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Functioning of the various forms of mental health care in Poland in the years 2010–2013. Organizational, economic and financial aspects

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Summary

Aim. The main objective of the study was to verify the hypothesis about the high growth rate of expenditure on the provision of mental health in the past few years. High dynamics of the expenditure increase will result in the development of a model of community psychiatry and a gradual move away from the hospital psychiatric treatment towards mental health care in the open system, including the community one.

Method. This research is based on data on the implementation of services for mental health care in the framework of agreements with the National Health Fund, which has been collected in the NFZ IT system. Some information is from 2010, which was adopted as the base date for the implementation of the principles of the National Mental Health Program in 2011. The data from the implementation of individual benefits in 2013 were used for the comparison. In addition, other selected organizational, economic and financial elements of the psychiatric care system were analyzed.

Results. In 2013, compared to 2010, increased the number of mental health care organizations: outpatient mental health clinics (an increase of 37 clinics), outpatient mental health day hospital wards (an increase of 25 wards) and community psychiatric treatment teams (an increase of 74 teams). The largest increase in the value of contracts (approx. 150%) was related to community treatment teams.

Conclusions. Between 2010 and 2013 there was an increase in the value of cleared contracts in psychiatric care, in general and in each of the three forms of psychiatric care (i.e., in day wards, outpatient mental health clinics and in community teams). The highest increase in investments included community treatment teams, to a lesser extent day wards and outpatient clinics. The adopted organizational, economic and financial solutions in the mental health care

system are in line with the objectives of the National Mental Health Program, including the assumed structure of Mental Health Centers.

Key words: community psychiatry, mental health services

Introduction

The contemporary model of mental health care involves community-based psychiatry, which focuses on the local community and the patients with mental disorders living in it [1]. This modern and effective form of mental health care is generally

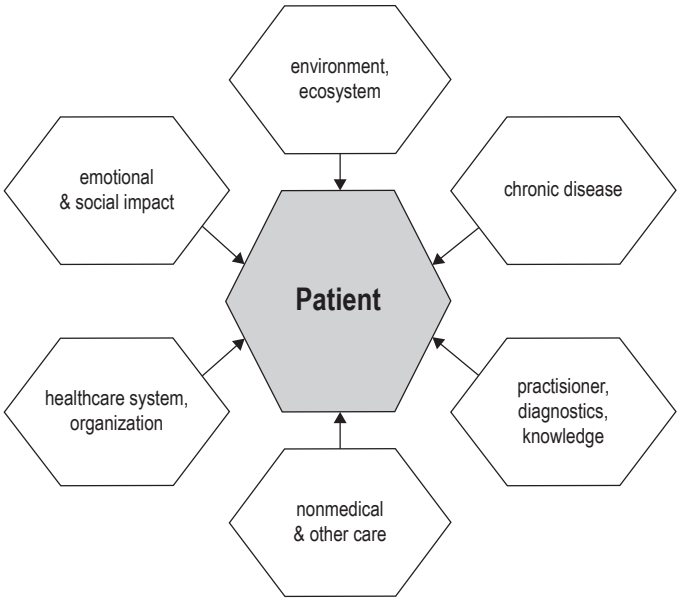

Figure 1. **The main factors affecting the patient with a chronic disease under the current health care system**

Source: M. Lisiecka-Biełanowicz, Z. Wawrzyniak, *Healthcare model with use of information and communication technology for patients with chronic disease,* "Annals of Agricultural and Environmental Medicine", in press.

accepted worldwide. Mental conditions are generally chronic and the patients require continuous specialist and comprehensive mental health care [2] (see Figure 1).

The first years of the 21st century saw a change in community psychiatry, which was a result of the field being recognized internationally as the only appropriate direction for mental health care. This finds confirmation in many documents that define the desired strategy for mental health care in the world and in Europe. The importance of mental health in a given population, the need of preparing a reform program, as well

as appropriate priority ranking of measures in this regard was reflected in a number of documents of international significance. For example, the "Mental Health Declaration for Europe" was adopted by the World Health Organization (WHO) in the presence of representatives of the European Commission and the Council of Europe in January 2005 [3]. Also that year, the European Commission issued a "Green Paper" on improving the mental health of the population, proposing a strategy on mental health for the European Union [4]. The most important tasks for the EU member countries listed in the "Green Paper" are:

- to promote the mental health of all,
- to tackle the major mental disorders and support vulnerable groups,
- to improve the quality of life of people with mental disability through social inclusion and protection of their rights and dignity [4].

Shifting the burden of mental care towards a community-based model is also addressed in other WHO documents, such as the WHO report *Mental Health: New Understanding, New Hope, the Way Forward*, which recommends constant efforts towards transferring patient treatment from psychiatric hospitals and other institutions of long-term care to community-based care. This is supported by a number of arguments, including the fact that community-based care is associated with a higher quality of life, guarantees a better respect of human rights, and provides a better cost-benefit balance [5]. The new WHO document, *Health 2020 – a European policy framework supporting action across government and society for health and well-being*, identified the need for cooperation toward common political priorities for health. Among the four priority areas of action was the area of building resilient societies and health supporting environments [6]. The document also states that: "Building resilience is a key factor in protecting and promoting health and well-being at both the individual and community levels" [6, p. 12].

In the 1940s and 1950s, the United Kingdom introduced a day-care model in psychiatric hospitals, which called for reducing the number of beds in large psychiatric institutions in favor of creating psychiatric beds in general hospitals, hospital day-care centers, and social centers [7, 8]. Unfortunately, the transfer of patients from closed institutions to the society, thereby shifting the burden of care onto their families, without providing any supporting strategies for meeting the needs of the most severely ill meant that it was precisely those patients and their families who were left without adequate assistance. Due to their inability to function in the society, these patients were not able to use the offered solutions [9]. Therefore, mental care solutions should be tailored to the needs of patients and not offered on an all-or-nothing basis, without addressing the needs of their recipients, who are the mentally ill and their families.

The Polish National Mental Health Program, established by the Council of Ministers on December 28, 2010, defined strategies for action aimed at reducing the prevalence of mental health risks, improving the quality of life of people with mental illnesses and their families, and ensuring their access to health care benefits in the period of 2011–2015 [10]. This new model of mental health care arose as part of a trend toward

shifting mental health care from closed, inpatient settings to open, community-based settings. Thus, the mental health care solutions that are being currently introduced in Poland are in line with the priorities identified by the WHO. Nonetheless, this approach is not easy to implement due to a lack of detailed or alternative health care protocols.

Planning for mental health care in the new model requires close cooperation of many entities, supported by consistent legal regulations and adequate financing. Institutions that should be involved in the task of creating community-based psychiatric care already have other pre-defined tasks (e.g., psychiatric hospitals) or remain unprepared for this kind of tasks (e.g., multidisciplinary hospitals, which should open new wards). Moreover, the funding of mental health services in Poland remains glaringly inadequate. Therefore, new psychiatric wards are unlikely to be opened at the request of general hospital directors. Despite of these obstacles, the available data indicate what changes should be made in order to get closer to the solution known as community-based psychiatric care.

The purpose of this study was to analyze: (a) mental health system resources in 2010 and 2013; (b) the reasons for patient discharge from psychiatric hospitals/wards in 2013; (c) the proportion of the Polish National Health Fund (NHF) expenditures on mental health services and addiction treatment out of all health care-related expenditures in 2003–2013; (d) changes in the number of units of account (points of account) contracted by the NHF and the value of cleared contracts in various forms of mental health care between 2010 and 2013, as well as (e) to compare the rate of changes in the number of health care facilities and the value of health care-related contracts between 2010 and 2013.

One of the reasons for conducting these analyses is the currently ongoing discussion about the long-term effects for the patients of a shift from hospital-based health care model to community-based treatment.

The following hypotheses were tested as part of the study:

Hypothesis 1: The current mental health service financing policies result in a conversion from a psychiatric care model involving patient isolation to community-based treatment. This solution is consistent with one of the main objectives of the Polish National Mental Health Program and may result in an increased patient access to other forms of treatment than inpatient mental care, such as outpatient mental health clinics, day hospitals, or community-based psychiatric homecare by increasing the number of these institutions.

Hypothesis 2: The reduced number of wards and beds in psychiatric hospitals in the years 2010–2013 can attest to the achievement of the objectives of the Polish National Program for Mental Health. This policy resulted in a transfer of patients to outpatient mental health clinics, day hospitals, or community-based psychiatric homecare, which can be a step towards creating Mental Health Centers (MHCs).

Material and methods

Mental health resources were analyzed based on the number of entities providing psychiatric care, beds or places in these entities, patients treated, consultations or

visits, and diagnoses. The analysis was performed using the data from the Institute of Psychiatry and Neurology (IPiN). The reasons for hospital discharge were determined on the basis of special statistical forms.

The proportion of expenditures on mental health care out of total NHF health care-related expenditures was determined based on NHF data. To analyze the number of contracted units of account and the value of contracts, we used information about provided health care benefits under the agreement with the payer, which was gathered in the IT system of NHF Center. The analyzed psychiatric benefits included neither addiction treatment nor psychiatric treatment of children and adolescents. We analyzed all psychiatric benefits in total and in groups stratified by the type of mental health care (24-hour inpatient facilities, day hospitals, outpatient mental health clinics, and community-based psychiatric homecare). The data from 2010 were adopted as the baseline, as they were collected before the initiation of the Polish National Mental Health Program, which began in 2011. In order to show changes in financing the individual service types, we used data from 2013 as reference. Subsequently, we calculated the percentage of increase in the value of cleared contracts in the individual service types and compared it with the increase in the number of benefits providing facilities. The data on the number of these facilities in 2010 and 2013 was obtained from the respective statistical yearbooks compiled at the Institute of Psychiatry and Neurology.

Results

Psychiatric care resources in 2013

Under the current psychiatric health care system, the majority of patients took advantage of outpatient and hospital benefits (Table 1). The patients receiving community-based psychiatric homecare constituted a relatively small group.

Table 1. **Number of providers of various forms of psychiatric care and numerical indices of benefits provided in 2013**

Forms of psychiatric care	Number of entities	Number of beds/ places	Number of consultations/ visits	Number of treated people	Diagnoses
hospital wards	47 psychiatric hospitals 119 general hospitals (including 154 psychiatric wards, 59 detoxification wards) 22 treatment centers for alcohol addiction 32 rehabilitation centers for substance addicts 26 MONAR facilities 57 health care centers and educational facilities	34,184	NA	201,922	201,922 people with mental disorders, (F00–F99), including 84,303 newly diagnosed cases (42%)

table continued on the next page

Day wards	352	7,191	NA	24,793	NA
Outpatient care	1,403	NA	7.3 mln (including 4.3 mln medical consultations, 3.1 mln psychologist and other therapist consultations)	1,610,543	1,587,869 people with mental disorders (F00–F99), including 395,048 newly diagnosed cases (25%)
Community-based homecare	138	NA	330,000 (including 197,000 in the patient's home, 133,000 at the community-based facilities)	37,783	NA

The reasons for hospital discharge in 2013

In 2013, approximately 84% of patients were discharged from hospitals with the intention of receiving further treatment in an outpatient clinic, day hospital, or a community-based mental health care facility. Figure 2 shows, in detail, the reasons for patients being discharged from hospitals in the evaluated period.

The proportion of NHF expenditures on psychiatric care and addiction treatment

With the exception of some increase in expenditures for psychiatry between 2003 and 2004, the average mental health care expenditures constituted only approx. 3.5% of the total expenditures of the payer for health benefits (excluding chemotherapy and drug programs). Exact values are shown in Figure 3.

Units of account and the value of contracts in 2010 and 2013

Psychiatric care in total

Between 2010 and 2013, the number of contracted units of account in psychiatry increased and the value of contracts concluded by the NHF in the field of psychiatry

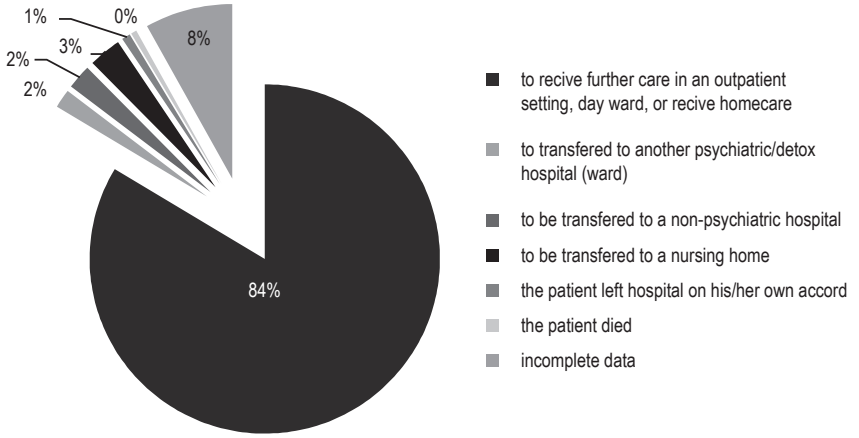

Figure 2. **Reasons for discharge from psychiatric hospitals in 2013**

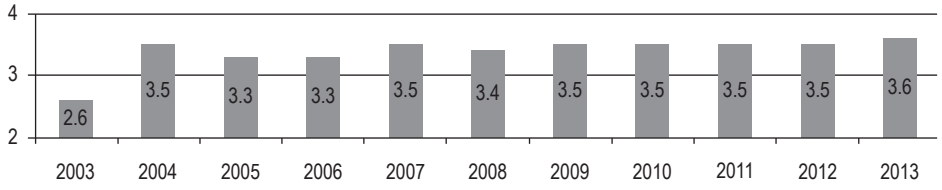

Figure 3. **The proportion of expenditures on psychiatric care and addiction treatment out of the total expenditure on health care planned by health insurance in the years 2003–2013 (in%)**

increased by more than PLN 153 million (Figure 4 and 5). Despite the absolute increase in expenditures, the proportion of spending on mental health care out of total expenditures by the payer has not changed for years.

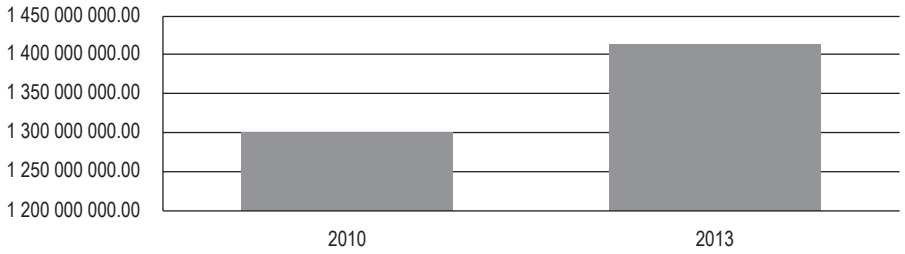

Figure 4. **The number of cleared units of account in psychiatric care**

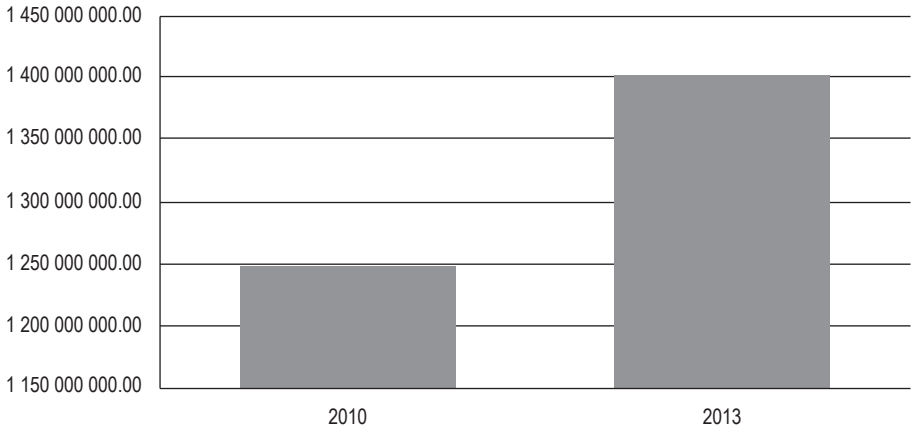

Figure 5. **The value of cleared contracts in psychiatric care**

Hospitalization/24-hour-care wards

In 2013, fewer unit were cleared than in 2010, but the value of contracts was higher (Figure 6 and 7). In 2013, expenditures on inpatient psychiatric care were by approx. PLN 49 million higher than in 2010.

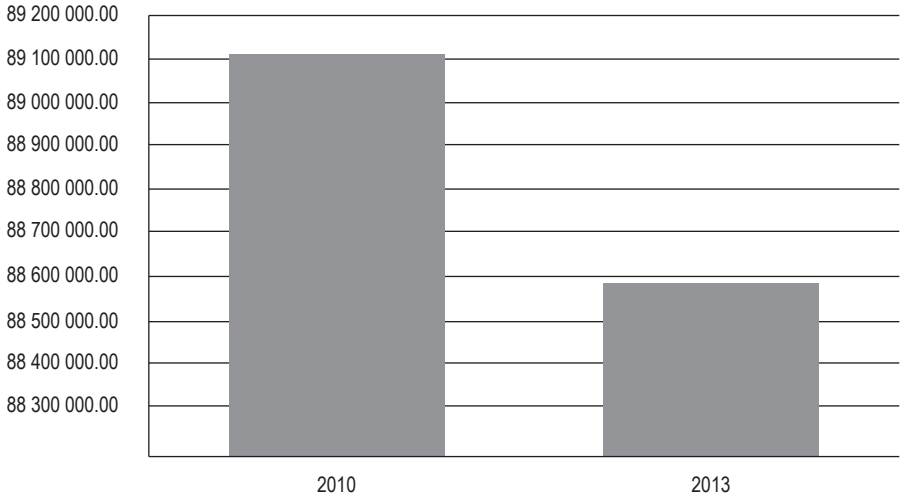

Figure 6. **The number of cleared units in 24-hour-care inpatient settings**

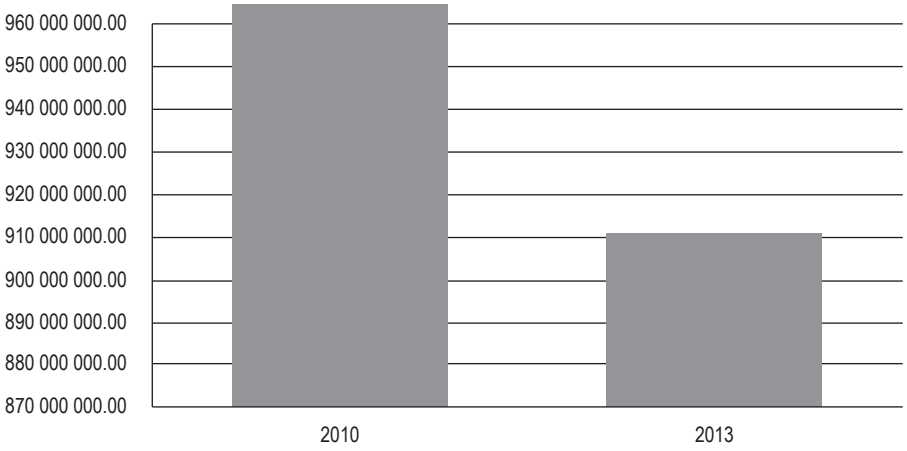

Figure 7. **The value of cleared contracts in 24-hour-care inpatient settings**

Day wards

In the case of psychiatric day wards, there was an increase in both the number of provided benefits as well as the value of contracts (Figure 8 and 9). In 2013, expenditures on health care services provided in these wards were by approx. PLN 31 million higher than those in 2010.

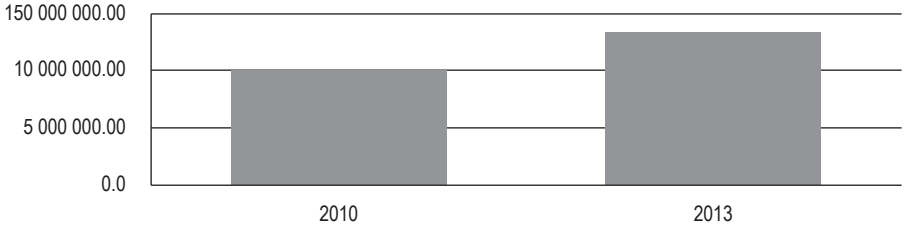

Figure 8. **The number of cleared units in day wards**

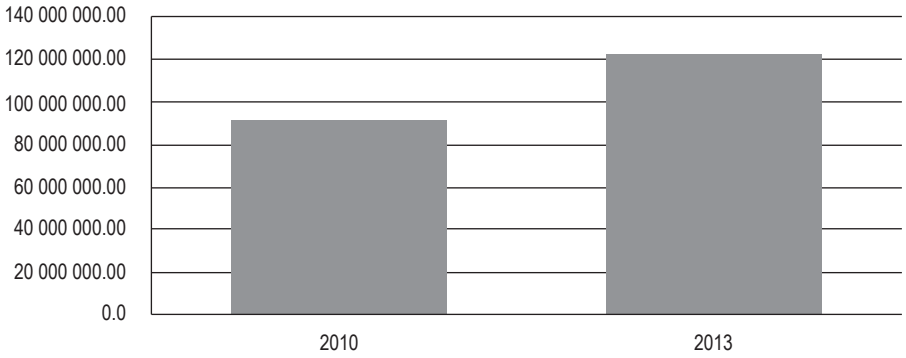

Figure 9. **The value of cleared contracts in day wards**

Outpatient mental health care facilities

In 2013, compared to 2010, twice as many units were cleared, while PLN 57 million more was spent on benefits provided in clinics (Figure 10 and 11).

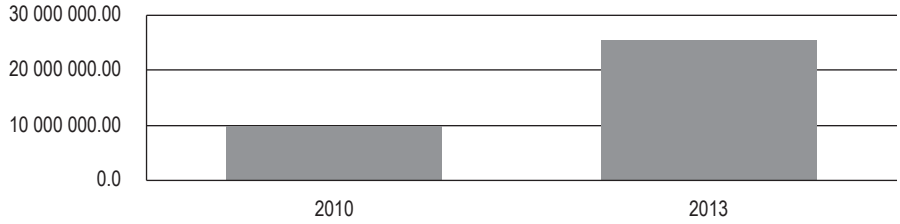

Figure 10. **The number of cleared units in outpatient mental health care clinics**

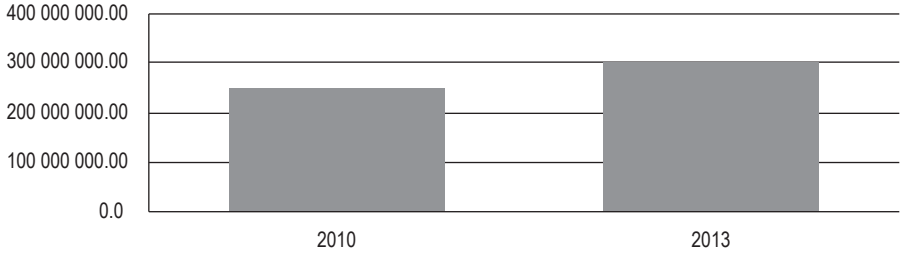

Figure 11. **The value of cleared contracts in outpatient mental healthcare clinics**

Community-based homecare

With the increase in units of account, the increase in expenditures on homecare services was shown to have reached approx. PLN 15 million (Figure 12 and 13).

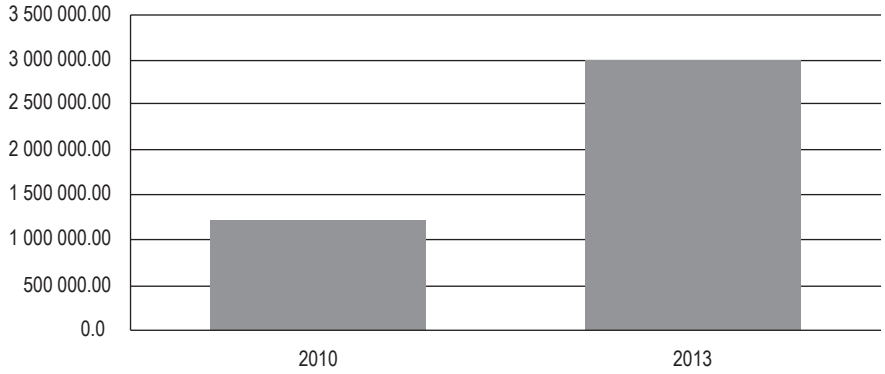

Figure 12. **The number of cleared units in community-based homecare**

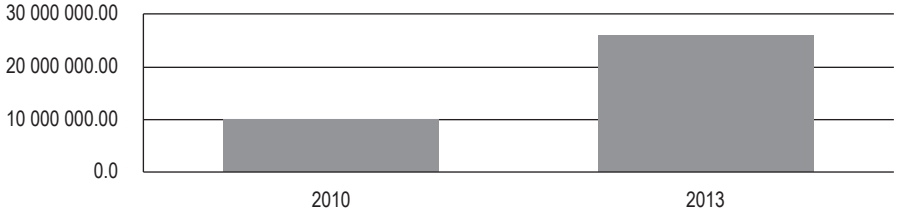

Figure 13. **The value of cleared contracts in community-based homecare**

The rate of changes between 2010 and 2013

This 3-year period saw an increase in the number of entities providing benefits in the field of mental health care covered by the NHF. Despite a loss of 33 hospital wards, the number of health care providers offering other forms of health care increased. Namely, there has been an increase in the number of day wards (25 wards), mental health clinics (37 clinics), and community-based homecare facilities (74 facilities). The increase in the number of entities in which the NHF contracted benefits was smaller than the increase in total NHF expenditures on the benefits provided by individual group (Table 2). The relatively greatest increase in NHF health care-related expenditures (by approx. 150%) was observed in the field of community-based homecare.

Table 2. **Comparison of changes in the number of entities offering mental health benefits contracted by the NHF and the values of cleared contracts in 2010 and 2013**

Type of entity	Number of entities in a given year		Increase in the number of entities (%)	Increase in the value of cleared contracts (%)
	2010	2013		
Hospital wards	436	403	-7.6	5.5
Day wards	190	215	13.2	33.9
Outpatient care	1,366	1,403	2.7	22.2
Community-based homecare	44	118	168.2	146.7

Discussion

The collected information shows that the number of patient stays in, consultations at, or visits to the entities providing psychiatric health care is enormous and is probably still just the tip of the iceberg.

The first Polish study of the mental health of Poles (EZOP) estimated the prevalence of selected mental disorders in the population aged 18–65 years, taking its demographic and social diversity into consideration. The study also assessed the society's attitude toward mental disorders and its opinions on the availability of psychiatric treatment. Over 23% of the study population was found to be affected with at least one mental disorder. Extrapolated to the general population, these findings suggest the presence of a mental disorder in more than six million Polish citizens of working age, with one in every four of those affected diagnosed with more than one of the evaluated disorders and one in every 25 – with three or more. The number of people who have experienced several mental disorders, can be estimated to include nearly a quarter of a million people [11].

The greatest demand for mental health care seems to be in the field of non-inpatient care, as indicated by the number of patients who use it, the most prevalent reasons for hospital discharge, and the results of the EZOP study. Our analysis also showed that the system of contracting mental health care services by the NHF is beneficial for such forms of care, particularly community-based homecare. Thus, our findings confirm the hypothesis that the current contracting of benefits by the payer on a national scale is related to the departure from the psychiatric care model of patient isolation towards community-based treatment. However, this trend should continue to be monitored in the coming years. In addition, it would be important to conduct similar analyzes in individual Polish provinces to determine regional and local trends.

The collected data on the way of financing psychiatric health care from public funds support the rationale of establishing Mental Health Centers in line with the Polish National Mental Health Program guidelines. The structure of such centers should include at least four types of entities (Figure 14).

Attempts at modernizing mental health care by adopting models where the rights and autonomy of patients suffering from mental disorders or those seeking or needing

help because of the risk of mental health are respected emphasize the significance of currently existing barriers [see 12]. However, the EZOP study confirms a clear delay in terms of the organizational preparations to introduce modern solutions in mental health care.

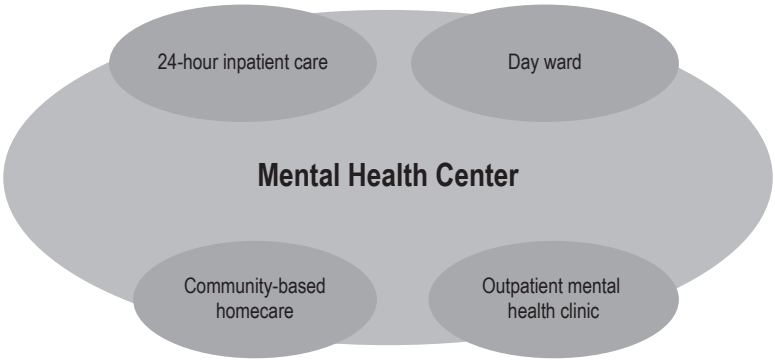

Figure 14. **Model of mental health care as part of a Mental Health Center**

Conclusions

1. With an unchanged estimate, the value of cleared contracts in psychiatric care, in total and in all three types of psychiatric care implemented in outpatient mental health clinics, day hospital, and community-based homecare facilities, increased between the years 2010 and 2013. Despite the increase in total expenditures on mental health care, for years they have accounted for about 3.5% of total expenditures by the insurer.
2. Between the years 2010 and 2013, the largest increase in expenditures involved community-based forms of homecare, with day hospitals and outpatient clinics receiving a smaller increase in funding. The solutions being currently introduced in Poland tend to reduce the role of full-time hospital care in favor of other forms of care – outpatient care and community-based homecare.
3. The adopted financial and organizational solutions in the system of mental health care are consistent with the objectives of the Polish National Mental Health Program and aim to create Mental Health Centers. The establishment of such centers, however, requires certain conditions, including changes in the Polish law.

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