The Journal of Mental Health Policy and Economics
J. Mental Health Policy Econ. **3**, 59–60 (2000)

Editorial

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The articles in this issue consider the effects of the US veterans administration's mental health funding on veteran's use of state mental health facilities (**Desai** and **Rosenheck**), the 'evidence-based' approach in organizing mental health services (**Goldman *et al.***), the organization and financing of mental health care in Poland (**Langiewicz** and **Slupczynska-Kossobudzka**), the factors which lead employer-based health plans to adopt a carve-out strategy for mental health benefits in the United States (**Salkever** and **Shinogle**), and the value and limitations of randomized clinical trials in the evaluation of socially complex service interventions (**Wolff**). Two Commentaries by **Essock** and by **Fenton** are also presented.

Desai and **Rosenheck** (p.61) analyze the variations in funding and access of different health care services and the consequences on mental health service use by people affected by mental disorders.

In the United States, veterans with a military service-connected disability (or low income) are eligible to receive a full range of physical and mental health services from Veteran Administration (VA) health care facilities. As citizens of the state in which they reside, they are eligible to receive state-funded programmes such as community mental health centres and state psychiatric hospitals. The authors rely on this particular case of double eligibility for analyzing the reciprocal influences between the Annual State Mental Hospital expenditures and the VA *per capita* mental health expenditures.

The authors claim that the more the state spends on mental health care, the more likely a male patient in a state hospital is to be a veteran. Conversely, the more the VA spends per veteran on mental health care the less likely a state hospital patient is to be a veteran. In other terms, the higher the availability of VA mental health services, decreases the likelihood that veterans will use state hospitals. Conversely, the level of state hospital funding has a much smaller, but positive, effect upon veterans' use of state hospitals.

The authors, while underlining the limitations of the study and the large changes due to managed care (and the closing of 80% of VA inpatient mental health beds in 1996) in the last few years, claim that these data show that the interdependence of healthcare systems and restrictive financing strategies within one healthcare system can stimulate the use of services of another healthcare system.

The article by **Goldman *et al***. (p. 69), presents a conceptual framework for providing evidence-based guidance to health policy makers and programme developers on how to organize and finance mental health services. He claims that, driven by the immediate need to make policy decisions and design service programmes, policy makers and programme developers have proceeded with their work without a clear set of decision rules. Mental health service systems are typically shaped by historical tradition, political decisions and conventions of practice, financing and organization and not by a body of research evidence about effectiveness and efficiency.

The research aimed at analyzing contribution of the organization of services on health has been distinguished into two types of research: *Clinical Services Research*, mostly dealing with the individual as the unit of analysis in an investigation of the effectiveness and cost of mental health services and *Services Systems Research* dealing with the organization and financing of the service system.

Examples of empirical investigations from clinical services research and services system research are presented to demonstrate potential sources of evidence to support specific decisions for organizing mental health services. A Commentary to this article is given by **Essok** (p.111).

Langiewicz and **Slupczynska-Kossobudzka** (p.77) describe the changes in organization and financing of mental health care in Poland during the last decade.

The authors describe the general aims of the Mental Health Programme approved for implementation by the Polish Ministry of Health and Social Welfare in 1995. The main goal of the Programme was to develop a community-based psychiatry model, where the basic form of care should be outpatient clinics and intermediate care facilities, and inpatient care provided mostly in psychiatric wards of general hospitals.

The administrative and health insurance reforms of 1999 interacted with the implementation of the Programme. The reform introduced new financing conditions for psychiatric services, as well as for the whole health care system. Functions of the owner and payer were separated. As a result, local self-government at the provincial level became owners of psychiatric facilities and new institutions (regional Sickness Funds) appeared as independent main payers.

The authors claim that since 1999, the word '*contract*' became the most important one and both parties (owners/providers and payers) started their contract negotiations, not equipped with such instruments as medical procedure standards, services, conditions and staff qualification. The current problems of the reform implementation are discussed.

The use of specialized behavioural health care companies to manage mental health benefit separately ('carve-out') has recently increased in the US. **Salkever** and **Shinogle** (p. 83), explore the factors which led employer-based health plans (private insurance plans offered in the United States by employers to employees) to adopt a carve-out strategy for mental health benefits. They explore several hypotheses (moral hazard, adverse selection, economics of scale, and alternate utilization strategies) that have recently advanced to explain the increasing demand of carve-outs.

The analysis uses data from a survey of 248 employers who have long-term disability contracts with one large insurer and offer mental health benefits. These data are combined with local market information, state regulations and employer characteristics. Authors claim that the factors associated with higher use and/or costs of mental health services increase the demand for carve-outs. Further research that relies on more information on employee characteristics is expected to confirm if the factors associated with higher demand of mental health services are also associated with higher demand of carve-outs.

The article by **Wolff** (p. 97) focuses on research designs aimed at the evaluation of socially complex service (SCS) interventions and their value of informing mental health policy.

The SCS interventions require the coordination of various clinical treatments and social services performed by professionals with different roles, competencies, responsibilities and aim at taking care of the multilevel impact of severe mental disorders on patients, relatives and society. The frequent presence of psychiatric and medical co-morbidities and the common judiciary consequences due to the behaviour of the people affected by these disorders, further increase the number of services involved in the management of these disorders and the complexity of their coordination.

The author analyzes the options research has in identifying the 'active principles' of complex interventions that can be reliably replicated, taking as an example the complex array of medical, social and legal institutions involved in the management of mentally disordered offenders.

The utility of randomised clinical trials data (RCT) in providing valid and reliable data for generalizable inferences is discussed and ten recommendations are offered for adapting the RCT design to the characteristics of socially complex services. This article has stimulated a Commentary by **Fenton** (p. 113)

The international implications of the Langiewicz and Slupzynska-Kossobudzka article seem to be important. In several countries a significant aspect of health care reform is the separation of the roles of owners–providers and payers of health services, the development of contractual arrangements between them and the consequences of financial risks for both. Research as well as technical competence in this field has been rarely developed in countries where health care services is financed and provided primarily by public institutions. The Polish experience may offer useful information for psychiatrists, economists and decision makers in those countries where health care reform is changing the relationship between the provision and financing of health and mental health services.