, underfunding may result from an unwillingness or inability of individuals with mental disorders (or their families) to pay for treatment. Stigma, cultural considerations and low income may be among the causes.
- Policy-makers may not understand what can be done to prevent or treat mental disorders and may therefore believe that funding for services other than those of mental health is of greater benefit to society. In other words the economic argument for funding mental health services has been elusive. Stigma and a lack of information also keep the demand for mental health services at a level lower than is commensurate with need.

Developing the resource base for mental health therefore requires policy-makers and planners to address the reasons for underfunding and to find ways to overcome it.

The active expansion of the resource base is as much an issue of politics and priorities as it is of analysing the sources of funding with a view to advancing the case for mental health care. This point should be reiterated: **expanding the financial base of the mental health system is largely a matter of policy priorities.** Funds are limited and mental health has to compete not only with other parts of the health sector but also with many other vital programmes, e.g. those of economic development, roads, transportation, communications and education. A starting point for expanding the resource base therefore rests with policy initiatives.

Policy initiatives to expand the resource base

Some of the ways of making the case for mental health are set out in other modules (*Mental Health Policy, Plans and Programmes; Advocacy for Mental Health; Planning and Budgeting to Deliver Services for Mental Health*). They include:

- developing and demonstrating the evidence for cost-effective mental health interventions;
- demonstrating the economic argument/business case for issues such as quality, information systems and other aspects of service infrastructure;
- building strategic alliances with key individuals and groups and with government ministries, nongovernmental organizations and the private sector;

Underfunding for mental health can arise for various reasons.

- supporting the advocacy movement in order to create a popular demand for mental health services and thus to increase pressure on government to fund mental health services appropriately.

These policy and planning initiatives have the potential to significantly improve funding for mental health services. Details of how to develop such initiatives are set out in other modules (*Mental Health Policy, Plans and Programmes; Planning and Budgeting to Deliver Services for Mental Health; Advocacy for Mental Health*).

Financing mechanisms to expand the resource base

1. Seeding innovative projects

Apart from policy initiatives for expanding the resource base, financing mechanisms can be established. One method would involve establishing a mental health innovation fund in order to implement the proposals and initiatives outlined in policy (Institute of Medicine, 2001.)

The objective of such a fund would be to seed projects that aimed to achieve the objectives set out in the mental health policy. The fund would finance the demonstration and evaluation of programmes implementing the types of changes recommended by policy. These could include: policy development, advocacy, and quality improvement initiatives. The goal would not only be to fund good ideas but also to focus on innovations with broad applicability which could subsequently be adopted or adapted elsewhere.

Monies could be provided to individual local health care organizations, private organizations, public agencies or advocacy groups. A portion of the fund should be set aside for tackling critical research projects.

Such a fund makes it possible for innovation to occur and helps to ensure that additional resources are not devoted to the system in the usual way. The commitment of monies for several years can ensure a sustained and stable funding source whereby necessary changes can be achieved. Furthermore, a fund of this kind can help to meet the initial costs that health care organizations and other bodies face when embarking on recommended changes.

Initially, special government grants or donor sources may be needed to support innovation funds. International and external development agencies may be in a position to soften the burden of transitional costs. Box 5 indicates how to apply for such funds from the World Bank. Similar processes exist for other sources.

The establishment of a mental health innovation fund could promote ongoing change and quality improvement

Box 5. How to access funding from the World Bank

- Designate a focal person for mental health in the ministry of health of the country concerned.
- Identify and document mental health activities and programmes, including those funded by WHO.
- Establish a budget line for mental health. A separate budget line within the ministry of health is useful as it can serve as the basis for the development of a proposal to be submitted to the World Bank.
- Identify health projects funded by the World Bank and consult appropriate persons in order to:
 - determine what has been funded and how far the projects have progressed;
 - discover possibilities of including mental health in currently funded activities;
 - identify procedures for submitting a proposed mental health project for consideration.
- Explore the possibility of accessing World Bank funding through a ministry other than the ministry of health. For example, social sector loans can be obtained through the ministry of education or the ministry of social welfare or can even administered by a nongovernmental organization identified by the ministry of finance. (The Burundi Ministry of Finance requested a nongovernmental organization to administer a social sector loan for work on early childhood development with a mental health component.)
- Explore the possibility of obtaining funds for mental health projects from the World Bank at its Headquarters, although this is more difficult. Small amounts of money are available in specialized units in the Bank, e.g. the Post-Conflict Fund and some trust funds.

(More information is available on the World Bank web page at www.worldbank.org)

2. Include mental health in general health resource development

Another avenue involves including mental health explicitly in ventures aimed at increasing resources for general health. Similarly, when funds are sought from donor or external grant agencies for general health programmes, mental health should be part of the agenda. Currently, in many of these initiatives, little attention is given to mental health.

There are two ways of addressing this difficulty. The first is to continue to make the case for mental health in general health policy and planning. This has been demonstrated in some of the policy initiatives listed above.

The second is to include mental health in general health initiatives. In other words the possibility of pursuing funding for mental health resources should not be limited to strategies that are specific to mental health but should also be included and specifically defined as belonging to initiatives for the development of resources for general health care. For example, in South Africa, funding for mental health has been increased by including a mental health component in the national crime prevention strategy. Among other components this has required the training of primary care nurses in counselling techniques for treating victims of crime (Freeman, 2000).

With regard to establishing when a resource base has been adequately developed it should be noted that there are no simple formulae for an adequate funding level. Moreover, cross-national benchmarks have limited value. There are wide variations in system objectives and priorities, in target populations and in the assigning of budgetary responsibility. A mental health expenditure in one country may be a social service expenditure in another. As noted in other modules, the adequacy of the resource base should ultimately be judged in relation to whether the mental health service is improving outcomes for people with mental disorders and the wider population.

Key points: Step 3. Develop the resource base for mental health services

- Understanding the reasons for underfunding is an important starting point for developing the resource base for mental health services.
- Underfunding can arise for various reasons. These include: overall economic adversity in the country concerned; low recognition of mental health problems and their consequences; unwillingness or inability of individuals with mental health problems (or their families) to pay for treatment; failure of policy-makers to understand what can be done to prevent or treat mental disorders and, consequently, a belief that funding for services other than those of mental health is of greater benefit to society.
- The resource base may be developed through policy initiatives as outlined in other modules in the guidance package.
- The resource base may also be developed through financial mechanisms such as seed funding for innovative projects and the inclusion of the development of mental health resources in that of general health resources.

Step 4. Allocate funds to address planning priorities

Step 4 follows logically from Steps 2 and 3. When the resource needs have been defined and the resource base has been developed the next step is the allocation of resources. There are many ways of doing this: by region, type of services, target population and income level. These allocation strategies must be tied to the priorities defined in policies and plans. Because of the diversity of countries and their needs, no single allocation strategy is available.

Nevertheless, the broad strategies defined in the *World health report* (World Health Organization, 2001a), viz. shifting care away from large psychiatric hospitals, developing community mental health services and integrating mental health services into general health services, provide an initial framework for moving forward. However, the more specific allocation strategies must emerge from strategies implied or defined in policies and plans.

There are various ways in which policies and plans can allocate funds, e.g.:

- from the national level to the district level;
- to income strata in countries;
- to components and interventions within mental health systems;
- to target populations;
- to regions.

As with previous steps it is essential to gain an understanding of these mechanisms in order to improve the allocation of appropriate funds to mental health. Equity and accountability are key issues related to such allocation. Is mental health receiving a fair share of funding? Are poor people receiving mental health services or are the primary beneficiaries the well-to-do? Are there major regional disparities, i.e. are mental health services concentrated in urban areas or in some regions? Are funds primarily going to institutional settings? In other words, are community services and other proven interventions receiving appropriate funding?

Allocations from the national level to the district level

The devolution of control and accountability for health care finances to the district level is increasingly being adopted in order to make better use of existing resources. In this way each district can control and disburse resources in accordance with particular requirements, and districts can be held accountable for resources so that, theoretically, the ability to track funds and improve efficiency is increased.

The mechanisms for funding mental health services can be complex, involving allocation from national, state and local governments as well as from trade unions, voluntary organizations and donor agencies. However, allocation formulae can be used to reflect mental health priorities and to address issues of inequity in mental health status and access. At their simplest, they could be based on equal shares of resources per head of population, as happens in Spain (M. Knapp and D. McDaid, personal communication, 2001).

Such formulae, however, do not take account of factors related to differences in the prevalence of different mental disorders (prevalence being higher among persons in low-income groups than among the better-off), in existing resources (some areas may already have better access than others to mental health services) and in the costs of providing services (e.g. transportation, infrastructure maintenance, salaries).

There are various ways of allocating funds.

Equity and accountability are key issues related to allocation.

Formulae can be developed to incorporate and reflect these concerns. Because the transition to the use of such allocation formulae may be complicated it is important to ensure that some degree of consensus is achieved concerning admissible components and that various data sources are included.

Formulae for allocation from the national level to the district level can also include guidelines or requirements on the use of funds. In the USA, for example, the federal block grant for mental health includes a specified amount that is set aside for mental health programmes for children and adolescents.

Even within a district, however, allocations may not be made equitably or appropriately. For example, local planners may not understand the importance of mental health issues and may therefore underfund mental health services within general health care. Local planners may not have the management skills and financial accountability necessary for implementing mental health services of proven value. Thus it is not always certain that local authorities can mobilize more resources through allocation from the central level to the district level. Box 6 reflects the uncertainty that can accompany such decentralization. Contract mechanisms, discussed in a later section of this module, are useful devices for aligning local expenditures with national priorities.

Allocation formulae can include guidelines or requirements on the use of funds at the district level.

Box 6. Impact of decentralization policy on public mental hospitals in Indonesia: a financial perspective

- In 2001 a new decentralization policy in Indonesia devolved authority from central government to provincial and district government, including authority over the transfer of funds to these levels. The central government, however, still has a centralized budget.
- Responsibility for public mental hospitals was transferred from central to provincial government. Community mental health is a responsibility of district government.
- The central government budget for mental health is approximately 1.7% of the total health budget. Excluding 3% of the funding for mental health which is allocated to the central office for mental health in the Ministry of Health and four schools for mental health nurses, the budget is allocated to public mental hospitals. There is no budget for community mental health within the Ministry of Health. (Chronic patients are the responsibility of the Ministry of Social Affairs rather than health agencies.) At the provincial government level, the budget for mental health hospitals is 0.3% of the total health budget.
- The decentralization policy transferred 25 central government hospitals to provincial governments. The central government budget declined from 146.8 billion rupiah in 1999 to 63.5 billion rupiah in 2001.
- Although the aim of decentralization is to provide local control and commitment there is still a question as to whether the result is beneficial or harmful. The likely effect of decentralization remains unclear because provincial government has no history of providing a mental health budget and mental health has not been a priority at this level.

Source: Trisnantoro, 2002.

If a separate mental health budget exists, mental health planners may have to develop or provide input for the creation of allocation formulae. Some of the factors that may have to be taken into consideration are: the current distribution of resources; priority needs; rurality; the percentage of the population that is unemployed or on low incomes. If there is not a separate mental health budget, planners may need to develop mechanisms for including explicit mental health components or line items as part of budgets at the district level. If expenditure and utilization reports are produced at the district level, provision should be developed for tracking mental health expenditures and services.

Allocation of funds to income strata in countries

The way in which funds are allocated to different income strata in countries is directly relevant to the goal of equity. Equity is explicit in many national mental health programmes (whether in terms of mental health status or access). WHO advocates policies that ensure equity in health and access.

Such equity goals, however, do not exist everywhere. Access to mental health services differs dramatically between income groups in many countries. The common pattern is that people in high-income groups have better access to such services than people who are less well off. This parallels access to general health services.

Some inequities are legacies of past practice. In Ghana and Zambia, for example, policies dictated that public hospitals in Accra and Lusaka provide free or heavily subsidized medical care to the colonial élites. It has been extremely difficult for policy-makers to shift this care to private hospitals or to charge full costs to the wealthy for care in government teaching hospitals. Trade unions seek to protect public subsidies in the middle-income countries of Latin America, where governments extend financial support for health care based on social security through combinations of tax relief, public contributions to insurance premiums, and direct budgetary transfers to social security agencies. Health workers and their unions are a major source of resistance to change. A shift in public funding to basic care would require doctors and nurses to be redeployed from large urban-based hospitals to smaller peripheral facilities in poor urban neighbourhoods and rural areas, where living and working conditions are commonly inferior to those associated with central hospitals. Consequently, it is not surprising that health workers oppose such changes in deployment. Similarly, a reallocation of government spending on health would reduce the demand for publicly financed services from medical specialists.

Given these circumstances, how is equity to be achieved?

Countries that have been comparatively successful in achieving equity have experienced moderate to high economic growth. They have tapped an expanding resource base in order to improve health care overall and, especially, for the poor. While growth does not automatically lead to a redistribution of basic public services, such redistribution is extremely difficult to achieve without it. Ghana, Peru, and Zambia experienced stagnating or even declining national income in the 1970s and 1980s, when government spending on health was severely constrained. In contrast, Costa Rica's economy grew at an average rate of nearly 6% a year in the 1970s and by 3% a year in the 1980s, and in Malaysia the economy grew at an average rate of 7% a year during these decades. The examples of Costa Rica and Malaysia in achieving increased equity in general health care are instructive in connection with the development of equity in the area of mental health.

Policies can be focused explicitly on the relatively disadvantaged. Programmes can be targeted on low-income rural households. Zimbabwe's focus on rural health facilities and district hospitals is a good example of this type of targeting, involving the use of simple geographical criteria. Costa Rica's emphasis on basic primary and preventive

Countries that are comparatively successful in achieving equity have experienced moderate to high economic growth.

Equity results from programmes that focus on the relatively disadvantaged.

care, viz. immunization, control of diarrhoeal diseases and safe childbirth services also effectively targeted the poor, who suffered a greater disease burden of vaccine-preventable illnesses, diarrhoea and childbirth complications than did the rich. At the same time, these primary and preventive services also benefited the middle class and the wealthy, thus helping to maintain political support for the initiatives.

At least in the case of middle-income countries, equitable access and public spending for health have been pursued through the effective universalization of health insurance. In the early 1980s, for example, Costa Rica decided to expand the health system based on social security so that it reached the entire population. This meant extending it to the 20% of Costa Ricans who had not previously been covered, predominantly the poor. It was necessary to subsidize health services for the poor because their employment-based contributions to the social security fund was insufficient to meet the cost of services.

The generation and dissemination of information, e.g. on differences in health status, service utilization, total health spending and government expenditures among different income groups can be a crucial element in achieving reforms that improve equity.

The experiences of the few reforming countries and of the much larger number that have not yet shifted the balance of public resources for health towards low-income groups also points to the many serious obstacles to equity-oriented reforms. Politically influential groups that stand to lose from a change in the status quo can be expected to block change. The achievement of lasting reforms requires a combination of advocacy, skilful coalition-building, negotiation and leadership.

How can mental health planners or policy-makers confront these inequities? To some extent this depends on whether emphasis is placed on them in plans and policies. If it is there are several options for a financing strategy. First, resources can be allocated so as to specifically target certain population groups or regions. Second, user fees, if used, can be developed so that persons who meet certain criteria either do not have to pay for services or pay in accordance with their incomes. Third, mental health planners should work closely with health officials who are establishing policies for access and eligibility so that special provisions or rates can be created for people with mental disorders.

Allocations to components and interventions in mental health systems

Policy-makers have to make decisions related to the allocation of scarce resources within the mental health sector. Thus decisions may relate to: *types of service*, e.g. hospital-based or community-based; psychotropic medication or case management; *target populations*, e.g. children or adults; persons with severe mental disorders or mild depression; and *geographical regions*, e.g. where people with mental disorders are underserved or where natural disasters have led to populations having special needs. In the Introduction, it was pointed out that there must be an intimate connection between the needs and priorities identified through policy development and planning processes, and the allocation of these resources. Financing decisions should be based on these processes.

Hospital-based vs. community-based system. The use of funds invested in mental hospitals is often proposed as an approach to building a community-based system. (See *Organization of Services for Mental Health*.) This may be viable in a well-developed mental health system where a functional community-based system is operational. In most countries, however, extra funds are required for introducing community mental health services. Planning for the dual running costs of community and hospital services may be required during the transition (Thorncroft & Tansella, 1999). Furthermore, in some countries where there is a shortage of psychiatric hospital beds it may not be optimal to close these down in order to support community services. Indeed, such beds

The universalization of health insurance has helped to advance equity.

Policy-makers have to make decisions related to the allocation of resources within the mental health sector.

Various factors must be considered when allocations are being made from institution-based to community-based systems.

may be an important backup and safety net for the community-based system. In countries where there is a surplus of hospital beds their number can be reduced and the savings can be transferred to supportive community services. Even in such a system certain factors make this difficult. Some of them are indicated below.

- **Fixed costs of hospitals.** A considerable portion of hospital operations is linked to infrastructure maintenance and staffing. The reduction of utilization can result in savings if an entire unit or ward is closed down so that the associated personnel budget can be transferred. In other words, savings occur if reductions occur in lumps (as in a unit or a ward) and not merely as a result of the discharge of a few patients.
- **Availability of community-based services.** The use of hospital resources to fund the development of a community-based mental health system is based on the assumption that capacity and resources exist in the community for absorbing persons who previously received care in hospital settings. Double funding may be needed to develop community services so that persons who need them can be transferred.
- **Vested interests of hospital staff.** Hospital staff may have positions, salaries, benefits or other advantages that they are not ready to forgo as part of the transition process. Communities in which hospitals are located may have acquired economic advantages and may therefore resist reductions in hospital size. These possibilities must be considered in any transfer process.
- **Hospital care may be appropriate.** In an underfunded system, persons may receive optimal specialized and acute care in hospital settings. It may be appropriate for a large proportion of mental health funding to be budgeted for hospitals. In this circumstance, community-based care should not be predicated on reduced hospitalization.

Box 7. Closure of Pachuca Psychiatric Hospital

The closing of Pachuca Psychiatric Hospital in Mexico is a good example of the shifting of funds from institutional to community care.

- The hospital had 287 beds and served long-stay patients whose diagnoses were primarily schizophrenia and mental retardation.
- Following exposés about poor conditions at the hospital, it was decided to use the funding for the hospital to develop a model of mental health services based on community psychiatry.
- Funds that previously funded the operation of the hospital were used to fund 10 houses (each accommodating 12 persons), an acute 30-bed inpatient unit in the old hospital, an outpatient department and two halfway houses for 34 people.
- In order to implement this model, 117 residents of the hospital were transferred to institutions in other states.
- The new model started operations in November 2000 and after a year the results were positive, notably in improved psychosocial functioning and quality of life.

Sources: Goering et al., 1997; Dirección General de Rehabilitación Psicosocial, Participación, Ciudadana y Derechos Humanos, Mexico 2001.

From the financing perspective the shifting of resources from hospital to community (or the development of a specific service or target population) has to be predicated on the identification of and commitment to such changes in plans and policies. At the same time, the premise of feasibility depends on a financial analysis of the costs of the alternatives. As shown in the above example the shifting of funding from hospital to community requires projections of the costs of new homes and services. There are transitional costs: funding is needed initially for the old services and the development of the new services so that the transition from the old model to the new one can occur. Unfunded transition can result in a loss of services for persons in the old system. Finally, it is necessary to assess the financial implications for staff positions, retirements and other factors in order to facilitate the development of the new approach.

Target populations. Allocations for target populations should be made when information indicates that some groups, identified as high priorities, are underserved. In many systems responsible for persons with mental illness, special priority is given to persons with severe mental disorders. The rationale for this is that under a general mandate such persons sometimes receive inadequate attention because of budgetary constraints: the population in question requires long-term care that is comparatively costly. Among other populations that often need special funding are children, adolescents, persons with dual diagnoses (e.g. mental disorder and substance abuse) and persons requiring care from multiple agencies.

In addition to people afflicted with mental disorders, many persons are at special risk of mental problems because of extremely difficult circumstances. Among them are: people living in extreme poverty, such as slum dwellers; children and adolescents experiencing disrupted nurturing; abused women; abandoned elderly people; people traumatized by violence, e.g. victims of armed conflicts; migrants, including refugees; and many indigenous persons (World Health Organization, 1997).

Regions. Particular geographical areas may have special needs because of economic conditions, population characteristics or emergencies. Specific funding initiatives could be used in a targeted fashion under such circumstances.

In the context of limited funding, allocations are equivalent to rationing with specified priorities. Prior consensus on a priority scheme is difficult to achieve. The processes of policy development and planning should attempt to make this consensus explicit so that it becomes the rationale for decisions on allocation.

Allocations to vulnerable underserved populations are critical if their needs are to be met.

Key points: Step 4. Allocate funds to address planning priorities

- The allocation of funds should be tied to policy and planning priorities.
- Allocations to regions can be based on per capita funding but this does not take account of differences in the prevalence of different mental disorders (persons in low-income groups have higher prevalence than persons who are better off), in resources (some areas have better developed mental health resources than others), and in accessibility (remote and rural areas may have more difficulty than urban areas in providing access to services). As part of the planning process these factors should be considered in the development of strategies for allocation from the national level to the local level.
- Allocations to regions should be coordinated with any strategies for decentralizing or devolving authority to the local level. It is important to consider the development of local management skills and commitment to mental health so that the impact is positive and involves increased local ownership and control.
- Allocations to different components and interventions should be based on target populations and types of service. Identified through the planning process, a knowledge base of the most cost-effective services for special problems in different subpopulations can inform this process.
- One approach proposed for building a community-based system is to transfer resources from the hospital-based system. However, this needs careful evaluation and should be based on an assessment of the number of hospital beds needed as the community system grows. Double funding may be needed initially to ensure that the community system can accommodate people discharged from hospital. Transfers of funds cannot be gradual. They have to be lumped because hospital resources cannot be transferred until units can be closed and staff reductions become feasible.

Step 5. Build budgets for management and accountability

Following the development of the resource base for mental health and the appropriate allocation of resources, budgeting is the next essential step. The budget of an organization is a plan to achieve the organization's objectives, stated in monetary terms, for a fixed period. The budget is essentially a plan of operations stated in fiscal terms (Warren, 1992). As emphasized in the previous section, planning rather than financial issues should drive the budgetary process. All too often, plans and budgets are developed independently so that strategic goals and objectives are not explicitly reflected in the budgets.

Planning can be considered at the strategic and operational levels. Strategic plans focus on what is to be achieved and identify the mechanisms and processes in a broad way. Operational plans indicate in detail how goals are to be achieved, i.e. who will do what and how much in a defined period. Budgets are tied more to the operational level and they define both the resources available and their allocation. Budgeting processes differ in their specificity and in the logic used in their construction.

Functions of a budget

A budget serves the functions of planning, policy, control and accountability. With regard to **planning** a budget defines the service delivery system by defining the costs of its components. For example, in order to build a budget for a psychiatric hospital it is necessary to define the numbers of beds and staff, both clinical and administrative, so that the cost of operating the hospital can be projected. Similarly, the amount of the budget allocated to community services shapes their maintenance or growth.

A budget is also a statement of **policy**. If a service is not budgeted for, even if it is a critical component of a national mental health programme or a strategic plan, the budget reflects the reality or ability to implement the policy in question. For example, if the stated policy is that persons with severe mental disorders shall receive medication free of charge and if the budget does not accommodate this, the policy effectively becomes that persons with severe mental disorders shall not receive medication free of charge.

A budget also serves the management function of **control**. Budgets allocate funds and identify resources for specific activities. However, it does not necessarily follow that these activities will be carried out. Monitoring expenditures associated with activities and monitoring the objectives which the activities are intended to address allows managers to track whether actual expenditures and activities are commensurate with projections. A systematic study of these matters provides an opportunity for corrective action, review of existing activities and improved performance.

Finally, a budget serves the function of **accountability**. A budget is usually allocated to various departments or sub-organizational units. Each unit is responsible for its resources and expenditures and is accountable for achieving targets and contributing to key strategic goals. Reports from these units at regular intervals, e.g. weekly, monthly and quarterly, allow comparisons to be made between actual performance and budgeted performance. Thus budgets can define responsibility, monitor accountability and even foster a sense of organizational purpose.

Types of budget

There are four types of budgets: global budgets, line or object budgets, performance-based budgets and zero-based budgets.

Global budget. A global budget is a fixed amount that is appropriated for an organization.

The budget is a plan for achieving objectives stated in monetary terms.

The four functions of a budget are planning, policy, control and accountability.

The amount is usually based on some allocations formula or on historical funding. The advantage of a global budget is that it allows maximal flexibility in the organizations for which monies are appropriated. Organizations can allocate resources so as to reflect local needs and resource structures for the achievement of overall goals. The major disadvantage is that there is no assurance that funds will be allocated to priorities identified by the funding authority. Furthermore, there is no incentive for sound fiscal management. If the organization's objectives are easily attainable within the budgeted amount there is no incentive to contain costs or achieve targets that are higher than expected. If the annual budget is based on the previous year's expenditures, cost containment might be penalized by the imposition of a smaller budget in the future.

A global budget is a total amount appropriated to the funded entity.

Line or object budget. A line or object budget designates, line by line, the amount of money available for each category of expense. In such a budget the items of expenditure are explicitly delineated. For example, each hospital (or all hospitals combined) could be a line item. Or, in a more detailed version, the number of employees in each professional category could be a line item. The greater the specificity of each line item, the greater the accountability and controls. On the other hand a line budget imposes rigidity that sometimes prevents managers from using the available resources in an optimal manner. An important aspect of line budgets is the specification of the freedom to transfer funds. For example, budget guidelines may specify the percentage of the line item for psychiatric hospitals which is transferable to community services, or the proportion of funds for a specific hospital which may be transferred to another.

A line budget designates monies available for each category of expense.

Performance-based budget. A performance-based budget is based on what is to be accomplished rather than on the money spent in order to accomplish goals. Such a budget defines objectives and indicates measures for determining outcomes. This type of budget requires:

A performance-based budget ties monies to proposed accomplishments.

- the organization to be divided into a series of programmes, activities, or services;
- the objectives and services to be detailed for each programme;
- performance measures to be established for programme functions, e.g. outpatient visits;
- funds to be allocated on the basis of programme costs;
- a reporting system to be established which relates total units produced or accomplished to total cost.

This type of budget requires an efficient accounting system such that the costs of activities can be related to the intended outcomes or outputs. The budget is intended to facilitate monitoring and accountability in terms of outputs rather than inputs.

Zero-based budget. Zero-based budgeting requires each manager to fully justify the entire budget request in detail and allows the re-evaluation of all programmes and all expenditure for every budgeting cycle. In zero-based budgeting each manager prepares a decision package that includes an analysis of cost, objectives, performance measures, consequences of not performing the proposed activity, and benefits. The decision packages are then ranked in order of importance. The ranking process allows managers to identify unit and organizational priorities. This process cumulatively provides an organizational picture of needs, expenditures and priorities so that reasonable funding decisions can be made (Warren, 1992). The value of zero-based budgeting is that it forces recognition of the fiscal realities of ongoing (or proposed) activities or practices and also becomes a process for forcing links between planning, priority-setting and budgeting. Large transaction costs represent a significant disadvantage.

A zero-based budget provides an overall picture of needs, expenditures and priorities.

To a large extent, the type of budget used depends on contextual factors such as the budgetary process used for the health sector in departments of government. However, as has been shown, a budget is a management tool that must correspond to the service

delivery system and the planning and policy objectives. A budget is much more than a projection of the costs of the service delivery system: it is an instrument for communicating standards of performance expected by the organization, a tool for motivating employees to achieve goals and objectives and a mechanism for monitoring and assessing the performances of different sub-organizational components.

Effective budgeting relies on rational thought when choices are being made between alternative courses of expenditure. Prioritization as between competing demands is fundamental. What specific objectives will be the focus over a specified period? A budget provides an opportunity to evaluate alternative courses of action for the same end. Furthermore, it forces a clarification of goals and objectives throughout the organization concerned. It is information-driven and depends on accurate, clear communication across all levels of the organization.

Experience gained in Victoria, Australia provides an example of how a budgeting system can be used to focus on services of higher quality (Victoria Department of Human Services, 1994). The new approach encouraged managers' use of judgement and innovation and devolved greater authority to managers for the development of strategies aimed at producing services of high quality at reduced cost. The mechanism for achieving these changes included the establishment of a results-based financial and management system that focused on outputs and outcomes rather than inputs. In the proposed management accountability framework, government purchases goods and services from its departments in order to meet its policy goals. Managers were given increased responsibility and were also made accountable for their decisions.

This results-based structure has two key components. First, government sets government-wide financial goals and parameters of fiscal policy. Second, it sets objectives for individual departments within this fiscal framework. Full accrual accounting was an important aspect of this system, allowing the complete attribution of costs to particular outputs both at a point in time and over time. Key initiatives in the redesigning of the budget were the continuing redevelopment of the mental health services, involving the progressive dismantling of large state-run institutions and the development of a statewide integrated service delivery system, managed, in the main, through the public hospital system. The new arrangements offer improved services through a more responsive system encompassing child, adolescent, adult, aged and specialist statewide services.

This example illustrates how the budgetary process can be used to shape the development of a mental health system. The implementation of the process is described in detail in *Planning and Budgeting to Deliver Services for Mental Health*. The different stages of the budgeting process described in this module are:

- review of the previous year's budget;
- review of service objectives and targets;
- provision of guidance on resources to central government;
- discussion and negotiation between different levels;
- development of a draft budget;
- setting of a final budget by central government.

As proposed in Step 3 (Developing the resource base for mental health), budgeting for both innovation and infrastructure is an important component. Furthermore, Step 3 proposes the explicit linking of the budget to priorities in plans and policies that are not limited to services. This includes priorities such as policy development, quality improvement and advocacy, which are often unfunded mandates or expectations. In Step 3, one approach proposed for addressing innovation is the creation of a special mental health innovation fund to promote the ideas and initiatives proposed in this document. In

The budget is a management tool that must correspond to the service delivery system and to planning and policy processes.

some situations, however, this may not be practicable. Nevertheless, some budgetary process or component should include demonstration and evaluation projects for the promotion of critical aspects of the budget development process so as not to limit it to “business as usual”.

How can a budget promote mental health policies and plans?

A first step involves the ability to track funds allocated for mental health at both the national level and the district level. At a minimum this provides an estimate of government resources for mental health. Mental health planners should ensure that a budget line is established for mental health at each level of government which relates to health financing, i.e. the national, provincial and district levels.

The next step is to relate these budgets to the ways in which they are used for allocating resources, to the promulgation of priority initiatives related to quality improvement, and to advocacy, planning and infrastructure. This may already be identified in the budgets. In this case, tracking whether expenditures conformed to the budget helps to identify the use of resources. If this is not possible, progress can be made by obtaining information on utilization and on priority initiatives. These processes facilitate the mapping process described earlier.

Once there is information on the use of current resources it becomes easier to build budgets for plan and policy priorities. It also becomes easier to project the costs of expanding existing services or ones that may be more cost-effective. It may be possible to identify inefficiencies in the system. This requires the mental health planner to advocate for consistent if not standardized budgetary approaches across local levels and across levels of government.

For the budgetary process to tie to planning and policy priorities, the ability to make budgetary projections and scenarios increases with the operational specificity of plans. The relationship between the budget and the plan is such that the plan informs what should be in the budget while the budget and associated expenditures identify whether funds are available or lacking for priority initiatives.

The mental health planner also has to provide the specificity for budget components so that there is continuity as well as innovation. Budget components for key activities should be represented in the budget if they are identified as priorities in plans and policies. The creation of a budget component for demonstration and evaluation projects or for innovations perhaps seems extravagant, but this may be a low-cost mechanism for introducing change and avoiding the stagnation of a system in its current form.

Should there be a separate budget for mental health?

The question arises as to whether the mental health budget should be separate or integrated into the general health budget. From a policy perspective it is recommended that mental health care should be integrated with general health care. From a budgetary perspective, however, it is often recommended that there be a distinct, separate, identifiable mental health budget, either under the control of mental health planners and policy-makers or as a component within the general health budget.

The chief reason for this is that mental health is a special case within general health which has not received the deserved priority. This has arisen because of a lack of information regarding the impact and costs of mental disorders, stigma, perceptions of the ineffectiveness of interventions, the fragmentation of existing funding streams and services needed to meet the needs of persons with mental illness, and an absence of effective advocacy for change in the field of mental health.

As distinct mental health policies and plans are formulated (which may or may not be subsumed under general health policies and plans), each country has to decide how to use financing and budgeting for implementing them. The advantage of a separate mental health budget is that new resources that become available for mental health can be targeted on the implementation of mental health policies and plans. Even when these are allocated to the district or local level there is some assurance that the expenditures will be on mental health services. Moreover, a separate mental health budget allows for a certain degree of flexibility in transferring resources from one component of mental health care to another.

There are several advantages in having a separate mental health budget.

Even if mental health care is covered by part of a general health budget it is essential to document the use of resources for mental health. This information can provide a means of monitoring the way in which resources are used for mental health. It can also be employed in the planning process to highlight the additional resources that are needed. Within the general health budget it may also be useful to specify that the mental health budget is exempt from budgetary cuts until a certain critical level is reached.

Whether a mental health budget should be separate or integrated into a general health budget is as much a function of structure, consensus, advocacy and policy-making in the country concerned as it is of care delivery. Which strategy to adopt depends on the country's political, administrative and health delivery structure. In either case the objective is to ensure the availability of the resources needed for identified mental health priorities.

It can be useful to have a dedicated percentage of the general health budget for mental health.

Many of the recommendations and innovations in this module can only be fulfilled if funding is available. Whether there is a separate budget for mental health or one that is integrated into the general health budget, a critical aspect is the inclusion of a line item or funds for the implementation of strategies that are priorities in policies and plans. These should not be limited to the service delivery system but should include funding for the policy-making, plan development and quality improvement functions. Infrastructure for supporting management, such as funding for information systems and training, should be specified. These are the pillars on which the mental health system of the future will be based. Without funding for these functions their implementation becomes less feasible and their inherent potential is diminished.

Key points: Step 5. Build budgets for management and accountability

- A budget is a plan for achieving objectives stated in monetary terms. Planning must drive the budget process. All too often, plans and budgets are developed independently so that the objectives are not explicitly reflected in the budgets.
- A budget serves four functions: planning, policy, control and accountability.
- There are four types of budgets: global budgets, line budgets, performance-based budgets and zero-based budgets. Mental health planners may not have the option of defining the type of budget to be used but the main advantages and disadvantages are identified.
- A budget must be tied to priorities in plans and policies and must not be limited to services. Included are priorities such as policy development, planning and advocacy.
- One approach to addressing innovation is the creation of a special mental health innovation fund, which could provide for demonstration and evaluation projects, even on a small scale, for the promotion of change and quality improvement.
- In summary, a budget is much more than a projection of the costs of a mental health system. It is an instrument for communicating the standards of performance expected by organizations, a tool for motivating employees to achieve goals and objectives and a mechanism for monitoring and assessing the performance of different sub-organizational components.

Step 6. Purchase mental health services so as to optimize effectiveness and efficiency

The purchasing of mental health services is a further mechanism by which effectiveness and efficiency can be optimized and the goals of policy can be achieved. As Jönsson & Musgrove (1997) point out, there is not necessarily a connection between the way services are paid for and the way they are delivered. Decisions have to be made whether the government (the entity with the resources to pay for mental health services) provides services directly, contracts or purchases services for the population, or perhaps even transfers income to the population or segments of it so that services can be purchased directly. It is common to distinguish the following three relationships between funders and providers of health care.

- Reimbursement. Providers receive retroactive payments for services supplied. The payments may be billed directly to the purchaser or to the patient, who may be partly or entirely reimbursed by the purchaser. This approach, often coupled with fee-for-service payment, can be found in systems with multiple private and public purchasers and multiple, usually private, providers. In low-income and middle-income countries it is rare for the reimbursement model to be combined with public finance.
- Contract. This involves an agreement between payers or insurers (possibly government) and providers, the aim being to achieve increased control over total funding and its distribution. This approach tends to be found in social insurance programmes with predominantly private (non-profit) providers.
- Integrated. The same agency controls both the funding and the provision of services. The personnel are generally paid salaries, and budgets are the main instrument for allocating resources. Integrated models are used in Nordic countries and are common in ministries of health in developing countries.

Most countries include elements of all three systems, just as most have a mix of financing models. Changes from one model to another are occurring in many countries. There are two broad types. One involves what is almost a public monopoly in the funding of health care and competitive contracts with public and private providers. The other is an integrated model with competition between different integrated systems.

The role of government differs between these two models. In the first, government regulates competition between payers or insurers. Once the decision is made as to which model applies there are different approaches to optimizing effectiveness and efficiency. This section addresses issues of purchasing where government is not the direct provider. These arrangements can also be simulated in relationships between government and a funded entity. Thus a ministry of health could contract with a psychiatric hospital or a district with certain deliverables as objectives and with associated rewards or sanctions if these are desired.

Contracting for the non-clinical components of health services is relatively common in most countries. Thus Mulago Hospital, the main referral hospital in Uganda, contracts out meals, staff, elevator services and the management of steam and boiler houses. Similarly, non-clinical services are contracted out in Thailand, the USA, and Zimbabwe (McPake and Banda, 1994). While the contracting of health services is relatively common in Western Europe and North America, this mechanism is still under exploration in many developing countries (e.g. Pakistan, South Africa, Zimbabwe).

Purchasing is a mechanism that can optimize effectiveness and efficiency.

All these arrangements fall into the following four broad categories.

- **Block contracts** essentially allow the continuation of a global budgeting system in the form of a contract. A total amount is paid to a provider who must then provide specified services.
- **Cost and volume contracts** specify a total payment for a total expected workload.
- In **cost per service contracts** a fixed rate is specified for each service provided.
- **Performance-based contracts** are structured around the purpose of the work to be performed as opposed to the manner in which it is to be performed. The focus is on measuring the outcomes of efforts rather than on managing efforts in order to achieve outcomes. Thus the contracts define requirements in terms of the required results rather than work units. They usually include performance sanctions and incentives.

An argument against contracting is that mental health providers are scarce in low-income countries and remote areas and that competition, which is expected to create market efficiencies, is not viable in such circumstances. Moreover, the management of contracts requires skills in negotiation, accounting, information systems and monitoring. Nevertheless, contracts are useful for detailing mutually agreed expectations in qualitative terms and can form a basis for rewards or penalties. Such contracts could exist between any purchaser or funder and the entity receiving funds.

What are the options for purchasing mental health services?

The purchasing of mental health services largely depends on the structures and capacities in the country concerned. It may occur in conjunction with the purchasing of general health services. Such purchasing may occur directly or funds may be allocated to local entities, e.g. subunits of government, provinces and authorities, that are responsible for obtaining services. The arrangements vary widely between countries. Broad options for purchasing or for the use of purchasing techniques are indicated below.

Public purchasers often have a variety of goals when developing, implementing and overseeing mental health services. Typically, these goals involve some combination of containing or reducing costs, expanding access to services and improving the quality of care. Providers may share many of the purchasers' goals but they operate under a different set of incentives and consequently may have some very different goals. The vehicle by which purchasers define their goals is the contract; but the structure required to achieve these goals is a carefully designed financing and payment system.

It is important to distinguish between **retrospective payments** and **prospective payments**. Retrospective payments are made after a service has been given. Prospective payments are fixed fees paid to providers of care for a designated period, whether or not services are used. Persons are enrolled by paying a fixed fee before treatment to cover designated mental health services for a specified period. In this method of payment, called **capitation**, a provider receives payment for each person served without regard to the amount or nature of the services provided.

Purchasing may be based on a global budget (services purchased for a defined population), capitation (a defined subset of a population is eligible for services), the case rate (recipients of services) or fee-for-service (services provided).

a. Global budget

A global budget arrangement allows the purchaser to predict with certainty the level of expenditures on mental health in a given year. Global budgets are often used when the number of eligible persons is unknown and are usually based on the preceding year's

Several options exist for purchasing mental health services.

costs, reduced by a predetermined percentage for savings. A global budget creates very strong incentives for a provider system to control costs and improve the efficiency of its service delivery and administrative practices, especially if the provider is to retain all savings as profit or as new operating capital.

Under budgeted payment approaches a budget is set for some defined set of services for a specified period and becomes a spending ceiling. A budget can be set on a per capita basis or it can be based on historical costs. The budgetary approach provides an incentive to control costs and produce care efficiently, and it can make costs more predictable for the funder. It can also give providers flexibility in deciding how to spend budgeted amounts. Among the disadvantages are the possible avoidance of patients who might be high-cost users of care and the potential for providing insufficient or reduced quality of services so as to minimize costs and stay within budget.

Salaries represent a variant of the budget approach when applied to the payment of clinicians. The advantage is good control over total costs and the dissociation of treatment from remuneration. The disadvantage is that there is a potential for reduced productivity.

b. Capitation

In capitation the budget is based on a fixed fee for each enrolled person. A specified level of health care is covered, regardless of the amount of services provided.

Under a completely capitated full-risk arrangement the purchaser pays the provider a monthly per capita rate to cover all costs associated with providing mental health care services to a certain population. The per capita rate for each person is fixed, regardless of whether the person uses the services. It may be set by the purchaser in advance or determined in the context of a competitive bidding process. Fully capitated payment arrangements are like fixed-budget arrangements in providing a strong incentive to control costs and improve efficiency. Although full capitation may create strong, short-term financial incentives to unduly restrict access to and the use of services, it may offer equally strong incentives to provide services of high quality and to secure effective linkages with other types of service providers in order to support positive outcomes. The strength of the mechanisms for monitoring contract access and quality and the effective use of incentives and sanctions largely determine the way in which a full capitation payment system affects the mental health system.

c. Case rate

Under the case-rate model of payment the purchaser pays a fixed rate for each case, i.e. each designated individual who enters the system and uses services. One of the reasons for the development of this approach was the difficulty of accurately estimating demand. The case rate is calculated by estimating the expected average expenditures for service users only. Thus a case rate is typically higher than a full capitation rate, because a pure capitation rate is calculated as an average of expected expenditures over a population that includes both users and non-users of services.

This baseline rate can be adjusted in accordance with included services, definition of episode or time, user characteristics, region and so forth. When setting case rates, purchasers should make every effort to obtain all relevant national and regional data in order to begin to establish norms. Determining what case rates to pay is difficult because of the paucity of cost and utilization data on mental health services.

Case rates could be applied to priority conditions of mental disorder. For example, a case rate could cover a comprehensive bundle of services provided across different settings and over a defined period corresponding to an episode of care. The advantage

of this approach is that it allows providers to design care and allocate resources for a population of patients. The disadvantage is that optimal services may not be provided to individual patients.

d. Fee-for-service

Fee-for-service payment to providers gives them economic incentives to provide access to the delivery system to persons in need because the providers are paid a fee each time someone accesses the system. It is necessary to consider whether purchasers can discover the appropriateness of purchased treatments by reviewing records.

In the retrospective payment model (case rate or fee-for-service), payments to providers increase with the amount of services provided. From the provider’s perspective there is a financial incentive to provide more units of care so as to increase reimbursement. There is no incentive to contain costs. From the purchaser’s perspective, once rates have been set there is clear accountability in terms of what has been purchased as a service for the payment made.

Box 8 indicates some differences in the incentives between these models with reference to a fee-for-service system and a capitation system.

Box 8. Fee-for-service vs. capitation

Fee-for-service	Capitation
Focus on service recipients	Focus on population
Retrospective payment	Prospective payment
Funder bears risk	Provider (or agency assuring provision) bears risk
Focus on services	Focus on outcomes
Incentive to provide more services than needed	Incentive to impose limits and avoid expensive cases

As Box 8 shows, the capitation model assumes responsibility for services or for a population whereas the fee-for-service system is limited to persons who present for services. The transfer of risk to providers gives them an incentive to keep populations healthy and to invest in prevention and early intervention so as to reduce costs. (In a less benign form there is an incentive to limit services. Consequently it is necessary to establish standards and expectations on the quality of care.) Moreover, in a capitation model the focus is on health status rather than the types or amounts of services provided.

It is important to note that each of these purchasing models has its own incentive structure. With global budgets, which have inherent flexibility allowing for creativity and innovation, there is no explicit incentive to serve persons or increase access or quality. Global budgets are usually based on historical numbers. With capitation there is an incentive to enrol persons even though there may not be incentives for the provision of services. With the case-rate approach the provider does not receive payment unless the patient has received some services. Consequently there is an incentive to provide services to more patients. However, there is also an incentive to minimize the level of service.

With the fee-for-service approach there is an incentive to give more services to increased numbers of patients. This sometimes leads to the overuse of services.

Key points: Step 6. Purchase mental health services so as to optimize effectiveness and efficiency

- There are essentially three broad types of relationships between funders and providers: reimbursement, contract and integrated. While integrated models (where the funder is the provider and there is no funder-provider dichotomy) are widespread, most countries have a mix of models. Moreover, models are changing within countries.
- Purchasing may be based on a global budget (i.e. services are purchased for a defined population), capitation (i.e. a defined subset of a population is eligible for services), the case rate (i.e. the recipients of services) or fee-for-service (i.e. fees for services provided).
- Each of these purchasing arrangements has particular incentives associated with it, allowing government (or purchasers) to decide which mechanism is the most appropriate.

Step 7. Develop the infrastructure for mental health financing

An infrastructure for mental health financing is essential for the attainment of policy and planning objectives. The adequacy of the financing processes discussed in this module depends largely on the management structures in which they are embedded and the quality of information that they can access. This point is critical and deserves emphasis: too often, the development of management and administrative capacities is neglected. The key areas addressed in this section are:

- management/purchasing structures;
- information systems;
- evaluation and cost-effectiveness analysis;
- information-sharing and the involvement of key stakeholders.

Management/purchasing structures

As issues of cost and quality have emerged in mental health systems there has been a trend towards adopting business and management techniques used in private industry. (See *Quality Improvement for Mental Health*.) In the USA, for example, concepts from managed care are increasingly being incorporated into the public sector. However, managed care organizations have been criticized for fragmenting care. As a result, the concept of a mental health authority has gained currency in relation to coordination and efficiency issues associated with multiple funding streams and fragmented systems of service delivery.

Managed care, broadly defined, is a comprehensive approach to service delivery which encompasses the planning and coordination of care, quality monitoring and cost control. It involves a range of techniques for matching people's levels of care to the level of need within a system of care. It includes systems of financing service delivery such as capitation and putting providers at risk for the cost of delivery. A major role of managed care has been in the control of spending levels within clearly established financial parameters. In the USA, for example, managed care enterprises cover more than 80% of the population. The negative side to managed care is that the emphasis on cost control often results in a reduction of access and in inappropriate limitations on services.

Many public entities have successfully organized their infrastructures in such a way as to incorporate managed care techniques. Others have contracted directly with managed care organizations for the management of the delivery of mental health services. The contract development process is vital to the success of such arrangements: purchasers have to direct and maximize the design and outcomes of the system. Although the concept of managed care may not have direct application in many countries and has received criticism for the reasons stated, some of the technologies are useful for increasing both efficiency and quality. (See *Quality Improvement for Mental Health*.)

The creation of local authorities has been proposed, especially where funding sources for mental health are fragmented (Goldman et al., 1992; Hadley & Goldman, 1997; Goldman et al., 2000). A local authority is essentially an organizational entity responsible for the centralized planning, purchasing, management and delivery of mental health services to the population in a designated geographical area.

Information systems for mental health financing

The various aspects of mental health financing critically depend on the availability of timely, accurate and complete information. For policy decisions, data are needed at different levels. Aggregated data are needed at the national (or state) level for evaluating mental health funding, and data are needed at the agency level for assessing financial solvency and performance and at the service level for assessing unit costs and efficiencies. In systems where purchasing is based on fee-for-service payments it is necessary to track the types of service provided, the providers and the recipients, and encounters must be recorded so that appropriate billing can occur. Capitation payments and financial incentives are not associated with single encounters but still depend on information of high quality.

Considerable work has been done to specify the requirements of mental health organizations for financial data. Major initiatives related to the computerization and standardization of needed data have been undertaken in Australia, Canada, the United Kingdom and elsewhere. In many countries this automated infrastructure is not available. Mental health reporting does not occur in 27% of countries and data collection or epidemiological studies are absent in 44% (World Health Organization, 2001b).

Nevertheless, information should be collected and analysed, even if surveys or other record-keeping mechanisms are involved. WHO has developed recommendations for health information systems (World Health Organization, 2000) which are a useful starting point for such activities. (A module entitled *Mental Health Information Systems* is being developed.)

It is often assumed that information systems involve the use of computers. However, these may not be available or affordable. Many key data can be collected by other means, e.g. monthly or quarterly reports provided by various organizations at different levels. Clearly, for complex systems that depend on automation for billing transactions and reporting, computers are administratively efficient. For less complicated systems, more manual approaches may be reasonably effective.

Evaluation and cost-effectiveness analysis

Costs and results depend on the particular context of a mental health system. Consequently there is no single service package that can be universally prescribed. Unless some relationship exists between costs and outcomes, however, there is no basis on which to choose appropriate interventions. Choices have to be made between differing treatments, treatment settings and illnesses so as to allow the judicious use of scarce resources. As Shah & Jenkins (2000) have indicated, there are several methods

of economic evaluation, including cost-minimization, cost-benefit, cost-utility, cost-effectiveness and cost-of-illness analyses. Notwithstanding the acknowledged value of such analyses, however, few have been conducted in either developed or developing countries.

With a view to assisting planners, WHO is developing a generalized Cost-Effectiveness Analysis (CEA) through the Choosing Interventions that are Cost-Effective (CHOICE) project. This project aims to generate regional databases of cost-effective mental health interventions that will allow planners to select the most effective and least costly interventions in specific settings. Generalized CEA compares a range of mental health interventions and their associated costs with the null hypothesis of no intervention or the natural course of a disorder (Murray et al., 2000). The CHOICE method offers the opportunity for planners to select a set of interventions that maximize the health benefits received by a population within a given set of resource constraints. (Further information is available from the WHO CHOICE website: www.who.int/evidence/cea).

Information-sharing and the involvement of key stakeholders

Policy-makers are confronted with difficult decisions and choices related to mental health services, especially in contexts of limited funding. The need for a more responsive system for the delivery of mental health services often results in new policies and planning objectives being developed with key stakeholder groups. Unfortunately, the budget and allocation processes are frequently not a component of what is shared. Mental health advocates and supporters are often not familiar with the inadequacy of funding and with the choices that have to be made between access and quality and between the maintenance of existing services and the development of new ones. A better understanding of budgets, budgetary processes and allocation methodologies by key stakeholder groups is vital for the development of the financial base for mental health services.

Key points: Step 7. Develop the infrastructure for mental health financing

- Adequacy of financing processes and activities depends largely on the management structures in which they are embedded and the quality of needed information on which they are based.
- The following areas are identified as critical:
 - management/purchasing structures;
 - information systems;
 - evaluation and cost-effectiveness analysis;
 - information-sharing and the involvement of key stakeholders.

Step 8. Use financing as a tool to change mental health service delivery systems

The question arises as to how the budgetary and allocation options described above can be used to change delivery systems for mental health services.

The first step, especially if funding is inadequate, is to build the resource base. An information base for documenting current levels of funding and services is essential for growing a budget. It is difficult to construct a strong argument without specific knowledge of the amounts being expended and the services that are available or provided. If budgets do not exist, surveys can be conducted in order to obtain estimates. Sometimes a mental health budget is not easily obtainable because it is part of a larger budget, e.g. the general health or social services budget. Again, estimates may provide the only short-term answers.

It is important to note that a budget for services for people with mental disorders may be fragmented and distributed across several agencies. It is vital to obtain a picture of the entire resource base in order to assess the total amount and its allocation to various services, any duplication or lack of coordination, and, continuity across the spectrum of services.

Growing the resource base in order to build appropriate comprehensive mental health services depends on several factors, including political will and the state of the economy. Many of the modules in this guidance package are tailored to the building of political will. Commitment to a national mental health programme, advocacy and the setting of standards that establish a quality threshold are important drivers of this process. Similarly, the state of the economy is a critical determinant: growth is less likely during an economic downturn. The implication of this dependence is that budget growth is more likely to occur in spurts than in a continuous fashion. In other words the probability of growth in a mental health budget increases when there is a crisis in the quality of care, when a critical mass of political and stakeholder will has been built or when the overall economy is in a growth mode. The growth of mental health budgets is often the result of what has been described as opportunistic incrementalism. It is necessary for policy-makers to have defined plans, needs and priorities so that advantage can be taken of such opportunities in the environment.

Finance can be used as a tool for changing various aspects of the mental health delivery system, e.g.:

- shifting from mental hospitals to community care, including general hospitals;
- integrating mental health care with primary care;
- funding for quality.

Shifting funds from mental hospitals to community care, including general hospitals

Even in well-resourced systems a substantial proportion of available funds is often committed to the budgets of large facilities. Some of the barriers in the way of transferring resources to community care have been discussed. Most systems of mental health care recognize that hospitalization is an integral part of the spectrum of services.

A fundamental first step is to define the levels of care and the types of problems that need to be addressed in general hospital and community settings as a result of transferring patients from mental hospitals. (See *Planning and Budgeting to Deliver Services for Mental Health* for details of this process.) The transfer of resources associated with inappropriate placements in mental hospitals can be a starting point for the expansion of programmes based in general hospitals and the community.

Among the financial and budgetary factors that can facilitate and encourage the process of transfer are the following.

- **Budget flexibility.** The independence of mental hospitals and community services in separate line items often creates a rigidity that prevents the transfer of funds between the two sectors. Budgetary guidelines should allow permeability of funding. A solution offered by some models is to build a budget that combines hospital and community services so that no specific allocations are rigidly defined for either.
- **Funding of community services.** Clearly, community services must be available before persons can be transferred from mental hospitals. Even if the long-term vision is that resources are to be transferred from mental hospitals to the community, resources must be made available to ensure that there are community services for persons for whom such hospitals are no longer appropriate. This implies that funds must be made available for community services development while the existing capacities of mental hospitals are maintained. Double funding is thus necessary to enable the eventual transfer of funds from facilities to the community.

A perverse incentive can inadvertently occur when the newly available slots in the community are to be available to persons who are residing or have resided in a mental hospital. Two categories of people may avail themselves of the new slots: people with a history of hospitalization and people in the community who have never been hospitalized but need the new slots. If the eligibility criteria include prior hospitalization, this creates an incentive for persons in the community to be hospitalized before they can access the new services. Budgeting must project demand from both hospital residents and persons residing in the community.

- **Financial incentives.** The process of transfer can be accelerated if financial incentives are offered to community programmes. In a bonus programme in Texas, for example, community mental health agencies received a certain fixed amount for each bed-day reduced and this resulted in relatively rapid deinstitutionalization.
- **Multiagency funding.** When a person is discharged from a mental hospital, multiple agencies are often involved in providing support and services. If the funding is coordinated the process may be facilitated. In some cases, funding can be pooled for this purpose. The management and accountability of such pooled arrangements often present problems but the concept of a single authority represents one mechanism that can be used to address these matters.

Integration of mental health care with general health care and primary care

The integration of mental health care with primary care has been undertaken in many systems to address not only stigma but also the shortage of adequate mental health resources. Many mental health problems can be appropriately tackled by trained primary care professionals.

From the financing perspective there is concern that mental health services in such settings should not be neglected. Integration allows mental health services to become part of a primary care budget and there is a danger that, given other health care priorities, mental health funding could remain static or even diminish, in particular for persons with severe mental illnesses. Some ways of preventing this are indicated below.

- The funds expended on mental health services, the training of primary care providers in mental health detection, and persons receiving mental health services can be tracked.

- Line items can be developed for specialized services in priority populations, e.g. adults with severe mental disorders, children with serious emotional disturbances and persons with dual diagnosis, e.g. persons affected by both mental illness and substance abuse.
- The amount being expended on mental health services can be established, with a proviso that it cannot be reduced (given that the current level of funding is considered inadequate).

Funding for quality

Major scientific breakthroughs are occurring in the field of mental health and new medications and technologies are emerging that will have a significant impact on the lives of persons with mental illnesses (World Health Organization, 2001a). On the basis that it is necessary to maintain current levels of services a mechanism exists for facilitating the introduction of these innovations. It involves a demonstration grant or pilot project which could be funded through an external donor agency, a private foundation or a government initiative. New evidence-based services, such as assertive community treatment and supported employment should be shown to make a significant impact in a small number of settings before being disseminated more widely. Similarly, major savings may be possible through the funding of prevention and early detection programmes. Again, a population-based financing system where there is integrated coverage facilitates the financing of such services.

As these examples illustrate, financing is essentially a tool for building and transforming mental health systems. For this tool to be effective, however, it must fit in with the service delivery system and current operations and must reflect the political and economic realities in which it is embedded. Financing structures and processes are products of the same system and organizational culture that they seek to transform.

Funding structures are currently largely tied to curative and institutional care. In order to promote quality it is necessary to bring about change not only in financing but also in the encapsulating policies and structures.

Key points: Step 8. Using finance as a tool to change mental health service delivery systems

- Financing mechanisms can be used to facilitate change and introduce innovations in the systems.
- Financial and budgetary factors that can encourage the transfer of services from mental hospitals to the community include: budget flexibility, ring-fencing of funding for community services, financial incentives and the coordination of funding between ministries or agencies.
- In the integration of mental health with primary care it is important from the financial perspective to ensure that funding for mental health services is adequate. There is concern that mental health services may not receive sufficient attention and that funding could remain static or diminish. Some mechanisms for preventing this are: tracking funds expended on mental health services; developing line items for specialized services for mental health populations; establishing (and protecting) levels of funding for mental health services.
- It is important to maintain some financing capacity for introducing innovation through demonstrations and pilot projects.

3. Barriers and solutions to financing mental health services

Barriers to financing mental health services can be classified as (1) those relating to societal values and a general understanding of mental health services and their effectiveness and (2) those relating specifically to financing strategies and procedures. Both sets of barriers must be confronted in order to achieve adequate financing. It is essential to have a broad societal consensus on mental health as a priority. Many of the modules in this guidance package delineate how this can be achieved. The present module considers many of the barriers that are related to specific financing aspects. Some of these barriers and possible ways of overcoming them are dealt with in this section.

Proving effectiveness/cost-effectiveness. The need to prove the effectiveness and cost-effectiveness of mental health care is one of the major social barriers in the way of acquiring adequate financing for mental health. Mental health services have to compete with other services for social and health resources, which are usually scarce. Until recently, the business case for mental health services was elusive. The nature of the benefits derived from mental health services is somewhat different from that of benefits that result from general health care. In contrast to the benefits that arise from the control of communicable diseases or from immunization, where treating one case may protect others, the benefits of mental health care are of a non-health form, such as lower costs of social services or reductions in accidents or injuries.

However, the situation is changing. There is evidence in the literature that mental health services may have a medical offset, i.e. they may result in lower general health costs. Moreover, this barrier is gradually being tackled as a consequence of studies on the global burden of disease and increasing evidence of the effectiveness of such services.

Long-term nature of some mental disorders. The long-term nature of some mental disorders, as with some chronic physical conditions and unlike acute unpredictable medical needs, makes them difficult to cover through private insurance and appropriate for public insurance. Furthermore, associated with the long-term factor is a need for housing and social supports. These do not fall under a health umbrella and result in the fragmentation of budgets associated with services for persons with mental disorders.

One solution is to attempt to map the varying sources of finance for mental health care (see Step 2). Such mapping may help to develop a more coordinated and systematic approach to planning and financing the multiple needs of people with mental disorders. A second solution is to allow for the long-term nature of some mental disorders in the planning of services, i.e. to tailor financing structures to long-term service needs. (See *Organization of Services for Mental Health* for discussion of the continuing care model).

Lack of adequate financial data. The lack of adequate financial data is a severe limitation on the financing of mental health services and on tracking the allocation of resources that are currently available.

In order to address this matter it is necessary to begin with the information that is available or with data that can be obtained easily from surveys, hospital budgets and other sources. It is essential to develop the database for mental health finance from this starting point if appropriate financing is to be obtained. Decisions on what data to gather depend on the specific financing needs of the mental health system concerned. Such data can be refined over time.

Reallocation of existing resources. In many countries, new resources may not be readily available and the development of mental health systems may require the reallocation of existing resources. This creates its own resistance through the politics and vested interests of organizations and employees that may be adversely affected.

Such reallocation is facilitated by transition funds or additional funds for easing the potential hardships that may be created. It is important to note that financing issues are never independent of the politics that define societal priorities. The financing of mental health services ultimately depends on activities related to advocacy, legislation, policies and planning, described in other modules, as much as on the specific steps outlined in the present module.

4. Recommendations and conclusions

1. Build and broaden a consensus on mental health as a priority

Many of the actions related to financing mental health are based on steps defined in other modules, e.g.: *Mental Health Legislation and Human Rights; Mental Health Policy, Plans and Programmes; Planning and Budgeting to Deliver Services for Mental Health; and Advocacy for Mental Health*. These create broad agreement that mental health needs are a societal priority. However, even these activities require financial underpinnings. A key role of the mental health planner is to develop a preliminary resource base for initiating a coalition-building effort to represent the perspectives of key stakeholder groups. Initial funding for this may comprise allocations made at a ministry of health or may be a subset of health planning efforts. Once the representatives of major constituent groups have been brought together, resources for such activities may be available through donor agencies or private organizations.

This step is critical. Initially, those involved are primarily mental health stakeholders, i.e. mental health professionals, family members and advocates, who already identify mental health as a priority. The development of consensus on key requirements then becomes a platform for additional financing activities. The first action related to financing is that of building a coalition in which there is agreement on key needs. This creates a foundation for advocacy that can move forward simultaneously on legislation, policy development and financing as a coherent set of activities rather than as independent, single-track initiatives. Financing ultimately depends on politics, advocacy and broader societal expectations. A major aim of this module and other WHO initiatives is to establish a priority for mental health. This in itself may garner additional allocations for mental health. However, the mental health planner must be prepared to explain what resources are needed and how they will be used. This leads to the next recommendation.

2. Identify priorities for financing

Countries are at different starting points in the development of their mental health systems. They have different sets of priorities, and they experience different barriers to addressing these priorities. This is true of both developed countries and developing countries. For example, affluent countries may be confronted with heavily institutionalized systems where the major financing issues concern the transfer of existing resources from hospitals to community services. On the other hand, some developing countries may have almost negligible mental health systems. Each country has its specific set of financing issues.

Countries that are just beginning to develop their mental health systems have to give special attention to the development of infrastructures that include legislation, the development of a plan, and the budget that will be associated with the proposed initial activities. Initial funding for such activities may be obtainable from the World Bank or from other donor organizations. The objective of initial financing might be the articulation of laws, policies, rights of individuals and broad structural arrangements that would be part of the long-term infrastructure of a mental health system. Once this foundation has been laid the financing of mental health services can be addressed more specifically. (The broad financing of mental health may be defined by general health financing arrangements.)

3. Tie mental health financing to general health financing

A major aspect of mental health financing, especially in countries that have not had well-articulated mental health systems, is to ensure that it is an integral component of general health financing and that specific allocations are made for mental health financing that is associated with other health initiatives. The case for such resource allocations has been strengthened by data on disability-adjusted-life-years and by the association of mental health problems with physical health problems such as heart disease, diabetes and other conditions.

4. Identify the steps in this module that are most relevant to your country's situation

Each of the steps in this document is a recommendation for action. The actions that are considered most pertinent will depend on the specific objectives defined in policies and plans and the specific issues that each country faces. In general, each country will have to address issues defined in each of the steps. The specific details and the degree of elaboration of the steps will have to be tailored to the particular circumstances in each country.

Out-of-pocket payment / Money spent by consumers or their families as the need arises.

Tax-based funding / Money for mental health services raised either as general taxes or as taxes earmarked specifically for these services.

Social insurance / People with incomes above a certain level are required to pay a fixed percentage of their incomes to a government-administered health insurance fund. In return the government pays for part or all of consumers' mental health services should the need arise.

Private insurance / The health care consumer voluntarily pays a premium to a private insurance company. In return the insurance company pays for part or all of the consumer's mental health services should the need arise.

External grants / Money provided to countries by other countries or international organizations.

Source: World Health Organization, 2001b.

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