



The REFINEMENT Project

Research on Financing  
Systems' Effect on the Quality  
of Mental Health Care

## The REFINEMENT Decision Support Toolkit Manual

### APPENDIX

Examples from the REFINEMENT  
data collection

**To be quoted as:**

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The REFINEMENT project is conducted by an experienced team of health economists, mental health service researchers, public health specialists and social care experts from eight European countries.



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# A Introduction

In this appendix to the REFINEMENT Decision Support Toolkit Manual we provide some examples on data collected from eight REFINEMENT countries\* on funding and payment mechanisms, services system characteristics and financial incentives. The examples presented here are results from pilot studies with preliminary versions of the REFINEMENT tools. The results shown are mainly intended to serve as illustrations of some of the information that can be collected using the REFINEMENT Tools and not a full comparison of service systems. A thorough comparison would need much more specifications and the tables presented should not be taken as representing the whole complexity of country systems.

The results should also be read with caution since they:

- may be collected at different levels (country, macro area and study area), and
- may represent expert opinions (and not "hard data"), and
- are based on preliminary versions of the tools.

First, chapter B provide some background information concerning population, land area, income level measured by Gross Domestic Product (GDP) and health care expenditures.

Chapter C provides an overview of mental health care financing and organisation in the REFINEMENT countries. The most common payment models in use for general practitioners (GPs), mental health outpatient services and mental health inpatient care are included.

Chapter D provides examples on service structure and utilisation patterns covering the following topics:

- The prioritisation of mental health,
- The involvement of GPs,
- Referral patterns and collaboration between GPs and specialist mental health services,
- Availability and geographical accessibility of outpatient services,
- Rates and utilisation of inpatient care beds,
- Care continuity.

For each topic some examples on financial incentives collected using a preliminary version of the FINCENTO Tool are included.

As far as possible we have tried to indicate at which level the data is collected. This is done by both (i) using the name of the area (country/macro area/study area) with a three letter country-code in brackets (see list on left) and (ii) letter codes: [c]=country, [m]=macro area, [s]=study area, [o]=other.

[AUT] = Austria

[ENG] = England

[FIN] = Finland

[FRA] = France

[ITA] = Italy

[NOR] = Norway

[ROM] = Romania

[SPA] = Spain

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\* Excluding Estonia due to missing/incomplete data.

In chapter D the number of outpatient Main Types of Care (MTCs) is used as an indicator of the number of outpatient services in the study area. This information is collected using the REMAST Tool which maps all services used by adults (18+ years) with mental health needs in an area. To define the MTCs we first need to define the BSICs. BSIC is defined in the DESDE-LTC\* as follows:

"A "service" or a Basic Stable Inputs of Care (BSIC) is defined as a minimal set of inputs organised for care delivery. It is usually composed of an administrative unit with an organised set of structures and professionals that provide care within a catchment area. BSICs are the minimal micro-level functional systems of care organisation. The functions provided by the service "micro-organisation" can be described by smaller unit of analysis called "Main Types of Care". The Main Type of Care (MTC) "provides a standardised method for classifying and coding basic care/service categories for the population of a particular catchment area, based on the main activities provided by every service".

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\* [www.edesdeproject.eu/instrument.php](http://www.edesdeproject.eu/instrument.php)

The REFINEMENT Toolkit covers services used by adults (18+ years) with mental health needs, excluding dementia and substance abuse.

# B Background information

## B.1 Population, land area and per capita GDP

The examples are based on information collected using several REFINEMENT Tools and may cover different level of analysis, i.e. country, macro area and study area. The macro and the study areas chosen in the REFINEMENT project are shown in Table B.1 and Figures B.1 – B.8. For England, Finland, France and Norway the country is also the macro area.

Table B.1 Macro and study areas of eight REFINEMENT project countries

Country		Macro area	Study area		
Name	Population <i>Land area (km<sup>2</sup>)</i>	Name	Name	NUTS* classification	Population >18 years <i>Land area (km<sup>2</sup>)</i>
Austria	8,169,929 <i>83,858</i>	Nieder-österreich (Lower Austria)	Industrieviertel	AT127 + AT122 (without the Lilienfeld district, ID 314)	445,748 <i>3,921</i>
UK	62,262,000 <i>243,610</i>	England	Hampshire (including Portsmouth and Southampton Unitary Authorities)	All NUTS-3 UKJ31, UKJ32, UKJ33	1,364,799 <i>3,769</i>
Finland	5,410,233 <i>338,424</i>	Finland	Helsinki and Uusimaa Hospital District	approx. FI181	1,206,446 <i>8,751</i>
France	63,601,002 <i>547,030</i>	France	7 sectors of psychiatry of the Georges Daumézon hospital in the Loiret département, "Centre" region	FR246	422,853 <i>5,626</i>
Italy	59,715,625 <i>301,230</i>	Veneto region	ULSS20 – Verona	ITD31	393,402 <i>1,061</i>
Norway	5,033,675 <i>385,252</i>	Norway	Sør-Trøndelag	NO061	225,081 <i>18,856</i>
Romania	19,043,767 <i>238,391</i>	Regiunea de Dezvoltare Nord-Est	Jud Suceava	RO215	484,212 <i>8,553</i>
Spain	46,777,373 <i>505,782</i>	Catalunya	Girona Area	ES512	599,473 <i>5,585</i>

\* Nomenclature of Territorial Units for Statistics

Figure B.1 Map of macro and study area: Austria

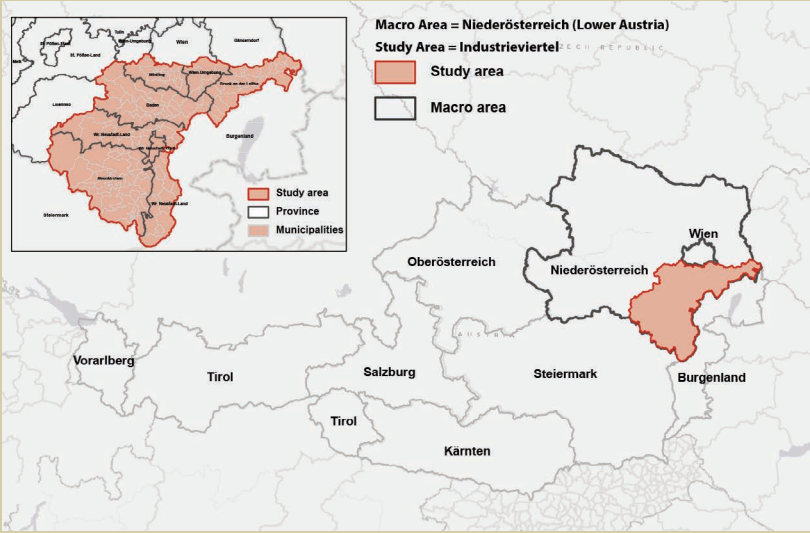


Figure B.2 Map of macro and study area: Finland

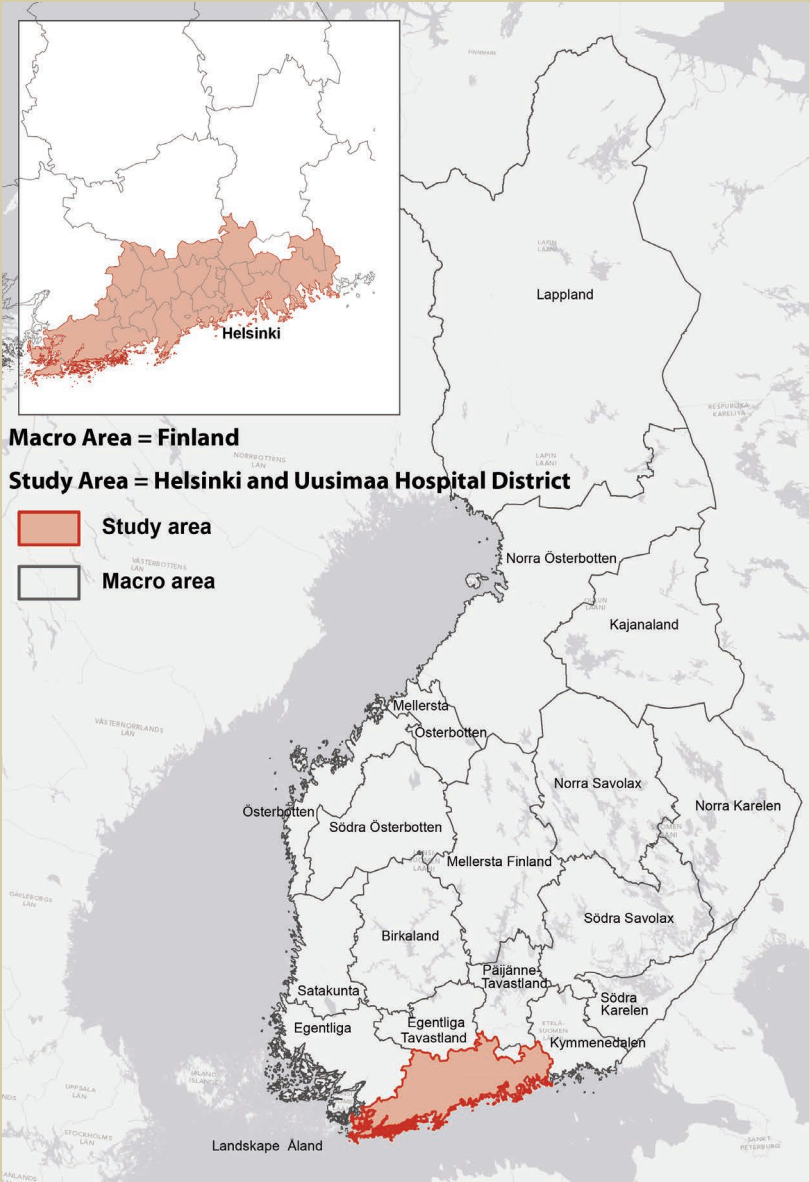




Figure B.3 Map of macro and study area: Romania



Figure B.4 Map of macro and study area: England

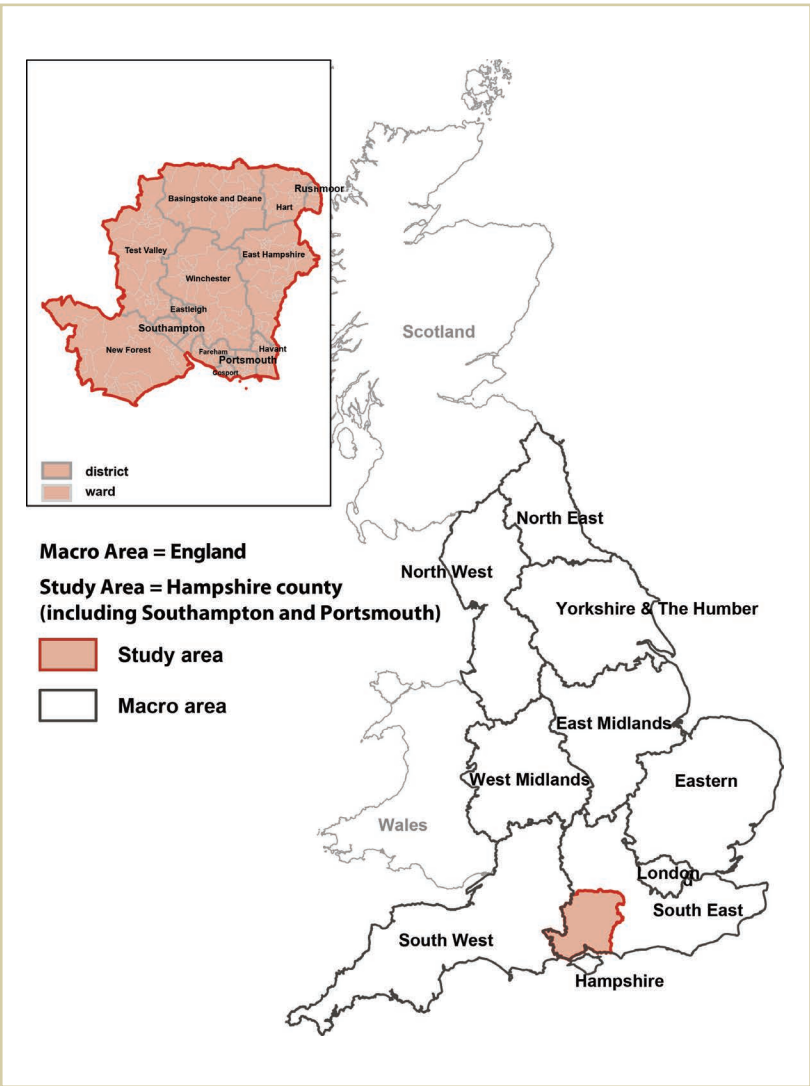


Figure B.5 Map of macro and study area: Spain



Figure B.6 Map of macro and study area: Italy



Figure B.7 Map of macro and study area: France

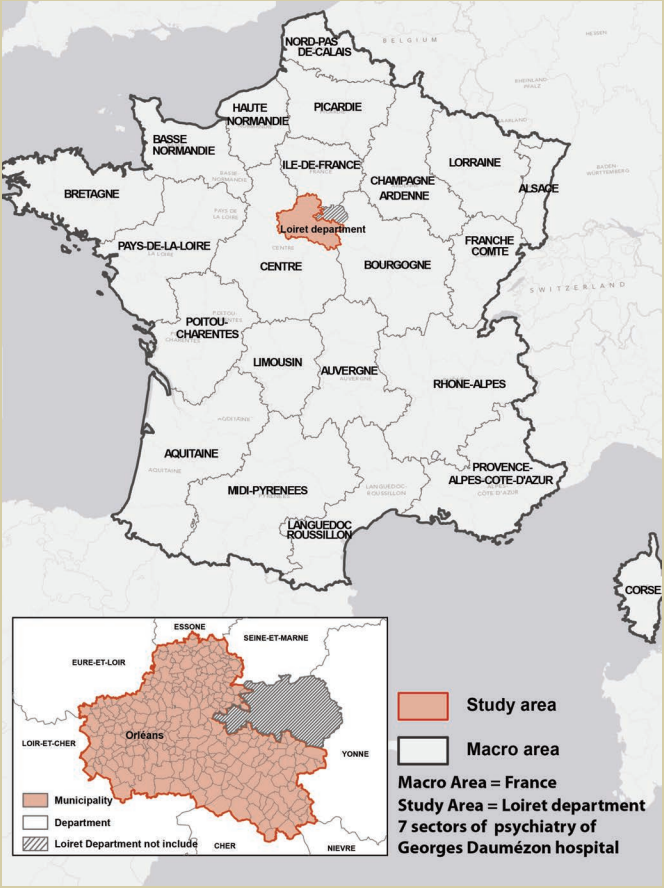
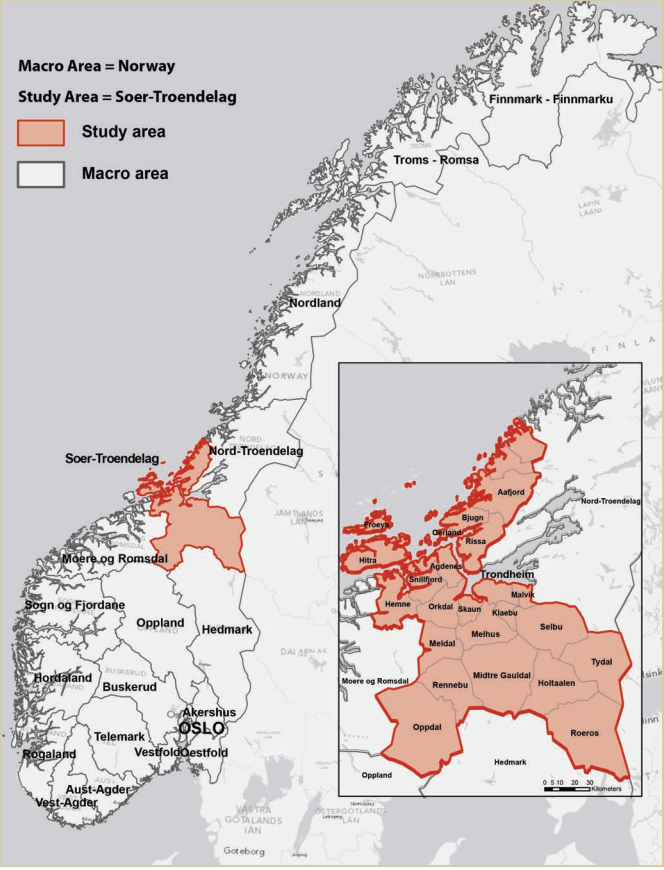


Figure B.8 Map of macro and study area: Norway



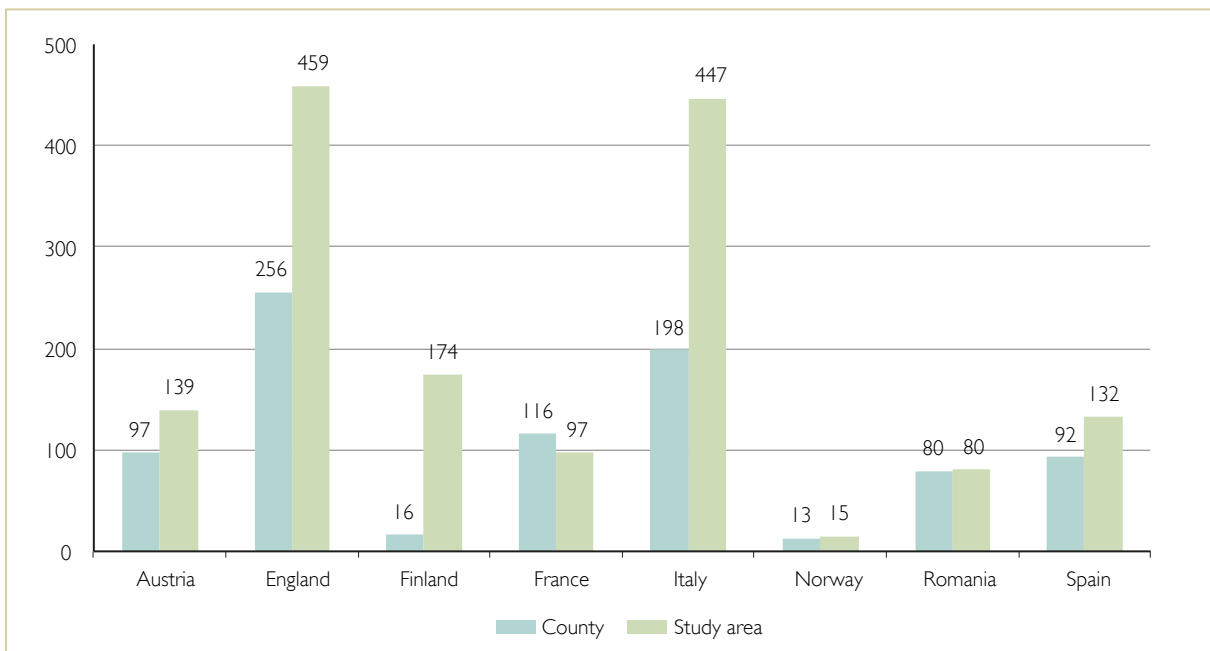
The size and population density of the study area are factors that may affect the shaping of the health care system in terms of e.g. number of services and travelling distances to services. These are important context factors when evaluating different quality dimensions such as efficiency and access.

The REFINEMENT study areas are different in terms of population, land area and population density. The study areas in England and Finland have the highest population numbers, with more than one million people aged 18 years or older. The capital city (Helsinki) is included in the study area of Finland. At the other end of the scale we find the study area in Norway with about 225,000 in this age group. The other study areas have between 300,000 and 600,000 inhabitants in the study population age group. In terms of land area, the study area in Norway and Italy are the extremes at each end of the scale; the ULSS20-Verona area in Italy covering 1,061 km<sup>2</sup> and Sør-Trøndelag in Norway covering 18,856 km<sup>2</sup>.

Norway on one hand and Italy and England on the other are also extreme in term of population density (population per km<sup>2</sup>); ranging from about 15 inhabitants per km<sup>2</sup> in the Norway study area to about 450 in the study areas in Italy and England as shown in Figure B.9.

The population densities of the study areas in Norway, Romania and France, are approximately the same as for the whole country. In the other REFINEMENT countries the population density in the study areas are higher than for the whole country. The difference between the study area and the country is very high in Finland, i.e. where the study area includes the capital city. High differences are also found in Italy and England (UK country data).

Figure B.9 Population density (population per km<sup>2</sup>); country and study area

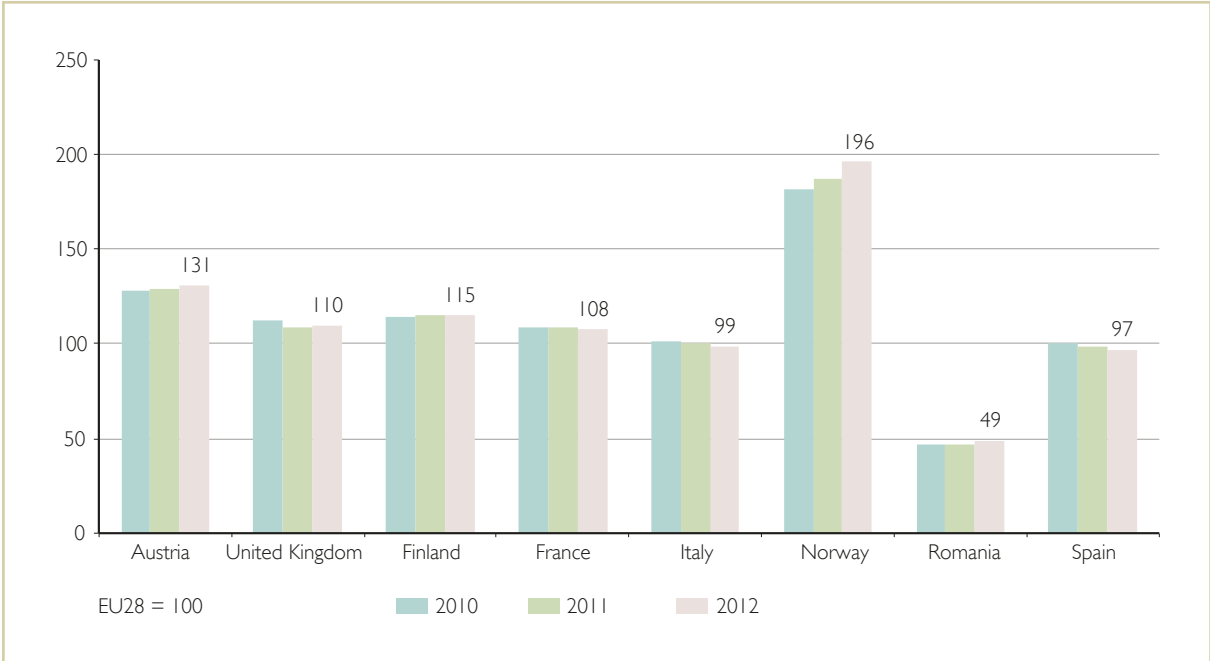


Country estimate for England is all of UK.

### B.2 Income level: per capita GDP

The REFINEMENT countries also differ in income levels (measured by Gross Domestic Product (GDP) per capita) as illustrated in Figure B.10. Norway is in a special position due to oil revenues, with a GDP per capita almost twice the average level of the 28 EU countries (EU28). Austria also has a relatively high per capita GDP, 30% above the EU average. The UK, Finland and France also have higher than EU average GDPs per capita, while Italy and Spain have about average income levels, however with a relative reduction in recent years due to the economic crisis. Finally the level of GDP per capita in Romania is less than half the average rate for the EU28. Hence, the eight countries have quite different levels of resources to invest into the health and social care sector.

Figure B.10 GDP per capita in PPS (purchasing power standards)



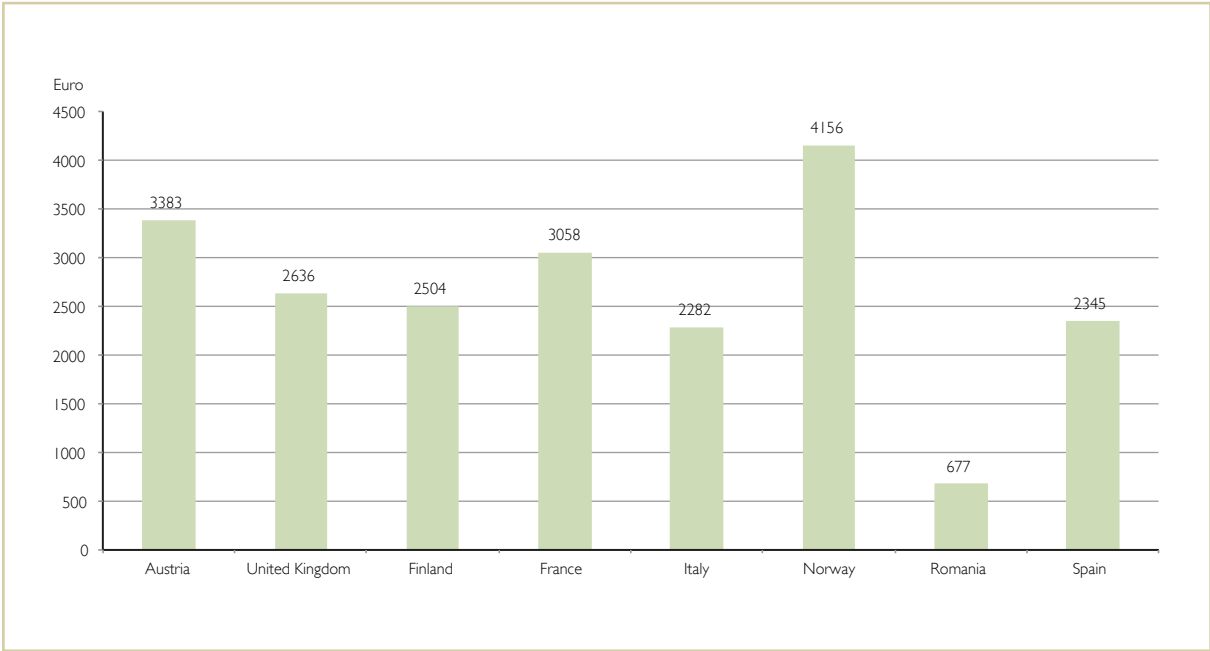
Source: Eurostat.

### B.3 Health care expenditure

Figure B.11 and Figure B.12 show health expenditures per capita and as share of GDP respectively.

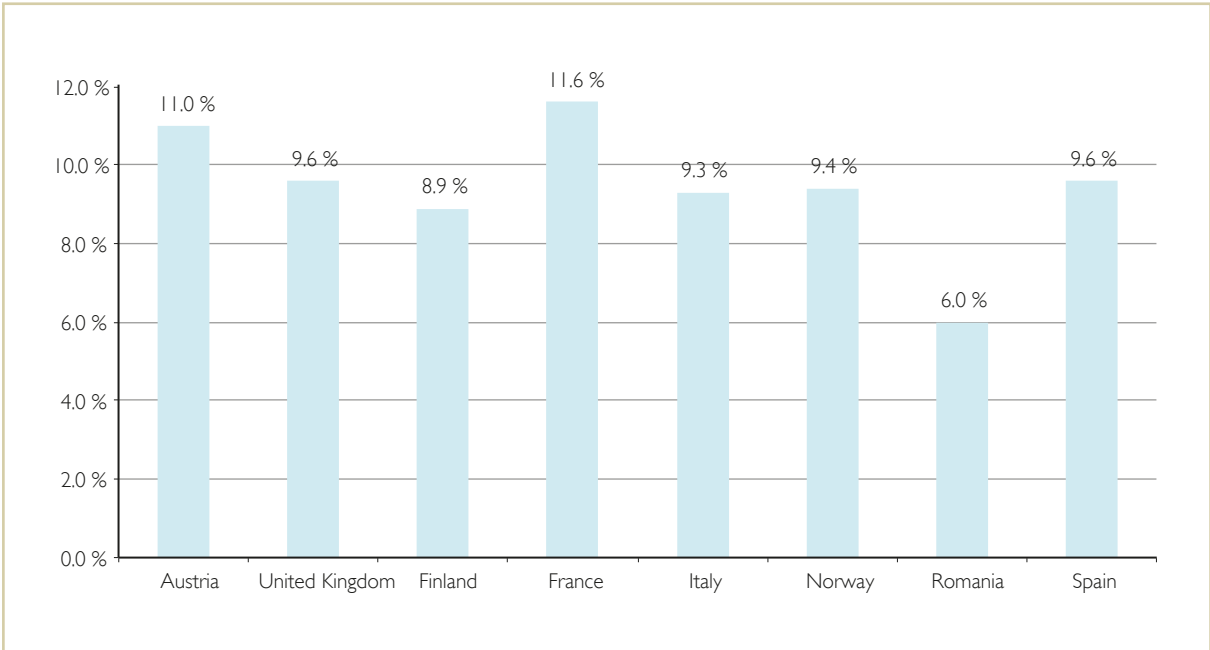
Austria and France have high per capita expenditures and a high share of GDP on health care expenditures. England, Finland, Italy and Spain are in a middle position, while Romania has much lower per capita health expenditure and also a lower share of GDP spent on health care, which reflects low GDP per capita. Norway is a special case; the share of GDP is in line with the middle group, however due to the high per capita GDP, Norway has clearly the highest per capita health care expenditure.

Figure B.11 Total health care expenditures per capita Purchasing Power Parity (PPP), 2010



Source: OECD (2012).

Figure B.12 Total health care expenditure as a share of GDP, 2010



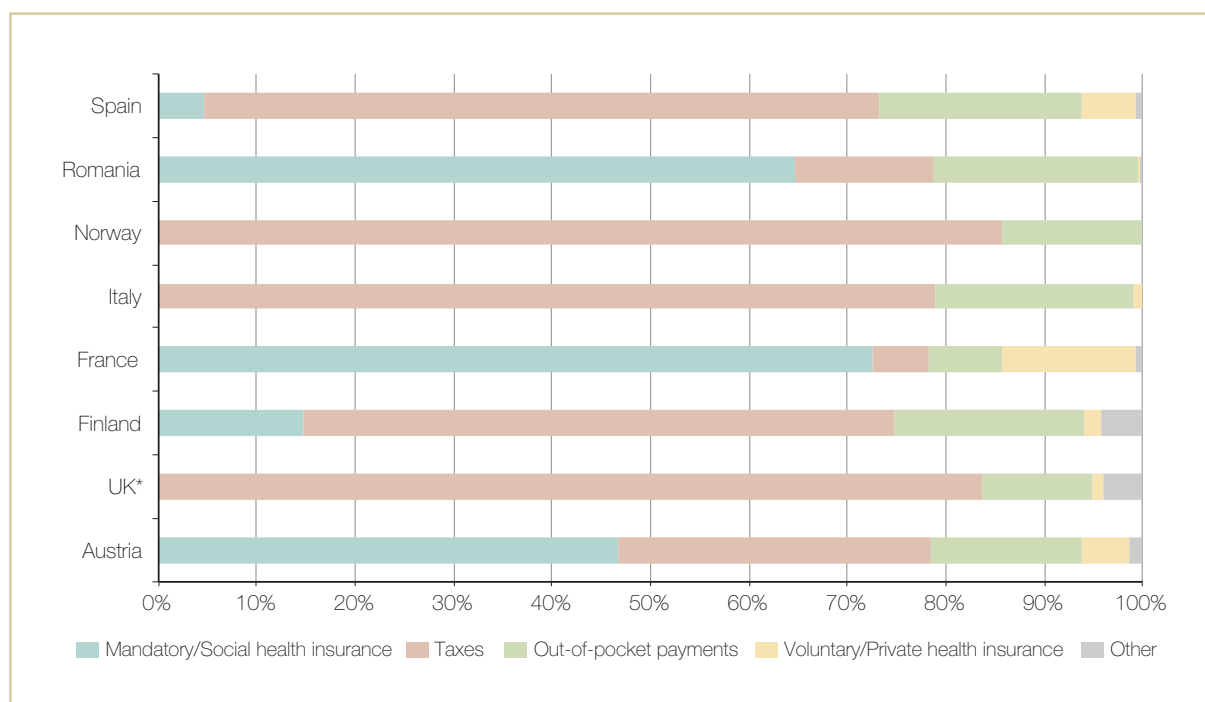
Source: OECD (2012).

# C Mental health care financing

## C.1 Funding of health care services

Figure C.1 shows the composition of funding sources of health care expenditures divided into five main categories: mandatory social health insurance (SHI), taxes, out-of-pocket payment (OOP), voluntary health insurance (VHI) and other (other private sources and external aid).

Figure C.1 Sources of funding for all health care expenditures



Source: FINCENTO-pilot/Eurostat. Data from 2009 (FRA, ITA, UK, ROM, SPA), 2010 (AUT, FIN), 2011 (NOR).

Of the eight REFINEMENT countries included here, five (England, Finland, Italy, Norway, Spain) raise funds mainly from general taxes. Three countries (Austria, France, Romania) have systems with a much greater use of mandatory social health insurance. Nearly one-third of the health care expenditures in Austria are, however, financed by taxes. Out-of-pocket payments constitute the largest share of total funding in Finland, Italy, Romania and Spain (about 20%), but are less than 10% in France. Private funding through voluntary health insurance is most substantial in France, where voluntary health insurance provides reimbursement for co-payments and better coverage for medical goods and services that are poorly covered in social health insurance. In Romania there is a culture of informal payment to medical personnel, and this type of OOP does not show up in the statistics but is reported to be considerable (e.g. Vlădescu et al 2008).

## C.2 Pooling and allocation of funds, purchasing and organisation of services

### Pooling and allocation of funds

Table C.1 shows some key features related to the pooling and allocation of publicly-collected funds.

The separate pooling of tax and insurance contributions to mental health or separate allocation of publicly collected funds to mental health services is not to be found in any of the REFINEMENT countries, except for the separate allocation to mental health services in France. England and Norway have a separate section for mental health in their resource allocation formulae used to provide funds to the local/regional health authorities. This is weighted in the overall need index to adjust funds for each local area. This allows variation in mental health needs to be reflected in the geographical distribution of health care funds, even though funds once received are not actually earmarked for mental health services.

### Integration of health and social services

Health care services cover a range of different types of services which may be more or less integrated in terms of the organisation of purchasing (who pays/contracts). Important services to mental health users are also found outside the health care sector. Evaluation of coordination and continuity of services, as well as the evaluation of resource use in mental health, needs to take into account the organisation of both health care services and social services like long term residential care, help with housing and employment. In most of the REFINEMENT countries these services are to be found outside of the health care sector. There are also varying degrees of integration of purchasing functions within the health care sector. This is elaborated in Table C.2, which shows the main purchasers of different types of health and social care services. By purchaser we here mean the entity that either pays and/or contracts with service providers. In some cases, purchasers may in fact own and directly provide services. Funding may (also) come from other sources.

In Austria SHI funds are the purchasers of outpatient care provided by self-employed physicians (both general practitioners and specialists) under contract. They also partially reimburse patients seeing physicians who do not have a contract, while outpatient clinics and acute care in hospitals are financed by the provincial hospital funds. Community mental health care and non-acute hospital care are paid by provincial social care funds. The provincial social care fund pays for most social services, together with state and local authorities.

In England there is one purchaser organisation for most health care services within a geographical area; until 2013 this function was provided by 151 Primary Care Trusts (PCTs). Since 2013 PCTs have been replaced by Clinical Commissioning Groups (CCG) managed by general practitioners. GPs receive their budgets for GP services direct from a central body NHS England. Local health authorities are also involved in funding social care services, in addition to local authorities and the state. CCGs tend to contract with one local Mental Health Trust, an organisation that will be responsible for providing most



**Table C.1 Pooling and allocation of publicly collected funds to health care services**

	Austria	England	Finland	France	Italy	Norway	Romania	Spain
Pooling and allocation (health care)	Outpatient care: 19 non-competing SHI funds, with some risk equalisation  Inpatient care: 10 pools from SHI and taxes (9 provincial health funds and 1 for private hospitals)	One national pool with most funds allocated to local health authorities <sup>1</sup>	One national pool allocated to municipalities (general purpose <sup>2</sup> )  320 pools at municipal level  One pool within National Health Insurance	One national pool allocated to 3 main <sup>3</sup> non-competing SHI-funds	Regional pools (19 Regions; 2 Provinces with autonomous regulations)	One national pool allocated to 4 Regional Health Authorities and to municipalities (general purpose <sup>2</sup> )  428 pools at municipal level	One national pool allocated to 42 district funds  2 pools for occupational funds	One national pool allocated to 15 (of 17) regional authorities (general purpose)  2 regional pools (Basque country and Navarra)  3 mutual funds for civil servants
Separate <sup>4</sup> pooling and allocation to mental health?	No	No <sup>5</sup>	No	Pooling: No Allocation: Yes	No	No <sup>5</sup>	No	No

1. Until 2013 152 Primary Care Trusts, now 211 Clinical Commissioning Groups.

2. General purpose means that the pool is not earmarked for health purposes, and the municipalities can decide how they spend the funds on e.g. schools, health care, culture, infrastructure etc.

3. And several small funds. The SHI allocates funds to Regional Health Authorities covering non private practice services.

4. Separate from physical health.

5. Mental health included as a separate part of the resource allocation formula that is weighted on a need index based on expenditure shares, i.e. funds are not earmarked.

Source: FINCENTO-pilot.

**Table C.2 Purchaser organisation (contracts/pays for the services)**

Type of care <sup>1</sup>	Austria <sup>2</sup>	England <sup>3</sup>	Finland <sup>4</sup>	France <sup>5</sup>	Italy <sup>6</sup>	Norway <sup>7</sup>	Romania <sup>8</sup>	Spain <sup>9</sup>
Primary health care (General Practitioners): all subtypes	19 SHI (contract GPs) Patient partly refunded by SHI (no contract GPs)	LHA	LA (public) Patient partly refunded by NHI (private) Employers partly refunded by NHI (occupational health care)	Patient partly refunded by SHI/VHI (limited) SHI	LHA	LA	District Health Insurance Funds	Regional Health Authorities (public) Patient/VHI (limited) (private) 3 mutual funds (civil servants)
Outpatient MH: self-employed	19 SHI (contract GPs) Patient partly refund by SHI (no contract GPs)	Not applicable	Patient partly refunded by NHI	Patient partly refunded by SHI/VHI (limited) SHI	Patient	Regional Health Authorities	District Health Insurance Funds	Patient/VHI (limited) 3 mutual funds (civil servants)
Outpatient MH: hospital/clinic	Provincial Hospital Fund	LHA	LA(s) (public) Patient partly refunded by NHI (private clinics)	Patient partly refunded by SHI SHI Regional Health Authorities	LHA	Regional Health Authorities	District Health Insurance Funds	Regional Health Authorities (public) Patient/VHI (private clinics)
Outpatient MH: community mental health centres/teams	Provincial Social care Fund	LHA	LA(s)	Regional Health Authorities	LHA	Regional Health Authorities (secondary) LA (primary)	Ministry of Health	Regional Health Authorities
Inpatient MH: acute hospital	Provincial Hospital Fund	LHA	LA(s)	Regional Health Authorities	LHA	Regional Health Authorities	District Health Insurance Funds	Regional Health Authorities
Inpatient MH: non-acute hospital	Provincial Social care Fund		LA(s)		LHA		District Health Insurance Funds	Regional Health Authorities

**Table C.2 Purchaser organisation (contracts/pays for the services)**

Type of care	Austria <sup>2</sup>	England <sup>3</sup>	Finland <sup>4</sup>	France <sup>5</sup>	Italy <sup>6</sup>	Norway <sup>7</sup>	Romania <sup>8</sup>	Spain <sup>9</sup>
Inpatient: mental health centres		LHA			LHA	Regional Health Authorities		Regional Health Authorities
Social housing	Provincial Social care Fund LA	LA Central government support	LA	LA Charities	LHA LA	LA	The National Housing Agency Ministry of Work, Family and Social Protection LA	Regional Social Authorities
Employment	Ausgleichstax-fonds (national compensation tax fund)		State LA	Cap Emploi (organisation for job placements for people with disabilities)	LHA LA	Local Norwegian Labour and Welfare services in collaboration with LA	National Agency for Employment County Employment Agencies	Regional Employment Authorities
Vocational rehabilitation	Federal Office for Social Affairs Provincial Social care Fund Pension Insurance Funds Public Employment Service	Department of Work and Pensions LHA	State NHI Pension Insurance Funds Public Employment Service	Cap Emploi	LHA		Ministry of Labour, Family, Social Protection and Elderly	Regional Health Authorities or Regional Social Authorities

**Table C.2 Purchaser organisation (contracts/pays for the services)**

Type of care <sup>1</sup>	Austria <sup>2</sup>	England <sup>3</sup>	Finland <sup>4</sup>	France <sup>5</sup>	Italy <sup>6</sup>	Norway <sup>7</sup>	Romania <sup>8</sup>	Spain <sup>9</sup>
Long term residential care	Provincial Social care Fund	LHA LA	LA	Regional Health Authorities LA	LHA LA	LA	LA + County	Regional Social Authorities
Long term home care	Provincial Social care Fund	LHA LA	LA	Regional Health Authorities	LHA LA	LA	LA	Regional Social Authorities

LA = Local Authorities/councils. England: unitary authorities. Austria, Finland, Norway, Italy, Romania: municipalities. France: general councils. LA(s) = several municipalities in cooperation.

LHA = Local Health Authority, England; Primary Care Trusts replaced by Clinical Commissioning Groups from 2013. Italy: Local Health Districts organised under Regional Health Departments.

MH = Mental health.

NHI = National Health Insurance.

SHI = Social Health Insurance Funds.

VHI = Voluntary Health Insurance.

1. The types of care categories used in the table are broader than the more detailed categories found in the final FINCENTO Tool.
2. Provincial Hospital Funds and Provincial Social care Funds are part of provincial government (Länder).
3. Primary Care Trusts replaced by Clinical Commissioning Groups from 2013 as local purchasers. The National Commissioning Board provides advice to CCGs and has responsibility for commissioning some specialist services. Local authorities have responsibility for the provision of public health services and social care.
4. Municipalities are responsible for all health and social services, however there is a separate organisation and budgets for secondary health care. Hospital care is organised in Hospital districts owned and financed by several municipalities in cooperation. Primary care services in local health centres may be owned and financed jointly by two or more municipalities (about 1/3 of the health centres). Municipal health and social services may be funded by joint or separate budgets depending on local organisation.
5. Health and social care sector for older people and those with disabilities is a separate sector (third sector) and is partly the responsibility of the regional health authority. Hospital-based outpatient clinics paid on a fee-for-service basis are predominantly provided in psychiatry departments of general hospitals. In stand-alone psychiatric hospitals, consultations are generally dispensed within the remit of ambulatory care centres (presented here under the category community health centres), providing care free of charge.
6. LHAs are part of NHS regional health authorities. Long-term residential care and housing is mostly funded by the NHS. There is regional variation in funding for employment support (within or outside the health sector). Social housing, residential non-hospital care and social support at home within health care budget restricted by budget limits, otherwise provided by municipalities.
7. Regional Health Authorities owned and funded by the Ministry of Health. Primary health care, long-term health and social care are the responsibility of the municipalities. They also provide social-psychiatric community services supplementing district psychiatric services provided by the secondary health care services. Local health and social services may be funded by separate budgets, depending on local organisation.
8. District Health Insurance Funds is the local branch of The National Health Insurance Fund.
9. Regional Health Authorities, Regional Social Authorities and Regional Employment Authorities are funded by separate departments of the Autonomous Community.

mental health services for a locality. Mental Health Trusts may themselves sub-contract some services with private, for-profit and not-for-profit organisations.

In Finland, 320 municipalities are responsible for funding and organising publicly funded health care. For services requiring a larger population base (hospital services, and often primary care health centres), the municipalities collaborate in financing through joint municipal federations. The municipalities are also responsible for funding and organising social care services. Municipalities can choose to provide health and social care services as a municipal activity, or they can choose to purchase services from private, for profit or non-profit, health and social care service providers.

In Italy, except for self-employed psychiatrists and psychologists, the Local Health Districts, which are the local branches of the Regional NHS, are the purchasers of health care services. They also finance social care services together with the municipalities.

In France outpatient care provided by self-employed physicians (both general practitioners and specialists) are partly (by partial reimbursement of OOP), or for some patient groups fully, paid by SHI-funds. Regional health authorities are the purchasers of outpatient care in hospitals and community mental health centres and hospital inpatient care. The regional health authorities are purchasers of social services as well, together with state and local authorities.

In Norway there is a division of responsibilities between municipalities – in charge of primary health care - and the state – in charge of secondary health care. The purchasing responsibility of secondary care is delegated to four regional health authorities. The municipalities, in cooperation with the state for employment services, are responsible for social care services.

In Romania health care is paid by the District Health Insurance Funds which are the local branches of SHI. The exception is for community outpatient services paid for by the state. Social services are paid by municipalities and different state agencies.

In Spain most health care services are public and funded by the Regional Health Authorities which are part of regional governments (autonomous communities). Private outpatient services (both general practitioners and specialists) are paid by patient/VHI and the mutual funds for civil servants. Social services are paid for by the social and employment authority within the regions.

## C.3 Provider payment models

In this section we look at financing mechanisms used to pay health care providers. Three types of organisation are covered in the text; general practitioners (GPs), mental health outpatient services and mental health inpatient services. The frequency of different organisational subtypes in Table C.3, Table C.6 and Table C.10 are only for illustration.

### C.3.1 Primary health care physicians (general practitioners)

Primary health care (PHC) plays an important role in mental health care. Several different organisational structures for general practice with different payment models can be found within a country. Table C.3 indicates the type and frequency of these structures found in the REFINEMENT countries.

Self-employed physicians are the dominant organisational model in the majority of the countries. In half of the countries (Austria, France, Italy and Romania) they typically also work in single-handed practices. Private group practice is the dominant model in England and Norway, and is also frequent in France. In Finland and Spain public health centres with salaried doctors are the dominant model.

**Table C.3 Frequency of organisational models of general practice**

0 = absent, 1 = occasional, 2 = common, 3 = dominant model

	Austria	England	Finland	France	Italy	Norway	Romania	Spain
Self-employed single handed – Type 1 <sup>1</sup>	3	1	1	3	3	1	3	1
Self-employed single handed – Type 2 <sup>2</sup>	3			1				
Self-employed group practice or similar – Type 1 <sup>1</sup>	1	3	2	3	1	3	2	1
Self-employed group practice or similar – Type 2 <sup>2</sup>	1			1				
Health centre <sup>3</sup>	0	0	3	0	0	1	0	3
Other <sup>4</sup>	0	1	2	0	0	0	0	0

1. Type 1: In Austria: PHC physicians with contract with SHIs (60%). In France: Sector 1 -applying statutory tariffs (92%).

2. Type 2: In Austria: PHC physicians without contract with SHI. In France: Sector 2 GPs are allowed to use extra billing.

3. Norway: GPs working on salary basis for the municipality.

4. England: GPs work on salary basis in GP practice or in small private companies. Finland: Occupational health care

Source: FINCENTO-pilot.

**Main payment mechanisms** In Table C.4 the payment models for the main or dominant organisational type for GPs\* in the REFINEMENT countries are shown (grey colour in Table C.3). All countries combine different payment mechanisms for GPs.

Capitation is the main payment mechanisms of GPs in three of the countries (England, Italy, and Romania) and is also used in Norway.

\* For details on the different organisational models see Straßmayr et al (2013).

Fee-for-Service is the main payment mechanism in France and Norway, but is also used (in varying degrees) in all countries except England and Spain.

**Table C.4 Forms of GP payment models (for dominant GP organisational subtype see Table C.3)**

Red implies dominant source of funding; blue implies additional source of funding

	Austria <sup>1</sup>	England	Finland <sup>4,5</sup>	France <sup>2</sup>	Italy <sup>3</sup>	Norway <sup>4</sup>	Romania	Spain
Capitation non risk adjusted						Blue		
Capitation risk adjusted		Red			Red		Red	
Global budget			Red					Red
Flat rate per period	Red			Blue				
Fee-for-Service (FFS)	Blue		Blue	Red	Blue	Red	Blue	
Target Payments		Blue		Blue	Blue			Blue
Out-of-pocket Payments <sup>6</sup>	Blue		Blue	Blue	Blue	Blue		
Other <sup>7</sup>		Blue	Blue			Blue		

1. GPs with contract with a SHI institution: OOP only used in the minority of 19 SHI institutions. Self-employed GPs without contract bill to patients are partially reimbursed.

2. Type 1: Flat rate per year is used as a supplementary scheme for chronically ill (30 specified long-term illnesses). No OOP for this group.

3. OOP and fee-for-service for limited set of services.

4. OOP subject to annual ceiling and exceptions for some patient groups e.g. children and adolescents and maternity care. In Finland can each municipality choose whether to require OOPs or not, up to the annual ceiling (which is based on legislation and cannot be exceeded). Most municipalities use OOPs.

5. There is a fee-for-service component (circa 25 %) in physician salary in health centres. Salaries are to some extent negotiated locally between physicians and health centres. There is no fee-for-service in use for providers, i.e. health centres.

6. OOP for prescriptions is not considered here.

7. For example, payments for providing additional services such as out-of-hours services

Source: FINCENTO-pilot.

Flat rate per visiting patient per period (usually three months) is the main payment mechanism used to pay doctors in Austria.

Global budgets are the main source in Finland and Spain, which are the two countries with publicly employed (salaried) GPs working in health centres.

England, France, Italy and Spain have some additional payments related to achieving targets or defined levels of performance. The same type of payment systems is used for self-employed GPs working single-handedly and in group-practice in most countries.

Finland, France and Norway use OOP for GP services. This is also the case for some SHI-funds in Austria. Italy also has OOP but only for a limited set of procedures. In France there is no OOP for patients living with one of 30 specified long-term illnesses (affection de longue durée; ALD), including long-term psychiatric condition (patients living for at least one year with psychotic disorders, mood disorders, intellectual deficiencies or severe personality disorders).

The information on payment mechanisms and other key characteristics of the primary care physician system are summarised in Table C.5.

**Other payment mechanisms** In half of the countries there are different payment mechanisms for different sub-types of GPs.

In Austria patients can visit self-employed GPs without contract with SHI. The patient pays the GP and is partially refunded by SHI (80% of tariff catalogue prices). Using this sub-type implies higher OOP since the GP can charge above tariff-catalogue prices.

Also in France there exist two sub-types of self-employed GPs, where Sector 2 physicians can have additional billing for patients.

In Finland there are two additional subtypes with different payment mechanisms. Patient visiting private GPs are billed and later partly reimbursed by the National Health Insurance (about 30% of physician outpatient visits in any year). Furthermore an occupational health care system exists alongside the public system. The occupational health care system is, in first instance, paid by the employers, who receive a 60% reimbursement for their costs from the NHI and for which patients do not pay OOP (for more than one third of the population, the service is provided either by the private system or health centres).

Also in Spain there are two additional models; patients covered by private insurance can visit self-employed physicians (limited) and for civil servants there is an obligatory health insurance system (patients can choose to attend health centres or self-employed physicians).

**Gate keeping** In the majority of countries GPs act as gate-keepers to secondary care. In the REFINEMENT countries gate-keeping systems are typically accompanied by a requirement for register with a GP/health centre and patient list-systems.

In Italy gatekeeping does not however apply for mental health.



**Table C.5 GP system characteristics**

	Austria	England	Finland	France	Italy	Norway	Romania	Spain
Most frequent model	Self-employed with contract (typically single handed)	Self-employed group practice (about 75% of all primary care practices)	Health centre	Self-employed-Sector 1 (60 % single handed)	Self-employed (typically single handed)	Self-employed (typically group practice)	Self-employed (typically single handed)	Health centre
Who pay/ contracts (main subtype)	19 different SHI funds	Clinical Commissioning Groups since 2013	Municipalities	Patients are billed and partly refunded from SHI	Local health authority	Municipalities contract/pay capitation (state pays FFS)	District Insurance House	Regional health authority
Out of pocket payment (OOP)	No (most SHIs)	No	Yes (up to an annual ceiling)	Yes, but not for the majority of chronic disease patients	Only some limited procedures	Yes (up to an annual ceiling)	No	No
Main payment mechanism	Flat rate	Capitation	Budget	Fee for service	Capitation	Fee for service	Capitation	Budget
Capitation	No	Yes	No	No	Yes	Yes	Yes	No
Fee For Service	Yes (one-third)	No	Yes (to the individual GP ca 25% of salary)	Yes	Yes (limited)	Yes (70–75% included OOP)	Yes (10%)	No
Target payments	No	Yes (about 25% of GP practice budget)	No	Yes (max 10%)	Yes (less than 10%)	No	No	Yes

Table C.5 GP system characteristics

	Austria	England	Finland	France	Italy	Norway	Romania	Spain
Different models with different payment mechanisms?	Yes Self employed without contract (ca 40%): patients billed and partially refunded from SHI OOP higher	Yes Self-employed: patients billed and partly refunded from NHI Occupational health care: no OOP No gate-keeping	Yes Self-employed: patients billed and partly refunded from NHI Occupational health care: no OOP No gate-keeping	Yes, sector 2 can use additional billing				Yes Self-employed: covered by VHI (limited) Civil servant system with no OOP No gate-keeping
Gate-keeping	No	Yes	Yes, for public health care	Soft (but over 90% in preferred doctor scheme)	Soft	Yes	Yes	Yes
Fixed patient lists	No	Yes	No	No	Yes	Yes	Yes	Yes
Patients must register with one primary care physician or centre	No	Yes	No/party	No/soft (financial incentive but no obligation)	Yes	Yes	Yes	Yes

In France soft gate-keeping is practiced through the “preferred doctor scheme”. The system is backed by financial incentives that are mainly directed towards patients. If a patient has not registered with a preferred doctor, or has registered with a preferred doctor but nevertheless visits another GP, or visits a specialist without a GP referral, the rate of coverage he/she is entitled to from SHI will drop from 70% to 30%. Well over 90% of French citizens have now enrolled in the preferred doctor scheme. They can also go directly to ambulatory mental health care centres.

In Finland patients can circumvent the public health care gate-keeping by obtaining a referral from the private sector or the substantial occupational health care service.

In Spain civil servants can go directly to private providers.

There is no gate-keeping system in Austria.

**Equity** The co-existence of different GP types of organisational model within a country may raise equity issues. In some cases patients, typically the more affluent, can pay more to get easier access (no waiting-time) to more generous care (more time per patient). In other cases specific groups (e.g. civil servants or the employed population) can achieve this without paying OOP. These sub-types may also represent an opportunity to avoid the gate-keeping mechanism of primary health care for secondary care. The potential inequality in access is particularly relevant for mental health since many patients are not employed and have low incomes.

### **C.3.2 Mental health outpatient services**

Outpatient mental health services also comprise several organisational types of model, including self-employed psychiatrists and psychologists (single-handed or in group practices), outpatient clinics – often based in hospitals – and outpatient services provided in community mental health centres or by community mental health teams. Table C.6 shows the frequency of different organisational models in the REFINEMENT countries. For details on the different organisational models see Straßmayr et al (2013).

In all countries, except for Romania, Community Mental Health Centres/Teams is a dominant type of outpatient services.

In Austria, France and Romania self-employed psychiatrists also are a dominant organisational structure. This organisational structure is not frequent in Finland, Italy and Spain, and is absent in England.

Outpatient services are more often found in hospitals in Finland, Norway and Romania than in the other REFINEMENT countries.

**Table C.6 Frequency of types of organisational outpatient service**

0 = absent, 1 = occasional, 2 = common, 3 = dominant sub-type

	Austria <sup>1</sup>	England	Finland	France <sup>2</sup>	Italy	Norway <sup>3</sup>	Romania	Spain
Self-employed psychiatrists	3	0	1	3	1	2	3	1
Self-employed psychologists	2	0	1	2	1	2	2	1
Outpatient services at hospitals (or standalone)	1	1	2	1	1	2/3	2	1
Community mental health centres/teams	3	3	3	3	3	3	2	3

1. Two types of self-employed; with and without contract with SHI.

2. Two types of self-employed psychiatrists; Sector 1 and 2 (practice extra billing).

3. District psychiatric centres which are community based are included in the hospital sub-type in the subsequent Tables C.7, C.8 and C.9 since they have the same payment mechanisms as hospital services and since Norway also has another community based (municipal) subtype. Both district psychiatric centres and municipal mental health services are dominant types.

Source: FINCENTO-pilot.

As shown in Table C.2 the different types of outpatient mental health services found within a country are often funded/contracted by different organisations/authorities. Tables C.7 – C.9 show the dominant forms of payment mechanism in the REFINEMENT countries for self-employed psychiatrists, outpatient clinics at hospitals and community mental health centres/teams respectively.

### Self-employed psychiatrists

The dominant form of payment mechanisms for self-employed psychiatrists are fee-for-service and out-of-pocket payment (Table C.7).

In Norway self-employed psychiatrists also receive an operating subsidy from the Regional Health Authority.

In Finland, Italy, Norway, Romania and Spain self-employed psychologists/psychotherapists are paid by the same main model as self-employed psychiatrists.

Self-employed psychologists/psychotherapists in Austria are either paid by FFS for services provided by associations that hold contracts with SHI or are otherwise paid by the patients. The latter are partially refunded by SHI.

In France patients must pay (without any reimbursement) for self-employed psychologists/psychotherapists.

This is also the case for the use of self-employed psychiatrists and psychologists without contracts with Regional Health Authorities in Norway.

**Table C.7 Payment models outpatient care: self-employed psychiatrist**

Red implies dominant source of funding; blue implies additional source of funding

	Austria <sup>1</sup>	England	Finland <sup>2</sup>	France <sup>3</sup>	Italy	Norway <sup>4</sup>	Romania	Spain <sup>5</sup>
Global budgets						Red		
Flat rate per period	Red							
Fee-for-service	Red		Blue	Red		Blue	Red	Red
Target payments								
Out-of-pocket Payments			Red	Blue	Red	Blue	Red	Red
Other								

1. Psychiatrists with contract with a SHI institution: OOP only used in the minority of 19 SHI institutions. Self-employed psychiatrists without contract bill to patients is partially reimbursed according to the FFS catalogue by SHI.

2. Bill to patients and reimburse.

3. Bill to patients and reimburse. Sector 2 practice extra billing. Long-term psychiatric conditions exempt from OOP.

4. Global budget= operating subsidy amounting to about 50 % of income in 2009.

5. Paid according to FFS tariffs either by patients or VHI.

Source: FINCENTO-pilot.

### Hospital outpatients

Global budgets are often used for outpatient services in hospitals (Table C.8), either as the sole payment mechanism (Austria) or in combination with target payment (England, Italy and Spain) or with FFS (France and Norway).

FFS is the main payment mechanism used in Finland and Romania.

OOP for outpatient services in hospitals are used in half of the countries.

### Community mental health services

Global budgets are the main payment mechanisms used for outpatient services in community mental health services (Table C.9), either as the sole payment mechanism (Austria, France and Norway) or in combination with target payments (England, Italy and Spain).

OOP for outpatient services in community mental health services are used in Italy and Romania. If we include the District Psychiatric Centres in Norway in this category, OOP is also found for community mental health services in Norway.

**Table C.8 Payment models for outpatient care: outpatient clinics at hospitals**

Red implies dominant source of funding; blue implies additional source of funding

	Austria	England	Finland <sup>1</sup>	France <sup>2</sup>	Italy	Norway <sup>3</sup>	Romania	Spain
Global budgets	Red	Red	White	White	Red	White	White	Red
Fee-for-service	White	White	Red	White	White	Blue	Red	White
Target payments	White	Blue	White	White	Blue	White	White	Blue
Out-of-pocket Payments	White	White	White	Blue	Blue	Blue	Blue	White
Other	White	White	White	White	White	White	White	White

1. The provider set the tariffs.

2. Long-term psychiatric conditions exempt from OOP. Hospital-based outpatient clinics paid for on a fee-for-service basis are predominantly provided in psychiatry departments of general hospitals. In stand-alone psychiatric hospitals, consultations are generally dispensed within the remit of ambulatory care centres (presented here under the category community health centres), providing care free of charge.

3. Including district psychiatric centres.

Source: FINCENTO-pilot.

**Table C.9 Payment models outpatient care: community mental health centres/teams**

Red implies dominant source of funding; blue implies additional source of funding

	Austria	England	Finland <sup>1</sup>	France	Italy	Norway <sup>2</sup>	Romania	Spain
Global budgets	Red	Red	White	Red	Red	Red	Red	Red
Fee-for-service	White	White	Red	White	White	White	White	White
Target payments	White	Blue	White	White	Blue	White	White	Blue
Out-of-pocket Payments	White	White	White	White	Blue	White	Blue	White
Other	White	White	White	White	White	White	White	White

1. The provider set the tariffs.

2. Municipal mental health services (district psychiatric centres have the same financing model as hospital outpatient clinics).

Source: FINCENTO-pilot.

### C.3.3 Mental health inpatient care

Several organisational models of care can be found also within inpatient care, serving different purposes and patient groups (see Table C.10).

Two main types of model are acute and non-acute (chronic) inpatient care. In some countries they have different forms of payment model. Also we may find different payment models for stand-alone mental hospitals and mental health departments in general hospitals, and for public and private beds. Unlike outpatient mental health care, the same organisation/authority typically funds/contracts the different types of inpatient care in the REFINEMENT countries. The exception being stand alone non-acute beds in Austria which are funded by social care budgets (Table C.2). For details on the different organisational types of model see Straßmayr et al (2013).

**Table C.10 Frequency of organisational models of inpatient care**

0 = absent, 1 = occasional, 2 = common, 3 = dominant sub-type

	Austria	England	Finland	France	Italy	Norway	Romania	Spain
Stand-alone psychiatric hospitals – acute care	3	2	2	3	0	2	1	1
Stand-alone psychiatric hospitals – non-acute care	1	0	2	3	0	2	2	1
Psychiatric departments in general hospitals (non-university)	3	3	2	2	3	2	3	2
Psychiatric departments in university hospitals	3	1	1	2	1	2	2	2
Psychiatric beds in psychiatric centres/ mental health centres	0	0	0	0	0 <sup>2</sup>	3 <sup>3</sup>	0	2
Other <sup>1</sup>		1	1		1			

1. England e.g. eating disorders or very complex severe mental disorders – often delivered in the private sector. Finland: state mental hospital. Italy: private inpatient facilities.

2. Only one experience in Trieste mental health centres.

3. Typically beds in district psychiatric centres in Norway.

Source: FINCENTO-pilot.

## Acute hospital inpatients

Table C.II shows the forms of payment for acute hospital inpatient mental health care in use in the REFINEMENT countries.

Global budgets are the main payment mechanisms used for inpatient acute services in half of the countries (England, France, Norway, and Spain).

Activity-based financing is used in three countries (Austria, Italy and Romania).

Daily rates are not commonly used to finance acute inpatient care and are only used as the main payment mechanism in Finland and for paying stand-alone private for-profit hospitals in France.

England, Italy and Spain use target payments for some inpatient care services.

Out-of-pocket payments for acute inpatient care is used in Austria (daily rate with a ceiling of 28 days per calendar year), Finland, France and Romania.

In Romania flat rates are used for stand-alone acute psychiatric hospitals.

**Table C.II Payment models acute hospital inpatient mental health care**

Red implies dominant source of funding; blue implies additional source of funding

	Austria	England <sup>1</sup>	Finland	France <sup>2</sup>	Italy	Norway	Romania <sup>3</sup>	Spain
Global budgets		Red		Red		Red		Red
Activity-based payment/case-based (e.g. DRG)	Red				Red		Red	
Daily rate			Red	Blue				
Target payments		Blue			Blue			Blue
Out-of-pocket payments	Blue		Blue	Blue			Blue	
Other							Blue	Blue

1. At time of data collection. Activity-based payment (payment by result based on HRG) was planned to be introduced in 2013 but is delayed.

2. Daily rate for private for profit hospitals.

3. Flat rate per patient per period is used for stand-alone acute psychiatric hospitals.

Source: FINCENTO-pilot.

## Chronic hospital inpatients

Daily rates are also observed for paying inpatient non-acute (chronic) care in stand-alone psychiatric hospitals in Austria, Italy and Romania. In Romania flat rates are also sometimes used for this type of beds.



### **C.3.4 Summary: out-of-pocket payment for health care services**

Out-of-pocket payments (OOP) are of specific interest since they may represent a barrier to use for economically disadvantaged groups, among which we often find severely mentally ill people, especially if they have to pay at the point of use and are only later reimbursed and if the ceiling on annual payments are high. OOP for prescription drugs is not included in Table C.12.

There are huge variations in the use of OOP among European countries. There are no OOP for mental health care services and general practitioners in England. The same is true for most services in Spain, except for self-employed physicians. There are no clear patterns for which type of services patients typically have to pay OOP, except that patients typically have to pay for mental health outpatient services provided by self-employed specialists and they often do not pay for outpatient services provided by community mental health centres/teams.

**Table C.12 Out-of-pocket payment for health care services**

Green = yes, blue = yes, with important exceptions, red = no, otherwise not applicable

	Austria	England	Finland	France	Italy	Norway	Romania	Spain
GP: self-employed Type I	Most SHI: no			Not longstanding illness	(Limited)			
GP: self-employed Type II								
GP: Health centre								
GP: Other			Occupational health care					Civil servants
Outpatient: self-employed Type I	Most SHI: no			Not longstanding illness				
Outpatient: self-employed Type II								
Outpatient: hospital/clinic								
Outpatient: community mental health								
Stand-alone psychiatric hospitals – acute care								
Stand-alone psychiatric hospitals – chronic care								
Psychiatric departments in general/university hospitals								
Psychiatric beds in psychiatric centres/mental health centres								

Source: FINCENTO-pilot.

# D. Service structures and utilisation patterns

In this chapter we provide some examples from the data collection in the REFINEMENT countries characterising essential features of mental health care service provision. The chapter also includes selected examples on incentives collected with the FINCENTO Tool (Straßmayr et al 2013). The following topics are covered:

- Prioritising of mental health
- General practitioners involvement in mental health care
- Referral patterns and collaboration between GPs and specialist mental health services
- Availability and geographical accessibility of outpatient services
- Bed rates and acute care bed utilisation
- Care continuity: outpatient follow up after acute psychiatric hospitalisation and outpatient "drop-out"

## D.1 Prioritising mental health

The proportion of total health expenditures directed towards mental health is an indication of the priority given to mental health within the health sector (World Health Organization (2011)). There are large variations between countries in the level of spending on mental health care services (ibid). These differences arise both because countries have different levels of spending (health care as share of GDP) and because countries differ in the share of the total health care budget that is spent on mental health.

Experience from the REFINEMENT-partner countries shows that collecting data on mental health care expenditures is challenging, at least when it comes to comparable data at country level. This is due both to the (lack of) availability of expenditure data divided by function and differences in what type of mental health care expenditures are included. The boundaries of mental health care may be drawn differently in different countries contributing to the difficulty of comparing expenditures between countries, and even within countries. For example, in the Veneto region in Italy there is a strong integration of health and social care, and supported housing and employment services for people with health needs, vocational rehabilitation, long term care and mobile services are financed within the health care system up to the budget ceiling for each local health district. In other countries such as Norway these services are mainly the responsibility of municipalities and the organisation and hence classification of expenditures between (primary) health and social

services may be different. Thus municipal spending on mental health care is not identified in official statistics even for services provided exclusively for mental health users.

## Expenditure

Some countries (Austria and Romania) did not provide any estimates of the share of mental health expenditure.

Some countries provided estimates for the share of (public) health care budget. England: 10.8% of total NHS expenditure, Finland: 4.6% total health expenditure and 5.9% of total publicly-funded health expenditure, including mental health at health centres (primary care level), France: *public* mental health care 6.25% of total health care expenditure.

Other countries provided estimates for share of secondary health care expenditure. Norway: 17.7% of secondary health care expenditure, secondary mental health care expenditure amounts to 7.7% of total health care expenditure (9.2% of expenditure to treat substance abuse is included). The estimate does not include mental health services provided by the municipalities.

Italy and Spain reported estimates at regional level. Veneto, Italy: 3–4% of the health care budget and Catalonia, Spain: 7% of the publicly-funded health care budget.

Since it was clear that comparable data was not possible to collect, further work (securing equal definitions etc.) on collecting expenditure data was not pursued.

The priority given to mental health in the financing of health care may however be contingent on how the planning and management of services are organised (see Table D.1).

**Table D.1 Planning and organisation of mental health care services**

N = national, R = regional, L = local

	Austria	England	Finland	France	Italy	Norway	Romania	Spain
Mental Health Plan	R	N, L	N, L	N	R	N, R, L	N	N, R
Mental Health Authority (MHA)	No	No	No	No	MHA (R)	No	MHA (R)	MHA (R)
MHA involved in service planning					Yes		Yes	Yes
MHA involved in service management					Yes		No	Yes (study area)

Source: REMAST-pilot.

## Mental health plans

Mental health policy and plans are essential for coordinating activities and for improving the organisation and quality of service delivery. Separate mental health plans may also be an effective tool for providing incentives for prioritising mental health and securing additional funding (see the example from Norway in Box 1).

### Box 1 Incentive: prioritising mental health

#### Example EARM 1: Earmarked grants to mental health (Norway)

In the years 1999–2008 a ten-year *Escalation Plan for Mental Health* was implemented in Norway. In addition to quantitative and qualitative strengthening of secondary care, including a restructuring of secondary care from hospitals to District Psychiatric Centres, building municipal services (a broad range of health and social care services) for patients with mental health needs was a key priority in the plan. Municipal services for adults and children constituted almost half of the planned increase in operating costs to services for people with mental health needs. The main economic instrument in the Plan was the use of earmarked grants. The earmarked grants to the municipalities accounted for an increase in annual operating expenses during the plan period amounting to NOK 2.823 million in 2008. The grants were distributed to the municipalities according to the criteria used for health and social services in The General Purpose Grant Scheme. The municipalities could also apply for investment subsidies for the construction of new apartments for people with mental health needs. The Escalation Plan set the following targets for mental health services for adults in the municipalities:

- 3,400 new apartments for people with mental illness.
- 3,400 new man years in home based care
- 4,500 additional users of day centres
- 10,000 additional people receiving personal support
- 15,000 additional people receiving cultural and leisure activities
- Strengthening treatment activities (184 psychologists and 125 additional personnel with college graduate with additional training in psychiatry)

Most targets were achieved or almost achieved. The use of earmarked grants was coupled with a strong regime of development of Municipal Plans for mental health and central government control of the use of grants to ensure that the money did not leak to non-mental health related services. An evaluation of the effectiveness of the instruments used to implement the plan concluded that they were effective and necessary to achieve the goals for the Escalation Plan for Mental Health (Kalseth et al 2008, Kalseth and Eikemo 2008). No clear indications of leaks of earmarked grants was found, on the contrary, the results indicates that municipalities contributed by supplementing the grants with use of their free disposable income, and this funding increased throughout the period. According to the Plan the operating expenditures to secondary mental health care were to increase by 22.8% during the plan period. The actual increase in 2008 was 31% (Pedersen 2009).

Plans at national level contribute to ensuring that mental health is given priority throughout the country and to the coordination of service organisation for more effective delivery. Plans at regional and local level will be more responsive to specific local circumstances (WHO 2004). All REFINEMENT countries have mental health plans at either the national, regional or local level.

Most countries have mental health plans at the national level. In England, Finland, Norway and Spain mental health plans are also found at lower levels. In Finland, for example, the municipalities have a strong role and most of them have local plans for mental health and addiction services\*. Austria and Italy have mental health plans at the regional level.

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\* Local plans may exist in most local authorities, but not necessarily in all.

## Separate mental health authority

Separate mental health authorities may be an effective tool for implementing mental health plans and ring-fencing mental health budgets, but this may, of course, go both ways, i.e. also hindering financial flows into health care to be sensitive to mental health service needs. Italy, Romania and Spain have separate mental health authorities at the regional level. In Romania the mental health authority is not involved in service management.

The examples provided by the REFINEMENT countries on financing mechanisms and incentives include one example from Norway which is relevant for the discussion of prioritisation of mental health in health care funding; ring-fencing of mental health by the use of earmarked grants (Box 1). The example shows that use of earmarked grants can be an efficient financial instrument in building up mental health services from an initial low level, and ensure that funding targeted at mental health does not leak in to other areas, as may be the case with multi-purpose authorities responsibility for service financing. A challenge with the use of earmarked grants to fund new services is to uphold the financing level when earmarking is phased out.

## D.2 GP involvement in mental health care

The utilisation of primary health care in mental health relates to the efficiency of the health care system. In terms of the limited resource availability and the overall demand for cost-effectiveness, the intensity of mental health care should be directly related to the severity of mental health problems. Thornicroft & Tansella (1999) postulate that specialist mental health services should concentrate entirely on the care for service users with the most severe symptoms and disabilities, while primary care services should provide for all other individuals with less severe conditions (Weibold et al 2013).

The REPATO Tool is concerned with patient pathways and care continuity and coordination. In Table D.2 answers to four questions concerning GP involvement in treatment of mental health patients in the REFINEMENT countries are reproduced. For further details see Weibold et al. (2013).

There seems to be a high degree of GP involvement in Austria, England and Norway; these countries report that exclusive utilisation of primary health care is the typical pattern for mental health treatment. This may be linked to psychopharmacological therapy very often being exclusively received from a GP, and also that GPs are involved in psychotherapy/psychological therapy. This seems also to be the case in Finland and France.

The answers for Italy and Spain indicate that GPs are less exclusively involved in psychopharmacological therapy and not involved in psychotherapy/psychological therapy. The answers indicate low GP involvement in Romania.

**Table D.2 General Practitioner involvement in treatment of mental health**

[c] = country, [m] = macro area, [s] = study area, [o] = other

	Austria	England	Finland	France	Italy	Norway	Romania	Spain
Exclusive use of primary health care services for mental health treatment	Very often [c]	Very often [c]	Often [s]	Often [c]	Often [m]	Very often [c]	Sometimes [c]	Often [c]
Psycho-pharmacological therapy <sup>1</sup>	Yes [c]	Yes [c]	Yes [c]	Yes [c]	Partially [c]	Yes [c]	Partially [c]	Yes [c]
Psychotherapy/psychological therapy <sup>1</sup>	Partially [c]	Partially [c]	Partially [c]	Partially [c]	No [c]	Partially [c]	No [c]	No [c]
Psycho-pharmacological therapy is exclusively delivered by a GP	Very often [c]	Very often [c]	Very often [c]	Very often [c]	Sometimes [o]	Very often [c]	Seldom [c]	Often [c]

1. GPs authorised to carry out (reimbursed) psychopharmacological/psychotherapy

Source: REPATO-pilot.

There is no clear and systematic pattern of correlation between type of payment mechanisms used or GP practice types and the involvement of GPs in mental health treatment in the REFINEMENT countries. There may be a range of factors influencing the utilisation pattern of GPs in mental health, including payment mechanisms (e.g. FFS vs capitation vs budget) and type of GP practices (e.g. private vs public). Other factors related to GP practice may be the existence of gate-keeping system, the entitlement of GPs to carry out psychiatric treatment, the significance of psychiatric issues in the training of GPs, policies and regulations concerning treatment responsibilities, guidelines for referral and treatment of mental disorders, caseloads and consultation frequencies in primary health care (Weibold et al 2013).

The answers reproduced above are a key starting point in revealing service utilisation patterns. The appropriateness of observed patterns can be evaluated combined with answers to other questions included in the REPATO Tool.

GP practices are characterised by high workload, time pressure and short consultation times. Consultation lengths vary between patients, doctors and countries, and are found to be less than ten minutes on average in e.g. Spain and UK (Deveugele et al 2002). Diagnosing and managing psychological problems and disorders are typically more time consuming than physical problems, and there is some evidence in the literature of improved outcomes with longer consultations for

patients with psychological problems (Hutton and Gunn 2007). Time pressures and short consulting time are viewed by GPs as the main barrier to addressing psychosocial problems (ibid). Studies have also shown that time pressures may compromise adherence to clinical guidelines (Tsigas et al 2013). The examples provided by the REFINEMENT countries on financing mechanisms and incentives include examples on use of specific tariffs in the FFS catalogues that may mitigate the time constraint, including tariffs tailored for mental health patients (see Box 2).

## Box 2 Incentives: general practitioners

### Example FFS 1: FFS to counteract the shortage of time in doctor-patient consultation (Norway)

The GP can charge additional fees (NOK 148) for each new 15 minutes for consultations lasting more than 20 minutes. It includes only direct doctor-patient time (not pre/post consultation work). This fee-type is quite often used; on average the number of times this fee is used amounts to 35% of the total number of consultations for the GPs (it can be used several times during a single consultation). The tariff seems to be often used for patients with mental health problems. Doctors often make a "double-appointment" in advance.

### Example FFS 2: Psychotherapeutic session (Norway)

A tariff for psychotherapy (*samtaleterapi*) lasting more than 15 minutes (NOK 200, can only be used once per visit) can be used in combination with the ordinary consultation rate (however the GP cannot claim the extra time rate mentioned in example FFS 1 above). This rate is used in about 5% of all consultations. Given that 12% of GP patients having a mental health diagnosis, this rate does seem to be quite often used. Prior to 2010 the patient had to have a contact with or be referred to a specialist to claim this rate.

### Example FFS 3: In-depth counselling of patients with mental disorders (Austria)

GPs are reimbursed for in-depth counselling of patients with mental disorders who are insured by the Viennese Health Insurance Fund. This implies that they are incentivised to deal with such patients. The minimum time spent for in-depth counselling of patients with mental disorders has to be at least 15 minutes. This service can be reimbursed three times per patient per quarter, but a second compensation is only applicable in 50% of all reimbursed cases. Thus GPs have an incentive to examine patients with a mental health problem themselves and to not immediately refer them to a specialist. However, because of volume limits in case extensive service becomes necessary, GPs should have an incentive to refer the patient to a specialist. While this incentive in the tariff catalogue of the Viennese Health Insurance Fund has a positive effect on GPs spending more time with patients with mental disorders and supporting the stepped care approach, it also has to be noted that GPs are not sufficiently trained in Austria (a) to recognise specific mental disorders and (b) to treat such patients therefore.

### Example FFS 4: Extensive psychiatric exploration and psychotherapeutic session (Austria)

The Lower Austrian Health Insurance Fund (NÖGKK) has two tariffs as incentives for dealing with patients with mental disorders: "extensive psychiatric exploration" and "psychotherapeutic session". Physicians have an incentive to carry out extensive psychiatric explorations in the case of suspected symptoms and to pay more attention to psychiatric symptoms. Nevertheless, volume limits are set as far as this tariff is only reimbursed once per case and per quarter. The necessity of an approval of a chief physician for charging the "psychotherapeutic session" tariff more than ten times is a barrier and acts as a disincentive for providing this service more than ten times and may negatively affect the continuity of care in a broader sense. Regarding psychotherapeutic sessions, in the tariff catalogue of the NÖGKK, it is not clear or officially listed which educational certificate is necessary to receive an extra payment for this service. This might lead to misinterpretations and different ways of implementing and handling the reimbursement of this tariff.



### **D.3 Referral patterns and collaboration between GPs and specialist mental health services**

Other factors that may influence the pattern of utilisation of GPs in mental health care are related to the interface between primary health care and specialist mental health outpatient care. They include policies and regulations concerning treatment responsibilities, guidelines for referral and treatment of mental disorders, referral patterns, type of services offered and capacity/waiting time, as well as payment mechanisms used in specialist outpatient mental health care, integration/fragmentation of services, collaboration and contact styles between primary care and specialist care (Weibold et al. 2013).

A selection of questions concerning the interface between primary health care and specialist mental health care is shown in Table D.3.

Even though it needs to be taken into account that the answers may reflect expert judgments, subject to differences in interpretation of questions due to different context etc., they seem to reveal different patterns concerning the interface between GP services and specialist mental health care in the REFINEMENT countries.

There seems to be less contact, collaboration and integration of services in the countries where self-employed specialists are the most frequent type of services referred to by (self-employed) GPs.

Fragmented financing and care systems, and absence of regulated service responsibilities are reported as barriers to care coordination and collaboration in e.g. Austria and France.

Organisational boundaries and separate budget responsibilities are also mentioned as limiting factors in other countries e.g. Finland and Norway.

Care coordination and collaboration may, among other things, be achieved through organisational and budgetary integration of services (e.g. Italy), on site mental health professionals in primary health care (e.g. Spain) and financial and non-financial governmental incentives (e.g. Norway). Examples of financial incentives for collaboration between GPs and specialised mental health care (including inpatient care) collected by FINCENTO (pilot) are given in Box 3.

**Table D.3 Factors related to the interface between primary health care and specialist mental health outpatient care**

[c] = country, [m] = macro area, [s] = study area

	Austria	England	Finland	France	Italy	Norway	Romania	Spain
Most frequent referral pathway	Self-employed psychiatrists [c]	Access and assessment teams /community mental health teams [c]	Mental health professionals in primary care health centres [c]	Self-employed psychiatrists [c]	Community mental health centres [m]	Community mental health centres [c]	Self-employed psychiatrists [c]	Community mental health centres [c]
Waiting time in specialist outpatient mental health care (days)	30–90 [s]	n.a.	21–30 [c]	21–30 [c]	14–21 [s]	30–90 [c]	21–30 [s]	21–30 [s]
Mental health workers on site in primary health care (with GP)	No [c]	Sometimes [c]	Often [c]	Very seldom [c]	No [c]	Seldom [c]	Very seldom [c]	Often [m]
Integrated care models/mechanisms	Rare [c]	n.a.	Yes, some; (e.g. ACT teams, weekly consultation etc) [m]	Rare [c]	Yes, single management [c]	Yes, some (e.g. ACT-teams, responsibility groups, individual plan etc) [c]	No [c]	Yes, mental health support programme to the primary care team [m]

**Table D.3 Factors related to the interface between primary health care and specialist mental health outpatient care**

[c] = country, [m] = macro area, [s] = study area

	Austria	England	Finland	France	Italy	Norway	Romania	Spain
Support of integrated care through financing and/or regulatory mechanisms	No [c]	n.a.	No [c]	n.a.	Yes, single budget [m]	Yes, earmarked funding of collaborative models. Specific FFS tariffs for collaboration [c]	n.a.	Yes, special funding of support programme [s]
Collaboration between GP and specialized mental health <sup>1</sup>	No [c]	n.a.	Partly [c]	No [c]	Yes [m]	Partly [c]	n.a.	Yes [m]
Contact between GP and specialized mental health	No regular contact [c]	Regular contact [c]	No regular contact [c]	No regular contact [c]	Some contact [m]	Some contact [c]	No regular contact [c]	Some contact [m]

1. Does collaboration between primary and specialist mental health function to ensure that the needs of the individual service user are matched to the appropriate level of care, and only graduate to a more intensive intervention if required

n.a. = not available

Source: REPATO-pilot.

### Box 3 Incentives: cooperation and care coordination between primary and specialised care

#### Example FFS 5: FFS for participating in multi-disciplinary cooperation meetings (Norway)

A recurring issue is the involvement (or lack thereof) of GPs in cooperation with other services, e.g. mental health workers in the municipalities and secondary mental health care. Due to the responsibility for acute visits and the heavy workload, the GPs face time constraints and cooperative meetings may be less prioritised. The FFS-system includes a tariff for participating in multi-disciplinary cooperation meetings as part of patient treatment. The rate (500 NOK) covers work (including travel time) for half an hour, and may be charged for each new half hour. 1.28% of all bills from GPs in 2011 include this fee. The use of this tariff increased from about 140,000 in 2001 to about 260,000 in 2009, and the GP used this rate on average 65 times in 2009. The rate for cooperative meetings only covers meetings concerning specific patients, not general cooperation meetings. Hence the GPs lack a financial incentive to participate in the general cooperative work on mental health. There are also tariffs for patient related collaboration in the FFS-schedule for secondary outpatient mental health care.

#### Example TAR 1: Special procedure to coordinate care between inpatient care and primary care after hospital discharge (Spain)

The target included in the purchase contract in primary care is called "Accomplish a minimum percentage of patients included in the PREALT protocol that have contact with the Primary Care Team, within 48 hours after discharge". The PREALT protocol applies to acute hospital units, long-stay social-health units, palliative care and sub-acute hospital units for mental health. It requires that the Hospital Unit, at referral, detects patients with specific needs to be treated in primary care at discharge. Then, 24-48 hours previous to discharge, a PREALT reference person notifies the primary care centre of reference concerning the close discharge of the patient. The procedure consists of filling in a document with the date of discharge and to address it to the primary care centre. At discharge, the primary care PREALT reference person calls the patient/carer to get to know their status and to arrange needed appointments. In the case of mental health care, only sub-acute units participate in the PREALT Protocol. The requirement of the patient is to have a severe mental disorder and organic comorbidity. Results: The coordination between specialist hospital care and primary care in patients with Severe Mental Disorders and organic comorbidity has improved. There has been an increase of appointments in primary care after discharges from PREALT Protocol concerned units. The target is also included in the target payment system for specialist mental health care.

## D.4 Availability and geographical accessibility of outpatient services

Outpatient services play a key role in mental health care service system and include a range of different type of ambulatory and mobile service, such as hospital based and stand alone outpatient clinics, including both general ambulatory services and specialist outpatient facilities for specific disorders or patient groups, and community mental health teams, including both generic teams and specialist team such as assertive community treatment (ACT) teams and early intervention teams. In this section we provide examples of availability and geographical accessibility of outpatient services in the REFINEMENT study areas based on data collected by the REMAST Tool-pilot.

### Availability

Availability is illustrated using four indicators:

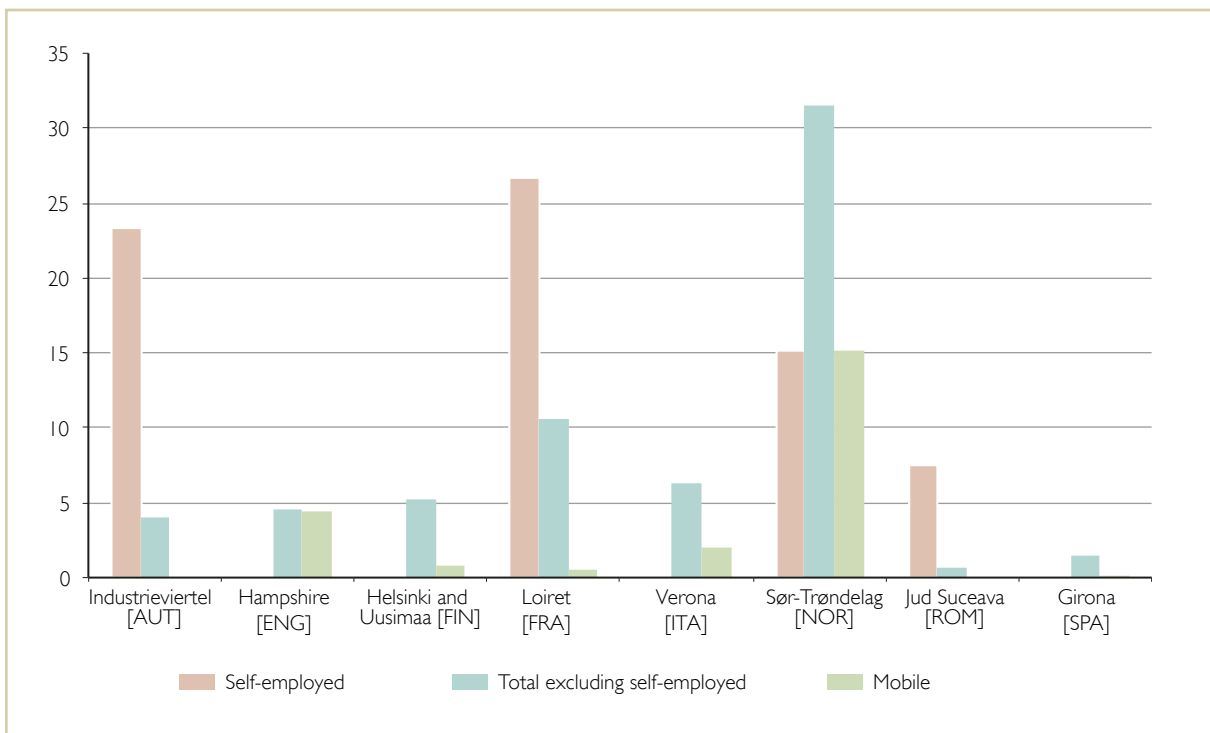
- The number of *outpatient services* per 100,000 population aged 18 years or above
  - Separate indicator for self-employed specialists
- The number of *mobile services* per 100,000 population aged 18 years or above

- The number of *staff* (full-time equivalents) by category in outpatient services per 100,000 population aged 18 years or above

Availability is not only related to the number of services in an area, but also to capacity of each service. Hence, we show indicators illustrating both the number of services and staff rates in the study area.

The total number of outpatient services includes all outpatient services mapped in the study areas. Since self-employed specialists typically works single-handedly, inclusion of this service type would inflate the number of services. Still, they constitute a significant part of the service system in some countries and this is important to illustrate. They are therefore included in a separate bar in the Figure D.1.

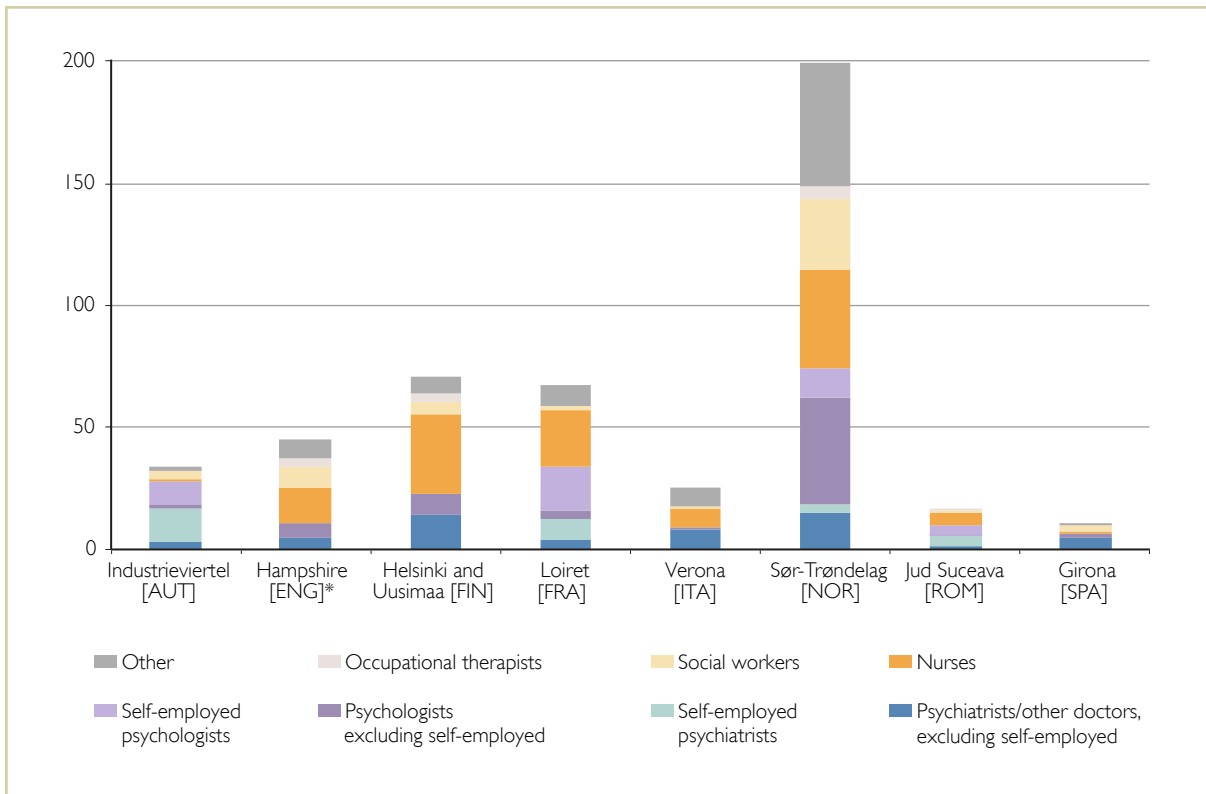
**Figure D.1 Number of outpatient services per 100,000 capita (18+ years) in REFINEMENT study areas**



Source: REMAST-pilot.

Staff levels for eight categories are shown in Figure D.2. Information on staff is missing for some services. Hence the staff level shown for some study areas may be to low. This is especially the case for the study area in England, where about one-quarter of the services have missing staff levels.

Figure D.2 Number of full-time equivalent personnel in outpatient services per 100,000 capita (18+ years)



\* Missing data on personnel for 25% of the services. If the missing services have mean staff numbers, the total personnel rate would be 34% higher

Source: REMAST-pilot.

## Accessibility

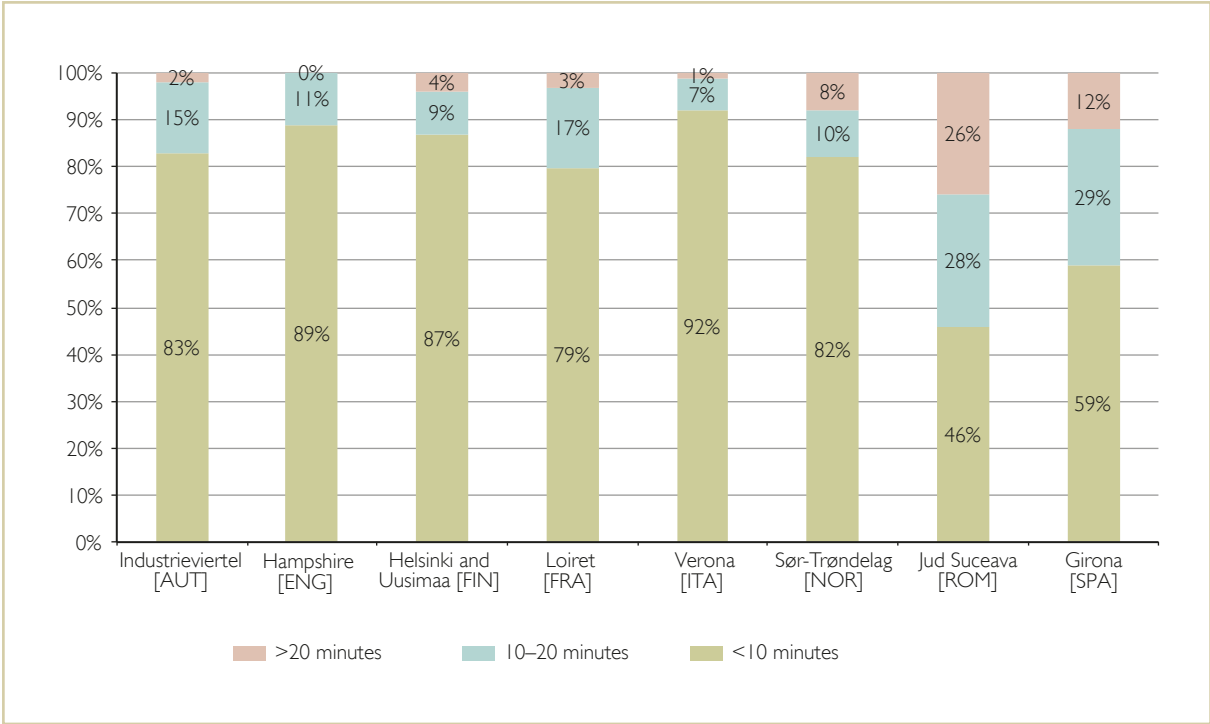
Accessibility is illustrated by the average travel time to outpatient services for the study area population (Figure D.3). The indicator is calculated using Geographical Information System (GIS).

## Number of outpatient services

\* Some of the service units mapped have more than one Main Type of Care. In Norway the municipal teams work both office-based and mobile. The rate for Norway drops from 31,5 to 24 if these are counted as one service. The municipal services do include psychiatrists

England, Finland, Italy and Spain have not reported data on self-employed specialists for their study area. These are countries where self-employed specialists are not common or do not exist (Table C.6). In Austria, France and Romania they constitute a significant part of the outpatient service system, and are the service type the GPs most often refer their patients to (Table D.3). The rate of outpatient services excluding self-employed specialist are very high in Sør-Trøndelag [NOR]\* and also relatively high in Loiret [FRA] compared to the other study areas. The rates are lowest in Girona [SPA] and Jud Suceava [ROM]. In Girona [SPA], and Helsinki and Uusimaa [FIN], on site mental health workers are often found in the primary care health centres (Table D.3). In the macro area of Spain the integrated care model "The Mental Health Support Programme for the Primary Care Team" is implemented, implying that mental health professionals, mainly psychologists, psychiatrists and nurses, move to primary care to offer support, facilitate detection, liaison and treatment of mild cases and referral of complex cases. In the study area the mental health

Figure D.3 Proportions of population with travel time from outpatient mental health service of <10 minutes, 10–20 minutes and >20 minutes



Source: REMAST/REPATO/REQUALIT-pilot.

professional behaves more as a collaborator working together with the primary care professional in order to provide an agreed response to the problem. It is very rare that the mental health professional provides direct attention in primary care. In Finland, secondary level specialist mental health care is provided in multi-professional community mental health centres. To ensure expertise and specialisation of staff, these centres have been centralised.

In terms of numbers (rate) mobile services are also most common in Sør-Trøndelag [NOR]. However as share of services, the mobile service approach is most developed in Hampshire [ENG], where most services are mobile. Mobile services are not very typical in the other study areas, however constituting about 30 per cent in Verona [ITA]. No mobile services are mapped in Industrieviertel [AUT] and Jud Suceava [ROM].

**Personnel in outpatient services**

The availability of outpatient services does not only depend on the number of services but also on staff levels. Taking the different staff levels into account Sør-Trøndelag [NOR] still stand out, having a very high staff rate, see Figure D.2. The mean number of staff per service (not shown) is highest in Helsinki and Uusimaa [FIN], Jud Suceava [ROM] and Hampshire [ENG] and lowest in Industrieviertel [AUT], Loiret [FRA] and Verona [ITA]. This is taken into account in staff rates at the study area level. Hence, even though the number of services per population 18+ years is lower in Helsinki and Uusimaa [FIN] than

e.g. Loiret [FRA], the two areas have quite comparable staff rates for outpatient services. Hampshire [ENG] also has a relatively high staff rate (especially considering a high share of missing staff data). Jud Suceava [ROM] and Girona [SPA] have the lowest staff rates. Some countries also rely heavily on day services (not shown). In e.g. Italy the staff rate for personnel working in day services is higher than for outpatient services.

The level and composition of the different personnel categories also vary much between the study areas. Nearly 70% of the outpatient staff is self-employed specialists in Industrieviertel [AUT]. The share is high also in Jud Suceava [ROM] (46%) and Loiret [FRA] (40%). The share of psychiatrists\* and psychologists (self-employed and others) are over 80% in Industrieviertel [AUT] and is also over 50% in Jud Suceava [ROM] and Loiret [FRA]. Girona [SPA] also has a high share of psychiatrists. Sør-Trøndelag [NOR] has the highest rate, and a high share, of psychologists. However the share of psychiatrists is low. Hampshire [ENG] which mostly has mobile services has the lowest share of psychiatrist and psychologists. This area has a high share of social workers, occupational therapists and "other" staff. This is also the case for the study area in Norway.

More than half of the outpatient services in Sør-Trøndelag [NOR] are found at the municipal level. Establishing mental health services as part of the municipal responsibility to provide community based care for all patient groups, including people with needs related to mental health, was a key priority in the ten-year Escalation plan for mental health (see Box 1). Norway has a low population density (Figure B.9) and a dispersed settlement pattern. Measured per km<sup>2</sup> the number of services is low in Sør-Trøndelag [NOR]. Relative to land area covered, the number of services are highest in Hampshire [ENG] and Verona [ITA].

### Travel time to outpatient services

The high number of (municipal) services in Norway thus contributes to bringing the outpatient services closer to the population, i.e. to the geographical accessibility of services. This is illustrated by the fact that average travel time to outpatient services is relatively high in Sør-Trøndelag [NOR] despite the huge land area covered in the study area, see Figure D.3. In most study areas less than 20% of the population need to travel for more than 10 minutes to reach an outpatient service. The exceptions are the study areas in Romania and Spain (more than 40%).

The information collected on financial incentives using the pilot-version of the FINCENTO Tool includes examples related both to accessibility and other quality aspects for outpatient services. Some examples are showed in the Boxes 4 and 5.

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\* And other doctors, including psychiatrists in training.



## Box 4 Incentives: accessibility – outpatient services

### Example FFS 6: Activity independent FFS to facilitate outpatient services compared to inpatient services (Norway)

The outpatient services in secondary mental health care (the largest part taking part at the District Psychiatric Centres, DPC) are financed by a combination of FFS and global budgets. The design of the outpatient financing system can be seen to balance the need for cost control, stimulate the development of outpatient services and enhance efficiency/productivity and activity mix. The FFS constitute two different types of tariffs. One is the activity independent rate per hour patient related outpatient work per year that is performed by approved personnel. The other is activity dependent rates. The activity-independent part stimulates developing outpatient services (however maintaining (in combination with global budget) some degree of cost control). The FFS-system introduces financial incentives favouring outpatient activities rather than inpatient care, by reducing the price of new personnel and activity in outpatient services compared to inpatient services (which is financed 100% by global budgets).

### Example EARM 2: Earmarked grants to stimulate establishments of ACT-teams in District Psychiatric Centres and municipalities (Norway)

This example concerns financial initiatives stimulating new, collaborative (between secondary health care and municipal mental health care) services for persons with severe mental illness in need of long term, complex and continuous services. The initiative involves the use of earmarked grants (subsidies) by the central government to co-finance development of ACT-teams and other organisationally binding cooperative projects (models for cooperation) between secondary health care and the municipalities (which are responsible for primary health care, long-term care and social services; i.e. responsible of assisting people to live good lives in the community). The subsidies are allocated based on project applications. Evaluation of the initiative shows significant positive results regarding use of inpatient care; both the number of admissions and the number of days in inpatient care were significantly reduced.

### Example TAR 2: Target for Mental Health Centres to treat patients with severe mental disorders (Spain)

In 2009, Mental Health Centres belonging to the Institut d'Assistència Sanitària had 12 objectives to achieve as the variable part of the purchase contract signed with Health Region. Ten objectives were common to all of 72 Catalan Mental Health Centres, and 2 were specific for the Girona health region. There were three objectives related to accessibility, one of resolution, two of efficiency, two on users' perceptions of quality and two related to criteria for transfer of information. The incentive related to "Mental Health Centres treat patients preferably with severe mental disorders" was defined as an accessibility goal. The description of the incentive is: Achieve a minimum percentage (20%) of patients treated in the Mental Health Centre with a diagnosis of one of the ten severe mental disorders (SMD).

### Example OOP 1: No user charges to support accessibility (France)

Consultations in ambulatory care centres (CMP) are free of charge. CMPs are meant to coordinate care: they are at the centre of sectorised psychiatric care (secteurs de psychiatrie; mental health areas), and help with social and professional reinsertion with a multidisciplinary team (psychiatrists, psychologists, nurses, social workers etc.). They are responsible for coordinating care, providing patients with individualised care plans, and also for prevention and screening. The fact that they are free is an incentive for patients to consult as it withdraws the economic barrier to access.

## Box 5 Incentives: other quality aspects – outpatient care

### Example TAR 3: National Quality Indicators in Contracts (England)

There are a number of specified national indicators of quality in contracts for mental health. It is up to individual contract negotiations to determine what consequences of breaches are set. One potential consequence would be financial penalties. National Quality Measures that must be included in contracts with mental health service providers are:

1. Early Intervention in Psychosis – this target measures the number of cases of first episode psychosis taken on by Early Intervention Teams for treatment and support from 1 April 2012 to 31 March 2013.
2. Crisis Resolution – this measure is split into two parts, a commissioning measure and a provider measure. The commissioner is measured against the number of home treatments carried out by Crisis Resolution/Home Treatment teams every quarter throughout 2012/13. The aim is to provide prompt effective home treatment, including medication, in order to prevent hospital admissions and give support to informal carers. There is no specific target associated with this measure but there is an expectation that Primary Care Teams show a progressive increase from quarter to quarter.
3. Care Programme Approach (CPA) seven-day follow-up – the Operating Framework measure requires 95% of patients discharged to their place of residence, care home, residential accommodation, or to non-psychiatric care must be followed up within seven days of discharge. This will reduce the risk of social exclusion and improve care pathways to patients following a spell on inpatients.
4. Improving Access to Psychological Services (IAPT) – the Operating Framework 2012/13 requires people with depression and/or anxiety disorders to have improved access to therapies. This is done using two indicators in the first place, the proportion of people that enter treatment against the level of need in the general population and secondly, the proportion of people who complete treatment and who are moving to recovery. The plans are submitted by Primary Care Teams and are based on national recommendations applied to the local population. For instance in 2012/13 in Manchester the expectation is that 7.2% of people with anxiety and/or depression access services and 44% of these move to recovery.

An additional target payment linked to quality of care in use in England is *The Commissioning for Quality and Innovation (CQUIN) payment framework*. The CQUIN framework is a national framework for locally agreed quality improvement schemes. It enables commissioners to reward excellence by paying a quality increment to providers using NHS Standard Contracts if they achieve agreed quality improvement goals. This can be no more than 2.5% of the total contract value. Relates to both outpatient and inpatient care.

### Example FFS 7: Time spent with patient as quality criteria in FFS system (Romania)

Psychiatrists can only ask for reimbursement for 14 patients a day and it is assumed that psychiatrists work 7 hours a day and therefore they work 30 minutes per patient – which is regarded as a quality criteria. Services offered above this limit are not reimbursed.

## D.5 Inpatient/ residential care

Residential care still constitutes a major care setting in mental health. According to Thornicroft and Tansella (2004) there is no evidence that a balanced system of mental health care can be provided without acute beds. In this chapter we take a look at mental health bed rates (input) and related process indicators.

Residential care covers several types of inpatient care. In the REMAST Tool the type of residential care are separated according to a series of hierarchically arranged qualifiers. In the examples shown here eight main types are identified (codes for MTC in parenthesis):

- Acute hospital care (R1: high intensity, R2: medium intensity, R3.0: non-24-hour physician cover)
- Acute non-hospital (R3.1)
- Non-acute hospital care (R4: time limited, R6: indefinite stay)
- Non-acute non-hospital care with 24-hour physician cover (R5: time limited, R7: indefinite stay)
- Other, time limited stay 24-hour support residential care (R8)
- Other, time limited stay non-24-hour support residential care (R9: daily support, R10: lower support)
- Other, indefinite stay 24-hour support residential care (R11)
- Other, indefinite stay non-24-hour support residential care (R12: daily support, R13: lower support, R14: other)

Forensic beds and beds for substance abuse treatment are not mapped in the REFINEMENT project.

A special adaption is made for Norway and Spain where hospital beds are found both in traditional hospital settings and also in new type of settings. These are identified by an additional code for "New" which applies to hospital BSICs of recent creation in health complexes or community centres that do not fulfil criteria for typical hospitals. In Spain these facilities are called "Complejo/complex" and are, in Girona, part of the Institut d'Assistència Sanitària. In Norway they are called District Psychiatric Centres (DPC) and are also termed local hospitals, and are organised within the same hospital trusts as the more specialist hospital beds. However the DPCs are considered to be part of the community mental health services, as are municipal mental health services. While the municipalities provide long term care and support, e.g. supported housing services, the DPCs provide time-limited inpatient treatment and care.

An adoption is also made for Romania where we separate beds in "institutional" settings from other beds. These are identified by an additional code for "Institutional care" which describes residential BSICs characterised by indefinite stay for a defined population group, which usually have over 100 beds and which are described as "Institutional care".

### D.5.1 Bed rates

#### Comparison of hospital bed rates reported at country level in international statistics and in the REFINEMENT study areas

Before presenting the bed rates for different types of care found in the study areas, it is interesting to compare the study area rates with rates at the country level found in international statistics. We have collected psychiatric bed rates from the WHO Mental Health Atlas 2011. Figure D.4 shows the reported rates for hospital beds, excluding beds reserved for children and adolescents only. In the WHO Mental Health Atlas data beds reserved for children and adolescents were not available for wards in general hospitals in Spain and in mental hospitals in England. This should not bias the data very much.

In all countries except Italy the rate in the REFINEMENT study areas are less than the rates reported in the WHO Mental Health Atlas. The REFINEMENT study area in Norway is quite representative of the whole country in terms of bed rates. For England and Spain the rates for the study area are less than half of the WHO Mental Health Atlas rate; the potential bias related to not being able to correct adequately for beds reserved for children and adolescents is not likely to explain the difference. The difference is also large in France. For Italy the rate for hospital beds reported for the study area is twice the rate reported in the WHO Mental Health Atlas.

The difference between the rates for the study area and rates at the country level found in international statistics may either relate to the study area not being representative for the whole country or that the type of beds included in the statistics are different. Except for Finland, the study area covers less than 10% of the population in each country.

Figure D.4 Hospital beds per 100.000 capita (excluding beds reserved for children and adolescents)



Sources: WHO Mental Health Atlas 2011 and REFINEMENT project/REMAST-pilot.

In Finland the study area covers about 30% of the total population. For most countries the study areas are more densely populated than the whole country. In the case of Italy one might expect that only acute beds are included in the international statistics, since the rate for acute beds in the study area (11.6) is closer to the hospital bed rate reported for the country in the WHO Mental Health Atlas data.

The comparison of bed rates from different sources illustrates the challenge in making international comparisons of health care services. The definition of (type of) service and how beds are reported may differ between countries. Differences may arise both related to how services are organised and funded and how they are reported in national statistics. For example, what is defined as a hospital bed? Are non-acute/rehabilitation beds included? Are different types of beds organised and funded by the health care sector in different countries? The latter may be even more significant, so it is important how and whether long term/social care residential services are reported. Even though the rates of the study area differs from the rates reported at country level, the REFINEMENT data confirms relatively high rates in Norway, Finland, Romania and France and low rates in Austria, Italy and Spain, with England in a middle position.

### Bed rates in the REFINEMENT study areas

The level and composition of beds concerns the availability, efficiency and appropriateness of mental health services. Figure D.5 shows the rate of beds in different categories per 100,000 population aged 18+ years (in Figure D.4 the rate was per 100,000 total population).

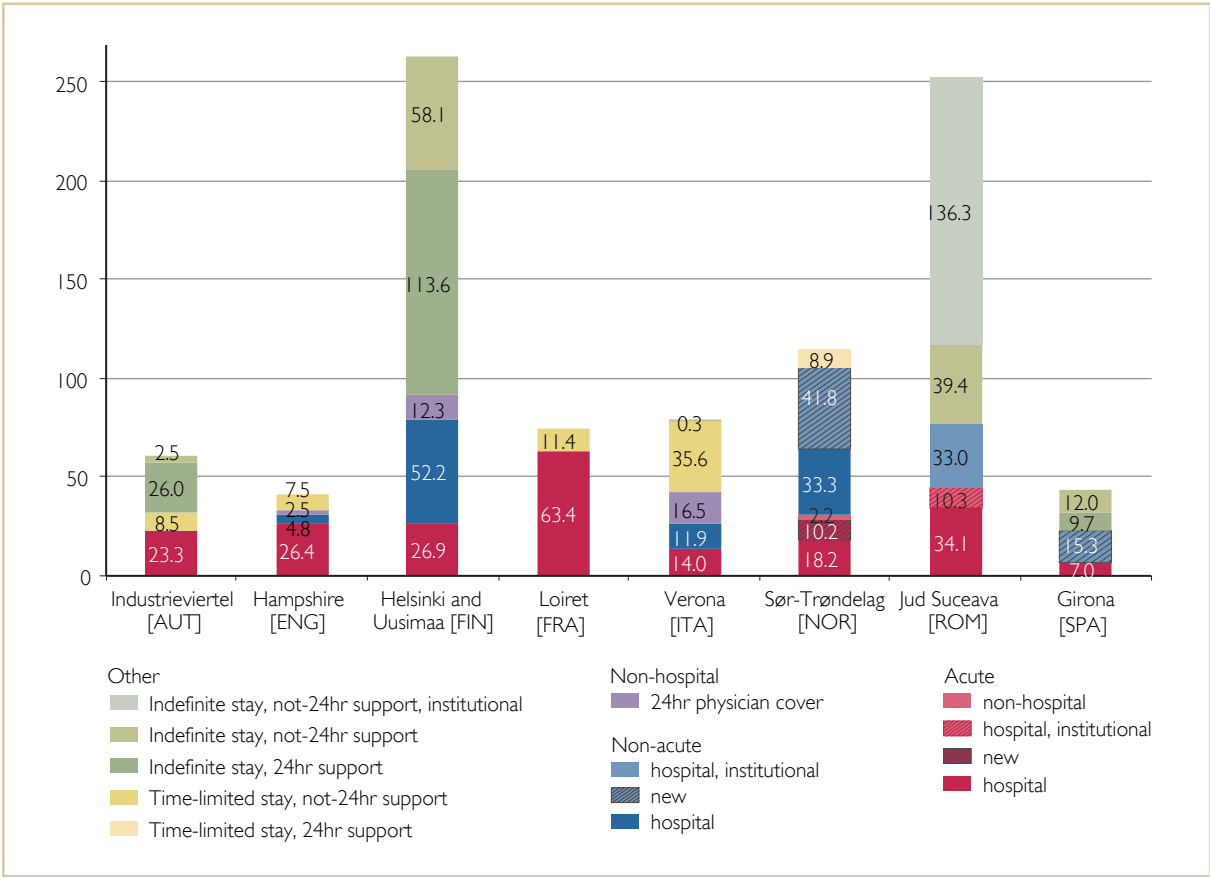
Total mental health bed rates are much higher in Helsinki and Uusimaa [FIN] and Jud Suceava [ROM] than in the other countries. This relates to the very high rates of community indefinite stay beds. In Helsinki and Uusimaa [FIN] the majority are in nursing homes with 24-hour staffing providing permanent care for people with severe mental disorders. The rest are mainly beds in nursing homes with daily support. These categories of beds have been rapidly increasing in Helsinki and Uusimaa [FIN], and represent trans-institutionalisation (a shift from hospitals to other institutions), as well as private entrepreneurship (the majority of these nursing homes are private for-profit under public contract and highly profitable). Jud Suceava [ROM] also has a high number of indefinite stay beds (daily support). A majority of these are found in institutional settings. Industrieviertel [AUT] and Girona [SPA] also have community-based indefinite stay beds. This category should not include housing/apartments for mental health users supporting independent living (separate flats, users pay rent etc) even though 24-hour support are available from mobile/home based services\*. However the demarcation line between different types of permanent dwelling arrangements, i.e. "beds" versus "flats", are not clear since a range of different arrangements exists with different degrees of independent living characteristics and which are labelled differently in different countries (or even within countries).

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\* In, for example, the study area of Norway there are more than 50 such apartments per 100,000 population aged 18+ years where the users receive 24-hour support.

Verona [ITA] reports high rate for community limited-stay beds without 24-hour physician cover (35.6). Such beds are also found in Industrieviertel [AUT], Hampshire [ENG], Loiret [FRA] and Sør-

Figure D.5 Beds per 100,000 population aged 18+ years in different organisational settings in REFINEMENT study areas



Source: REMAST-pilot.

Trøndelag [NOR], and only very few in Helsinki and Uusimaa [FIN]. In Sør-Trøndelag [NOR] these have 24-hour support.

Helsinki and Uusimaa [FIN] and Verona [ITA] report a substantial amount of community beds with 24-hour physician cover. A few such beds are also reported for Hampshire [ENG]. In Helsinki and Uusimaa [FIN] these are mostly (nearly 80 %) indefinite stay beds.

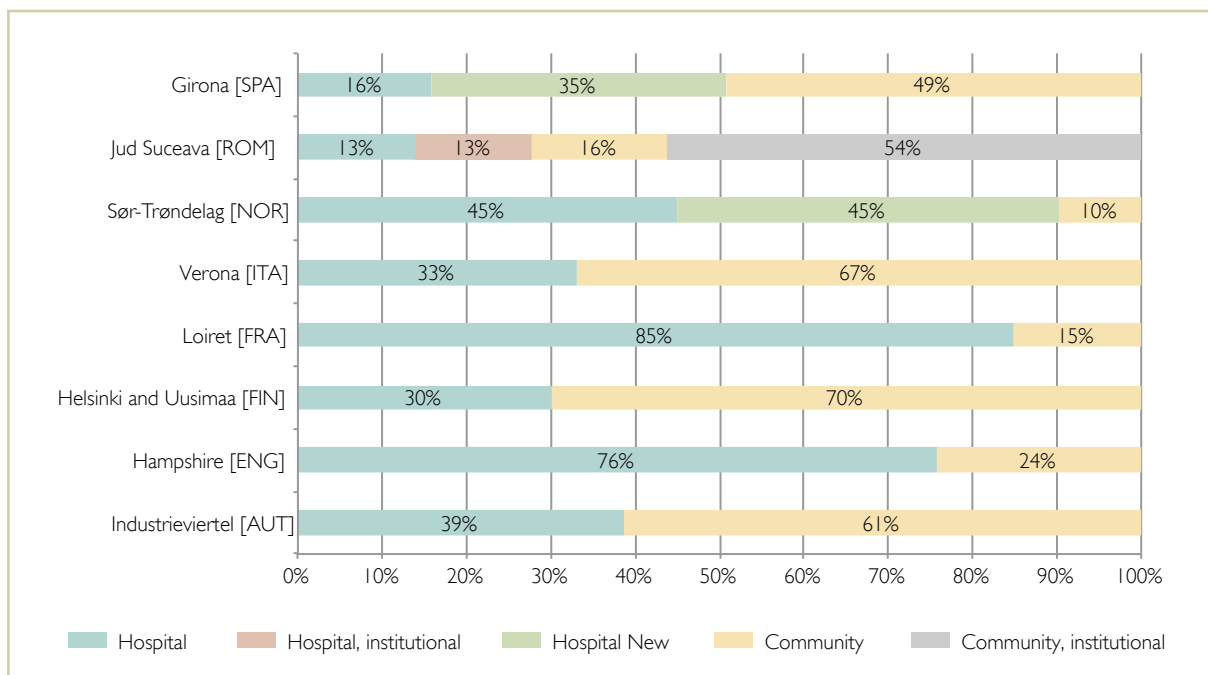
High rates of non-acute hospital beds are reported for Sør-Trøndelag [NOR] (75.1), Helsinki and Uusimaa [FIN] (52.2) and Romania (33). Such beds are also found in Verona [ITA], Hampshire [ENG] and Girona [SPA]. The high rate for Sør-Trøndelag [NOR] is to a large degree related to beds in the District Psychiatric Centres (DPC) (41.8), which are termed local hospitals but are also considered to be part of community care. Still, the rate for non-acute hospital beds is high also excluding the DPCs (33.3). Also in Girona [SPA] these beds are of the "new" type. A majority of the non-acute hospital beds (60%) in Helsinki and Uusimaa [FIN] are indefinite stay beds. In Jud Suceava [ROM] the beds are found in indefinite stay "institutional" settings.

There is also a huge variation in the reported rate of acute hospital beds. Varying from 7 in Girona [SPA] to 63.4 in Loiret [FRA]. Verona [ITA] also reports a low acute bed rate (14). Industrieviertel [AUT],

Hampshire [ENG], Helsinki and Uusimaa [FIN] and Sør-Trøndelag [NOR] are in a middle position (23.3–28.4), while Jud Suceava [ROM] is on the high side (44,4). More than one-third of the acute beds in Sør-Trøndelag [NOR] (10.2) are acute and crisis beds in the DPCs. Where different types of beds are found in the same hospital, as is the case for Helsinki and Uusimaa [FIN] and Sør-Trøndelag [NOR], the split between acute and non-acute beds may be somewhat misleading; e.g. in Sør-Trøndelag [NOR] acute patients are admitted to acute wards but may be transferred to non-acute ward if the initial assessment indicates further hospital treatment. The average length of stay at the acute hospital wards in the study area in Sør-Trøndelag [NOR] are about 7 days, while the average length of stay of the entire hospital stay for acute admissions are nearly twice that. About 80% of the admissions to the hospital in Sør-Trøndelag [NOR] (excluding the DPCs) are acute admissions. In Loiret [FRA] acute mental health beds are de facto a mix of acute and chronic beds, since there are no dedicated services for patients requiring long term hospital care. Hence the classification of beds may be dependent on how the inpatient services are organised (ward structure). Sør-Trøndelag [NOR] is the only area that has reported non-hospital acute beds.

The data based on REMAST hence show very large differences between the study area chosen in REFINEMENT countries both in number and type of mental health care beds. The characterisation of the systems concerning e.g. the balance of hospital and community care may vary depending on whether they are judge by the rates of different types of beds or by the composition of beds. The share of hospital bed versus community beds is presented in Figure D.6.

**Figure D.6 Bed composition: share of hospital, community and institutional beds in REFINEMENT study areas**



Source: REMAST-pilot.

Judged by share of total beds, Hampshire [ENG], Loiret [FRA] and Sør-Trøndelag [NOR] are most hospital dominated, while Helsinki and Uusimaa [FIN], Verona [ITA] and Industrieviertel [AUT] have the highest share of community beds. Girona [SPA] has almost equal shares of hospital and community beds, however the majority of hospital beds are of the new type. If the beds in DPCs in Sør-Trøndelag [NOR] are labelled as community beds, also Sør-Trøndelag [NOR] has a relatively balanced composition of hospital and community beds. Jud Suceava [ROM] is a special case having a very high share of institutional beds.

However, Helsinki and Uusimaa [FIN] are among the regions in the REFINEMENT countries with the highest hospital rates. Hence labelling them as A community based system (based on shares) therefore is misleading. This illustrates that in evaluating system one must not only look at composition in terms of shares, but take the levels (rates) as the starting point. Judged by bed rates, Helsinki and Uusimaa [FIN], Loiret [FRA], Sør-Trøndelag [NOR] and Jud Suceava [ROM], rely heavily on hospital beds. The high indefinite stay bed rates in Helsinki and Uusimaa [FIN] and Jud Suceava [ROM] gives them a high share of non-hospital beds. This does not necessarily imply that they have well balanced systems.

Comparing areas with similar total bed rates indicates that Verona [ITA] has a community based system, while Loiret [FRA] has a hospital based system. And that Girona [SPA] has a more community based system, in terms of beds, than Hampshire [ENG]. However the community beds in Girona [SPA] are indefinite stay beds.

In evaluating the balance of the mental health care system one also need to take into account the balance between outpatient and inpatient care. E.g. Sør-Trøndelag [NOR] and Loiret [FRA] does not only have high hospital bed rates, they also have high rates of outpatient services. While Hampshire [ENG] has one of the lowest number of beds of any of the REFINEMENT regions, with the most mobile based community outpatient services including access and assessment teams, community treatment teams, outreach teams and early interventions teams etc. that serve as alternative to hospital admissions.

#### **D.5.2 Acute bed utilisation**

In Table D.4 three process indicators for acute inpatient care related to the *availability*, *efficiency* and *appropriateness* of mental health services are shown; discharge rate, bed occupancy, and average length of stay (ALOS), as well as the acute bed rate. The table indicates that the study areas not only differ in bed rates, but also in bed occupancy and ALOS for acute beds.

The high acute bed rate and ALOS in Loiret [FRA] may be partly explained by the fact that acute mental health beds are de facto a mix of acute and chronic beds, since there are no dedicated services for patients requiring long term hospital care. Jud Suceava [ROM] and Sør-Trøndelag [NOR] have low ALOS for acute beds, contributing to



**Table D.4 Acute beds: bed rate (per 100,000 18+ years), discharge rate, bed occupancy, and average length of stay. REFINEMENT study areas**  
 Exceptions indicated by [c]=country, [m]=macro area

	Industrieviertel [AUT]	Hampshire [ENG]	Helsinki and Uusimaa [FIN]	Loiret [FRA]	Verona [ITA]	Sør-Trøndelag <sup>4</sup> [NOR]	Jud Suceava [ROM]	Girona [SPA]
Bed rate	23.3	26.4	26.9	63.4	14.0	28.4	44.4	7.0
Discharge rate <sup>1</sup>	585	n.a.	(440)	(760)	293	1080	1090	(143)
Bed occupancy (%) <sup>2</sup>	77	n.a.	95 [c]	91 [c]	89	76	78	84 [m]
ALOS <sup>3</sup>	11.2	51	21.2	27.7	15.5	7.3/14	11.6	15

1. Calculated residually. Bed occupancy and ALOS are collected from Weibold et al (2013). The indicators are interlinked, and the discharge rate is calculated as follows: Discharge rate = Bed rate \* Bed occupancy rate \* 3.65/ALOS. Since the bed occupancy rate is not for the study area but collected at the country level in Finland and France, and the ALOS as well as bed occupancy is collected at the macro level in Spain, the calculated discharge rate is merely illustrative for these countries, assuming that the value for the indicators for the study area are equal the values at country/macro level.

2. Number days divided by number of beds \* 365.

3. Average Length of Stay.

4. 7.3 = ALOS in acute beds, 14 = ALOS taking into account days in non-acute beds for acute admissions.

n.a. = not available

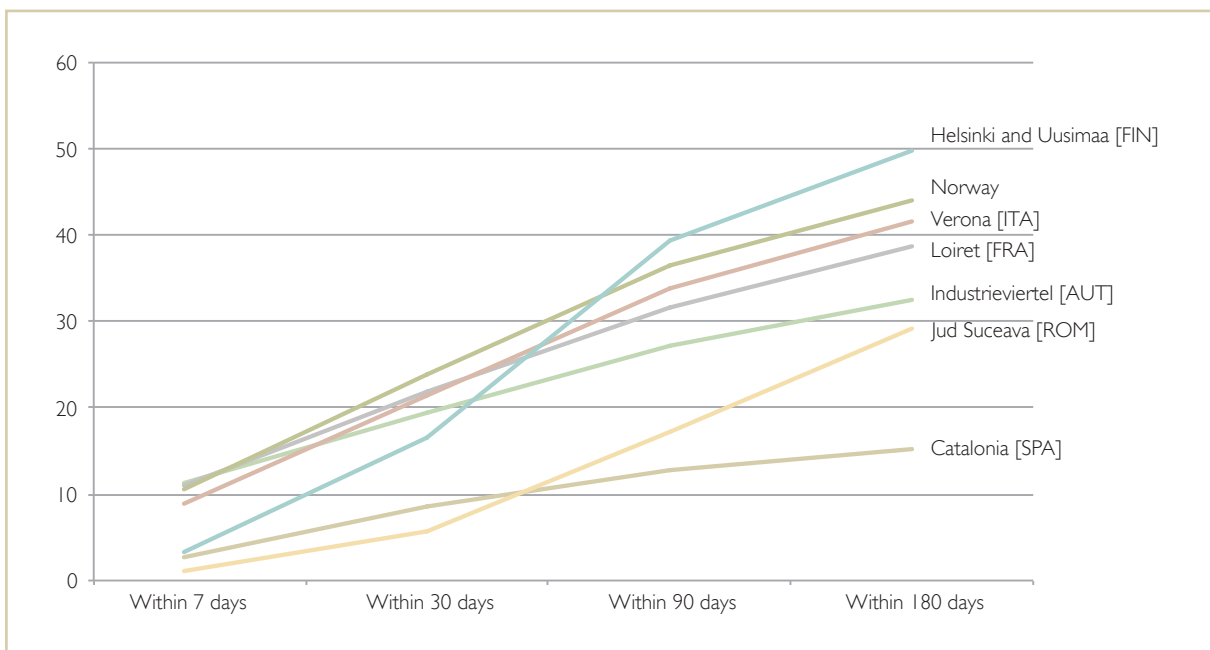
Source: REMAST/REPATO-pilot.

high discharge rates. The ALOS for the entire stay for acute admissions (including days in non-acute/sub-acute wards) in Sør-Trøndelag [NOR] is however comparable to the ALOS in Verona [ITA] and Girona [SPA], i.e. median position (about 15 days). Industrieviertel [AUT] and Helsinki and Uusimaa [FIN] have comparable acute bed rates, however Helsinki and Uusimaa [FIN] have higher ALOS than Industrieviertel [AUT], and hence indicating a higher discharge rate in Industrieviertel [AUT] than in Helsinki and Uusimaa [FIN]. Information on bed occupancy is missing for Hampshire [ENG]. However ALOS is high relative to the other countries, which indicates lower discharge rates in Hampshire [ENG] than in Helsinki and Uusimaa [FIN] which have comparable bed rate.

The discharge rates do not reveal the use of acute beds by individual patients since the same patient may be admitted several times. Readmission has often been used as an outcome measure for the effectiveness of community care as well as for the quality of the previous hospitalisation. Readmission rates (proportions of all acute psychiatric admissions) for the intervals of 7, 30, 90 and 180 days are shown in Figure D.7. The results are for the country level in Norway and macro level in Spain.

Readmission within the first week after discharge happens in 1 to 11% of all cases in the areas included. Lowest rates was found for Jud Suceava [ROM], Catalonia [SPA] and Helsinki and Uusimaa [FIN] (1.1– to 3.3%). The other areas had quite similar rates (8.9 to 11.3%). Two areas have very deviant patterns regarding the increase in readmission rates as time from discharge increases: Helsinki and Uusimaa [FIN] has the steepest increase; having among the lowest rates for readmissions

Figure D.7 Readmission rate (acute admissions)



Source: REPATO/REQUALIT-pilot.

within one week and having the highest rate of readmissions within 180 days (nearly 50 %). Catalonia [SPA] on the other hand has a much slower increase than the other countries, with clearly the lowest readmission rate within 180 days (about 15 %).

The information collected on financial incentives using the FINCENTO Tool includes examples related both to efficiency and other quality aspects for inpatient services. Some examples are showed in the text boxes below.

### **Box 6 Incentives: efficiency – inpatient care**

#### **Example Diagnosis Related Grouping (DRG) 1: Higher DRG rates for reducing inpatient care and increasing day care (Romania)**

In the beginning of the year, all hospitals make a contract with the Health Insurance House (CNAS). The contract includes (a) in case of acute psychiatric wards: the number of inpatient episodes expected in the coming year and (b) if day care facilities exist in the hospital or in the community mental health centres: the number of admissions for a day to these facilities (it is irrelevant whether one patient comes 200 days or 200 patients come for one day each). Acute psychiatric wards in general hospitals (paid by DRG) which also have day care facilities receive a 5% higher rate of the fixed fee contractually established for day care facilities, if they reduce the number of inpatient episodes and increase the number of day care admissions.

#### **Example DRG 2: Adjusting admission, discharge and diagnosis towards DRG tariff (Romania)**

Psychiatric sections of general hospitals are mainly paid by DRGs. The average duration of stay is set at 14 days. This payment system potentially influences provider behaviour in several ways, some of which may have a negative effect on quality of care:

- Admission of more less severe cases which could be treated in outpatient settings (mild depression)
- Administrative discharge of patients who are not fully recovered followed by a rapid readmission
- Diagnosis of better reimbursed diagnostic categories (e.g. personality disorders) – Upcoding

#### **Example DAY 1: Penalties for exceeded duration of stay (Romania)**

Services provided to mental health patients in chronic units of psychiatric hospitals or in psychiatric hospitals are reimbursed on a per diem based payment model. As this type of payment usually results in a large number of psychiatric days used by a small number of patients, an average duration of stay is calculated at national level (50 days at the moment) and penalties apply when this average duration is surpassed (reduction of the per diem rate or even no refund of extra days). This is assumed to have a positive effect on cost containment.

#### **Example TAR 4: Incentive for staff to reduce inappropriate hospital stay, length of stay and to increase of complex DRGs (Italy)**

Professionals (psychiatrists and nurses) who work in outpatient departments and also those who work in hospitals can receive extra payments in addition to their salaries if they fulfil requirements of a complex system of indicators in order to obtain a specific score (max 100). Psychiatrists, psychologists and nurses who work in a service that reached a score between 80 and 100 receive an amount of money on top of their salary. Indicators cover several areas, including inpatient, outpatient, home visits and day care. The system includes measures related to efficiency among others:

1. two measures related to inpatient care, (a) reducing the number of inappropriate DRG and (b) reducing the number of outliers days (days above the ceiling for each DRG);
2. two measures related to expenditure: (a) maintaining the expenditure within the assigned budget and (b) reduction of the difference between forecast and actual costs.

This system allows improvement of responsibility and cohesion of the whole team (psychiatrists, psychologists and nurses); if the team does not reach the score, all members of the team do not receive the money.

## Box 7 Incentives: other quality aspects – inpatient care

### Example DRG 3: More DRG points for admission of psychiatric patients to psychiatric units than to non-psychiatric units (Austria)

Adult inpatients with mental disorders characteristics of the hospital are relevant for the number of LDF (Leistungs- und Diagnosenorientierte Fallgruppen)-points. Psychiatric hospitals/departments which have complete responsibility for a catchment area (including involuntary admissions) and do not select patients get more LDF points for the same HDG (main diagnostic group) than other hospitals/departments. Among the latter a differentiation is made between psychiatric and non-psychiatric departments, whereby the latter get fewer points for a patient with a psychiatric diagnosis than the former. The incentive is to shift psychiatric patients to psychiatric units (away from non-psychiatric units in general hospitals), in order to improve quality of inpatient care which is assumed to be better if provided in a specialist psychiatric unit.

### Example DRG 4: DRGs for somatic disorders with psychiatric comorbidity (France)

Somatic hospitals are financed by DRGs. In each DRG, there are four levels of severity that will vary with patient characteristics (age, other comorbidities etc.) and earn a higher tariff to the hospital the more severe they are (reflecting resource use). Psychiatric conditions are associated with a level of severity of 2 (although some alcohol-related disorders are a level 3, and anorexia is level 4). This means that if a patient with a psychiatric disorder is hospitalised for a somatic disorder that would otherwise be coded at severity 1, they will be billed at level 2 instead and the hospital will receive a higher payment. This acknowledges the fact that patients with mental health problems use more resources than patients without, and hospitals therefore have an incentive to avoid cream skimming. However, if the patient is already at a level 2 severity or more, the hospital will not receive a higher payment, which may be a disincentive for hospitals to handle severe somatic patients who also have mental health comorbidities.

### Example TAR 5: Process indicators of quality of care and patient satisfaction (Italy)

The targets system described in Example TAR 4 which relates to both inpatient and outpatient services also includes measures related to quality of care (process indicators) and quality perceived by users:

1. three measures related to the completeness of clinical records and reduction of errors in the data uploaded in Health Information Systems;
2. two indicators of process: (a) definition of protocols of integration between hospital and community (including drug abuse services, services for mental retardation and other organic disabilities, other health and social services in the community); (b) reduction of the waiting lists time;
3. two indicators of patient satisfaction: (a) reduction in the number of complaints; (b) analysis of patients' satisfaction in at least 70% of the residential facilities.

### Example TAR 6: Target to reduce readmissions (Spain)

The Purchase Contract of Mental Health Services consists of a common part of objectives shared by all Catalan Health Regions and a specific part that corresponds to each Health Region, adjusted to territorial care needs. The Purchase Contract of Mental Health Services has a quality of care incentive related to readmissions, included in their variable part regarding 'acute units'. The objective is to ensure that the proportion of urgent readmissions in acute psychiatric units within 30 days of discharge does not exceed a certain percentage (up to 15%). This kind of incentive helps professionals to be aware of the importance of an adequate discharge. Acute units usually are under pressure of quick discharge of patients, due to the need of beds to treat new admissions. Sometimes psychiatrists may discharge patients not well stabilised or without enough social support. This kind of disincentive (losses linked to readmissions within 30 days after discharge) can help to avoid it.

## D.6 Care continuity: outpatient follow up after acute psychiatric hospitalisation and outpatient drop-out

Most countries did not provide data for the calculation of outpatient follow-up after care acute psychiatric hospitalisation and outpatient "drop-out", see Table D.5.

The data indicate relatively high rates of outpatient follow-up care after acute psychiatric hospitalization in Verona [ITA] and Girona [SPA], and a high number of follow-up visits for those receiving outpatient after care in Verona [ITA]. The data also indicate a low degree of discontinuity of outpatient care in Girona [SPA].

**Table D.5 Care continuity: outpatient follow up after acute psychiatric hospitalisation and outpatient drop-out**

[c] = country, [m] = macro area

	Nieder- österreich [AUT] <sup>4</sup>	England	Finland	Loiret [FRA]	Verona [ITA]	Norway <sup>5</sup>	Romania	Girona [SPA]
Outpatient follow-up care <sup>1</sup>								
≤7 days	≤10% [m]	n.a.	n.a.	n.a.	30–40%	≤10% [c]	n.a.	30–40%
≤30 days	10–20% [m]	n.a.	n.a.	n.a.	60–70%	10–20% [c]	n.a.	50–60%
≤180 days	30–40% [m]	n.a.	n.a.	n.a.	80–90%	30–40% [c]	n.a.	>90%
Average number of follow-up visits <sup>2</sup>								
≤30 days	1.6 [m]	n.a.	n.a.	n.a.	5.3	3.0 [c]	n.a.	2.4
≤180 days	4.3 [m]	n.a.	n.a.	n.a.	21.7	7.8 [c]	n.a.	4.0
Drop out <sup>3</sup>								
All users	62% [m]	n.a.	n.a.	19%	31%	n.a.	n.a.	3%
New users	n.a.	n.a.	n.a.	29%	50%	n.a.	n.a.	4%

1. Outpatient follow-up care after discharge from acute psychiatric hospitalisation.

2. Average number of outpatient follow-up visits after acute psychiatric hospitalisation. Average values were calculated exclusively for the populations of service users who had outpatient follow-up visits within 30 and 180 days respectively.

3. Proportions of psychiatric outpatient service users who had no psychiatric outpatient service contact for at least six consecutive months.

4. Only outpatient contacts with health insurance funded self-employed psychiatrists are included (no data availability for other psychiatric outpatient services).

5. Only secondary outpatient care is included (hospital outpatient clinics and DPC outpatient clinics); municipality follow-up services not included.

n.a. = not available

Source: REPATO/REQUALIT-pilot.

Some examples on financial incentives related to care continuity collected by the use of the FINCENTO Tool are provided in the text box below.

### **Box 8 Incentives: care continuity**

#### **Example TAR 7: Arranging follow-up visits in Mental Health and Drug Addiction Centres (Spain)**

Continuity of care is a crucial aspect to avoid premature treatment withdrawal. For psychiatric inpatient treatment it is especially relevant to support patients after discharge. The appointments in the discharge document help patients to comply with the visits in their reference centre. It is very important that the purchase contract emphasises these objectives to the providers of mental health institutions. It is important to highlight that in some health territories there are different providers, and a proactive and effective coordination cannot be assured. The Institut d'Assistència Sanitària as a provider to Public Mental Health Services in Girona Province has one incentive related to accessibility in its Purchase Contract of Mental Health Services. The objective is: Ensure that follow-up visits at a Mental Health Centre (MHC) and Drug Addiction Centre (CAS) of reference are arranged for patients (minimum percentage higher than 90%). The patients treated in the Girona Mental Health Grid have a higher continuity of care, and attend the appointments in the Mental Health Centres after their discharge. There are some aspects to ensure continuity of care, which are not only related to an incentive in the purchase contract: First, the weekly face-to-face coordination between each mental health centre and the two inpatient units (acute & subacute). Second, a reminder to the users in the case of non-attendance of an appointment. Third, there are patients participating in specific programs (early psychoses, severe mental disorders) that have more intensive treatment and home support after their inpatient treatment.

#### **See also:**

Example TAR 1: Special procedure to coordinate care between inpatient care and primary care after hospital discharge (Spain)

Example TAR 3: National Quality Indicators in Contracts (England), including Early Intervention in Psychosis, Crisis Resolution and 7 day follow-up Care Programme Approach (CPA)

Example TAR 5 Process indicators of quality of care and patient satisfaction (Italy) including definition of protocols of integration between hospital and community.

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