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How do health systems finance and control spending on mental health, particularly spending on acute psychiatric inpatient care:

A rapid response to the 'Psychiatric Cap Committee', 2024

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Abstract

This rapid response examined how health systems in selected high-income countries finance and control spending on mental health (MH) services, particularly acute inpatient psychiatric care. Countries sampled included Canada, Finland, Denmark, England, Germany, and Israel. Data was collected from experts in each country on topics such as the existence of dedicated MH budgets, mechanisms for determining inpatient psychiatric spending levels, payment methods for inpatient care, and tools to promote outpatient MH service development. The review found that National Health Insurance (NHI) systems like Israel and Germany do not have earmarked MH budgets but set revenue caps for psychiatric hospitals to control inpatient spending. Conversely, single-payer National Health Service (NHS) systems sometimes allocate specific MH budgets that inherently limit inpatient expenditures. Payment methods vary, with global budgets common in NHS systems and per-diem payments with revenue caps used in NHI systems. Promoting outpatient MH services typically requires separate targeted investments rather than relying on inpatient spending controls alone. Overall, countries employ a mix of budget-setting practices, payment mechanisms, and targeted programs to simultaneously fund and regulate mental health care spending across inpatient and outpatient settings. Policymakers can consider adopting multi-pronged approaches suited to their health system's financing structures.

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1. Background

The current war against the Hamas has (1) created a huge surge in the need for mental health care, and (2) diverted public funds to the war, and as a result cuts have been made in other public services. The MoH plans to expand the supply of mental health services, particularly in outpatient settings, while also curbing, or at least controlling, expenditures on inpatient care. The Myers-JDC-Brookdale Institute was asked by the Ministry of Health to learn from international experience how health systems finance and control spending in mental health (MH), particularly acute inpatient care.

2. Objectives

To learn from international experience how health systems finance and control spending in mental health, particularly acute inpatient care.

3. Methods

This rapid response employed a qualitative approach. We created a template to collect standardized and comparable data through questions about financing MH and acute psychiatric inpatient care (see questions in box 1 below). We sampled a small group of countries with rates of psychiatric acute care beds and workforce similar to those in Israel, to learn from countries with similar resources and contexts: Canada, Finland, Denmark, and England. All these countries have health systems organized as National Health Systems (NHSs); therefore, we collected data from Germany, to have an example of a country with a health system with a National Health Insurance (NHI) system of competing public insurers, like Israel. Experts from the sampled countries were invited to collect the data by answering the questions posed in the template. We extracted the data from the templates and collated them in a summary table. We then analyzed, compared the data, and summarized the findings.

Box 1: Questions for the rapid response on financing mental health and psychiatric inpatient care

1. Is there a dedicated budget for mental health in [COUNTRY]? How does it relate to the overall health budget? What services are included in this budget (i.e., are there mental health services outside that budget)?
2. Is there a dedicated budget for acute psychiatric inpatient care? Is this care provided exclusively by publicly-funded institutions? [Asked because in some countries there are private psychiatric facilities that do not rely on government budgets for revenues]
3. If so, how is the budget for mental health services/ acute psychiatric inpatient care in [COUNTRY] determined?
4. If not, are spending levels on mental health services limited in any way? How?
5. Is the number of beds limited or regulated by government, or established independently?
6. Are inpatient mental health services paid directly by the public insurance or are these services carved out and funded separately?
7. How do payer agencies (e.g. health plans/ sickness funds, the public insurer, the NHS) pay for acute psychiatric hospitalization services? E.g. per diem, global budget, DRGs, FFS
8. Is there a cap or mechanism that limits public spending on psychiatric hospitalization? If yes, how is it set?
9. Do inpatient acute mental health facilities play a role in developing outpatient alternatives?
10. Are there economic tools that are used to promote the development of mental health services? For example, incentives for developing outpatient services as an alternative to inpatient care or to shorten lengths of psychiatric inpatient stay?

4. Results

In Israel, the national system of hospital revenue caps sets a budget framework for inpatient psychiatric care for each payer agency (health plan). This is based on past use and the number of psychiatric beds. Other countries set budgets at the payer agency level too, but it is usually not earmarked for MH or for inpatient psychiatric care. The exception is Germany, that has a budgeting and capping system similar to that of Israel. The table below summarizes the results for each country.

Both in Germany (with an NHI-organized system with competing sickness funds), and in NHS-organized health systems (England, Denmark, Finland, Canada), the payer agencies (regions of sickness funds) receive the bulk of the budget for the health system from the government. They receive the budget through an allocation (capitation) formula. In NHS-organized health systems there is no earmarked budget for mental health or psychiatric inpatient care. The payer agencies (regions) are free to determine how much of their budgets will be dedicated to mental health. These decisions are made in a manner that is not transparent; instead, they rely on a historical base, negotiations, or policy priorities. England has a minimum budget for all MH services. In the countries reviewed, aside from Canada, the regions do not have an earmarked budget for acute psychiatric inpatient care.

Germany has "indicative budgets" for mental health, and specific indicative budgets for inpatient and outpatient care. However, these are not earmarked budgets. In practice these indicative budgets set two caps, for out- and in-patient care respectively. The cap for outpatient care sets a maximum "volume" of services that MH workers can bill to each sickness fund. Moreover, there are individual budgets for practices (that are physician-specific). Beyond the practice budget, physicians or psychologists need a permit from the sickness fund to provide the service. The inpatient psychiatric cap is similar to the Israeli one. Beyond the cap, sickness funds pay the per diem tariff with a discount of 85% (the hospital gets 15% of the tariff). The cap is set based on past use (cost), projected costs, and adjusted for medical inflation.

The number of beds, and the rates of beds per population, have decreased significantly over time in all countries. This trend was part of a purposeful policy to shift care to outpatient settings, as there is no conclusive evidence that inpatient treatment is more effective than outpatient care. Nor is there conclusive evidence that the level of specialty of the MH provider affects the effectiveness of the treatment.

Spending on MH is not limited in any country directly except in Germany. In Canada it is limited by the budget, while in England "competition" with the physical acute sector is a limiting factor. In addition, in England and Denmark the availability of funds or providers is a limiting factor.

All the NHS-organized countries pay for inpatient psychiatric care with global budgets, but it is not clear how these budgets are determined. None of the NHS-organized countries apply capping on psychiatric hospitalizations, and the spending on psychiatric inpatient care is curbed by the budget, through management, clinical guidelines or supply. Germany pays psychiatric hospitals on a per diem basis, adjusted for case mix (diagnosis, severity, age groups) and by certain services based on the procedure codes (OPS codes) e.g. for group therapy. The per diem tariff decreases with the length of stay (the first days are higher). As mentioned above, Germany sets revenue caps for hospitals.

Hospitals are not much involved in the development of outpatient care. Some do that indirectly by reducing the length of stay and shifting care to the outpatient setting. In Canada and Germany, hospitals provide some outpatient psychiatric care. Many countries promote the development of mental health services mainly by allocating dedicated funds for special programs, or by changing the referral policies to prioritize outpatient care.

Table 1: Findings from the data collection, by country

	Canada	England	Denmark	Finland	Germany	Israel
Is there a dedicated budget for mental health?	No	Not as such. There is a minimum budget for mental health set for the regions. This covers most services, both inpatient and outpatient care.	No. The regions and the government (MoF) negotiate to decide on the yearly total health budget. The budget is allocated to the regions by an allocation (capitation) formula, but there is no earmarked budget for MH.	No. The counties receive the total health budget from the government. The services offered may vary across the counties, as the legislation does not provide a strict list of services required. MH for workers and students is funded by The Social Insurance Institution of Finland (Kela)	There are 'indicative budgets' for all care, including psychiatrists and psychiatric acute care hospitals to calculate the basic tariff for the DRGs.	No
Is there a dedicated budget for acute psychiatric inpatient care?	Yes, Funds are separated by delivery organization: there is a budget for psychiatric hospitals, and this is separate from community mental health	No	No	No	Yes, the indicative budget above.	No
how is the budget for mental health services/ acute psychiatric inpatient care in [COUNTRY] determined?	Budgets for psychiatric hospitals are determined mostly on a historical basis at the provincial level. They do not include physicians' costs.	The minimum budget was set to ensure that mental health would grow as a proportion of spending over the years following 2016: before this, spending was decreasing	There is no dedicated budget for MH, each region decides how to spend their health budget.	Each county decides how much to allocate to psychiatric care, mainly based on need.	These indicative budgets are based on past use and predicted revenues in the current year and adjusted for medical inflation.	There is no specific budget, health plans can use their budget at their discretion.

	Canada	England	Denmark	Finland	Germany	Israel
Is the number of beds limited or regulated?	Yes, beds are limited; this is based on the inpatient psychiatric care budget.	No	Yes. In addition, the Danish health authority sets "specialty plan" that allocates hospitals into one of 3 levels of care, that determines what care or treatment each hospital can provide. That curbs the number of psychiatric beds and spending.	No, and number of beds has been decreasing over time.	It is limited by the "hospital plans" of the Lander (regions)	Yes, the MoH defines the number of beds in each ward for each hospital.
Are spending on mental health services limited in any way? How?	Yes, by the inpatient psychiatric care budget	Not explicitly. In practice, "competition" with the physical acute sector puts considerable pressure on the funds for MH	Not directly. Budget is limited through restrictions on the expansion of mental health programs, limitations in availability of services or professionals	No	It is indirectly limited by the supply (workforce). In addition, in some regions, psychiatrists have a "volume cap" on the volume of services that they can bill. Moreover, there are individual budgets for practices (that are physician-specific). Beyond the budget they need the permit from the sickness fund to provide the service.	Yes, inpatient psychiatric care is limited by a cap on hospitals' income. Outpatient care is limited to "packages of care" – e.g. 10 visits to psychotherapy. If the patient needs more, then another package is given, but there is an assessment for each request. In addition, there are long waiting times and limited workforce.

	Canada	England	Denmark	Finland	Germany	Israel
Are inpatient mental health services paid directly by the public insurance? (Or are these services carved out and funded separately?)	Yes, by each province	Yes, by the NHS	Yes, the regions pay the psychiatric hospitals.	It is paid by the regions (wellbeing services counties)	Yes	Yes
How do payer agencies pay for acute psychiatric hospitalization services?	Global budget. (with FFS for physicians who work there).	Global budgets	Global budgets	Global budgets. Counties use different economic tools to allocate the budget to psychiatric hospitals, but this information is not available.	Per diem adjusted for case mix (diagnosis, severity, age groups) and by certain services based on the procedure codes (OPS code) e.g. for group therapy. The PD tariff decreases with LoS (the first days are higher).	Per diem, adjusted for age and severity
Is there a cap or mechanism that limits public spending on psychiatric hospitalization?	No. the limiting factor is the budget.	No cap. The limited number of beds and workforce limit the spending on MH in general, in inpatient care too	No. the limiting factor is the total health budget.	No.	Yes, there is a "soft" cap for each hospital. Beyond the cap sickness funds pay the PD tariff with a discount of 85% (the hospital gets 15% of the tariff). The cap is set based on past use (cost), projected costs, and adjusted for medical inflation.	Yes, set at 60% on previous year's income from each HP. Beyond the cap, the HP pays the hospital only 40% of the PD tariff. The cap is set for each hospital and each HP based on previous year's number of inpatient days, and the payment that each HP paid to each hospital

	Canada	England	Denmark	Finland	Germany	Israel
Do inpatient acute mental health facilities play a role in developing outpatient alternatives?	Inpatient mental health facilities offer some outpatient services, but these vary from facility to facility.	Outpatient interventions attempt to reduce length of stay, but this is in part to enable more inpatient capacity	No	In specialized care, inpatient and outpatient care are both under the same management. This allows the management to define, for instance, the role of community treatments.	Yes, hospitals can provide also outpatient care – e.g. day clinics, psychiatric ambulatory care (psychiatric consultations and medications)	Hospitals provide some, not much, outpatient care.
Are there economic tools use to promote the development of mental health services?	Increasing funding for outpatient care programs (e.g. structured psychotherapy) or for the providers (e.g. community agencies and public health units).	Non-economic tools: changes in referral and treatment practice, and the planning of the inpatient estate, not through spending controls per se	Yes, there are earmarked budgets for specific programs like in 2020 for developing outpatient mental health	There are no explicitly set incentives for this, but as the counties are funded by a fixed need-adjusted capitation budget, they have incentives to look for the most efficient mix of services.	Yes, some regions have regional psychiatry budgets to promote the development of in- or out-patient services by hospitals.	Not explicitly. The HPs not only pay but are also responsible for providing the services. If they fail to do that, individuals can complain to the MoH or the ombudsman, that can enforce the HP.

5. Discussion and Conclusions

We have reviewed and compared financing sources and fund flows for mental health, particularly psychiatric inpatient care in six high-income countries with similar levels of resources. Health systems organized with NHI and competing payers do not have earmarked budgets for MH or for inpatient care, but do set caps on psychiatric inpatient payments (which are linked to activity) as a mechanism to curb expenditures. Systems organized as NHS with a single payer sometimes are more likely to have earmarked budgets for psychiatric inpatient care, which is the mechanism that curbs spending on this type of care, and therefore there is no need for capping hospital payments.

The payments to hospitals and the cap can curb the spending on inpatient psychiatric care, but it will not promote the development of outpatient care in itself. In Israel the cap will not incentivize hospitals or health plans to develop outpatient services because 40% of a psychiatric per diem fee is still cheaper than developing outpatient care. To develop outpatient services, direct investments and specific programs for outpatient care should be designed. This includes diversifying the type of outpatient care offered (e.g. by introducing or expanding the use of balancing homes). Outpatient care will not necessarily be less costly than inpatient care, but the price has to be lower than inpatient care, so the health plans have incentives to send patients to outpatient care instead of inpatient care. Finally, box 2 highlights the future need for more outpatient mental health care in Israel.

Box 2: the October 2023 attacks and the war against the Hamas are likely in increase the demand for outpatient mental health care more than inpatient care

Based on the experience from New York's 9/11 attacks, the demand for inpatient care is not likely to increase much after the October 7th attacks (Jack & Glied, 2002) – not among victims nor among those indirectly affected. Those that needed inpatient psychiatric care, are probably discharged by now. Over the longer term, the increase in need for mental health care for the civilian population will probably be for outpatient care. Regarding soldiers and veterans of war it is yet early to predict the future demand for mental health, but the demand for outpatient care is likely to be higher than the demand for inpatient care. It is therefore important to invest in outpatient care, maybe even at the expense of a scaling back of the volume of inpatient care.

Sources

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