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Editorial

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The articles in this issue consider the use of typical and atypical antipsychotic medications for schizophrenia in different financing and delivery systems (Bloom *et al.*), the impact of federal grants on state spending for substance abuse in the U.S. (Cowell *et al.*), the relationship between mental hospital and community care in South Africa (Lund & Flisher), and the effects of the general health system reform on mental health service use in Colombia (Romero-González *et al.*)

Bloom *et al.* (p. 163) analyze the joint effects of the financing and delivery systems on the use of typical and atypical antipsychotic medications. The study relies on the capitation Medicaid pilot program implemented in the state of Colorado in 1995, where three major delivery and financing systems were introduced for the provision of mental health services: fee for service (FFS), direct capitation (DC) and managed behavioral health organizations (MBHO). Colorado's Department of Health Care Policy and Financing reimburses on a capitation basis prescription drugs for HMOs and on a fee-for-service basis for those not enrolled in HMOs. The authors analyze the impact of HMOs' cost-containment strategies on the use of antipsychotics for treating schizophrenia, by studying 282 subjects with a diagnosis of schizophrenia (86 in FFS, and 196 in capitation, of whom 93 in DC and 103 in MBHO) and collecting data on the use of antipsychotics from 1995 to 1997. They report that utilization of atypical antipsychotics following capitation was lower in the FFS areas than in the MBHO and DC groups. They also discuss possible explanations for this finding, which contradicts the hypothesis that consumers who receive their medication benefit through an HMO are less likely to use atypical antipsychotics medications.

Cowell *et al.* (p. 173) examine the federal Substance Abuse Prevention and Treatment Block Grant (SAPTBG), established by the U.S. Congress to help the states fund substance abuse services. This block grant (USD 1.7 billion in 2002) amounts to 40% of the total public financing of substance abuse prevention and treatment in the U.S. States are required to report their use of funds to the Substance Abuse and Mental Health Services Administration (SAMHSA), the federal agency administrating the SAPTBG. The authors examine the impact of SAPTBG on local and state spending for substance abuse prevention and treatment and report that the SAPTBG is not associated with reductions in state substance abuse spending.

Lund & Flisher (p. 181) report the effects of a new policy, introduced in South Africa in 1997, which aims to downscale chronic custodial institutions and foster the development of community-based mental health care. The authors collected information on the distribution of psychiatric staff at all levels of public sector health care, psychiatric patient attendance at all ambulatory care services, and admission to all mental health facilities in 1997. Their instrument was a questionnaire distributed to provincial mental health coordinators, supplemented by face-to-face consultations with the coordinators in each of the nine provinces involved. The authors report that 25% of public sector psychiatric staff was located in the community. They found a wide variation in the availability of service staff and in the balance between inpatient and outpatient service contacts in the various provinces. They stress that psychiatric service use in South Africa is mainly directed at hospitalization, and that the use rate for ambulatory care seems extremely low, compared with ambulatory care attendance in the country's medical sector.

Romero-Gonzáles *et al.* (p. 189) evaluate the impact of a comprehensive general health system reform in Colombia, initiated in 1993 on the pattern of mental health services delivery and access. The law at the basis of the reform granted citizens and legal aliens alike the right to receive health promotion, disease prevention and emergency services at no additional personal charge, and to freely select a health provider who would deliver a basic health benefit package at an affordable cost. The health care system was funded through an employment-based payment schedule, allowing special populations (i.e. the disabled and unemployed, or those relying on an income less than twice the minimum wage) to receive coverage at no personal cost. In addition to instituting a universal right to basic health care services, the law also required the health system to limit costs while improving access to health services by implementing a funding system based on ''managed competition''. Mental health services were not included in the basic health benefit package. The authors report that the reform was internationally considered a success and discuss whether its implementation has had an indirect impact on the mental health sector. They compare changes in national economic indicators and in measures of mental health and non-mental health service delivery for the years 1987 and 1997. Population-adjusted access to mental health outpatient services declined by 2.7%, while access to general medical outpatient services increased by 46%. Inpatient mental health admissions increased by 7% compared with a 22.5% rise in general medical admissions. The authors discuss these findings and recommend that mental health services be added to the standardized package of health benefits.