Financing mental health services in low- and middle-income countries

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Mental disorders account for a significant and growing proportion of the global burden of disease and yet remain a low priority for public financing in health systems globally. In many low-income countries, formal mental health services are paid for directly by patients out-of-pocket and in middle-income countries undergoing transition there has been a decline in coverage. The paper explores the impact of health care financing arrangements on the efficient and equitable utilization of mental health services. Through a review of the literature and a number of country case studies, the paper examines the impact of financing mental health services from out-of-pocket payments, private health insurance, social health insurance and taxation. The implications for the development of financing systems in low- and middle-income countries are discussed.

International evidence suggests that charging patients for mental health services results in levels of use which are below socially efficient levels as the benefits of the services are distributed according to ability to pay, resulting in inequitable access to care. Private health insurance poses three main problems for mental health service users: exclusion of mental health benefits, limited access to those without employment and refusal to insure pre-existing conditions. Social health insurance may offer protection to those with mental health problems. However, in many low- and middle-income countries, eligibility is based on contributions and limited to those in formal employment (therefore excluding many with mental health problems). Tax-funded systems provide universal coverage in theory. However, the quality and distribution of publicly financed health care services makes access difficult in practice, particularly for rural poor communities.

Key words: mental health services, financing, organized, developing countries, developed countries, fees

Introduction

Consistently across cultures mental health has been a low priority in health systems (Eisenberg 1997). Two-thirds of the world’s population live in countries that spend less than 1% of their total public sector health care budget on mental health services (including 15 out of 19 countries in Africa for which data were reported) (WHO 2001a). This is despite the fact that mental health problems account for at least 12% of the global burden of disease, a proportion that is predicted to increase to 15% by 2020 (Murray and Lopez 1996). Resource insufficiency has been identified as a key barrier to improving mental health practice and policy (Knapp et al. 2006).

Low prioritization by those who fund health systems, together with widespread stigma and personal preferences for more traditional forms of healing (Desjarlais et al. 1995; Alem et al. 1999; Gureje and Alem 2000), may partly explain the limited public resources committed to the development of community- and hospital-based systems of mental health care in many health systems.

Lack of funding is of particular importance given that there is a strong body of evidence in high-income countries, and a small but growing body of evidence in low- and middle-income countries, that effective mental health interventions are available which can help maintain or reintegrate individuals back into society, and may be highly cost-effective compared with taking no action (Institute of Medicine 2001; The President’s New Freedom Commission on Mental Health 2003; Chisholm et al. 2004).

Overcoming resource insufficiency requires countries to generate additional revenue through the development of financing systems. Despite greater awareness of the case for investment in mental health, the reliance by mental health services on out-of-pocket payments in low- and middle-income countries remains high. Indeed, in some countries they are the only source of financing, with no public budget for mental health. What is the impact of funding mental health services out-of-pocket? Some countries have already embarked on or are committed to developing health financing systems such as general
Financing health care and mental health services

In order to examine these questions, we are interested in the relationship between general health care financing and the financing and delivery of mental health services.

‘Mental health policy and service provision occur within the context of general health systems and financing arrangements. The implications of these arrangements for the delivery of mental health services need to be considered in policy formulation and implementation’ (WHO 2001b).

In particular, this research paper aims to examine:

1. What implications does the method of financing general health care have on the efficient level of mental health service utilization? In this paper we are concerned with allocative efficiency, that is the extent to which different financing arrangements are likely to encourage levels of use that benefit both people with mental health problems and the wider society in ways that more than justify the associated opportunity costs of treatment and service provision.

2. To what extent do different financing arrangements promote a fair distribution of the benefits from mental health services? Fairness, or equity, has been defined in many ways, embodying a range of differing value judgements (Macinko and Starfield 2002; Oliver et al. 2004). Partly for clarity, but also for brevity, we focus on the extent to which utilization of mental health services is likely to be more or less independent of income under differing financing arrangements.

There has been argument and debate over the role of government in the financing of mental health services. Economic criteria, based on criteria developed by Musgrove (1999) and used in the World Health Report 2000 (WHO 2000), have been applied to mental health care in order to determine whether public financing is justified (Baingana et al. 2002). These discussions centre on whether mental health care is a public good and whether there are significant externalities associated with mental health, particularly negative externalities of untreated mental health problems.

This paper takes as its starting point that there are significant externalities associated with mental health problems which sets them apart from many other health problems. Individual behaviour patterns can directly impact on the welfare of others (including family members or the general public) through a small risk of violence (Taylor and Gunn 1999; Walsh et al. 2002) or antisocial behaviour more generally. The socially disabling nature of severe mental health problems can also place a significant care burden on the families of those affected (Giel et al. 1983; Magliano et al. 1998; Murray and McDaid 2001). Poor mental health for women can have significant consequences for their children, increasing the prevalence of child mental health disorders (Institute of Medicine 2001). Poor mental health may also have a negative impact on social capital in a community (Cullen and Whiteford 2001).

Previous studies of health care systems and mental health in industrialized countries have concluded that there is no clear evidence of a direct relationship between health system variables and utilization of mental health services (Alegria et al. 2000). Andrews et al. (2001) concluded that, given the diversity of health care systems (as measured by the amount spent on health care and the levels of out-of-pocket payments), ‘system variables do not seem to influence the met need’ (p. 424). In reviewing the available published evidence, this research paper aims to explore the impact of health care financing arrangements, both public and private, on the efficient provision of and equitable access to mental health services.

Definitions and structure

The term mental health is highly contested, with both historical and culturally specific meanings. This study is primarily interested in people with a diagnosed mental disorder. In the context of this paper we are restricting ourselves solely to mental health services, covering a wide range of support or treatment services within or outside the formal health sector, including pharmaceutical, psychosocial and traditional therapies. While we recognize the importance of public mental health interventions and prevention, this is not the focus of this paper. Mental health problems can have wide-reaching consequences, impacting on social welfare services, housing, education, and may bring individuals into contact with criminal justice systems. Future analysis should consider issues outside the health care sector (see Knapp et al. 2006).

Following this introduction, we briefly describe the methods. The main section of the paper analyzes the impact of different methods of financing on the utilization of mental health services. Starting with out-of-pocket payments, we then discuss in turn the implications of private insurance, social insurance and taxation. The paper concludes with a discussion of the policy implications for those designing financing schemes in low- and middle-income countries.

Methods

The analysis is based on two sources of data. The first is a non-systematic review of both theoretical and empirical studies of financing arrangements for mental health services. The search included a range of key bibliographic databases, including Medline and Psyclit, and the internet for official reports and grey literature. Bibliographies were also used to identify...
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The paper is also informed by data taken from a series of case studies focused on mental health policy and practice in 11 low- and middle-income countries (Azerbaijan, Bulgaria, Georgia, Lithuania, Kyrgyzstan, Pakistan, Nepal, Thailand, Malaysia, Chile, Kenya, Zambia). These were compiled by a local group of mental health experts (Gulbinat et al. 2004). The paper presents some of the evidence from a preliminary analysis of the financing sections of these case studies (Jenkins et al. 2004).

Much of the discussion in this paper is targeted at the challenges facing the financing and development of mental health services in low- and middle-income countries. Much of the supporting published evidence, however, relates to high-income countries. This carries with it some obvious caveats, particularly the limitations of translating evidence from relatively well-funded and institutionally developed health care systems to areas of the world where the basic apparatus for financing and delivering many types of hospital and community-based health services and treatments is very limited. Despite these differences, there should be much that can be learnt from a developed country context.

Results

Out-of-pocket payments

Contribution to spending on mental health care

Out-of-pocket payments make up a significant proportion of the total expenditure on mental health care in most low-income countries. The most recent estimates of their relative importance compared with other sources of finance are provided by the World Health Organization’s Atlas report which surveyed 171 countries (WHO 2001a). Close to 40% of low-income countries reported that out-of-pocket payments were the primary method of financing mental health care (compared with only 3% of high-income countries). These data were obtained through questionnaires completed by Ministry of Health officials and may in fact underestimate the contribution of informal payments or unrecorded out-of-pocket payments in the private sector. The results for the case studies included in this paper are provided in Table 1.

Evidence from the case studies suggests that while out-of-pocket payments make up a substantial proportion of mental health service financing in most countries, they are not the dominant form of financing. Two exceptions to this are Nepal and Pakistan, where out-of-pocket payments are the main way to acquire mental health services (see Box 1).

The majority of out-of-pocket expenditure in most countries is made up of direct payments for services which are excluded from public funding. In most countries this is because no system of financing has been put in place, rather than a result of resource allocation decisions or consultations that have taken place in the informal or traditional health sector. Where systems of financing generate insufficient revenues, there are also extensive co-payments, where patients are required to pay a proportion of the cost. Most of the empirical evidence is on the effects of co-payments. The impact of direct payments where the full costs of care have to be borne by the patient is likely to be the same or worse.

Efficiency arguments for and against user charges

User charges or co-payments, from an efficiency perspective, are generally seen as a means of discouraging ‘frivolous’ health care use, where this refers to levels of utilization for which the marginal opportunity cost of delivery exceeds the marginal social benefit of treatment. Efficient charging in this sense would therefore seek to ensure that what patients actually pay for their treatment is a closer reflection of the social opportunity cost of resources used. All other things being equal, economic theory would predict excessive utilization of any health care services that are partially subsidized by those who are already in contact with formal services. However, in the case of mental health, several conventional theoretical assumptions do not necessarily hold.

Some people with mental health problems may have less well-defined preferences and expressed valuations over the benefits of treatment because of cognitive deficits. Others may have views about the mind-altering consequences of medications that differ from the more widely

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**Table 1. Mental health financing in selected low- and middle-income countries, October 2000 to March 2001**

<table>
<thead>
<tr>
<th>Country</th>
<th>Primary method of financing mental health services</th>
<th>Specified budget for mental health</th>
<th>Specified budget as proportion of total health budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Azerbaijan</td>
<td>Taxation</td>
<td>Y</td>
<td>1.01–5%</td>
</tr>
<tr>
<td>Bulgaria</td>
<td>Taxation</td>
<td>Y</td>
<td>1.01–5%</td>
</tr>
<tr>
<td>Georgia</td>
<td>Taxation</td>
<td>Y</td>
<td>n.a.</td>
</tr>
<tr>
<td>Kyrgyzstan</td>
<td>Taxation</td>
<td>Y</td>
<td>5.01–10%</td>
</tr>
<tr>
<td>Pakistan</td>
<td>Out-of-pocket payments</td>
<td>Y</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Nepal</td>
<td>Out-of-pocket payments</td>
<td>Y</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Thailand</td>
<td>Taxation</td>
<td>Y</td>
<td>1.01–5%</td>
</tr>
<tr>
<td>Malaysia</td>
<td>Taxation</td>
<td>Y</td>
<td>1.01–5%</td>
</tr>
<tr>
<td>Chile</td>
<td>Social health insurance</td>
<td>Y</td>
<td>1.01–5%</td>
</tr>
<tr>
<td>Kenya</td>
<td>Taxation</td>
<td>Y</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Zambia</td>
<td>Taxation</td>
<td>N</td>
<td>n.a.</td>
</tr>
</tbody>
</table>

*Source: WHO (2001a, p. 44–54).*
Impact on efficient and equitable utilization of mental health services

Most evidence on the impact of user charges on the utilization of services is to be found in high-income countries, and the conclusions are mixed. For instance, US evidence has shown that the demand for mental health services is relatively price-elastic, significantly more so than for other kinds of health care among those patients who are already in contact with services (Newhouse and The Insurance Experiment Group 1993; Frank and McGuire 2000). This may justify some user charges to maintain utilization at socially optimal levels, but not if it is due to the reimbursement systems used by payers.

The distributional implications of out-of-pocket payments are also of concern, not least because of the inevitable link between access and ability to pay. Given the strong correlation between mental health problems and unemployment and low socioeconomic status, user charges for mental health services will be highly inequitable: those needing services will often be the least able to pay. Moreover, the chronic nature of many mental health problems potentially may mean that individuals will be subject to high lifetime costs of care.

Evidence specific to mental health can also be found. In a comparison of utilization of mental health services between individuals in Ontario (where tax-based universal coverage is provided) and the United States (where it is not) found that individuals with more severe mental health problems were more likely to be treated in Ontario than in the United States, where ability to pay impacted on access to services. However, a higher proportion of people with less severe problems were likely to be treated in the United States and it was contended this was because of a higher perceived need for services among the US middle classes (Katz et al. 1997).

However, the relationship between access to and utilization of services is complex. Contrary to expectations, Feinson and Popper (1995) found that mental health service utilization by adults over 65 years old was lower in Israel (where care is delivered free at the point of use) compared with the US (where financial barriers to access exist). To some extent, the unexpected differences that were observed suggest that user charges may only play a minor role in limiting levels of use. Organizational
characteristics and incentives and differences in patient preferences may in fact be more important sources of observed differences in utilization.

Of course, targeted exemptions can be used to counter negative distributional consequences of user charges. In Kenya, user charges are levied against medicines, while consultations with practitioners are free. Those with low incomes who are unable to afford the cost of the medicines should be exempted, and receive the medicines free of charge, but this exemption is rarely implemented, leading people either to spend more than they are able to afford or not to take the medicines they need (Jenkins, personal communication, 2002). In the Volta region of Ghana, psychiatric patients are among those groups who qualify for complete exemption from user fees for locally provided health care (Nyonator and Kutzin 1999). However, such exemption mechanisms may not be implemented.

Neither theoretical nor empirical research suggests that user charges for mental health services promote efficiency. Indeed, to the extent to which they discourage utilization, particularly among low-income groups, they generate negative externalities with high social costs. So what of the alternative financing options? Are they better able to meet equity and efficiency goals for access to mental health services?

**Private health insurance**

**Size and scope of the private health insurance market**

Though private health insurance markets remain relatively small in most low- and middle-income countries, this means of revenue collection has been advocated as offering both equity and efficiency improvements over out-of-pocket payments (WHO 2000). A number of middle-income countries, particularly in South America, have significant private health insurance markets, particularly for those on higher incomes, as in Chile where nearly 20% of the population has private health insurance. The market in central and eastern Europe and the former Soviet Union is still small but growing.

In most countries the majority of policies are bought at the discretion of an employer on behalf of the individual. Premiums are usually risk-rated (i.e. based on an assessment of individual risk), but may also be community-rated (based on an assessment of the average risk in a defined subgroup of the population) or group-rated (based on an assessment of average risk among the employees of a firm) (Mossialos and Thomson 2002).

**Coverage of mental health services**

Individual risk rating imposes the greatest financial burden on people with mental health disorders or with a family history of mental disorders (where this information is used to calculate premiums). Community- and group-rated premiums enable risks to be pooled together with other individuals. Most private insurers will refuse cover if there are pre-existing mental health problems or high probabilities of mental illness. Anyone with a family history of mental health problems or with a proven genetic pre-disposition to mental illness (e.g. early onset dementia) will find enrolment prohibitively expensive (if available at all). Where insurers have the freedom to define benefits, set premiums, terminate contracts or refuse insurance, there are likely to be at least three serious equity concerns for those with mental health disorders.

**Impact on efficient and equitable utilization of mental health services**

First, due to the chronic nature and high cost of mental health treatments and interventions, private insurers are likely to exclude mental health interventions from the benefits offered to enrollees. In Chile, only a very limited number of psychiatry and psychology sessions are covered by private insurance (Lopez-Stewart, personal communication, 2004). Psychiatric care, mental health disorders and drug and alcohol addiction are explicitly excluded in some European Union member states (Mossialos and Thomson 2002). Where these treatments are covered, premiums are likely to be higher.

Secondly, due to the association with unemployment, people with mental health disorders are less likely to benefit from group-rated premiums. Employed people generally have access to lower premiums through employer-purchased insurance policies which are group-rated and are offered at more competitive rates (Mossialos and Thomson 2002). Indeed, the majority of policies in most countries are employer-sponsored or group-purchased plans.

Thirdly, people with existing mental health problems seeking insurance for the first time are likely to find that they are refused insurance or that premiums are set very high. Within the European Union, pre-existing conditions are commonly excluded (Mossialos and Thomson 2002). Only in Austria are insurers prohibited from refusing to insure someone with a chronic illness. They are, however, permitted to charge higher premiums or impose cost-sharing.

Where insurance is offered as a long-term (life) contract, people who develop mental disorders would not have their insurance cover terminated. However, if insurers are free to increase premiums, they might find the cost of maintaining cover becomes prohibitive. The State can intervene to overcome some of these difficulties through regulation: requiring life-time cover or open enrolment, setting premiums or defining minimum benefits (Mossialos and Thomson 2002).

The empirical evidence is overwhelming that – unless it is heavily regulated – private medical insurance will not result in efficient or equitable utilization of mental health services. In the US, where the private health insurance market is most significant, a number of health insurance...
which has subsequently been extended three times up to 1998. The legislation, access (Sturm 2001). The Mental Health Parity Act was introduced in 1996 and implemented in 1998. The legislation, which has subsequently been extended three times up to the end of 2004, prohibited annual or lifetime dollar caps on mental health benefits that were lower than those for other medical benefits. Concern was expressed that as a result, insurers would drop mental health benefits altogether, although this has not been borne out by research (Buck 2002).

In the Netherlands up to 2006, people earning above a fixed ceiling were excluded from the social insurance scheme, which covered acute medical care, and purchased private medical insurance instead. However, mental health risks were excluded from the private market and are covered through a separate universal public insurance scheme for exceptional medical expenses (Algemene Wet Bijzondere Ziektekosten, or AWBZ).

A similar situation exists in Malaysia, where health is predominantly financed through private health insurance schemes. However, all of the private insurers exclude mental health services from their plans, leaving mental health services to be financed through general taxation and out-of-pocket payments (Parameshvara Deva 2004).

**Social health insurance**

**Characteristics and extent of social health insurance financing**

Social health insurance is based on mandatory wage-related contributions, usually shared between the employee and the employer (the relative proportions vary between countries), that are kept separate from other taxes and contributions (Normand and Busse 2002). Social health insurance is the dominant model of financing in some European countries, a number of countries in Asia (Japan, Taiwan, Korea, Malaysia and China) and most countries of South America (see Box 2). However, social health insurance cover is limited to only part of the population (often urban workers) in South America (Alarcon and Aguilar-Gaxiola 2000). Many of the countries of eastern Europe and the former Soviet Union have introduced social health insurance, though its contribution to overall health expenditure remains limited (see Box 3). There is increasing interest in social health insurance in sub-Saharan Africa and some small schemes already operate. In Mozambique, for example, a compulsory social insurance scheme exists exclusively for government-employed civil servants (DFID Health Systems Resource Centre 2002).

**Coverage of mental health services**

Under social health insurance, contributions are independent of risk and usually income-related. Thus those with a high risk of mental health disorders are not financially penalized as they might be by private insurers offering risk-rated premiums. In addition, unlike most private insurance, there is open enrolment so that no eligible individual can be excluded from the scheme because of their health status or risk. Benefits are usually standardized for all enrollees. The scope of the benefits package determines whether mental health benefits are included. In most high-income countries they are included, whereas where revenues are more limited, the extent of the benefits is also limited. In Georgia, for example, the State Medical Insurance Company will only reimburse inpatient and outpatient costs for individuals with mental health problems experiencing psychosis; no other mental health problems are covered (Georgian Association for Mental Health 2000).

**Impact on efficient and equitable utilization of mental health services**

Historically, under social health insurance there was a link between contributions made and benefits received. In other words, only those who contributed (or for whom contributions were made by the State or some other fund) were entitled to the benefits. In most low-income countries, it is only those who are in formal employment who are eligible (often public employees based in urban areas), thus excluding the poor, informal workers and the majority of the rural population (DFID Health Systems Resource Centre 2002). Thus access to effective treatment is partly conditional on employment status.

Severe and chronic mental health problems are associated with unemployment and low income, either because poor mental health directly or indirectly (through increased alcohol and drug use) affects the ability of individuals to work, or because low income and unemployment themselves increase the risk of poor mental health (Bartley 1994; Patel et al. 2001).

This is of particular importance in low-income countries. Stress and poverty have been identified as risk factors for mental health problems, and mental health problems increase the risk of unemployment, absenteeism and poverty. These reinforcing effects reduce productivity at the individual level and might also reduce total productivity in a low-income country (Bir and Frank 2001).

In addition, the emerging social health insurance systems for the formally employed often divert scarce resources away from the poor and rural regions to richer urban
workers (Bennett and Gilson 2001). Thus, although social health insurance in theory may provide more equitable access to services than private health insurance through the income-related contributions (i.e. access is independent of ability to pay and risk of mental illness), due to the association between mental disorders and unemployment it is unlikely to benefit those with mental health problems in countries where coverage is limited to urban employees.

In central and eastern Europe and the former Soviet Union, entitlement to health services was a universal right, often embodied in the constitution. Thus, despite many of these countries shifting from state-funded health services to social health insurance during the 1990s, most were required to maintain provision of services for everyone regardless of contribution status. This meant there were weak incentives to contribute (leading to low collection rates and widespread evasion). Due to the collapse in the formal labour market and the growth in the informal economy, these new systems generated very little revenue. Overstretched resources resulted in reduced benefit coverage including mental health services, as occurred in Georgia for example.

Taxation

Types and extent of tax-based health financing

Many high-income countries rely on taxation as the major source of financing. The case studies suggest that taxation is the dominant form of financing for mental health in a number of countries, including Kenya (see Box 4), Zambia, Azerbaijan and Kyrgyzstan. All of these countries also finance mental health services through out-of-pocket payments, levied both formally (Kyrgyzstan) and informally (Azerbaijan). The high reliance on out-of-pocket payments, even in tax-dominated systems, will
negatively influence equity of access to mental health services.

Coverage of mental health services

Due to the universal nature of most tax-financed systems (entitlement to benefit is based on residence), people with mental health problems are not excluded from access to treatment because of risk or employment status, thus meeting equity criteria and positively impacting on the externalities associated with mental health problems. However, in many low- and middle-income countries, taxes are insufficient to fund even basic health care for the whole population. Finances for health services are usually supplemented by external funds, and the reliance on out-of-pocket payments is also significant.

Impact on efficient and equitable utilization of mental health services

The quality and distribution of publicly financed health care services may make access difficult in practice. The extent to which tax-based revenues contribute to the efficiency and equity of service utilization is dependent on resource allocation mechanisms. Potentially, revenue can be distributed in accordance with identified needs (as in England where the resource allocation formula is weighted by estimates of psychiatric need). In less sophisticated systems with a lack of monitoring and epidemiological data, resource allocation is often based on historical expenditure patterns. Mental health service users may find that, although they are covered, the level of service available is of insufficient quality or is simply inaccessible, and thus they will forgo treatment or purchase services in the private sector and pay out-of-pocket. Resources often follow historical spending patterns and are concentrated in existing facilities. For example, in most African countries, dedicated mental health care facilities are effectively located only in major cities; these often being a legacy of mental health services provided during colonial times (Kilonzo and Simmons 1998; Kiima et al. 2004). In Kenya, however, a concerted mental health programme to establish decentralized facilities has meant greater accessibility even for the rural population (see Box 4).

Low-income countries may face difficulties raising sufficient taxes because of issues similar to those affecting social health insurance revenues, such as low formal employment. Yet, there are more diverse options for levying taxes than simply relying on wage income. However, whatever the source, if there is no government commitment to allocate the money according to need, access to mental health services will remain limited.

Discussion

International evidence on the impact of out-of-pocket payments on mental health service utilization is inconclusive. However, there is empirical data from developed countries that charging for health services deters utilization, though other cultural and organizational factors certainly play a role. Given that utilization of mental health services is already low in low-income countries, further increases in out-of-pocket costs would result in levels of use below socially efficient levels. The positive externalities associated with treatment of mental health problems and potentially high cost-effectiveness imply that greater public investment should be considered.

When out-of-pocket payments are the dominant source of finance, the benefits of mental health services are distributed according to ability to pay, resulting in inequitable access to care. Together with other indirect barriers to access for mental health services in low- and middle-income countries, such as distance and high opportunity costs of travel, utilization rates may be strongly correlated with income. Means testing and exemptions for lower income groups can improve equity of access but at the same time reduce available resources, which might ultimately limit service development. If charges could be applied to higher income groups and generate sufficient revenue to cross-subsidize and increase the level of mental health services offered to lower income groups, then user charging may offer more equitable access.

In low-income countries, heavily reliant on out-of-pocket payments for mental health services, the long-term aim should be to create systems of prepayment to overcome
the equity and efficiency problems highlighted above. The development of pre-payment systems was one of the stated policies in the World Health Report 2000 (WHO 2000), and yet in most low-income countries, publicly financed health care fails to reach the poor (Wagstaff 2002). Evidence suggests that financing which results in pooling across the population and offers coverage regardless of risk improves access for mental health service users by removing adverse financial consequences.

Commercial private health insurance markets tend to be small in low-income countries. The main interest from commercial insurers is in urban employees, who are likely to be lower-than-average risks. Even for this group, private health insurance is unlikely to provide a policy tool to increase coverage and access to mental health services. International experience suggests that mental health risks are notoriously difficult to insure on an individual actuarial basis without the premiums becoming unaffordable. Thus, private health insurance appears to offer neither an efficient nor an equitable means of financing mental health services, in high-, middle- or low-income countries.

Despite offering the promise of more equitable coverage for those with mental health disorders, where social health insurance has been implemented in low- and middle-income countries, it has tended to focus on the urban employed and their dependents, thus not improving access for those most in need of improved access to mental health services. However, the expansion of coverage of social health insurance in many western European countries took place gradually.

Tax-funded systems which offer universal coverage may help to prevent exclusion from access to health services. However, in lower-income countries, where revenues are particularly scarce, resource allocation mechanisms opaque and where other health issues historically have been given higher priority, mental health interventions may effectively remain out of reach for many people. In these circumstances, the poor (particularly in rural areas) with mental health problems would not benefit from increased public finance. Without better targeting, increases in general revenues will not promote equitable access to mental health services. Tax-funded revenues should therefore ensure that if a mental health policy is in place (based on evidence of both low-cost and effective interventions for mental disorders), a sufficient proportion of available funds can be allocated to support the implementation of the policy.

Endnotes

1 The global burden of disease study identified five major neuropsychiatric disorders: unipolar depression, alcohol use, bipolar affective disorder (manic depression), schizophrenia and obsessive compulsive disorder (Murray and Lopez 1996). The 10th edition of the International Classification of Disease sets out in Chapter V the main groups of mental and behavioural disorders: organic, including symptomatic, mental disorders, mental and behavioural disorders due to psychoactive substance use, schizophrenia, schizotypal and delusional disorders, mood (affective) disorders, neurotic, stress-related and somatoform disorders, behavioural syndromes associated with physiological disturbances and physical factors, disorders of adult personality and behaviour, mental retardation, disorders of psychological development, behavioural and emotional disorders with onset usually occurring in childhood and adolescence, and unspecified mental disorders. WHO's World Health Report 2001, on mental health, focused on depressive disorders, substance use disorders, schizophrenia, epilepsy, Alzheimer's disease, mental retardation, and disorders of childhood and adolescence as these
usually cause severe disability when not treated adequately and place a heavy burden on communities (WHO 2001b).

2 To date a total of 17 profiles have been completed from which this sample is drawn.

3 A co-ordinator in each country, usually the person responsible for mental health in the Ministry of Health, identified a small working party of key informants, and a further multi-disciplinary group of professionals were identified through a purposeful sampling technique.

4 Despite a public commitment to new parity legislation by both the President and leading Democrats, Congress has so far failed to get a new bill onto the Statute book.

5 However, only mental health conditions that can be treated in a short period of time (under 30 days) are covered by Austrian insurance funds. Other conditions have to be financed through social care budgets with significant out-of-pocket payments (see Zechmeister et al. 2002).

6 Even in universal tax-based systems, there may be certain groups of individuals who are excluded, such as illegal immigrants, asylum seekers, refugees and prisoners.

References


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