The REFINEMENT Project

Research on Financing Systems' Effect on the Quality of Mental Health Care

FINCENTO

Financing & INCENtive TOol

A tool for mapping health and other services for adults with mental health needs and identifying details of related financing systems

To be quoted as:

Heinz Katschnig, David McDaid, Christa Straßmayr, Tihana Matosevic, A-La Park, Sonja Scheffel in cooperation with the REFINEMENT group: The REFINEMENT Financing & Incentive Tool (FINCENTO). 2013. http://www.refinementproject.eu/

REFINEMENT Work Packages 4 and 5:
Analysis of the Financing of Health and Social Care Systems
Functional and Dysfunctional Financial Incentives

SEVENTH FRAMEWORK PROGRAMME

PARTNERS

The REFINEMENT project is conducted by an experienced team of health economists, mental health service researchers, public health specialists and social care experts from eight European countries.

	Italy	University of Verona
Ludwig Boltzmann Institute Social Psychiatry	**Austria**	Institute for Social Psychiatry Ludwig Boltzmann
LSE The London School of Economics and Political Science	**England**	London School of Economics and Political Science
PSI•COST	**Spain**	Scientific Association Psicost
SINTEF	**Norway**	SINTEF Technology and Society
National Institute for Health and Welfare	**Finland**	National Institute for Health and Welfare
UPEC Université Paris-Est Créteil Val de Marne — Connaissance • Action	**France**	University of Paris East Créteil
	Romania	Institute of Economic Previsions

AUTHORS

Heinz Katschnig
David McDaid
Christa Straßmayr
Tihana Matosevic
A-La Park
Sonja Scheffel

in cooperation with the REFINEMENT group.

If you have any questions please contact:
heinz.katschnig@meduniwien.ac.at

REFINEMENT PROJECT

WORK PACKAGES 4 and 5

Analysis of the Financing of Health and Social Care Systems
Functional and Dysfunctional Financial Incentives

FINCENTO

Financing & INCENtive TOol

A comprehensive detailed instrument for an in-depth mapping of health and other services for adults aged 18 or over with mental health needs (excluding dementia and substance use disorders) and for identifying details of related financing systems, incentives and disincentives in provider payment mechanisms related to the quality of mental health care.

Part of the REFINEMENT Mental Health Care Financing Toolkit

Country/
study area:

FINCENTO is a comprehensive detailed tool for an in-depth mapping of health and other services providing care for people with mental health needs. It identifies details of the related financing systems, including incentives and disincentives in provider payment mechanisms, related to the quality of mental health care for people with mental health needs. It also identifies related issues, as well as incentives and disincentives concerning the organisation and regulation of services and payment mechanisms, including user charges. It is aimed at obtaining an overview on key elements in how health care services in general, and services for people with mental health needs in particular, are organised, funded and paid for. It also looks at some services for people with mental health needs that are funded and delivered outside the health care system. One key element is to identify whether there are any differences in the organisation, financing, payment and regulation of care provided for people with mental health needs and care for other client groups. The tool helps to identify and better understand any financial and non-financial incentives and disincentives that may be in play.

Contents

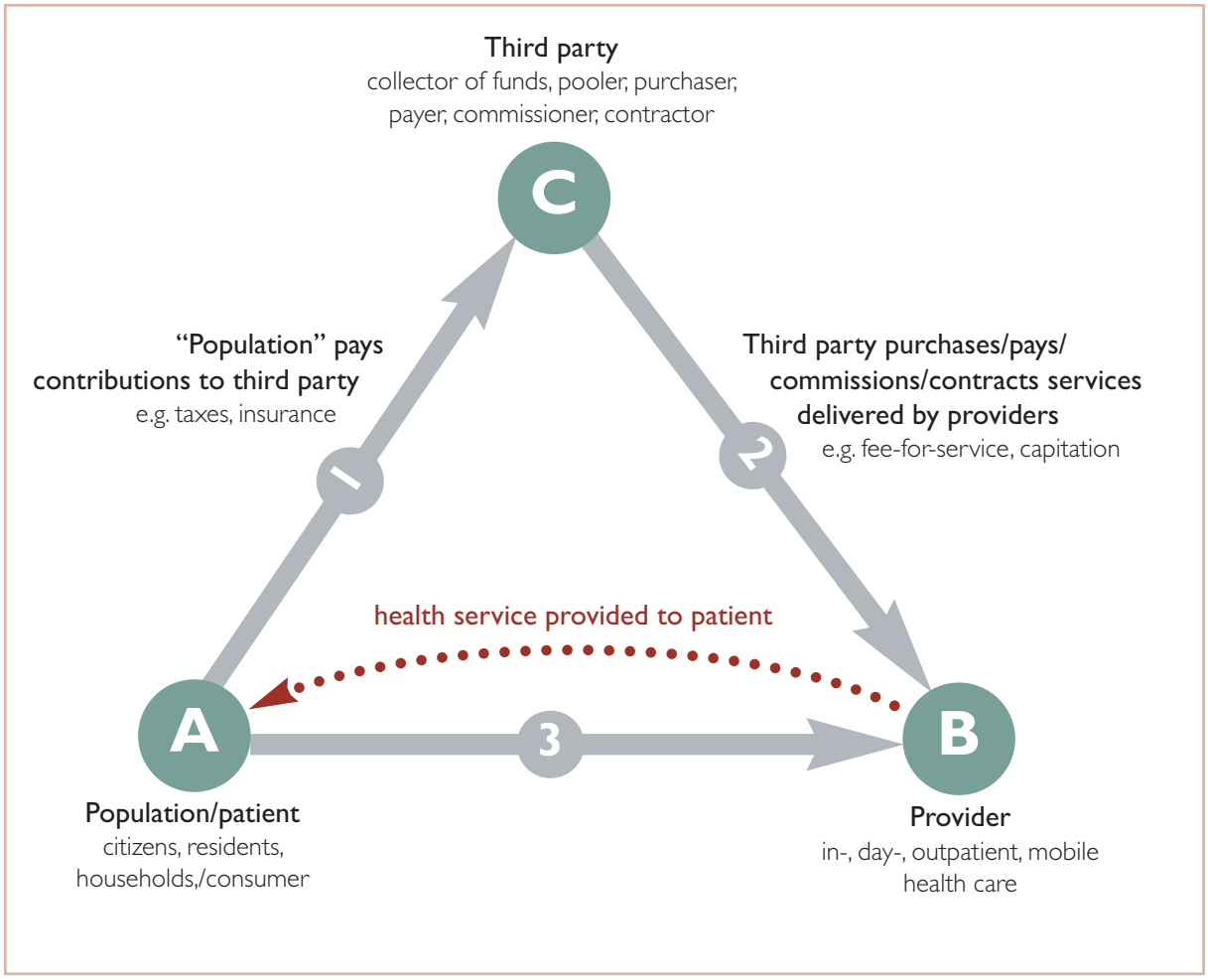
Introduction

General remarks

In Figure 1 the flow of funds between the three main players in most health and social care systems is shown. In modern health and social care systems a "third party" (C), typically pools funds that have been collected from various sources including taxes imposed on the general population, domestic and foreign businesses and foreign visitors, and/or insurance premiums from citizens and other residents (1). These funds are then used to pay (2) the different entities* that are the providers of health and social care (B). This can include funds to treat individuals who fall ill, as well as public health and prevention services, and help and support with social care needs. While most health and social care service users will have made some contribution to third party funds (including tax and/or health insurance funds) they may also be required to pay additional charges when using services called "user charges" below; (3). The different parts and sections of the FINCENTO tool are concerned with these different players and flows of funds, Part A mainly with (1) and part B mainly with (2) and (3).

* Although in some systems it remains that case that C and B are part of the same organisation with little or no separation between the purchaser and provider functions.

Figure 1: Flows of funds between the three main players in health and social care systems

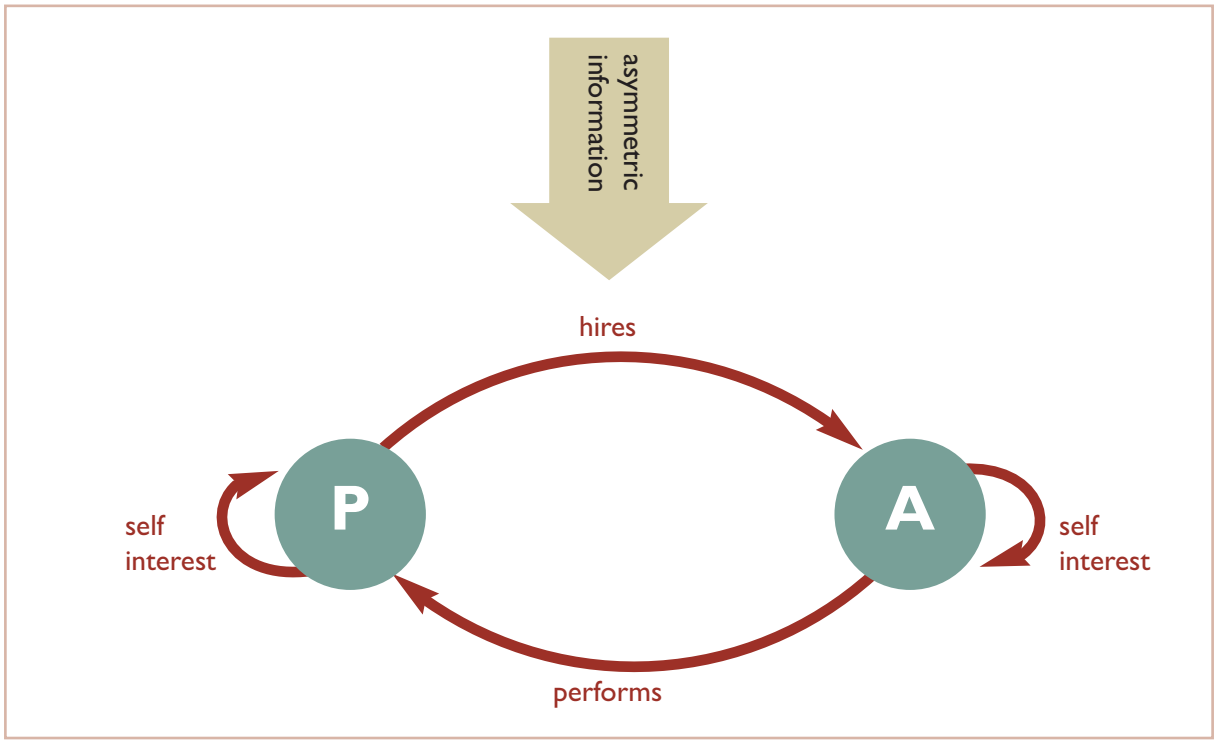


Maintaining the sustainability of health and social care systems is a key problem that has to be faced in many countries. Not only do systems have to contend with stemming the rising costs of care, but also how the flow of funds between the different players is regulated, in order to provide more equitable and efficient health and social care services. The FINCENTO tool covers this issue, especially in respect of regulations relating to this flow of funds (the "financing system") and how they affect the quality of mental health care and support. Care providers play an important role in this system and one task of the REFINEMENT project was to identify incentive and disincentive mechanisms faced by providers and analyse what effect they have on the quality of mental health care.

As a schematic framework for analysing such incentives, the "principal agent theory" was chosen, implying the existence of an "asymmetry in information" between a "principal", in this case an individual with mental health needs, who asks an "agent", for instance a primary care doctor, about a mental health related matter. Service users usually have to rely on one or more agents who have more information, mental health skills and training competence to diagnose problems, as well as provide advice, support and treatment for the "principal".

In political science and economics, the principal–agent problem or agency dilemma is concerned with the difficulties in motivating one party (the "agent" – A in Figure 2 below), to act in the best interests of another (the "principal"- P in the graph below) rather than in his or her own interests (from WIKIPEDIA "The principal agent problem").

Figure 2: The principal agent problem



Source: Wikipedia, http://en.wikipedia.org/wiki/Principal%E2%80%93agent_problem (accessed 11/2013)

It is assumed that unscrupulous service providers potentially could exploit their knowledge advantage for their own gain (financial or non-financial) (e.g. by providing unnecessary or better paid services, or conversely by limiting access to care and support). This has led to a whole range of provider payment mechanisms all of which have implicit or explicit incentives to better reflect the interest of the principals (i.e. the patient and their third party payers) (Arrow 1963). In this model the provider is the agent for the mental health service user who needs a service, but the provider is at the same time the "agent" for the third party payer. Since the provider (as an expert in health and social care) usually has more and better information than the service users or third parties, the latter are "in the hands" of the provider – the service user and third party have to trust the provider to act in their best interests rather than only in his or her own interest. Therefore the provider is a "double agent", i.e. an "agent" both for the patient, as well as for the third party payer.

With these mechanisms in mind provider payment mechanisms which have inbuilt financial incentives and disincentives to reward or penalise certain behaviours of health and social care provider organisations or individuals have been created. The way in which payments are made to organisations and individuals will have an influence on the services they deliver to consumers. Different payment mechanisms will therefore lead to different behaviour patterns in service providers. Some of these incentives and disincentives are contractual and intended, for example, to affect provider treatment decisions (Christianson et al. 2007; Chaix-Couturier et al. 2000). Others have emerged as unintended consequences of changes in funding systems introduced for other purposes.

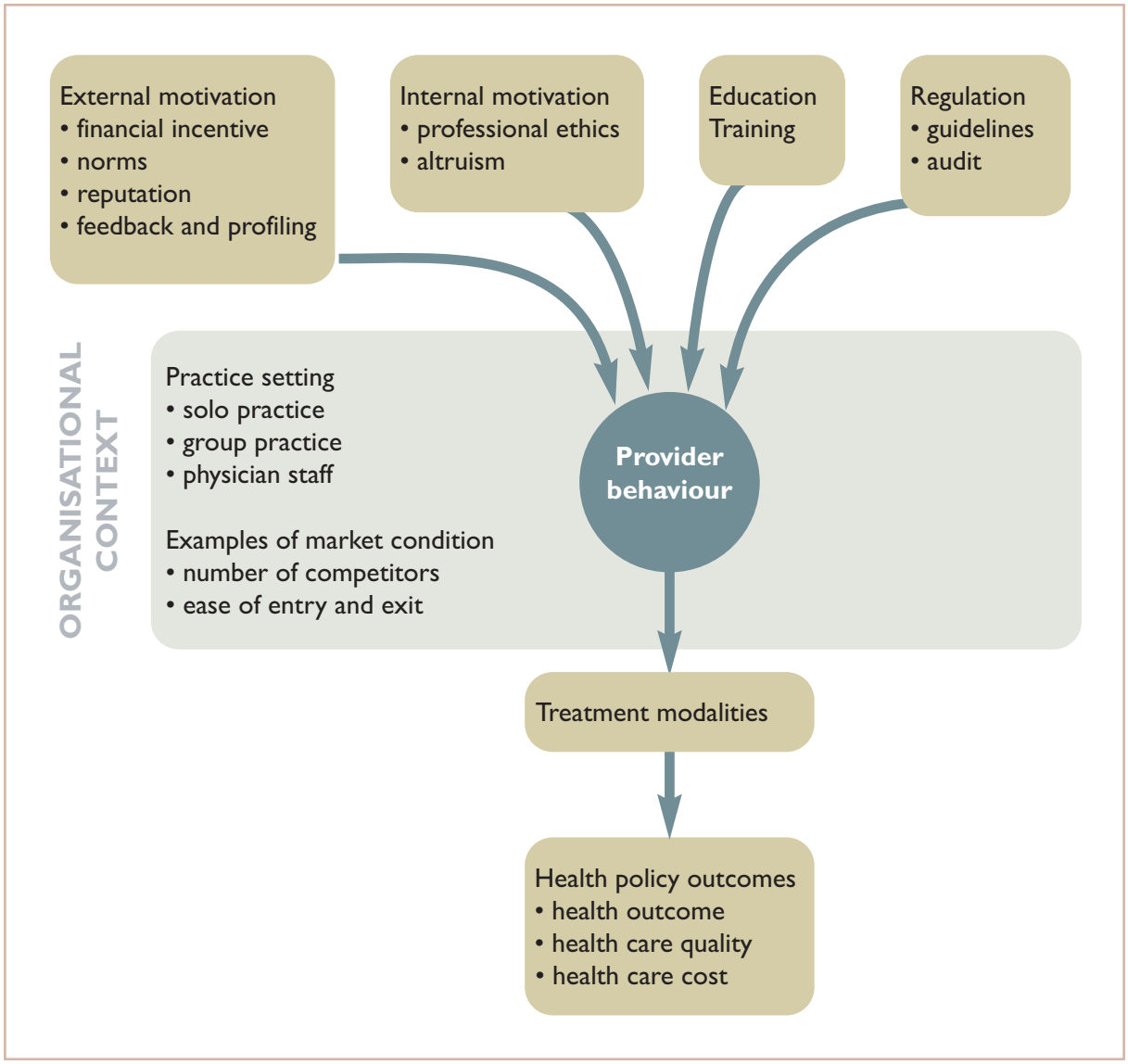
An example of this is the DRG (Diagnosis Related Groups)-system, a case payment system for hospitals first developed in the USA (Fetter et al. 1980) and now introduced in several European countries for some health care problems. The reasons for introducing the DRG system have varied from stimulating provider competition and facilitating patient choice of hospital, to controlling costs and improving transparency in hospital financing, as well as harmonising payment systems (Ettelt et al. 2006). A number of unintended negative consequences for quality of care have emerged in some systems because of hidden incentives and disincentives and gaming by health service providers. For instance, there may be incentives to discharge patients sooner than appropriate, transfer costly patients to other settings such as social care, cutting back unnecessarily on services and admitting less costly patients to generate revenue (Lave 2003; Busse et al. 2006). For complex mental health problems in particular, there have also been challenges in setting tariffs that fully cover the costs of care which in turn influences the motivation of services to provide care (McDaid 2011) (Mason et al 2011).

The FINCENTO tool is intended to help in examining the impact of financial incentives/disincentives for providers and users/consumers of "mental health care services" in order to explore the relationship with the quality of care received, including the appropriateness of pathways

* Synonyms used for mental health problems in this document include mental illness, mental disorder, mental ill health, mental health needs, psychiatric diagnoses, psychiatric illness, psychiatric disorder, psychiatric problem, psychiatric disease, and others

for people with mental health problems.* It is important to note that by "mental health care" in FINCENTO we mean not only care provided by specialist mental health services but also by general health services.). FINCENTO provides a systematic way of looking at the impacts of different payment mechanisms e.g. fee for service, capitation, payment for performance, etc. in relation to mental health care. It can, for example, look at some unintended consequences of different payment mechanisms. One issue may be cream-skimming i.e. whether service providers choose service users on the basis of characteristics other than their need for care which are beneficial to the service provider. The tool does not focus on the many non-financial factors that can influence quality of care, such as the use of professional guidelines, clinical audit or patient behaviour (see left side of Figure 3), although the tool throughout does provides an opportunity to highlight some of these issues when looking at different sectors of the system e.g. primary or inpatient care.

Figure 3: Factors that affect practice behaviour of physicians (Yip et al. 2010)



Working through the FINCENTO tool, answering questions in as much detail as practical, and collecting details of supporting references (including any personal communications with external experts) wherever feasible, will aid in the analysis of the strengths and weaknesses of a specific health and social care system, as well as potentially feeding into analysis of changes over time in a country where the analysis is repeated, or any analysis of differences between different areas in the same country. It can also feed into international comparative analyses of countries or regions. While the literature on financial incentives/disincentives on the quality of care in general health care is extensive, comparatively little is known in this respect about mental health care.

We recognise that some terms may have multiple meanings, so please be careful to use the definitions of terms set out in the REFINEMENT decision support tool (DST) glossary. Moreover, since the public-private issue is of high relevance in today's discussions on improving health care systems, a few definitional remarks are warranted (for more details please see the glossary). Please consider Table 0 which contains a matrix with different payer types and models of service ownership. FINCENTO only deals here with three of the four possible combinations (i.e. all where "public" plays a role) in either paying for or delivering a service. It does not (or only exceptionally) deal with **exclusively** privately paid private providers.

Table 0. Matrix of public and private payers and service owners

(1) Payer	(2) Service ownership	
	(2a) Public	(2b) Private
(1a) Public (tax fund, mandatory SHI fund)	Covered by FINCENTO	Covered by FINCENTO
(1b) Private (VHI, direct payment)	Covered by FINCENTO	Not covered by FINCENTO

References

Arrow KJ (1963). Uncertainty and the Welfare Economics of Medical Care. *The American Economic Review* (53)5: 941–973.

Busse R, Schreyoogg J, Smith PC (2006). Editorial: Hospital case payment systems in Europe. *Health Care Manage Sci* 9: 211–213.

Chaix-Couturier C, Durand-Zaleski I, Jolly D, Durieux P (2000). Effects of financial incentives on medical practice: results from a systematic review of the literature and methodological issues. International *Journal of Quality in Health Care* 12:113–142.

Christianson J, Leatherman, S, Sutherland K (2007), *Financial incentives,*

health care providers and quality improvement. A review of the evidence. London, The Health Foundation.

Ettelt S et al. (2006). *Reimbursing highly specialized hospital services: the experience of activity-based funding in eight countries*. Report commissioned by the Department of Health and prepared by the London School of Hygiene and Tropical Medicine. London, London School of Hygiene and Tropical Medicine.

Fetter RB, Shin Y, Freeman JL, Avrill RF, Thompson JD (1980). Casemix definition by diagnosis related groups. *Med Care* 18:S1–S53.

Lave JR (2003). Developing a Medicare Prospective Payment System For Inpatient Psychiatric Care. *Health Affairs* 22(5):97–109.

Mason A, Goddard M, Myers L, Verzulli R (2011). Navigating uncharted waters? How international experience can inform the funding of mental health care in England. *Journal of Mental Health* 20(3):234–248

McDaid D (2011). Psychiatric remuneration systems in Europe. *Die Psychiatrie* 8(1):1–7

Yip W CM, Hsiao W, Meng Q, Chen W, Sun X (2010). Realignment of incentives for health-care providers in China. *The Lancet* 75:1120–1130.

Technical remarks

FINCENTO is a structured catalogue of questions, which guides decision makers on how to collect essential information for systematically describing the financing mechanisms involved in providing care for adults with mental health needs in a specific country or otherwise defined geographical area.

It covers the regulations on how revenue for third party payers is generated and pooled, as well as on provider payments and user charges, including the description of financial and non-financial incentives and disincentives.

Based on experiences obtained in pilot studies in eight European countries, the final version of FINCENTO covers a wide array of different financing practices, which makes the paper version of this tool appear quite large. However, for a specific country or geographical area only a few of the categories will apply. Any subsequent web-based version of the instrument would be much shorter.

It also has to be kept in mind that some part of the complexity of FINCENTO results from the fact that care for people with mental health needs is not only provided by specialist mental health services but also by general health services and services organised and funded outside of the health sector (such as social services).

FINCENTO is divided into two main sections. Part A provides an

overview of the key features of the health and social care system. It collects essential information for characterising the financing of the general and mental health care system, including revenue collection and pooling of resources.

Part B maps organisations, structures, regulations and provider payment/user charge mechanisms for key health and social services for people with mental health needs. Additionally it covers the assessment of financial and non-financial incentives and disincentives related to the care of people with mental health needs. Prescription medications and incentives for the coordination of care are also covered in Part B.

Information should be derived from all available sources including publications, reports and statistics, as well as, where required, from interviews with experts and specific data analyses.

In the MS word version of this instrument FINCENTO has an automated table of content. Where it is required to fill in text or codes in the space provided for this purpose in the forms the document length will change. When saving your entries please also update the table of content, which then automatically have the correct page numbers assigned (click "update" in the reference tab in the table of contents in WORD).

For definitions see the REFINEMENT glossary (www.refinementproject.eu/)

Part A: Regulations, collection and pooling of funds

Part A: Regulations, collection and pooling of funds

Section 1: Context

A good starting point for this resourcing tool is to generate some brief data on the overall context in which the health care system (and mental health system in particular) is operating. Please provide a brief overview of the key features of the health and social care system in your country. If major social care/welfare services for people with health needs are organised outside the health care system, then please document this. Please reference any useful materials in your national language or international literature which you think may be useful for the reader wishing to learn more about the health care system.

This contextual overview will be important in helping the external reader in understanding some of the responses.

1.1 Checklist

In writing your short overview please also try and identify key features of the system that are going to be useful in analysing the way in which the system functions, and anything that historically may have meant that mental health has been treated in a different way to other health care needs. Some key points to cover include:

- The extent to which the health care system is organised at national and local levels, including whether primary care performs a gatekeeping function to specialist care services.
- The extent to which social care/welfare services such as long term residential care, help with housing, and employment services are located within or outside the health care system.
- The extent to which performance assessment and regulation are being applied within the health and social care/welfare system.
- Please note and briefly describe any major reforms that have been introduced recently or will be introduced in the near future.

1.2 Health system organisation and financial flows of funds

Please provide graphical illustrations of the health care system and the financial flow of funds in your country or region. One source of these figures might for instance be the Health in Transition Reports of the European Observatory on Health Systems and Policies*. Examples are provided in Figures 4 – 6.

* For a full list of 'HITs' see www.euro.who.int/en/about-us/partners/observatory/health-systems-in-transition-hit-series

Figure 4: Conceptual framework for understanding the organisation of health financing systems

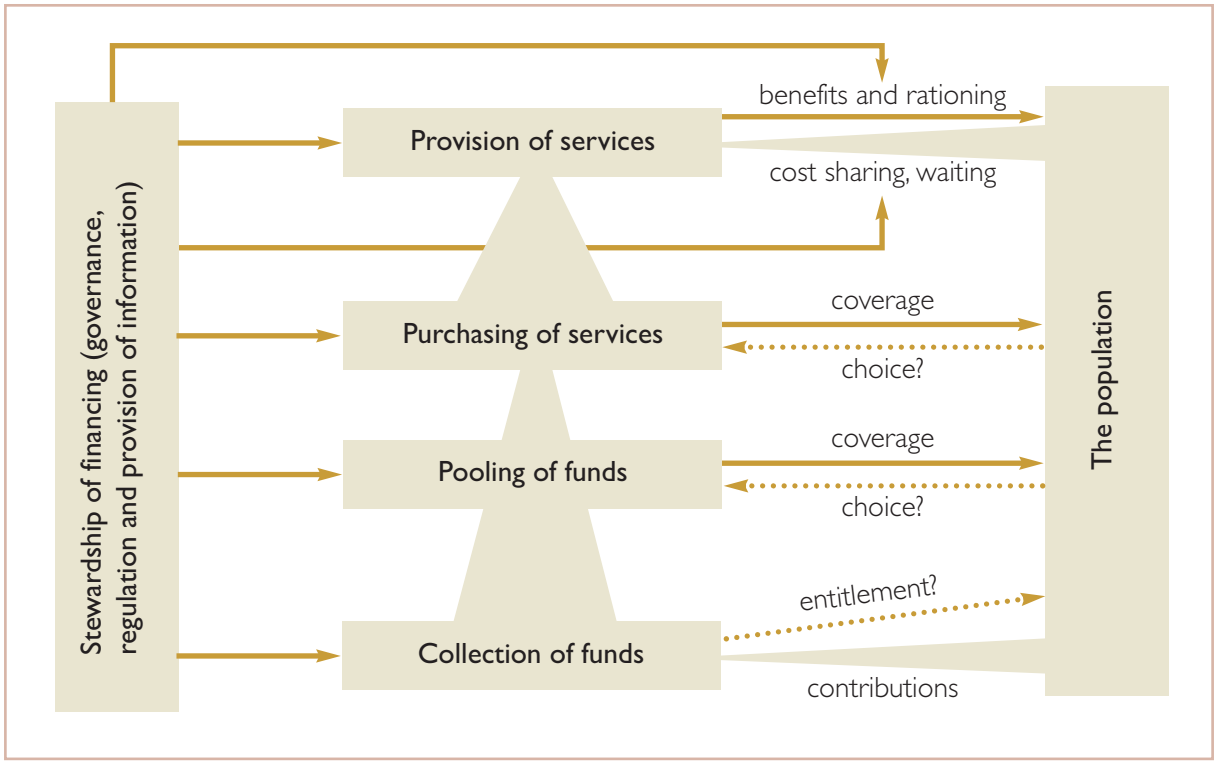
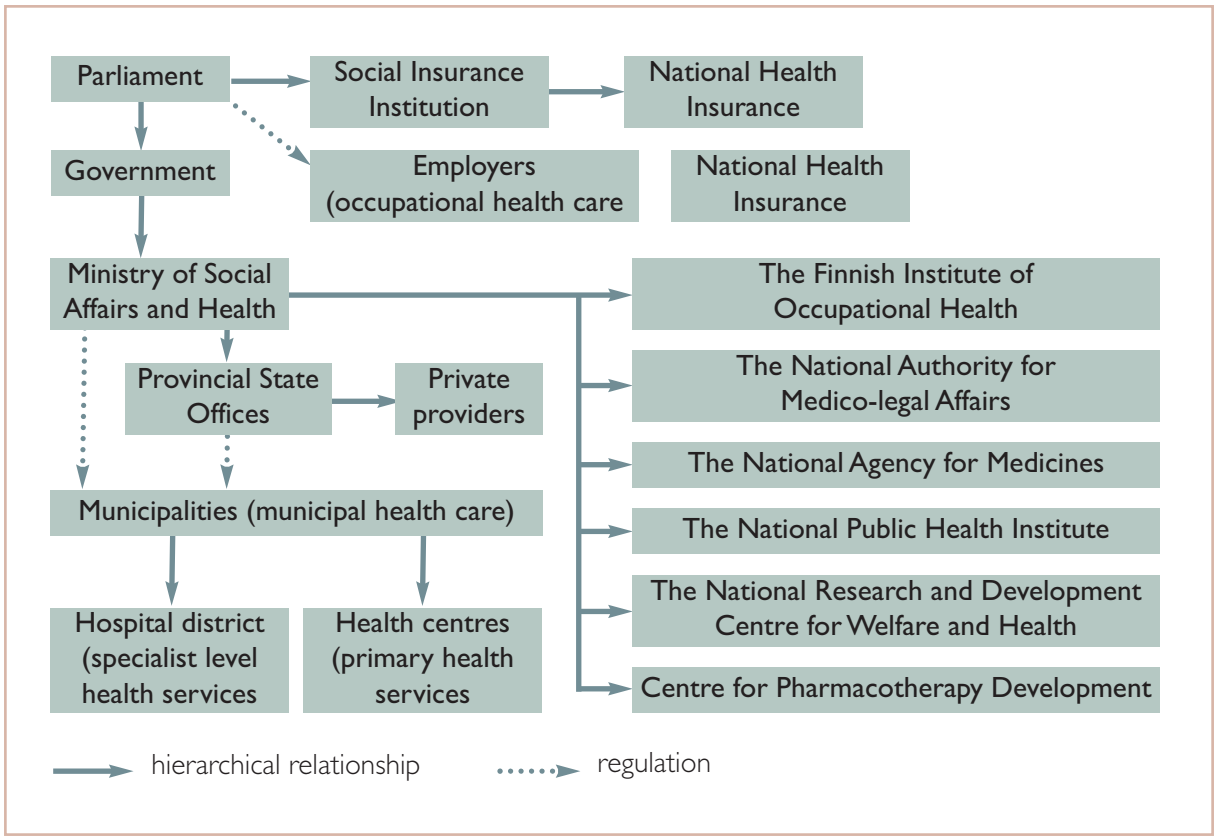
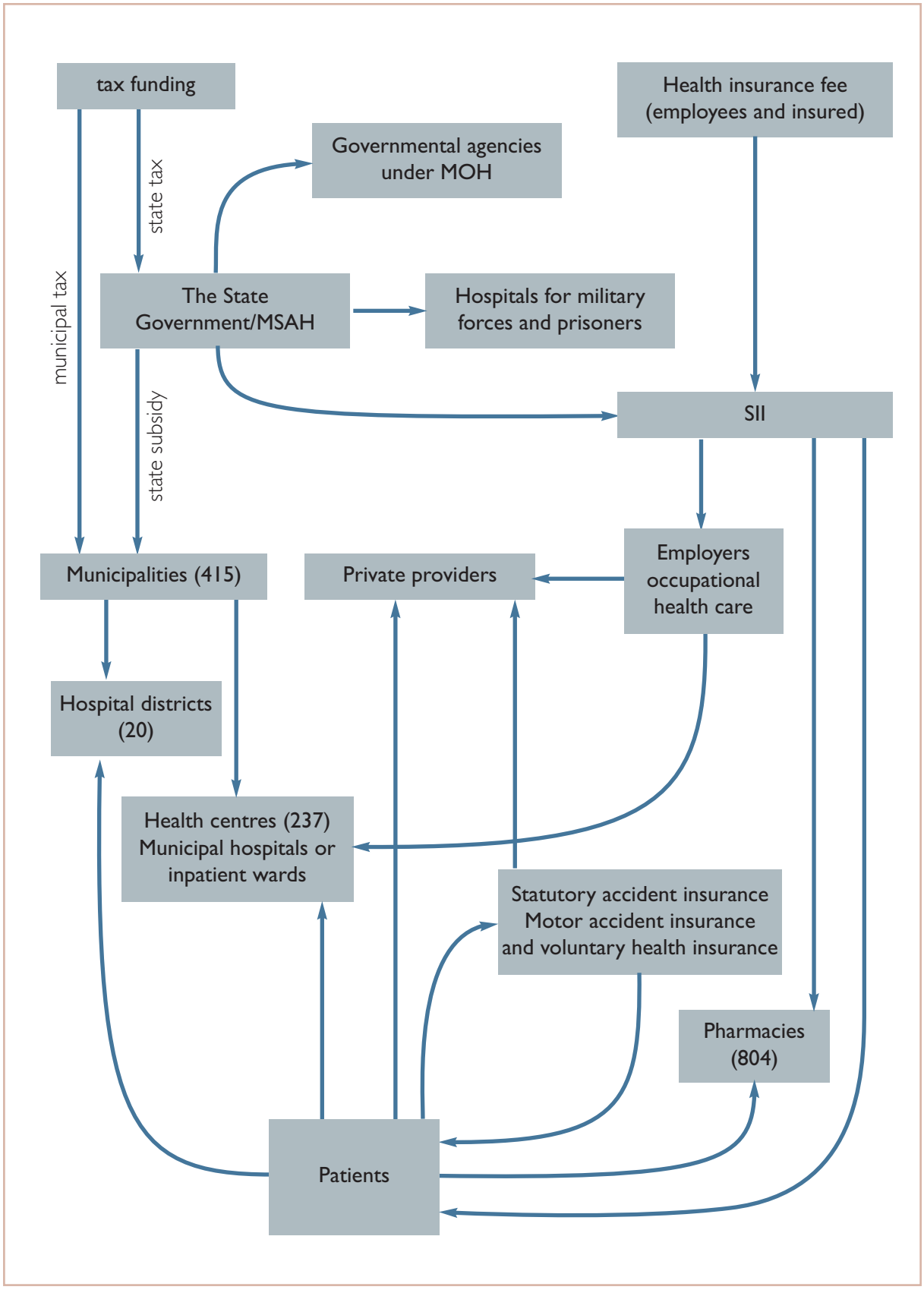


Figure 5: Organisation of the health system in Finland, 2010



Source: Vuorenkoski L, Mladovsky P, Mossialos E (2008). Finland: Health system review. *Health Systems in Transition* 10(4):1–168.

Figure 6: Financial flows in the Finnish health care system



Source: Vuorenkoski L, Mladovsky P, Mossialos E (2008). Finland: Health system review. *Health Systems in Transition* 10(4):1–168.

Section 2: Coverage and entitlements to health and social care/ welfare services

Please **draft a short overview** on coverage and entitlements to the health and social care/welfare system in your country. In doing so please take the following into account:

- Please report the proportion of the population of your country covered by the publicly funded health care system, i.e. by taxes or/and mandatory health insurance.
- Very briefly please state the basic rules on entitlement to use publicly funded health and social care services in your country. Is entitlement based on residency, citizenship etc?
- Please briefly describe any defined benefit packages and also indicate if there is a negative list of services that are excluded from coverage.
- Please indicate whether coverage of mental health services appears to be treated in any different way to physical health needs. For instance please indicate if there are any restrictions on entitlements to coverage, e.g. public funding for recovery from non-fatal suicide events or alcohol related injuries.
- Rules on entitlement to social care/welfare services such as long term care, independent housing support, vocational rehabilitation and employment support may be different. Very briefly indicate if different rules on entitlement to social care/welfare services exist and highlight key points, e.g. means testing of income or assets.

Section 3: Financing health care in your country

This section asks for information on the way in which funds are raised and collected to fund health and social care services. This is to obtain an overview on the sources of funding and also determine whether there are any distinctions between the ways in which funds are collected for health and social care, including key social welfare services to support people with housing and employment and everyday activities of daily living.

3.1 Overview of overall sources of revenue for the health care system

Please **complete Table 1** and **draft a text** on overall sources of revenue for the health care system. Please provide supplementary information if helpful. Identify the most recent figures for public current expenditure on health as a percentage of Gross Domestic Product (GDP). Please also provide information on total current health expenditure as a percentage of GDP. In your text can you confirm that these are the most accurate figures available or replace with more up to date figures as appropriate?

If available please indicate the level of public expenditure on mental health as a proportion of (i) total health expenditure, (ii) total publicly funded health expenditure, (iii) as a percentage of GDP.

Table 1. Sources of current health care expenditure in your country

Source	Percentage of total expenditure on health
Social health insurance	
Local/municipal government	
Central government	
Out of pocket payments	
Voluntary health insurance	
Not for profit institutions	
Corporations (excluding health insurance)	

Please briefly indicate the principal sources of funding for individuals who may not be able to make a significant contribution to funding health care, e.g. the unemployed, the retired, people with disabilities and children.

In your text please state whether services including supported housing for people with health needs, employment services for people with health needs, vocational rehabilitation and long term care, or any other (e.g. mobile services) are financed within the health care system.

Below we have listed specific questions on sources of funding. **Please have separate sections in your text responding to these questions on sources of funding and providing any additional information you believe to be helpful**. In responding to these questions please describe any differences in the funding of mental and physical health services or clearly state if there are no differences. Please also indicate any other significant sources of funding that have not been identified.

3.1.1 Tax generated revenues

If taxes are used in part to fund the health care system in drafting your text please look at the following requests:

- Very briefly outline the process of collecting any tax based revenue from central and/or local government. In doing this please state which body or bodies are responsible for collecting tax?
- Please state whether there are any taxes where revenue raised is specifically allocated to the health care system? (For instance, this might be the case for some earmarked taxes related to tobacco or a proportion of a payroll tax) (In France for example there is a General Social Contribution and taxes on the pharmaceutical industry). If so please briefly describe.

- Please state whether income taxes are progressive (i.e. – those with higher incomes pay higher rates of tax), proportional (i.e. they do not change with income) or regressive (lower for higher income groups)?
- Please describe any contribution that employers must make to income or payroll tax.

3.1.2 Mandatory Social Health Insurance

If there is mandatory social health insurance (SHI) in your country, in drafting your text please describe briefly how the system operates, considering the following issues:

- Please state the number of SHI funds. Please include a list of social health insurance funds and where feasible indicate the share of the market covered by major SHI funds.
- Where relevant please indicate if there is a choice of SHI, or if not, are there specific eligibility criteria linked to funds (e.g. linked to specific categories of employment, or by geographical area etc.?).
- Provide more information about the rate of contributions from salaries. For instance how is the level of contribution determined? Is this a fixed monetary contribution or linked to gross salary? What is the typical percentage from salary? Does this change with salary level? What is the typical amount (if any) not linked to salary. Please briefly state if there is a lower salary limit below which no contribution has to be paid or an upper limit above which no additional contributions have to be made?
- Please briefly describe the relative contribution of employees and employers to insurance premiums?
- Are some employers exempt from making a contribution (e.g. based on turnover, size of business etc., sector etc.)? If so please briefly explain?
- Are self-employed people covered in any different way to salaried employees under the social health insurance system?
- Is there a possibility to opt out from mandatory health insurance to private insurance; if yes please describe the circumstances where this can be done?
- Please state if mental health problems are treated in any way differently to physical health problems by SHI. If so please briefly describe.
- Please indicate if top up payments can be made for additional coverage beyond that provided under mandatory SHI?

3.1.3 Voluntary Health Insurance

If voluntary health insurance (VHI) plays a significant role in your country (i.e. accounting for more than 5% of all health care expenditure), please describe briefly how the system operates, considering the following issues:

- Please state the number of major VHI providers and indicate the balance between not for profit and for-profit organisations. Please include a list of VHI funds and where feasible indicate the share of the market covered by major VHI funds.
- Can VHI be used to cover some or all of the costs of patient out of pocket payments? If so please briefly describe.
- Are premiums community rated or risk rated? Are there any age restrictions on VHI?
- Is VHI a complement or substitute for SHI? If a substitute please briefly describe how an individual can opt out of SHI.
- Please indicate if there are greater or smaller restrictions on entitlements to mental health services than for physical health services under VHI.
- If VHI can be used as an alternative to SHI, please provide more information on how contributions are determined.
- Find out more about the rate of contributions. For instance how is the level of contribution determined? Is this a fixed monetary contribution or linked to specific benefit packages or to gross salary? What is the typical percentage from salary? Does this change with salary level? What is the typical amount (if any) not linked to salary.
- Do employers make a contribution and if so what are the relative contribution of employees and employers to these insurance premiums?
- Are some employers exempt from making a contribution (e.g. based on turnover, size of business, sector etc.)? If so please briefly explain?
- Is there a possibility for employers who contribute to employees' VHI to obtain a tax reduction?

3.1.4 Out of pocket payments

Describe the role of out of pocket payments in your health care system.

- Please briefly highlight the main areas where out of pocket payments are used, e.g. for prescription charges, fees for specific services e.g. opticians and dentists, charges for hospital beds etc.

- Please indicate any population groups who are exempt from out of pocket payments and the main criteria for exemption.

3.1.5 Other sources of funding

Please provide brief information on any other significant sources of funding for health care in your country. Potential sources of funding might include aid from the European Union, other external international donor aid, funding from not-for-profit organisations raised through donations or subscriptions, funding from churches and other faith groups, and research grants that support the delivery of services.

3.2 Consumer Directed Payments

Although not a source of funding but a transfer of resources, it is helpful to know if patients can directly receive funds or vouchers from health care authorities which they can directly use to choose the type of health care they wish to buy. In some countries these arrangements have been known as 'direct payments', 'individual budgets' or 'personal budgets'. If these systems are in place, please briefly describe; are they likely to become more significant over time as a way of paying for health (and other relevant social care/welfare) services?

Section 4: Pooling and resource allocation of publicly collected funds for health

Revenues are "pooled" before they are allocated to service providers. Pooling of funds refers to the accumulation of prepaid revenues on behalf of a population (this might refer to the whole country or regions, e.g. provinces in a federal state or regional trusts or from different health insurance funds).

In most EU countries publicly collected funds for health tend to be pooled at national level, but there may be multiple funds when funds are also collected at sub-national level. Mechanisms may then be used to address disparities in levels of revenue generated as well as different health-need profiles. Social health insurance funds may also have to pool their resources or participate in risk equalisation procedures to transfer money to those insurance funds whose members may have more risky profiles or who have lower levels of income due to the lower income of their members. Risk pooling therefore might be implemented in a way that can promote equity in health care systems.

For a summary of pooling procedures across the EU in 2007 see Table 2.3 pages 37–40 of *Financing Health Care in the European Union* www.euro.who.int/__data/assets/pdf_file/0009/98307/E92469.pdf

Please **draft a text** briefly providing an overview of pooling procedures in your country. Is this still the same as in the highlighted reference or has it changed significantly. For instance:

- Is there just one national pool of funds or are there multiple pools? Briefly highlight any key laws/rules which regulate pooling mechanisms/processes.
- Are there different pools for different types of services, or pools for one type of service (e.g. inpatient care in hospitals) and for another type (e.g. primary care)?
- Are there any separate pooling procedures for mental health e.g. if there is a specific insurance or tax system for mental health?
- Are funds from multiple social health insurers pooled and if so what level of funds collected can be reallocated between insurers? (In some countries this may be 100% of funds collected, but in other cases lower levels of funding may be reallocated.)
- In respect of funds from taxation how are these distributed across the country? Are any resource allocation formula used, as for instance may be the case in countries where taxes are collected at different levels, e.g. national, regional and local levels? If so what criteria are taken into account when distributing funds from national to regional/local funding pools?
- Are there specific adjustments in resource allocation formulae specifically to take account of differences in mental health needs?
- Where funds are raised from taxation and social health insurance – are tax and insurance revenues pooled before resources are reallocated among social health insurers?

Section 5: Health care system capital infrastructure

It is recognised that funding for capital infrastructure is usually rather different to that for recurring health system infrastructure. This area is complex and one brief overview of some of the approaches to infrastructure funding can be found in Chapter 7 of *Investing in Hospitals of the Future*. This is available at www.euro.who.int/__data/assets/pdf_file/0009/98406/E92354.pdf and Table 2 provides an overview of different procurement approaches that may be used to develop infrastructure.

Briefly collect some information on how funds are allocated for investment in health care system capital infrastructure, such as new psychiatric units or social care centres or costly investments in major equipment, such as brain image scanners. Again determine whether there are any differences in funding for new mental health specific capital investment compared with investment in health system infrastructure in general.

Table 2: Different procurement strategies

Procurement System	Management	Procurement Process	Risks	Funding
Traditional procurement	Public	Public actor puts one or more works out to tender	Risks and responsibilities for public actor	Costs and revenues for public actor
Innovative procurement	Public	Public actor puts output-specified question for overall solution out to tender	Design, build and/or maintain risks for private actor	Costs and revenues: lump sum for public actor, variable sum for private actors
Public-private partnership: concession contracts	Public	Public actor puts a service question out to tender, rewarded with a concession	Design, build, finance and maintain/ operate risks for private actor	Costs and revenues: lump sum for public actor, variable sum for private actors
Public-private partnership: joint venture contacts	Public-private	Joint procurement and shared responsibility	Public-private shared	Costs and revenues public – private shared
Privatisation	Private	Public tasks and competences are transferred to		

5.1 Overview of capital infrastructure funding

Please **briefly draft a text** providing an overview of the principal sources of funding for public sector capital infrastructure.

Who makes capital infrastructure investment decisions? Is it the same authority/organisation that makes decisions about allocating funds to service commissioners/providers?

Are mid- to long-term capital infrastructure plans routinely developed? If so please describe.

Are there separate annual or multi-annual budgets for health infrastructure or is there discretion to determine the proportion of an overall health budget spent on infrastructure projects?

Please include any brief discussion of different forms of loans and other borrowing mechanisms that may be used to finance capital projects. (Partnerships with the private sector are discussed in section 5.2)

Can health care budget holders or service providers borrow money on the capital markets to fund the costs of new infrastructure projects?

Please also include any discussion of any international donor aid, lottery or charitable funding to pay for new buildings or equipment. Please include here any use of European Union Structural Funding support.

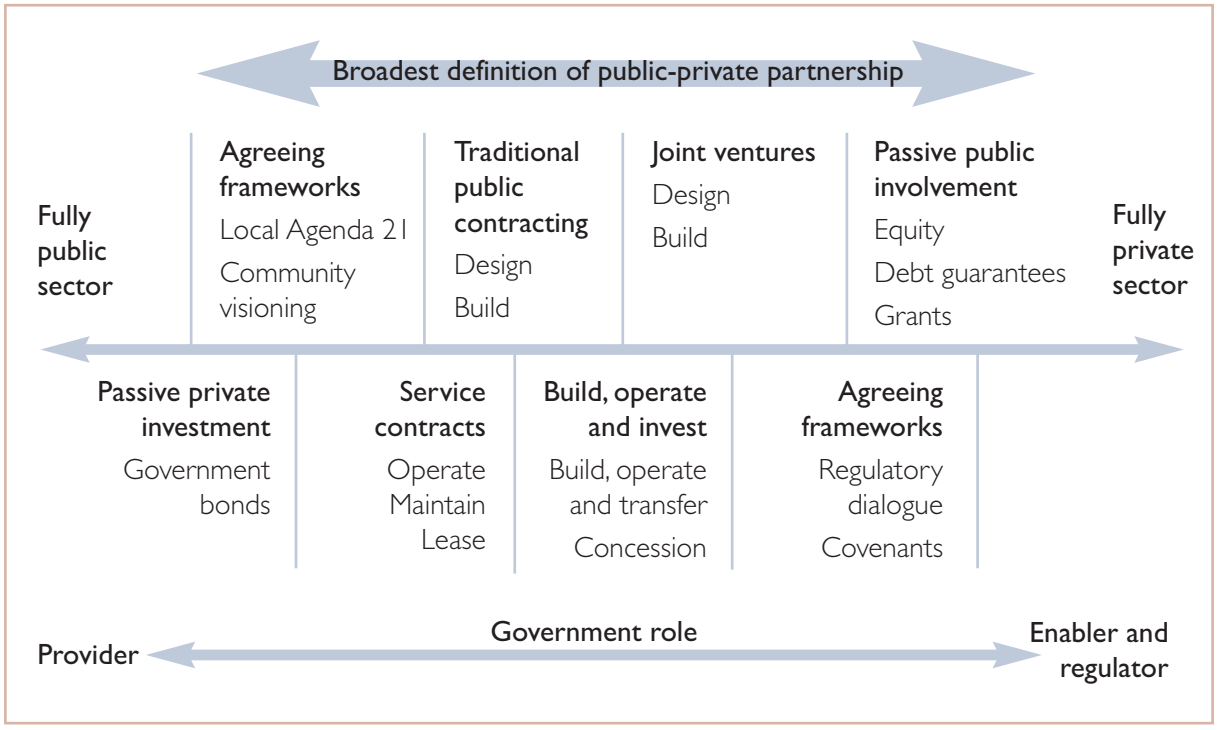
Can any of the borrowing costs for new infrastructure be passed on directly to service users?

Please indicate whether there are any restrictions on the receipt of donor aid for infrastructure, e.g. demonstrating the clinical need for infrastructure or demonstrating that there are sufficient funds for the ongoing maintenance of new infrastructure.

5.2 Public-private partnership initiatives for infrastructure

The use of public-private partnerships (PPPs) to replace and complement the public provision of infrastructure has become common in recent years. The term can cover rather a broad set of relationships as indicated in Figure 8 but it has been defined by the Institute for Public Policy Research in England as a mechanism for a risk-sharing relationship between the public and private sectors based upon a shared aspiration to bring about a desired public policy outcome. PPPs tend to be for fixed periods of time. One common approach in health systems is to award concession contracts where a private sector firm must then run operational activities but not usually clinical activities, for a set period of time.

Figure 8: Spectrum of Public-Private Partnerships



Adapted from: Bennett E, James S, Grohmann P (2000). Joint venture public–private partnerships for urban environmental services. New York, Public Private Partnerships for the Urban Environment (PPPUE).

Please provide a brief overview of the use of PPP. Are PPPs undertaken to expand mental health related infrastructure. If so, briefly what form do these PPPs take?

What are the main regulations and restrictions on these partnerships and on the return on investment that the private partner can expect to receive from the health system?

Please briefly clarify if there are any specific rules governing the ownership of the new infrastructure – for instance might it remain in the ownership of a private sector partner?

Can PPP contracts be flexible to reflect changes in the financial risks over time associated with infrastructure investment? Typically what is the length of time that a PPP contracts operates over. (Shorter fixed term contracts tend to place more of the financial risk on the concessionaire rather than the taxpayer).

Please describe any other features that you think are important.

Part B: Organisation, structure, payment mechanisms, regulation, incentives and disincentives

Part B: Organisation, structure, payment mechanisms, regulation, incentives and disincentives

Introduction

Purpose

In many countries services with one main general function of providing care (e.g. primary care; or specialist mental health outpatient care, or inpatient care) may exist in different forms, for instance with different ownership structures, different payment mechanisms or different levels of accessibility to the population. The purpose of Part B is to document these different subtypes of service for each country in a compact way, so that comparisons between countries are easier, and that links with information obtained from other REFINEMENT tools can be made. **Attention should be paid to the links between many of these different subtypes as Part B ends with consideration of coordination and continuity of care issues.**

Include services that are at least partly public funded, regardless of whether they are provided by public or private providers

It is important to distinguish between public and private financing and public and private (for profit and not for profit) provision of services. FINCENTO covers only services which are financed publicly (e.g. from taxes and/or mandatory social or substitutional voluntary health insurance) or by a mix of public and private contributions (e.g. taxes and patient co-payments, or supplemental or complementary voluntary health insurance).

Such services can be provided by public organisations (with or without a payer provider split) or by private organisations (which by definition will have a payer provider split). These services also include those that are paid for by service users directly using cash transfers they have received from the public purse, such as cash budgets or vouchers.

Services which are paid for exclusively privately, i.e. directly by patients to providers and not reimbursed at a later stage, are only of marginal interest here and are not the focus of FINCENTO (it can also be difficult to obtain this information).

Some examples of subtypes of services

In Austrian primary health care (PHC) self-employed single handed GPs dominate, but around 60% have a contract with the social health insurance (SHI) funds and are directly paid by SHI (with a flat rate per patient per time period plus fee-for service), while 40% do not have a contract with SHI but their patient will get their bills partially reimbursed by their SHI. While GPs without a SHI contract are quite frequent, they do not provide a large amount of care, since they can choose their opening hours and charge much more than the patient is reimbursed.

In Finland PHC is, on the one hand, provided by tax funded municipal health centres (asking for co-payments from patients) and, on the other hand by SHI funded occupational PHC (without such co-payments).

Looking at specialist outpatient ambulatory mental health care, in Austria, France, Norway and Romania for instance, SHI fee for service paid self-employed psychiatrists may be used by people with less severe mental health needs, while public services are used by the more severely ill. There are a number of different types of payment mechanism commonly used within and across countries.

In Romania people in psychiatric beds in general hospitals are paid for in a different way to those in psychiatric beds in specialist psychiatric hospitals; in Austria a general hospital receives less money for the same person in a non-psychiatric bed compared to someone treated in a psychiatric bed.

Relevance of service subtypes

Equity issues may be at stake if different types of publicly funded services exist. Accessibility is an important issue here, since it can be different for different parts of the population. For instance, in some REFINEMENT project countries the more affluent can bypass a service type where waiting lists are longer or consultation times shorter by making co-payments to use services with shorter waiting times and more consultation time.

It is also possible that a complex pattern of subtypes exist, e.g. in France, where patients can choose to have a gatekeeper general practitioner, and choose between a sector 1 doctor who cannot charge above the SHI tariff and a sector 2 doctor who can do this. Co-payments vary to a large degree between all these types of service, in general with higher accessibility and freedom of choice related to higher co-payments, albeit in France these co-payments can be covered by the complementary VHI.

Another example of inequity is that in Finland where patients who are employed do not have to co-pay if they use the occupational health care system, while those who are not employed have to co-pay.

A different issue is the possibility that some subtypes of services can cream skim and leave or send the more difficult/costly patients to other services who cannot refuse patients. We have already noted that self-employed private psychiatrists in several REFINEMENT countries focus on less severely ill people, while the more severely ill are dealt with by publicly owned services. Mechanisms of cream skimming on the part of a provider can be very subtle, if, for instance, it is possible to influence waiting lists.

Categories of services covered by FINCENTO Part B

The following types of function are covered in subsequent sections in FINCENTO Part B, all relating to services where patients can receive care for their mental health needs.

- Physician based primary health care services (section 6)
- Specialist mental health outpatient care (section 7)
- Inpatient and long stay care services (section 8)
- Selected additional services for housing, employment and vocational rehabilitation (section 9)
- Prescription medications (section 10)
- Incentives and disincentives for coordination of care (section 11)

It has to be noted that only section 7 "Specialist mental health outpatient care" exclusively covers mental health services. It is evident that section 6 covers mental as well as physical health care (sometimes involving competing incentives), while inpatient care can be delivered not only in psychiatric beds in hospitals, but also in non-psychiatric beds or in accommodation in the social care sector. Services covered by section 9 are in many countries funded and delivered largely outside the health sector.

Information required for the description of subtypes of services

The description of service subtypes starts out with an estimate of the frequency of the occurrence of a service subtype in a country, followed by an estimate of the relative volume of actual utilisation of the specific service. Issues of ownership of the service, identification of the payer(s), the payment mechanisms and patient co-payments follow.

PLEASE NOTE: In case the service provider is an organisation with employed staff (e.g. a health centre or a hospital), the payment mechanism required is that from the payer to the organisation (and not the way in which employed staff are paid). In addition, depending on the main type of service, other questions can follow. For instance, these might cover the gatekeeping function or specific criteria (if any) of the psychiatric patient populations served. Each table is followed by

a structured space, where more detailed information can be provided on the data inserted into the boxes. In addition, some extra tables are included in order to provide additional information not included in the main tables.

Technical remarks on coding

Please type the codes/your answers directly into boxes provided. PLEASE NOTE: several answers might be relevant in any one box and several codes might therefore have to be inserted. For the definition of the codes see the tables themselves and the glossary included in the Decision Support Toolkit. The "latest available information on the current situation" should be described. In case new regulations are discussed in the country write a text on this at the end of the respective sections.

Section 6: Physician-led Primary Care

In this section you should describe how physician-led primary care services are organised and identify how methods of payment and regulation may influence the way in which they operate. The form that physician-led primary care services will take may vary from country to country, for instance in France and in Austria this primarily refers to the work of self-employed generalist doctors, whilst in Finland it may refer to doctors working in municipal health centres and in England it most often relates to services provided by a number of general practitioners working together in partnership in a single practice.

6.1 Organisation, structure, payment and regulation – physician-led primary care

Please **complete Table 6.1 which helps provide a brief description on the organisation and role of physician-led primary care in your country.** Only organisational structures and payment mechanisms that are representative of what is normally provided in your country are of interest – experimental approaches or those which are only intended for small specialist client groups (for instance, in some countries this may include military health care services) should not be described here.

While there is no strict cut off point for guidance it is suggested that if a structure or payment mechanism is likely to account for less than 5% of all structures or all payment mechanisms then it is suggested that you consider carefully whether it is worth spending much time on its documentation. A key factor when thinking about such mechanisms will be the issue of innovation – it may be that a mechanism is very new and perhaps only being piloted in a small area of the country, but if this is being done with a view to roll out across the whole of the country then this is a payment mechanism that would be worth documenting. The innovative or experimental nature of a payment mechanism could be described in the supplemental narrative descriptions to the Table that is set out later in this section.

Table 6.1 requests information on the typical configuration of infrastructure and payment mechanisms in your country, in this case on different physician-led primary care organisational structures. For instance this will help give a sense of whether most physician-led primary care is provided by self-employed or salaried physicians. It will help analysts to understand whether they work on a single handed basis or are co-located with other primary care physicians.

Table 6.1, Part 1 of template to map structure and payment of physician-led primary care services

Where appropriate, please insert several codes into one box.

6.1.1a Provider type	**6.1.1b Provider subtype**	**6.1.2 Frequency** 0=absent 1=occasional 2=common	**6.1.3 Volume of care** L=large M=medium S=small	**6.1.4 Legal status/ ownership** PUB-DI PUB-INDIR PR-PROF PR-NOTPROF
6A Self-employed PHC physician, single handed				
6B Private company or partnership owned by the practising physicians (group practice)				
6C Physician-led public primary care organisations where physicians are employees				
6D Other, please describe				

NOTES:

6.1.1b Provider subtype

If subtypes of 6.1.1a providers exist name and describe the most common here (and others in the Elaborating information section using the categories provided in this table). Space is already provided for two subtypes of 6A)

6.1.3 Volume of care

Give a crude estimate of the volume of care (in terms of number of patients, visits, etc.) for each provider type in relation to the total care provided by physician-led primary care services

6.1.4 Legal status/ownership

PUB-DI = Direct public provision by national/local government or mandatory social health insurance

PUB-INDIR = Public indirect provision by a separate/independent structure e.g. a national health service organisation, public enterprise/company or similar

PR-PROF = For profit private sector

PR-NOTPROF = Not for profit private sector

In addition to completing this table, please **draft a supplementary text providing a brief description** of the physician-led primary care system and its place within the health care system in the country or region. The text should then go into more detail on some of the responses you have made to Table 6.1. Each of these issues is now considered in turn.

Elaborating on information provided in Table 6.1 – columns 6.1.1 to 6.1.4

If subtypes of the 6.1.1a provider type exist, please describe the subtype(s) existing in addition to the one described in the table by using the categories 6.1.2 to 6.1.10 for this/these additional subtype(s).

6.1.1a and b Physician-led primary care structures

Please provide examples of the typical names in your own language given to each type of physician-led primary care structure that you have indicated.

6.1.2 Frequency of different physician-led primary care service structures

You were already asked for information on the frequency of different models of physician-led primary care. Please provide any further comment here that you think may be useful, including any comment on gaps in information or difficulties in quantifying the balance between different types of service structure in your country. Ideally provide a percentage breakdown on the balance between different service structures.

6.1.3 Volume of primary care handled by different physician-led primary care service structures

Please provide a commentary for the estimate of volume of care you have provided for each type of physician-led primary care service, including any comment on gaps in information or difficulties in quantifying the balance between different types of service in your country.

6.1.4 Legal status, ownership

Please provide any clarifications on the legal status of each type of physician-led primary care organisation that you have identified. Please also provide the local language name for this legal status.

Table 6.1, Part 2 of template to map structure and payment of physician-led primary care services

Where appropriate, please insert several codes into one box.

6.1.1a Provider type	**6.1.1b Provider subtype**	**6.1.5 Who pays for physician-based primary care?** **Who is the contractor of the service?** Purchaser-provider split: NO YES	**6.1.6 Payment mechanisms** (specify percentage of total sources of finance or level of importance)
6A Self-employed PHC physician, single handed			
6B Private company or partnership owned by the practising physicians (group practice)			
6C Physician-led public primary care organisations where physicians are employees			
6D Other, please describe			

NOTES:

6.1.1b Provider subtype

If subtypes of 6.1.1a providers exist name and describe the most common here (and others in the Elaborating information section using the categories provided in this table). Space is already provided for two subtypes of 6A)

6.1.5 Who pays for physician-based primary care?

Please state the name(s) and legal status of organisations that pay for physician-led primary care either at country or regional level as appropriate. Note: user charges to the provider are covered in 6.1.7

6.1.6 Payment mechanisms

BUD = Budget

CAP = Capitation

CAPR = Capitation risk adjusted

FLA = Flat rate per attending patient for a defined time period

FFS = Fee for Service

TAR = Target payments

OTH = Other: please specify

Elaborating on information provided in Table 6.1 – columns 6.1.5 to 6.1.6

6.1.5 Who pays for physician-led primary care?

In the table you were asked to indicate how common any purchaser-provider split was in providing funds for physician-led primary care. Please elaborate further, on the different sources of payment stating whether these cover the national area, or a different focus, such as a specific sub national area or insurer (note user charges are looked at separately). If there are different payers and they use different payment mechanism this should be described below.

6.1.6 Payment mechanisms used

You were already asked, not only to identify the different types of mechanism that are used to pay physician-led primary care services but also their relative importance in terms of total revenue for these services.

Please provide any further comment here that you think may be useful, including any comment on gaps in information or difficulties in quantifying the balance between different types of service structure in your country.

Please note in relation to target payments (TAR), that this can cover a number of different mechanisms. For instance it could refer to an additional payment made for achieving a specific number of immunisations in set time period. In essence payment is made conditional on the achievement of pre-specified goal. Different countries will use different names for this type of payment mechanism, for instance pay-for-performance (P4P) or performance related payment (PRP). In commenting on target payments, please describe – after consulting the glossary – what the term covers in your country context in the subsequent comments section.

If risk adjustment mechanisms are used, please provide information on the most important approached used.

Please indicate whether there are any specific eligibility requirements or patient characteristics (e.g. age, chronic disease diagnosis) that may influence the use of different payment mechanisms.

Where relevant it would be helpful to know whether payments are made retrospectively or prospectively, and how often payments are made. If there are substantial differences in the use of payment mechanisms by different physician-led primary care structures can you provide a commentary on why this may be the case?

Can you provide any information about contracts or other regulatory devices that influence the use of payment mechanisms? For instance are there limits on the amount of activities that are funded by specific payment mechanisms – do these differ by different physician-led primary care organisational structures?

Table 6.1, Part 3 of template to map structure and payment of physician-led primary care services

Where appropriate, please insert several codes into one box.

6.1.1a Provider type	6.1.1b Provider subtype	6.1.7 User charges (do not consider any charges for prescriptions)	6.1.8 User payment reimbursement
6A Self-employed PHC physician, single handed			
6B Private company or partnership owned by the practising physicians (group practice)			
6C Physician-led public primary care organisations where physicians are employees			
6D Other, please describe			

NOTES:

6.1.1b Provider subtype

If subtypes of 6.1.1a providers exist name and describe the most common here (and others in the Elaborating information section using the categories provided in this table). Space is already provided for two subtypes of 6A)

6.1.7 User charges (see comments section for further guidance)

0=none

1=yes, for visit(s) at point of use

2=yes, for visits (and missed appointments) paid at future point in time

3=yes, for other reasons (specify the most typical examples) and paid at point of use

4=yes, for other reasons (please specify the most typical examples) and paid at future point of time

5=other (please specify)

6.1.8 User payment reimbursement

1 Reimbursement for visits

1.1 = 100%

1.2 = less than 100%

1.3 = no reimbursement

2 Reimbursement for other services

2.1 = 100%

2.2 = less than 100%

2.3 = no reimbursement

Elaborating on information provided in Table 6.1 – columns 6.1.7 to 6.1.8

6.1.7 User charges for physician-led primary care services

You were asked to specify whether user charges are made, and whether these are at point of service use or retrospective. For each different type of physician-led primary care organisational structure where users must make a contribution to the costs of care, can you provide more information? Can you provide examples of the typical charges for visits (including charges for missed appointments) to physician-led primary care and whether there are exemptions or ceilings on these payments? Can you do the same for examples of other services for which service users must make a contribution? Can you cite any information locally on how user charges have influenced use of physician-led primary care services?

Please do not include prescription drugs – these are covered elsewhere in FINCENTO.

6.1.8 Reimbursement of user charges

Please elaborate further on the way in which user charges are reimbursed and whether or not they are fully reimbursed. Are there different levels of reimbursements for different types of other services? If less than 100% are reimbursed can you indicate the exact proportion? How much time typically elapses before users are reimbursed? Are there any ceilings on the level of out of pocket charges for primary care general practitioner services? Are any user charges for mental health services delivered in physician-led primary care treated in a different way to user charges for physical health related services?

Table 6.1, Part 4 of template to map structure and payment of physician-led primary care services

Where appropriate, please insert several codes into one box.

6.1.1a Provider type	6.1.1b Provider subtype	6.1.9 Gatekeeping for referral to specialist services	6.1.10 Restrictions/ incentives on number of physician-led service providers in a geographical area (e.g. rural)
6A Self-employed PHC physician, single handed			
6B Private company or partnership owned by the practising physicians (group practice)			
6C Physician-led public primary care organisations where physicians are employees			
6D Other, please describe			

NOTES:

6.1.1b Provider subtype

If subtypes of 6.1.1a providers exist name and describe the most common here (and others in the Elaborating information section using the categories provided in this table). Space is already provided for two subtypes of 6A)

6.1.9 Gatekeeping for referral to specialist services

To physical health services (specify, if different for different specialties):

0 = no, 1 = "soft", 2 = strict

To mental health services

0 = no, 1 = "soft", 2 = strict

6.1.10 Restrictions/incentives on number of physician-led service providers in a geographical area

0=none

1= restrictions only

2= incentives only

3= restrictions and incentives

Elaborating on information provided in Table 6.1 – columns 6.1.9 to 6.1.10

6.1.9 Gatekeeping function

Please elaborate further on any responses you have made on the role of physician-led primary care services in terms of their gatekeeping function and in particular comment on any 'soft' gatekeeping functions where these are applied. Please also comment on any differences in the approaches taken towards mental and somatic specialist care services. Is there a strict gatekeeper system for primary care which prevents patients from directly contacting specialist psychiatric outpatient services?

6.1.10 Restrictions or incentives impacting on the supply of physician-led primary care services

Where you have indicated that there are restrictions or incentives impacting on the supply of physician-led primary care services in a geographical area, please elaborate further. For instance are any restrictions due to regulations stipulating the maximum number of physician-led establishments that can be provided or specifications set out in some national or local plan or needs assessment? Are there maximum limits on the number of people that can enrol with any one physician and/or practice? What incentives are provided to encourage the provision of physician-led primary care services in some areas of a country e.g. in socially deprived communities which might have a high rate of people with mental health problems/substance use disorders or in rural areas etc?

6.1.11 Other comments

Please provide any additional comments you might wish to make. In particular add relevant information that you feel is not adequately captured by this template.

6.2 Financial and non-financial incentives and disincentives – physician-led primary care for people with mental health needs

Attention: If more than one subtype of physician-led primary care exists (as described in Table 6.1), please copy Table 6.2 and the subsequent section (requesting you to elaborate on responses to Table 6.2) as often as necessary and insert after the section entitled "elaborating on responses to table 6.1).

In this section collate detailed information on the existence of financial and non-financial incentives and disincentives concerning physician-led primary care. For each of the different physician-led primary care service providers that you identified in Table 6.1, look in further depth at mental health related issues. Briefly indicate whether financial or non-financial incentives have a significant impact on access to, and utilisation of physician-led primary care for people with mental health needs.

To help in this process complete Table 6.2 on the provision of mental health services in physician-led primary care for each service subtype identified in Table 6.1.

Table 6.2 An overview of mental health-related activities provided in physician-led primary care services and related incentives

Mental health related activity in provider type/subtype ..... (please insert relevant name from column 6.1.1b above)	**6.2.1 Level of activity/ provision** 0 = no 1 = limited but available 2 = routinely provided	**6.2.2 Are specific financial incentives/ disincentives in place?** 0 = no 1 = yes for all population with mental health needs 2 = yes but only for specific population groups	**6.2.3 Are specific non-financial incentives/ disincentives in place?** 0 = no 1 = yes for all population with mental health needs 2 = yes but only for specific population groups	**6.2.4 Regulation and monitoring of performance** 0 = no 1 = regulated but poorly monitored 2 = regulated and actively monitored	**6.2.5 Financial and non-financial penalties for poor performance in achieving any activity target or quality standard** 0 = no 1 = available but rarely enforced 2 = available and often enforced
Diagnosis / Screening for mental health problems					
Initiating prescription of antidepressants					
Ongoing prescribing and monitoring use of antidepressants					
Initiating prescription of antipsychotics					
Ongoing prescribing and monitoring use of antipsychotics					

continued on next page

Table 6.2 (continued) An overview of mental health-related activities provided in physician-led primary care services and related incentives

Mental health related activity in provider type/subtype ..... (please insert relevant name from column 6.1.1b above)	**6.2.1 Level of activity/ provision** 0 = no 1 = limited but available 2 = routinely provided	**6.2.2 Are specific financial incentives/ disincentives in place?** 0 = no 1 = yes for all population with mental health needs 2 = yes but only for specific population groups	**6.2.3 Are specific non-financial incentives/ disincentives in place?** 0 = no 1 = yes for all population with mental health needs 2 = yes but only for specific population groups	**6.2.4 Regulation and monitoring of performance** 0 = no 1 = regulated but poorly monitored 2 = regulated and actively monitored	**6.2.5 Financial and non-financial penalties for poor performance in achieving any activity target or quality standard** 0 = no 1 = available but rarely enforced 2 = available and often enforced
Initiating prescription of anti-dementia drugs					
Ongoing prescribing and monitoring use of anti-dementia drugs					
Providing or prescribing psychological therapies					
Case managing/coordinating specialist care					
Case management/coordination of non-clinical care					

Elaborating on information provided in Table 6.2

6.2.1 Level of activity provision

Please provide further information on patient groups that this may apply to. If helpful provide broad ICD-10 codes that are covered.

6.2.2 Specific financial incentives and disincentives

Please provide further detailed information where you have indicated that financial incentives are in place. For instance are there specific fee-for-service tariffs or target payments related to the care of people with mental health needs?

Do different payment methods for physician-led primary care influence (a) recognition and (b) the management of mental health problems?

Are there any financial incentives/disincentives to refer patients (a) for diagnosis and/or (b) for management from physician-led primary care to specialist psychiatric care?

Are there any financial incentives for physician-led primary care services to carry out cooperative/shared care with specialist mental health services or other services in the health or the social sector?

Can physician-led primary care services refuse patients? E.g. patients who generate less income, because their third party payer pays less for the same service than other payers pay?

In list systems with a gatekeeper function: is a change of primary care service provider possible only at certain intervals? If patients can choose does this create any competition between primary care services? In other words is this an incentive to perform better?

Is there an incentive for primary care physicians to maximise the number of examinations and tests performed because they are afraid of medical litigation?

6.2.3 Specific non-financial incentives and disincentives

Are there any non-financial incentives/disincentives to refer patients (a) for diagnosis and/or (b) for management from physician-led primary care to specialist psychiatric care?

Are there specific non-financial incentives/disincentives that impact on the use of physician-led primary care services?

Can physicians refuse to treat some people with mental health needs? Are some people with mental health needs exempt from any performance related payment systems?

Are there any non-financial incentives for physician-led primary care services to carry out cooperative/shared care with specialist mental health services or other services in the health or the social sector?

Is stigma a barrier for referral to psychiatric services? For instance, the primary care practitioner may be concerned that a person might feel stigmatised by such a referral?

Is easy availability of specialist care a motive for referral (e.g. a psychiatrist is available in the same health care centre where a GP is working). Is there availability in the same village, town, city?

Is there any indication that extrinsic motivations (norms, reputation, feedback and profiling), intrinsic motivations (professional ethics, altruism), regulations (guidelines, audit) shape provider behaviour?

6.2.4 Regulation and monitoring of performance

Please elaborate further on the extent to which regulation and monitoring is enforced.

Publishing data on the performance of primary care practitioners can be an important incentive for changing provider behaviour (naming and shaming) – does this play a role?

6.2.5 Use of financial and non-financial penalties for poor performance

Please elaborate further on how frequently financial and non-financial penalties for poor performance are actually used. Can you provide examples of where they have made a difference to practice?

6.2.6 Other comments

If there are no financial and/or non-financial incentives and disincentives in place, find out whether there is any evidence that people with mental disorders are more frequently referred to specialist care than people with other health problems.

Does the level of training have an impact on your answers? How much training in mental health do general practitioners received in their medical training? Is this obligatory or optional?

Section 7: Specialist mental health outpatient care

Specialist mental health outpatient care services should be distinguished from primary care because of their specialist nature. They differ also from inpatient specialist care services where people with mental health needs stay overnight.

"Out-patient" in this section covers five types of specialist mental health care, two where the service user moves to the service (AMB, DAY), two where the service staff moves to the service user (MOB, C/L) and telephone, internet and computer-based services (TEL). These different types of outpatient mental health care are described in more detail below:

AMB = Ambulatory care

DAY = Day care

MOB = Mobile care

C/L = Consultation liaison service

TEL = Telephone, internet and computer-based services

7.1 AMB Psychiatric ambulatory care ("specialist outpatient care" in a narrow sense): the service user comes to the service for a short consultation (usually less than one hour) with a mental health professional, who talks with the patient, may hand out a prescription, perform a psychotherapeutic intervention etc. In some countries some of these services may be funded from outside of the health sector, e.g. from social welfare budgets. Psychiatric care provided at an accident and emergency unit of a hospital would be included here.

7.2 DAY Psychiatric day care: the service user comes to the service and stays for several hours while participating in structured treatment and/or a occupational programme and/or undergoes diagnostic procedures, but does not stay overnight (psychiatric day care services can include day hospitals and day centres, and they may have language specific names which are difficult to translate into English (e.g. in German "Tagesstrukturzentrum" = "day structure centre"). They can often be funded from outside the health care sector – they should not be restricted here to those funded by the health sector.

7.3 MOB Psychiatric mobile care service: the service visit service users in their own homes or in other locations in the community, such as at their place of work. This type of care can include many different mobile teams. It may also be funded from outside the health system.

7.4 C/L Consultation/liaison psychiatric services: in which an individual is treated in a hospital without specialist psychiatric care services or is being treated in a non-psychiatric bed/ward in a hospital that does have psychiatric services. Psychiatric services will then be brought into to provide consultation and other support to health care professionals on the psychiatric needs of patients in their care.

7.5 TEL Telephone, internet and computer-based services: There is a growing role for internet, telephone and computer-based services. They can have their own dedicated funding and payment arrangements, as in the case of psychological therapy services in England, where services are initially provided remotely by telephone and internet. Only in a minority of cases will individuals be treated on a face to face basis by mental health professionals.

The way in which these services are funded is looked at here. Not only services publicly funded by health budgets or social health insurance are of interest, but also services funded from other budgets, such as local or national government social welfare budgets etc.

It has to be noted that it is not uncommon that one service provider offers several of these types of specialist mental health outpatient care. For instance, a community mental health centre may offer ambulatory care, day care and mobile care. In this case a specific question arises concerning the provider payment mechanism in the sense that it must be clarified, whether all these types of care are financed jointly (e.g. by a common budget) or separately (e.g.by ring-fenced budgets) and what this might mean for the quantity and quality of services provided. In order to document such service configurations column (a) is used to name each type of specialist mental health service and in the subsequent fields of Tables 7.1, 7.2, 7.3, 7.4 and 7.5 a question on the mechanisms used for paying a service provider whose provides multiple specialist mental health outpatient care is provided.

7.1 Psychiatric Ambulatory Care

7.1.1 Organisation, structure, payment and regulation – psychiatric ambulatory care

Please **complete Table 7.1 which helps provide a brief description on the organisation and role of psychiatric ambulatory care in your country**. Focus on organisational structures and payment mechanisms that are representative of what is provided in your country – experimental approaches or those which are only intended for small specialist client groups (for instance in some countries this may include military health care services) are not of interest here.

While there is no strict cut off point for guidance it is suggested that if a structure or payment mechanisms is likely to account for less than 5% of all structures or all payment mechanisms then consider carefully whether it is worth spending much time on its documentation. A key factor when thinking about such mechanisms will be the issue of innovation – it may be that a mechanism is very new and perhaps only being piloted in a small area of the country, but if this is being done with a view to roll out across the whole of the country then this is a payment mechanism that would be worth documenting. The innovative or experimental nature of a payment mechanism could be described in the supplemental narrative descriptions to the Table that is set out later in this section.

Table 7.1 requests information on the typical configuration of infrastructure and payment mechanisms in your country, in this case on different psychiatric ambulatory care organisational structures. For instance this will help give a sense of whether most of this care is provided by self-employed psychiatrists or salaried physicians.

In addition to completing this table, please **draft a supplementary text providing a brief description** of the psychiatric ambulatory care system and its place within the health care system in the country or region. The text should then go into more detail on some of the responses you have made to Table 7.1. Each of these issues is now considered in turn.

Table 7.1, Part 1 of template to map psychiatric ambulatory care services (AMB)

Where appropriate, please insert several codes into one box.

7.1.1.1a Provider type	7.1.1.1b Provider subtype	7.1.1.2 Frequency 0=absent 1=occasional 2=common	7.1.1.3 Volume of care L=large M=medium S=small	7.1.1.4 Legal status/ownership PUB-DI PUB-INDIR PR-PROF PR-NOTPROF
A Self-employed				
A1 psychiatrist, single handed				
A2 psychologist/psychotherapist, single handed				
A3 psychiatrists/psychologists/psycho-therapist in group practice or similar				
B Organisation with employed staff				
B1 Standalone outpatient service (e.g. "polyclinic")				
B2 Outpatient service of a hospital				
B3 Outpatient service of a mental health/ psychiatric centre (with several other types of care provided), community mental health centre, community team				
C Other, please describe				

NOTES:

7.1.1.1b Provider subtype

If subtypes of 7.1.1.1a providers exist name and describe the most common here (and others in the Elaborating information section using the categories provided in this table). Space is already provided for two subtypes of 7A1 Self-employed psychiatrists, single handed)

7.1.3 Volume of care

Give a crude estimate of the volume of care (in terms of number of patients, visits, etc.) for each provider type in relation to the total care provided by psychiatric ambulatory services

7.1.4 Legal status/ownership

PUB-DI = Direct public provision by national/local government or mandatory social health insurance

PUB-INDIR = Public indirect provision by a separate/independent structure e.g. a national health service organisation, public enterprise/company or similar

PR-PROF = For profit private sector

PR-NOTPROF = Not for profit private sector

Elaborating on information provided in Table 7.1 – columns 7.4.1.1 to 7.4.1.4

If subtypes of the 7.1.1.1a provider exist, please describe the subtype(s) here in addition to the one described in the table by using the categories 7.1.1.2 to 7.1.1.11 for additional subtype(s).

7.1.1.1a and b Psychiatric ambulatory care structures

Please provide examples of the typical names in your own language given to each type of psychiatric ambulatory care structure that you have indicated.

7.1.1.2 Frequency of different psychiatric ambulatory care structures

You were already asked for information on the frequency of different models of psychiatric ambulatory care. Please provide any further comment here that you think may be useful, including any comment on gaps in information or difficulties in quantifying the balance between different types of service structure in your country. Ideally provide a percentage breakdown on the balance between different service structures.

7.1.1.3 Volume of care handled by different psychiatric ambulatory care structures

Please provide a commentary for the estimate of volume of care you have provided for each type of psychiatric ambulatory care service, including any comment on gaps in information or difficulties in quantifying the balance between different types of service in your country.

7.1.1.4 Legal status/ownership

Please provide any clarifications on the legal status of each type of psychiatric ambulatory care service that you have identified. Please also provide the local language name for this legal status.

Table 7.1, Part 2 of template to map psychiatric ambulatory care services (AMB)

Where appropriate, please insert several codes into one box.

7.1.1.1a Provider type	7.1.1.1b Provider subtype	7.1.1.5 Who pays? Purchaser-provider split: No/Yes	7.1.1.6a Payment mechanisms	7.1.1.6b Does this specific AMB service provide any of the other types of care?
A Self-employed				
A1 psychiatrist, single handed				
A2 psychologist/psychotherapist, single handed				
A3 psychiatrists/psychologists/psycho-therapist in group practice or similar				
B Organisation with employed staff				
B1 Standalone outpatient service (e.g. "polyclinic")				
B2 Outpatient service of a hospital				
B3 Outpatient service of mental health/ psychiatric centre (with several other types of care provided), community mental health centre, community team				
C Other, please describe				

NOTES:

7.1.1.5 Who pays for psychiatric AMB? Who is the contractor of the service?
Please state the name(s) and legal status of organisations that pay for psychiatric AMB either at country or regional level as appropriate. Note: user charges to the provider are covered below in 7.1.1.7

7.1.1.6a Payment mechanisms (specify percentage of total sources of finance or level of importance)

BUD = Budget
CAP = Capitation
CAPR = Capitation risk adjusted
FFS = Fee for Service
TAR = Target payments
OTH = Other: please specify
FLA = Flat rate per attending patient for a defined time period

7.1.1.6b Other types of care

DAY = psychiatric day care
C/L = consultation/liaison psychiatric care
MOB = psychiatric mobile care
TEL= telephone, internet and computer-based services
OTHER (for instance also inpatient care might be provided)

Elaborating on information provided in Table 7.1 – columns 7.4.1.5 to 7.4.1.6

7.1.1.5 Who pays for psychiatric ambulatory care structures/who is the contractor of the service?

In the table you were asked to indicate how common any purchaser-provider split was in providing funds for psychiatric ambulatory care. Please elaborate further, on the different sources of payment stating whether these cover the national area, or a different focus, such as a specific sub national area or insurer; (note user charges are covered separately). If there are different payers and they use different payment mechanism these should be described below.

7.1.1.6a and b Payment mechanisms used for one or several types of specialist psychiatric outpatient care

Services providing specialist psychiatric ambulatory care (AMB) may also provide other outpatient services, such as psychiatric day care (DAY), psychiatric mobile care (MOB), consultation/liaison psychiatric services (C/L) or telephone, internet, and computer-based services (TEL). See also sections 7.2, 7.3, 7.4 and 7.5 for the other four types of psychiatric outpatient services. Specify also if the specific service provider also provides inpatient care (see section 8).

When commenting on payment mechanisms used, please consider that a payment mechanism may relate to several types of specialist psychiatric outpatient care (or even also to inpatient care). If this is the case, please describe the respective mechanism(s) of payment (e.g. ring fenced payment for each of the provided services or global budget for some of them or for all).

Please note in relation to target payments (TAR), that this can cover a number of different mechanisms. In essence payment is made conditional on the achievement of pre-specified goal including quality of outcomes achieved. Different countries will use different names for this type of payment mechanism, for instance pay-for-performance (P4P) or performance related payment (PRP). In commenting on target payments, please describe – after consulting the glossary – what the term covers in your country context in the subsequent comments section.

You were already asked, not only to identify the different types of mechanism that are used to pay psychiatric ambulatory care services but also their relative importance in terms of total revenue for these services.

Please provide any further comment here that you think may be useful, including any comment on gaps in information or difficulties in quantifying the balance between different types of service structure in your country.

Please provide information on the principal risk adjustment mechanisms that are used.

Please indicate whether there are any specific eligibility requirements or patient characteristics that may influence the use of different payment mechanisms.

Where relevant it would be helpful to know whether payments are made retrospectively or prospectively, and how often payments are made. If there are substantial differences in the use of payment mechanisms by different psychiatric ambulatory care structures can you provide a commentary on why this may be the case?

Can you provide any information about contracts or other regulatory devices that influence the use of payment mechanisms? For instance are there limits on the amount of activities that are funded by specific payment mechanisms – do these differ by different psychiatric ambulatory care organisational structures? Is there a minimum amount/frequency of different types of outpatient activities defined, which has to be provided over a certain time period by the service in question?

For capitation payments please briefly describe how these payments are made and indicate if these are adjusted to reflect differences in population characteristics – e.g. linked to age, gender, socio-economic deprivation. Please indicate if any unspent money can be retained at the end of the financial year.

In the case of global budgets please briefly explain how these are normally set, e.g. based on historical use/activity patterns. Are any adjustments made for population need? Please indicate if any unspent money can be retained at the end of the financial year.

Please describe any flat rate budgets not linked to diagnosis or clinical need that may be used for an outpatient event or course of treatment.

For fee for service payments, please indicate if a national/regional standard set of tariffs are set or alternatively if these are determined in specific contracts with service providers.

Please indicate if service users can pay for outpatient services through individual budgets that they may have been allocated by the state or health insurance fund.

Please indicate if service users receive cash budgets or vouchers that can be used to purchase care.

Please describe any other significant ways in which psychiatric ambulatory care services receive money. This for instance could include charitable donations, faith group support, payments from other government departments, foreign aid or lottery support.

Table 7.1, Part 3 of template to map psychiatric ambulatory care services (AMB)

Where appropriate, please insert several codes into one box.

7.1.1.1a Provider type	7.1.1.1b Provider subtype	7.1.1.7 User charges	7.1.1.8 User payment reimbursement
A Self-employed			
A1 psychiatrist, single handed			
A2 psychologist/psychotherapist, single handed			
A3 psychiatrists/psychologists/psychotherapist in group practice or similar			
B Organisation with employed staff			
B1 Standalone outpatient service (e.g. "polyclinic")			
B2 Outpatient service of a hospital			
B3 Outpatient service of mental health/ psychiatric centre (with several other types of care provided), community mental health centre, community team			
C Other, please describe			

NOTES:

7.1.1.7 User charges (do not consider any charges for prescriptions)
0 = none
1 = yes, for visit(s) at point of use
2 = yes, for visits (and missed appointments) paid at future point in time
3 = yes, for other reasons (please specify the most typical examples) and paid at point of use
4 = yes, for other reasons (please specify the most typical examples) and paid at future point of time
5 = other (please specify)
(See comments section for further guidance)

7.1.1.8 User payment reimbursement
1 Reimbursement for visits
1.1 = 100%
1.2 = less than 100%
1.3 = no reimbursement
2 Reimbursement for other services
2.1 = 100%
2.2 = less than 100%
2.3 = no reimbursement

Elaborating on information provided in Table 7.1 – columns 7.4.1.7 to 7.4.1.8

7.1.1.7 User charges for psychiatric ambulatory care structures

You were asked to specify whether user charges are made, and whether these are at point of service use or retrospective. For each different type of psychiatric ambulatory care organisational structure where users must make a contribution to the costs of care, can you provide more information? Can you provide examples of the typical charges for visits (including charges for missed appointments) to psychiatric ambulatory care and whether there are exemptions or ceilings on these payments? Can you do the same for examples of other services for which service users must make a contribution? Can you cite any information locally on how user charges have influenced use of psychiatric ambulatory care?

Please indicate if there are any ceilings on total payments or if specific groups of the population are exempt from co-payments.

7.1.1.8 User payment reimbursement

Please elaborate further on the way in which user charges are reimbursed and whether or not they are fully reimbursed. Are there different levels of reimbursement for different types of other services? If less than 100% are reimbursed can you indicate the exact proportion? Are any user charges for mental health services delivered in psychiatric ambulatory care treated in a different way to user charges for physical health related services?

Table 7.1, Part 4 of template to map psychiatric ambulatory care services (AMB)

Where appropriate, please insert several codes into one box.

7.1.1.1a Provider type	7.1.1.1b Provider subtype	7.1.1.9 Restrictions/ incentives on number of services	7.1.1.10 Types of service users	7.1.1.11 Emergency care
A Self-employed				
A1 psychiatrist, single handed				
A2 psychologist/psychotherapist, single handed				
A3 psychiatrists/psychologists/psycho-therapist in group practice or similar				
B Organisation with employed staff				
B1 Standalone outpatient service (e.g. "polyclinic")				
B2 Outpatient service of a hospital				
B3 Outpatient service of mental health/ psychiatric centre (with several other types of care provided), community mental health centre, community team				
C Other, please describe				

NOTES:

7.1.1.9 Restrictions/incentives on number of specialist psychiatric outpatient services in a geographical area

0 = none

1 = restrictions only

2 = incentives only

3 = restrictions and incentives

7.1.1.10 Types of service users

0 = all

1 = rather less severely ill

2 = rather severely ill

7.1.1.11 Emergency care. Is crisis/emergency care provided?

YES

NO

Elaborating on information provided in Table 7.1 – columns 7.4.1.9 to 7.4.1.11

7.1.1.9 Restrictions or incentives impacting on the supply of psychiatric ambulatory care structures

Where you have indicated that there are restrictions or incentives impacting on the supply of psychiatric ambulatory care services in a geographical area, please elaborate further. For instance are any restrictions due to regulations stipulating the maximum number of psychiatrist led establishments that can be provided or specifications set out in some national or local plan or needs assessment? What incentives are provided to encourage the provision of psychiatric ambulatory care services in some areas of a country e.g. in socially deprived communities which might have a high rate of people with mental health problems/substance use disorders or in rural areas etc.?

Please indicate if there is a specified list of services and service providers that patients can choose from if they are to receive publicly funded services.

7.1.1.10 Types of service user

Please describe further the typical types of service user seen in each psychiatric ambulatory care structure.

7.1.1.11 Emergency care

If emergency care is provided, please give details.

7.1.1.12 Other comments

Please provide any additional comments you might wish to make. In particular provide relevant information that you feel is not adequately captured by this template.

7.1.2 Financial and non-financial incentives and disincentives concerning psychiatric ambulatory care for people with mental health needs

Please collate detailed information on the existence of financial and non-financial incentives and disincentives concerning psychiatric ambulatory care. Please consider that financial incentives and disincentives may be of a general nature (e.g. it is generally assumed that a fee-for-service incentivises a higher number of services to be provided whereas capitation is assumed to be a disincentive to this), or of a specific nature relating to mental health care (e.g. specific fee-for-service tariffs for mental health care, specific target payments for achieving specific mental health goals, and similar results-based/performance or quality related financing mechanisms).

For each of the different psychiatric ambulatory care service providers that you identified in Table 7.1, look now in further depth and briefly indicate whether financial or non-financial incentives have a significant impact on access to, and utilisation of psychiatric ambulatory care for mental health problems.

7.1.2.1 Incentives related to performance-related payment schemes

Please briefly describe how any performance-related payment systems may work. This may be based on individual factors or a weighted or non-weighted composite measure of factors such as individual productivity, patient satisfaction, impact on hospital admissions, quality of life measures, etc. Please also state if fines apply in the case of poor performance. Performance related systems may be associated with the introduction of systems of monitoring and inspection. How is performance monitored – is this a function of any outside regulatory body or other procedure? Are the results of any performance assessment made public? If so how? Could this influence demand for services by service commissioners and/or patients?

7.1.2.2 Incentives related to complex activity based payment systems

Please describe where relevant how any DRG or other needs-linked activity based payment systems deals with psychiatric ambulatory care services. If not linked to diagnosis, please explain how the system works. Please give an indication of whether tariffs are set at national, regional, sickness fund or other level. Please indicate if tariffs are linked to a primary diagnosis or some other indicator of need (e.g. linked to symptom profile). Please indicate if tariffs vary depending on co-morbidity.

Please indicate any broad categories of psychiatric diagnosis or psychiatric patient population groups that are excluded from any DRG system. Please indicate how payment is actually made (i.e. a defined amount of money or allocation of "points", whose monetary value will be determined retrospectively).

7.1.2.3 Incentives related to population sub-groups

If psychiatric ambulatory care subtypes deal with different groups of patients with mental health problems can they select specific patients? If so how is this done (e.g. by waiting list management)? Are there financial incentives and disincentives in place for the different service subtypes to take on or refuse specific ambulatory patients? For instance is there any cream-skimming occurring whereby ambulatory services deal with easier to manage individuals? Does the severity of disorder or the behaviour of service user play a role?

7.1.2.4 Non-financial incentives and disincentives and other incentives and disincentives

Please describe any other important financial and/or non-financial incentives or disincentives that might be in place. For instance are there any public ranking systems? These can be quite powerful, for instance if a service has poor performance can staff lose their jobs?

Are there specific non-financial incentives/disincentives that impact on the use of psychiatric ambulatory services?

Are there any non-financial incentives for psychiatric ambulatory care

services to carry out cooperative/shared care with other mental health services or other services in the health or the social sector?

Is stigma a barrier for the use of psychiatric ambulatory care?

Does the availability of psychiatric ambulatory care services play a role in service use? What is their availability in the same village, town or city?

Is there any indication that extrinsic motivations (norms, reputation, feedback and profiling), intrinsic motivations (professional ethics, altruism), regulations (guidelines, audit) shape provider behaviour?

7.2 Psychiatric Day Care

7.2.1 Organisation, structure, payment and regulation – psychiatric day care

Please complete Table 7.2 which helps provide a brief description on the organisation and role of psychiatric day care in your country. Focus on organisational structures and payment mechanisms that are representative of what is provided in your country – experimental approaches or those which are only intended for small specialist client groups (for instance in some countries this may include military health care services) are not of interest here. While there is no strict cut off point for guidance it is suggested that if a structure or payment mechanisms is likely to account for less than 5% of all structures or all payment mechanisms then consider carefully whether it is worth spending much time on its documentation. A key factor when thinking about such mechanisms will be the issue of innovation – it may be that a mechanism is very new and perhaps only being piloted in a small area of the country, but if this is being done with a view to roll out across the whole of the country then this is a payment mechanism that would be worth documenting. The innovative or experimental nature of a payment mechanism could be described in the supplemental narrative descriptions to the tables that are set out later in this section.

Table 7.2 requests information on the typical configuration of infrastructure and payment mechanisms for different psychiatric day care organisational structures in your country.

In addition to completing this table, please draft a supplementary text providing a brief description of the psychiatric day care system and its place within the health care system in the country or region. The text should then go into more detail on some of the responses you have made to Table 7.2. Each of these issues is now considered in turn.

Table 7.2.1, Part 1 of template to map the structure of psychiatric day care services (DAY)

Where appropriate, please insert several codes into one box.

7.2.1.1a Provider type	**7.2.1.1b Provider subtype**	**7.2.1.2 Frequency** 0=absent 1=occasional 2=common	**7.2.1.3 Volume of care** L=large M=medium S=small	**7.2.1.4 Legal status/ownership** PUB-DI PUB-INDIR PR-PROF PR-NOTPROF
7.2A Integrated with inpatient services in a hospital				
7.2B Separate organisational structure of a hospital and located in hospital				
7.2C Separate organisational structure of a hospital but not located in a hospital				
7.2D Part of a psychiatric centre/ community mental health centre				
7.2E Other, please describe				

NOTES:

7.2.1.1b Provider subtype
If subtypes of 7.2.1.1a providers exist name and describe the most common here (and others in the Elaborating information section using the categories provided in this table).

7.2.1.3 Volume of care
Give a crude estimate of the volume of care (in terms of number of patients, visits, etc.) for each provider type in relation to total care provided by psychiatric day care services

7.2.1.4 Legal status/ownership

PUB-DI = Direct public provision by national/local government or mandatory social health insurance

PUB-INDIR = Public indirect provision by a separate/independent structure e.g. a national health service organisation, public enterprise/company or similar

PR-PROF = For profit private sector

PR-NOTPROF = Not for profit private sector

Elaborating on information provided in Table 7.2 – columns 7.2.1.1 to 7.2.1.4

If subtypes of the 7.2.1.1a provider exist, please describe them here, in addition to the one described in the table, by using the categories 7.2.1.2 to 7.2.1.10 for this/these additional subtype(s).

7.2.1.1a and b Psychiatric day care structures

Please provide examples of the typical names in your own language given to each type of psychiatric day care structure that you have identified.

7.2.1.2 Frequency of different psychiatric day care structures

You were already asked for information on the frequency of different models of psychiatric day care. Please provide any further comment here that you think may be useful, including any comment on gaps in information or difficulties in quantifying the balance between different types of service structure in your country. Ideally provide a percentage breakdown on the balance between different service structures.

7.2.1.3 Volume of care handled by different psychiatric day care structures

Please provide a commentary for the estimate of volume of care you have provided for each type of psychiatric day care, including any comment on gaps in information or difficulties in quantifying the balance between different types of service in your country.

7.2.1.4 Legal status/ownership

Please provide any clarifications on the legal status of each type of psychiatric day care structure that you have identified. Please also provide the local language name for this legal status.

Table 7.2.1, Part 2 of template to map the structure of psychiatric day care services (DAY)

Where appropriate, please insert several codes into one box.

7.2.1.1a Provider type	7.2.1.1b Provider subtype	7.2.1.5 Who pays? Purchaser-provider split: No/Yes	7.2.1.6a Payment mechanisms	7.2.1.6b Does this specific DAY service provide any of the other types of care?
7.2A Integrated with inpatient services in a hospital				
7.2B Separate organisational structure of a hospital and located in hospital				
7.2C Separate organisational structure of a hospital but not located in a hospital				
7.2D Part of a psychiatric centre/ community mental health centre				
7.2E Other, please describe				

NOTES:

7.2.1.1b Provider subtype
If subtypes of 7.2.1.1a providers exist name and describe the most common here (and others in the Elaborating information sections using the categories provided in this table).

7.2.1.5 Who pays for psychiatric DAY? Who is the contractor of the service?
Please state the name(s) and legal status of organisations that pay for psychiatric DAY either at country or regional level as appropriate. Note: user charges to the provider are covered below in 7.2.1.7

7.2.1.6a Payment mechanisms (specify percentage of total sources of finance or level of importance)

BUD = Budget
CAP = Capitation
CAPR = Capitation risk adjusted
OTH = Other, please specify
FFS = Fee for service
TAR = Target payments
DAY = Daily fee for attendance
ABF = Activity based funding (e.g. DRG)
FLA = Flat rate per attending patient for a defined time period

7.2.1.6b Other types of care

DAY = psychiatric day care
C/L = consultation/liaison psychiatric care
MOB = psychiatric mobile care
TEL = telephone, internet and computer-based services
OTHER (for instance also inpatient care might be provided)

Elaborating on information provided in Table 7.2 – columns 7.2.1.5 to 7.2.1.6

7.2.1.5 Who pays for psychiatric day care structures?

In the table you were asked to indicate how common any purchaser-provider split was in providing funds for psychiatric day care. Please elaborate further, on the different sources of payment stating whether these cover the national area, or a different focus, such as a specific sub national area or insurer (note user charges are enquired separately). If there are different payers and they use different payment mechanism this should be described below.

7.2.1.6a and b Payment mechanisms used for one or several types of specialist psychiatric outpatient care

Services providing specialist psychiatric day care (DAY) may also provide other outpatient services, such as psychiatric ambulatory care (AMB), psychiatric mobile care (MOB), consultation/liaison psychiatric services (C/L) or telephone, internet, and computer-based services (TEL). See also sections 7.1, 7.3, 7.4 and 7.5 for the other four types of psychiatric outpatient services. Also, specify if the specific service provider also provides inpatient care (see section 8).

When commenting on payment mechanisms used, please consider that a payment mechanism may relate to several types of specialist psychiatric outpatient care (or even also to inpatient care). If this is the case, please describe the respective mechanism(s) of payment (e.g. ring fenced payment for each of the provided services or global budget for some of them or for all).

You were already asked, not only to identify the different types of mechanism that are used to pay for psychiatric day care services, but also their relative importance in terms of total revenue for these services.

Please note in relation to target payments (TAR), that this can cover a number of different mechanisms. In essence payment is made conditional on the achievement of pre-specified goal including quality of outcomes achieved. Different countries will use different names for this type of payment mechanism, for instance pay-for-performance (P4P) or performance related payment (PRP). In commenting on target payments, please describe – after consulting the glossary – what the term covers in your country context in the subsequent comments section.

Please provide any further comments here that you think may be useful, including any comment on gaps in information or difficulties in quantifying the balance between different types of day care service structure in your country.

Please provide information on the principal risk adjustment mechanisms that are used.

Please indicate whether there are any specific eligibility requirements or service user characteristics that may influence the use of different payment mechanisms.

Where relevant it would be helpful to know whether payments are made retrospectively or prospectively, and how often payments are made. If there are substantial differences in the use of payment mechanisms by different psychiatric day care structures can you provide a commentary on why this may be the case?

Can you provide any information about contracts or other regulatory devices that influence the use of payment mechanisms?

For instance are there limits on the amount of activities that are funded by specific payment mechanisms – do these differ by different psychiatric day care organisational structures? Also, is there a minimum amount/frequency of different types of outpatient activities defined, which has to be definitely provided over a certain time period by the service in question (might concern financing mechanism budget/capitation).

For capitation payments please briefly describe how these payments are made and indicate if these are adjusted to reflect differences in population characteristics – e.g. linked to age, gender, socio-economic deprivation. Please indicate if any unspent money can be retained at the end of the financial year.

In the case of global budgets not linked to capitation please briefly explain how these are normally set, e.g. based on historical use/activity patterns. Are any adjustments made for population need? Please indicate if any unspent money can be retained at the end of the financial year.

Please describe any flat rate payments not linked to diagnosis or clinical need that may be used day care services

For fee for service payments, please indicate if a national/regional standard set of tariffs is set or alternatively if this is determined in specific contracts with service providers.

Please indicate if service users can pay for day care services through individual budgets (cash or vouchers) that they may have been allocated by the state or health insurance fund.

Please describe any other significant ways in which psychiatric day care services receive money. This for instance could include charitable donations, faith group support, payments from other government departments, foreign aid or lottery support.

Table 7.2, Part 3 of template to map psychiatric day care services (DAY)

Where appropriate, please insert several codes into one box.

7.2.1.1a Provider type	7.2.1.1b Provider subtype	7.2.1.7 User charges	7.2.1.8 User payment reimbursement
7.2A Integrated with inpatient services in a hospital			
7.2B Separate organisational structure of a hospital and located in hospital			
7.2C Separate organisational structure of a hospital but not located in a hospital			
7.2D Part of a psychiatric centre/ community mental health centre			
7.2E Other, please describe			

NOTES:

7.2.1.7 User charges (do not consider any charges for prescriptions)

0 = none
1 = yes, for visit(s) to day care service at point of use
2 = yes, for visits to day care service (paid at future point in time)
3 = yes, for meals paid at point of use
4 = yes, for meals paid at future point of time
5 = yes for medications paid at point of use
6 = yes for medications paid at future point in time
7 = yes for transportation paid at point of use
8 = yes for transportation and paid at future point in time

7.2.1.8 User payment reimbursement

1 Reimbursement for visits	1.1 = 100%
	1.2 = less than 100%
	1.3 = no reimbursement
2 Reimbursement for other services	2.1 = 100%
	2.2 = less than 100%
	2.3 = no reimbursement
3 Reimbursement for medications	3.1 = 100%
	3.2 = less than 100%
	3.3 = no reimbursement
4 Reimbursement for transportation	4.1 = 100%
	4.2 = less than 100%
	4.3 = no reimbursement

Elaborating on information provided in Table 7.2 – columns 7.2.1.7 to 7.2.1.8

7.2.1.7 User charges for psychiatric day care structures

You were asked to specify whether user charges are made, and whether these are at the point of service use or retrospective. For each different type of psychiatric day care organisational structure where users must make a contribution to the costs of care, can you provide more information? Can you provide examples of the typical charges for visits to day care services and whether there are exemptions or ceilings on these payments? Can you do the same for examples of other services for which service users must make a contribution e.g. meals, medications or transportation to and from the day centre? Can you cite any information locally on how user charges have influenced use of psychiatric day care?

Please indicate if there are any ceilings on total payments or if specific groups of the population are exempt from co-payments.

7.2.1.8 Reimbursement of user charges

Please elaborate further on the way in which user charges related to psychiatric day care are reimbursed and whether or not they are fully reimbursed. Are there different levels of reimbursement for different types of other service? If less than 100% are reimbursed can you indicate the exact proportion? Are any user charges for day care services for mental health problems treated in a different way to day care for physical health problems? Please note if there are differences in user charges between any psychiatric day care services funded by the health system and services that are funded from outside the health system, such as from local municipalities or from different government departments such as social welfare.

Table 7.2, Part 4 of template to map psychiatric day care services (DAY)

Where appropriate, please insert several codes into one box.

7.2.1.1a Provider type	7.2.1.1b Provider subtype	7.2.1.9 Restrictions/ incentives on number of services	7.2.1.10 Number of places per day care service	7.2.1.11 Types of care provided
7.2A Integrated with inpatient services in a hospital				
7.2B Separate organisational structure of a hospital and located in hospital				
7.2C Separate organisational structure of a hospital but not located in a hospital				
7.2D Part of a psychiatric centre/ community mental health centre				
7.2E Other, please describe				

NOTES:

7.2.1.9 Restrictions/incentives on number of specialist psychiatric day services in a geographical area

0 = none

1 = restrictions only

2 = incentives only

3 = restrictions and incentives

7.2.1.10 Number of places per day care service

Insert Min to Max number of places in psychiatric day care services

7.2.1.11 Types of care provided

1 = general

2 = crisis

3 = rehabilitation

4 = other

Elaborating on information provided in Table 7.2 – columns 7.2.1.9 to 7.2.1.11

7.2.1.9 Restrictions/incentives on number of specialist psychiatric day services in a geographical area

Are any restrictions due to regulations stipulating the maximum number of psychiatrist day care services that can be provided or specifications set out in some national or local plan or needs assessment? What incentives are provided to encourage the provision of psychiatric day care services in some areas of a country e.g. in socially deprived communities which might have a high rate of people with mental health problems/substance use disorders or in rural areas?

Please indicate if there is a specified list of day care service providers that service users can choose from if they are to receive publicly funded day care services.

7.2.1.10 Number of places

Please elaborate further as appropriate on the number of places available in day care service (minimum number of places – maximum number of places)

7.2.11 Types of care provided

Please describe further the typical types of care provided seen in each psychiatric day care structure.

7.2.12 Other comments

Please provide any additional comments you might wish to make. In particular provide relevant information that you feel is not adequately captured by our template.

7.2.2 Financial and non-financial incentives and disincentives concerning psychiatric day care for people with mental health needs

Please collate detailed information on the existence of financial and non-financial incentives and disincentives concerning psychiatric day care. Please consider that these financial incentives and disincentives may be of a general nature (e.g. it is generally assumed that fee-for-service incentivises a higher number of services to be provided whereas capitation is assumed to be a disincentive for this), or of a specific nature relating to mental health care (e.g. specific fee-for-service tariffs for mental health care, specific target payments for achieving specific mental health goals, and similar results-based/performance or quality related financing mechanisms).

For each of the different psychiatric day care service providers that you identified in Table 7.2, look now in further depth and briefly indicate whether financial or non-financial incentives have a significant impact on access to, and utilisation of day care for mental health problems.

7.2.2.1 Incentives related to performance-related payment schemes

Please briefly describe how any performance related payment systems may work. This may be based on individual factors or a weighted or non-weighted composite measure of factors such as individual productivity, patient satisfaction, impact on hospital admissions, quality of life measures, etc. Please also state if fines apply in the case of poor performance. Performance related systems may be associated with the introduction of systems of monitoring and inspection. How is performance monitored – is this a function of any outside regulatory body or other procedure? Are the results of any performance assessment made public? If so how? Could this influence demand for services by service commissioners and/or patients?

7.2.2.2 Incentives related to complex activity-based payment systems

Please describe where relevant how any DRG or other needs-linked activity based payment systems deals with psychiatric day care services. If not linked to diagnosis, please explain how the system works. Please give an indication of whether tariffs are set at national, regional, sickness fund or other level. Please indicate if tariffs are linked to a primary diagnosis or some other indicator of need (e.g. linked to symptom profile). Please indicate if tariffs vary depending on co-morbidity.

Please indicate any broad categories of psychiatric diagnosis or psychiatric patient population groups that are excluded from any DRG system. Please indicate how payment is actually made (i.e. a defined amount of money or allocation of "points", whose monetary value will be determined retrospectively).

7.2.2.3 Incentives related to population sub-groups

If subtypes of psychiatric day care deal with different groups of patients with mental health problems can they select specific patients? If so how is this done (e.g. by waiting list management)? Are there financial incentives and disincentives in place for the different service subtypes to take on or refuse specific day patients? For instance is there any cream-skimming occurring whereby ambulatory services deal with easier to manage individuals? Do severity of disorder and troublesomeness of patients play a role?

7.2.2.4 Non-financial incentives and disincentives and other incentives and disincentives

Please describe any other important financial and/or non-financial incentives or disincentives that might be in place. For instance are there any public ranking systems – these can be quite powerful, e.g. if a service has poor performance can staff might lose their jobs.

Are there specific non-financial incentives/disincentives that impact on the use of psychiatric day care services?

Are there any non-financial incentives for psychiatric day care services

to carry out cooperative/shared care with other mental health services or other services in the health or the social sector?

Is stigma a barrier for the use of psychiatric day care?

Does the availability of the psychiatric day care services play a role on service use? Is there availability in the same village, town, city?

Is there any indication that extrinsic motivations (norms, reputation, feedback and profiling), intrinsic motivations (professional ethics, altruism), regulations (guidelines, audit) shape provider behaviour?

7.3 Psychiatric Mobile Care Services

Please complete Table 7.3 which helps provide a brief description on the organisation and role of psychiatric mobile care in your country, that is care delivered by service providers either travelling to the service user's home or to another venue in their local area. Focus on organisational structures and payment mechanisms that are representative of what is provided in your country – experimental approaches or those which are only intended for small specialist client groups (for instance in some countries this may include military health care services) are not of interest here. While there is no strict cut off point for guidance it is suggested that if a structure or payment mechanisms is likely to account for less than 5% of all structures or all payment mechanisms then consider carefully whether it is worth spending much time on its documentation. A key factor when thinking about such mechanisms will be the issue of innovation – it may be that a mechanism is very new and perhaps only being piloted in a small area of the country, but if this is being done with a view to roll out across the whole of the country then this is a payment mechanism that would be worth documenting. The innovative or experimental nature of a payment mechanism could be described in the supplemental narrative descriptions to the Table that is set out later in this section.

Table 7.3 requests information on the typical configuration of infrastructure and payment mechanisms in your country, in this case on different psychiatric mobile care organisational structures.

In addition to completing this table, please **draft a supplementary text providing a brief description** of the psychiatric mobile care system and its place within the health care system in the country or region. The text should then go into more detail on some of the responses you have made to Table 7.3. Each of these issues is now considered in turn.

Table 7.3.1, Part 1 of template to map the structure of psychiatric mobile care services

Where appropriate, please insert several codes into one box.

7.3.1.1a Provider type	7.3.1.1b Provider subtype	7.3.1.2 Frequency 0=absent 1=occasional 2=common	7.3.1.3 Volume of care L=large M=medium S=small	7.3.1.4 Legal status/ownership PUB-DI PUB-INDIR PR-PROF PR-NOTPROF
7.3A Organisationally part of a specialist psychiatric unit				
7.3B Organisationally part of a community mental health team				
7.3C Organisationally part of a stand alone community mobile mental health team				
7.3D Organisationally part of local/regional government social care services				
7.3E Other, please describe				

NOTES:

7.3.1.1b Provider subtype
If subtypes of 7.3.1.1a providers exist name and describe the most common here (and others in the Elaborating information section using the categories provided in this table).

7.3.1.3 Volume of care
Give a crude estimate of the volume of care (in terms of number of patients, visits, etc.) for each provider type in relation to the total care provided by psychiatric mobile services

7.2.1.4 Legal status/ownership

PUB-DI = Direct public provision by national/local government or mandatory social health insurance

PUB-INDIR = Public indirect provision by a separate/independent structure e.g. a national health service organisation, public enterprise/company or similar

PR-PROF = For profit private sector

PR-NOTPROF = Not for profit private sector

Elaborating on information provided in Table 7.3 – columns 7.3.1.1 to 7.3.1.4

If subtypes of the 7.3.1.1a provider type exist, please describe them in addition to the one described in the table by using the categories 7.3.1.2 to 7.3.1.11 for this/these additional subtype(s).

7.3.1.1a and b Psychiatric mobile care structures

Please provide examples of the typical names in your own language given to each type of psychiatric mobile care structure that you have indicated.

7.3.1.2 Frequency of different psychiatric mobile care structures

You were already asked for information on the frequency of different models of psychiatric mobile care. Please provide any further comment here that you think may be useful, including any comment on gaps in information or difficulties in quantifying the balance between different types of service structure in your country. Ideally provide a percentage breakdown on the balance between different service structures.

7.3.1.3 Volume of care handled by different psychiatric mobile care structures

Please provide a commentary for the estimate of volume of care you have provided for each type of psychiatric mobile care, including any comment on gaps in information or difficulties in quantifying the balance between different types of service in your country.

7.3.1.4 Legal status/ownership

Please provide any clarifications on the legal status of each type of psychiatric mobile care structure that you have identified. Please also provide the local language name for this legal status.

Table 7.2.1, Part 2 of template to map psychiatric mobile services (MOB)

Where appropriate, please insert several codes into one box.

7.3.1.1a Provider type	7.3.1.1b Provider subtype	7.3.1.5 Who pays? Purchaser-provider split: No/Yes	7.3.1.6a Payment mechanisms	7.3.1.6b Does this specific MOB service provide any of the other types of care?
7.3A Organisationally part of a specialist psychiatric unit				
7.3B Organisationally part of a community mental health team				
7.3C Organisationally part of a stand alone community mobile mental health team				
7.3D Organisationally part of local/regional government social care services				
7.3E Other, please describe				

NOTES:

7.3.1.1b Provider subtype

If subtypes of 7.3.1.1a providers exist name and describe the most common here (and others in the Elaborating information sections using the categories provided in this table).

7.3.1.5 Who pays for psychiatric mobile services? Who is the contractor of the service?

Please state the name(s) and legal status of organisations that pay for psychiatric MOB either at country or regional level as appropriate. Note: user charges to the provider are covered below in 7.2.1.7

7.3.1.6a Payment mechanisms (specify percentage of total sources of finance or level of importance)

BUD = Budget
FFS = Fee for Service
CAP = Capitation
TAR = Target payments
CAPR = Capitation risk adjusted
DAY = Daily fee for attendance
OTH = Other, please specify
ABF = Activity based funding (e.g. DRG)
FLA = Flat rate per attending patient for a defined time period

7.3.1.6b Other types of care

DAY = psychiatric day care
AMB = psychiatric ambulatory care
C/L = consultation/liaison psychiatric care
TEL = telephone, internet and computer-based services
OTHER (for instance also inpatient care might be provided)

Elaborating on information provided in Table 7.3 – columns 7.3.1.5 to 7.3.1.6

7.3.1.5 Who pays for psychiatric mobile care structures?

In the table you were asked to indicate how common any purchaser-provider split was in providing funds for psychiatric mobile care. Please elaborate further, on the different sources of payment stating whether these cover national area, or a different focus, such as a specific sub national area or insurer (note user charges are enquired separately). If there are different payers and they use different payment mechanism this should be described below.

7.3.1.6a and b. Payment mechanisms used for one or several types of specialist psychiatric outpatient care

Services providing specialist psychiatric mobile care (MOB) may also provide other outpatient services, such as psychiatric ambulatory care (AMB), psychiatric day care (DAY), consultation/liaison psychiatric services (C/L) or telephone, internet, and computer-based services (TEL). See also sections 7.1, 7.2, 7.4 and 7.5 for the other four types of psychiatric outpatient services. Also, specify if the specific service provider also provides inpatient care (see section 8).

When commenting on payment mechanism used, please consider that a payment mechanism may relate to several types of specialist psychiatric outpatient care (or even also to inpatient care). If this is the case, please describe the respective mechanism(s) of payment (e.g. ring fenced payment for each of the provided services or global budget for some of them or for all).

You were already asked, not only to identify the different types of mechanism that are used to pay psychiatric mobile care services but also their relative importance in terms of total revenue for these services.

Please provide any further comment here that you think may be useful, including any comment on gaps in information or difficulties in quantifying the balance between different types of service structure in your country.

Please note in relation to target payments (TAR), that this can cover a number of different mechanisms. In essence payment is made conditional on the achievement of pre-specified goal including quality of outcomes achieved. Different countries will use different names for this type of payment mechanism, for instance pay-for-performance (P4P) or performance related payment (PRP). In commenting on target payments, please describe – after consulting the glossary – what the term covers in your country context in the subsequent comments section.

Please provide information on the principal risk adjustment mechanisms that are used.

Please indicate whether there are any specific eligibility requirements or patient characteristics that may influence the use of different payment mechanisms.

Where relevant it would be helpful to know whether payments are made retrospectively or prospectively, and how often payments are made. If there are substantial differences in the use of payment mechanisms by different psychiatric mobile care structures can you provide a commentary on why this may be the case?

Can you provide any information about contracts or other regulatory devices that influence the use of payment mechanisms?

For instance are there limits on the amount of activities that are funded by specific payment mechanisms – do these differ by different psychiatric mobile care organisational structures? Also, is there a minimum amount/frequency of different types of outpatient activities defined, which has to be definitely provided over a certain time period by the service in question (might concern financing mechanism budget/capitation).

For capitation payments please briefly describe how these payments are made and indicate if these are adjusted to reflect differences in population characteristics – e.g. linked to age, gender, socioeconomic deprivation. Please indicate if any unspent money can be retained at the end of the financial year.

In the case of global budgets please briefly explain how these are normally set, e.g. based on historical use/activity patterns. Are any adjustments made for population need? Please indicate if any unspent money can be retained at the end of the financial year.

Please describe any flat rate budgets not linked to diagnosis or clinical need that may be used for an outpatient event or course of treatment.

For fee for service payments, please indicate if a national/regional standard set of tariffs are set or alternatively if these are determined in specific contracts with service providers.

Please indicate if service users can pay for mobile services through individual budgets that they may have been allocated by the state or health insurance fund.

Please indicate if service users receive cash budgets or vouchers that can be used to purchase care.

Please describe any other significant ways in which psychiatric mobile care services receive money. This for instance could include charitable donations, faith group support, payments from other government departments, foreign aid or lottery support.

Table 7.3, Part 3 of template to map psychiatric mobile services (MOB)

Where appropriate, please insert several codes into one box.

7.3.1.1a Provider type	7.3.1.1b Provider subtype	7.3.1.7 User charges	7.3.1.8 User payment reimbursement
7.3A Organisationally part of a specialist psychiatric unit			
7.3B Organisationally part of a community mental health team			
7.3C Organisationally part of a stand alone community mobile mental health team			
7.3D Organisationally part of local/regional government social care services			
7.3E Other, please describe			

NOTES:

7.3.1.7 User charges (do not consider any charges for prescriptions)

0 = none
1 = yes, for visit(s) to day care service at point of use
2 = yes, for visits to day care service (paid at future point in time)
3 = yes, for meals paid at point of use
4 = yes, for meals paid at future point of time
5 = yes for medications paid at point of use
6 = yes for medications paid at future point in time
7 = yes for transportation paid at point of use
8 = yes for transportation and paid at future point in time

7.3.1.8 User payment reimbursement

1 Reimbursement for visits	1.1 = 100%
	1.2 = less than 100%
	1.3 = no reimbursement
2 Reimbursement for other services	2.1 = 100%
	2.2 = less than 100%
	2.3 = no reimbursement
3 Reimbursement for medications	3.1 = 100%
	3.2 = less than 100%
	3.3 = no reimbursement
4 Reimbursement for transportation	4.1 = 100%
	4.2 = less than 100%
	4.3 = no reimbursement

Elaborating on information provided in Table 7.3 – columns 7.3.1.7 to 7.3.1.8

7.3.1.7 User charges for psychiatric mobile care structures

You were asked to specify whether user charges are made, and whether these are at point of service use or retrospective. For each different type of psychiatric mobile care organisational structure where users must make a contribution to the costs of care, can you provide more information? Can you provide examples of the typical charges for the receipt of psychiatric mobile care and whether there are exemptions or ceilings on these payments? Can you indicate whether there are any charges for any medications provided by mobile services? Can you cite any information locally on how user charges have influenced use of psychiatric mobile care?

Please indicate if there are any ceilings on total payments or if specific groups of the population are exempt from co-payments.

7.3.1.8 Reimbursement of user charges

Please elaborate further on the way in which user charges are reimbursed and whether or not they are fully reimbursed. If less than 100% are reimbursed can you indicate the exact proportion? Are there different levels of reimbursement for different types of mobile service? Are any user charges for mental health services delivered by psychiatric mobile care treated in a different way to user charges for mobile physical health services?

Table 7.3, Part 4 of template to map psychiatric mobile services (MOB)

Where appropriate, please insert several codes into one box.

7.3.1.1a Provider type	7.3.1.1b Provider subtype	7.3.1.9 Restrictions/ incentives on number of services	7.3.1.10 Number of places per day care service	7.3.1.11 Types of care provided
7.3A Organisationally part of a specialist psychiatric unit				
7.3B Organisationally part of a community mental health team				
7.3C Organisationally part of a stand alone community mobile mental health team				
7.3D Organisationally part of local/regional government social care services				
7.3E Other, please describe				

NOTES:

7.3.1.9 Restrictions/incentives on number of specialist psychiatric mobile services in a geographical area
0 = none
1 = restrictions only
2 = incentives only
3 = restrictions and incentives

7.3.1.10 Number of places per mobile care service
Insert Min to Max number of places in a psychiatric mobile service for specified time period

7.3.1.11 Types of care provided
1 = Routine care
2 = Crisis/emergency care
3 = Non-clinical care
4 = Other

Elaborating on information provided in Table 7.3 – columns 7.3.1.9 to 7.3.1.11

7.3.1.9 Restrictions/incentives on the number of specialist psychiatric mobile services in a geographical area

Are any restrictions due to regulations stipulating the maximum number of psychiatrist mobile services that can be provided or specifications set out in some national or local plan or needs assessment? What incentives are provided to encourage the provision of psychiatric mobile care services in some areas of a country e.g. in socially deprived communities which might have a high rate of people with mental health problems/substance use disorders or in rural areas etc?

Please indicate if there is a specified list of mobile care service providers that service users can choose from if they are to receive publicly funded mobile care services.

7.3.1.10 Number of places in mobile care services

Please provide some information on the minimum and maximum number of service users seen by a mobile care services, specifying the time period for this caseload. It would also be helpful to get a sense of how frequently the mobile service visits the service user.

7.3.1.11 Types of care provided by mobile care services

Please describe further the typical types of care provided by psychiatric mobile care structures, for instance routine community mental health services, assertive or crisis care or early intervention services for psychosis. Indicate if these services also provide non-clinical care, such as help finding employment, training or claiming social welfare benefits.

7.3.1.12 Other comments

Please provide any additional comments you might wish to make. In particular provide relevant information that you feel is not adequately captured by our template.

7.3.2 Financial and non-financial incentives and disincentives concerning psychiatric mobile care for people with mental health needs

Please collate detailed information on the existence of financial and non-financial incentives and disincentives concerning psychiatric mobile care. Please consider that financial incentives and disincentives may be of a general nature (e.g. it is generally assumed that fee-for-service incentivises a higher number of services to be provided whereas capitation is assumed to be a disincentive for this), or of a specific nature relating to mental health care (e.g. specific fee-for-service tariffs for mental health care, specific target payments for achieving specific mental health goals, and similar results-based/performance or quality related financing mechanisms).

For each of the different psychiatric mobile care service providers that you identified in Table 7.3, look now in further depth and briefly indicate whether financial or non-financial incentives have a significant impact on access to, and utilisation of psychiatric mobile care for mental health problems.

7.3.2.1 Incentives related to performance-related payment schemes

Please briefly describe how any performance-related payment systems may work. This may be based on individual factors or a weighted or non-weighted composite measure of factors such as individual productivity, patient satisfaction, impact on hospital admissions, quality of life measures, etc. Please also state if fines apply in the case of poor performance. Performance-related systems may be associated with the introduction of systems of monitoring and inspection. How is

performance monitored – is this a function of any outside regulatory body or other procedure? Are the results of any performance assessment made public? If so how? Could this influence demand for services by service commissioners and/or patients?

7.3.2.2 Incentives related to complex activity-based payment systems

Please describe where relevant how any DRG or other needs-linked activity-based payment systems deal with psychiatric mobile care services. If not linked to diagnosis, explain how the system works. Please give an indication of whether tariffs are set at national, regional, sickness fund or other level. Indicate if tariffs are linked to a primary diagnosis or some other indicator of need (e.g. linked to symptom profile). Please indicate if tariffs vary depending on co-morbidity.

Please indicate any broad categories of psychiatric diagnosis or psychiatric patient population groups that are excluded from any DRG system. Please indicate how payment is actually made (i.e. a defined amount of money or allocation of "points", whose monetary value will be determined retrospectively).

7.3.2.3 Incentives related to population sub-groups

If subtypes of psychiatric mobile care deal with different groups of patients with mental health problems can they select specific patients? If so how is this done (e.g. by waiting list management)? Are there financial incentives and disincentives in place for the different service subtypes to take on or refuse specific patients? For instance is there any cream-skimming occurring whereby mobile services deal with easier to manage individuals? Do severity of disorder and troublesomeness of patients play a role?

7.3.2.4 Non-financial incentives and disincentives and other incentives and disincentives

Please describe any other important financial and/or non-financial incentives or disincentives that might be in place. For instance are there any public ranking systems etc. – these can be quite powerful, e.g. if a service has poor performance can staff might lose their jobs.

Are there specific non-financial incentives/disincentives that impact on the use of psychiatric mobile care services?

Are there any non-financial incentives for psychiatric mobile care services to carry out cooperative/shared care with other mental health services or other services in the health or the social sector?

Is stigma a barrier for the use of psychiatric mobile care?

Does the availability of the psychiatric mobile care services play a role on service use? Availability in the same village, town, city?

Is there any indication that extrinsic motivations (norms, reputation, feedback and profiling), intrinsic motivations (professional ethics, altruism), regulations (guidelines, audit) shape provider behaviour?

7.4 Consultation/ Liaison Psychiatric Services

7.4.1 Organisation, structure, payment and regulation – consultation/liaison psychiatric Services

Please **complete Table 7.4 which helps provide a brief description on the organisation and role of consultation/liaison psychiatric services in your country**, that is, care delivered by specialist mental health service providers that either provide consultation services to hospitals that does not have any mental health services or alternatively provide consultation services in non-psychiatric departments of a hospital that does have some mental health services. Focus on organisational structures and payment mechanisms that are representative of what is provided in your country – experimental approaches or those which are only intended for small specialist client groups (for instance in some countries this may include military health care services) are not of interest here. While there is no strict cut off point for guidance it is suggested that if a structure or payment mechanisms is likely to account for less than 5% of all structures or all payment mechanisms then consider carefully whether it is worth spending much time on its documentation. A key factor when thinking about such mechanisms will be the issue of innovation – it may be that a mechanism is very new and perhaps only being piloted in a small area of the country, but if this is being done with a view to roll out across the whole of the country then this is a payment mechanism that would be worth documenting. The innovative or experimental nature of a payment mechanism could be described in the supplemental narrative descriptions to the tables that we set out later in this section.

Table 7.4 requests information on the typical configuration of infrastructure and payment mechanisms in your country, in this case on different consultation/ liaison psychiatric services structures.

In addition to completing this table, please **draft a supplementary text providing a brief description** of consultation/liaison psychiatric services and their place within the health care system in the country or region. The text should then go into more detail on some of the responses you have made to Table 7.4. Each of these issues is now considered in turn.

Table 7.4, Part 1 of template to map the structure of consultation/liaison psychiatric services (C/L)

Where appropriate, please insert several codes into one box.

7.4.1.1a Provider type	7.4.1.1b Provider subtype	7.4.1.2 Frequency 0=absent 1=occasional 2=common	7.4.1.3 Volume of care L=large M=medium S=small	7.4.1.4 Legal status/ownership PUB-DI PUB-INDIR PR-PROF PR-NOTPROF
7.4A Consultation service provided by psychiatric services based in the same hospital				
7.4B Consultation service provided in a hospital by psychiatrists who are not based at the same hospital: e.g. working in a community mental health service or another hospital with psychiatric services or based in an independent practice				
7.4C Other, please describe				

NOTES:

7.4.1.1b Provider subtype

If subtypes of 7.4.1.1a providers exist name and describe the most common here (and others in the Elaborating information section using the categories provided in this table).

7.4.1.3 Volume of care

Give a crude estimate of the volume of care (in terms of number of patients, visits, etc.) for each provider type in relation to the total care provided by consultation/liaison psychiatric services

7.4.1.4 Legal status/ownership

PUB-DI = Direct public provision by national/local government or mandatory social health insurance

PUB-INDIR = Public indirect provision by a separate/independent structure e.g. a national health service organisation, public enterprise/company or similar

PR-PROF = For profit private sector

PR-NOTPROF = Not for profit private sector

Elaborating on information provided in Table 7.4 – columns 7.4.1.1 to 7.4.1.4

If subtypes of the 7.4.1.1a provider type exist, please describe them here in addition to the one described in the table by using the categories 7.4.1.2 to 7.4.1.10 for this/these additional subtype(s).

7.4.1.1a and b Consultation/liaison psychiatric services structures

Please provide examples of the typical names in your own language given to each type of consultation/ liaison psychiatric service structure that you have indicated.

7.4.1.2 Frequency of different consultation/liaison psychiatric services

You were already asked for information on the frequency of different models of consultation/ liaison psychiatric services. Please provide any further comment here that you think may be useful, including any comment on gaps in information or difficulties in quantifying the balance between different types of service structure in your country. Ideally provide a percentage breakdown on the balance between different service structures.

7.4.1.3 Volume of care handled by different consultation/ liaison psychiatric service structures

Please provide a commentary for the estimate of volume of care you have provided for each type of psychiatric consultation/liaison care, including any comment on gaps in information or difficulties in quantifying the balance between different types of service in your country.

7.4.1.4 Legal status/ownership

Please provide any clarifications on the legal status of each type of consultation/ liaison psychiatric service structure that you have identified. Please also provide the local language name for this legal status.

Table 7.4, Part 2 of template to map consultation/liaison psychiatric services (C/L)

Where appropriate, please insert several codes into one box.

7.4.1.1a Provider type	7.4.1.1b Provider subtype	7.4.1.5 Who pays? Purchaser-provider split: No/Yes	7.4.1.6a Payment mechanisms	7.4.1.6b Does this specific C/L service provide any of the other types of care?
7.4A Consultation service provided by psychiatric services based in the same hospital				
7.4B Consultation service provided in a hospital by psychiatrists who are not based at the same hospital: e.g. working in a community mental health service or another hospital with psychiatric services or based in an independent practice				
7.3C Other, please describe				

NOTES:

7.4.1.1b Provider subtype

If subtypes of 7.4.1.1a providers exist name and describe the most common here (and others in the Elaborating information sections using the categories provided in this table).

7.4.1.5 Who pays for consultation/liaison psychiatric services? Who is the contractor of the service?

Please state the name(s) and legal status of organisations that pay for psychiatric C/L care either at country or regional level as appropriate. Note: user charges to the provider are covered below in 7.4.1.7

7.4.1.6a Payment mechanisms (specify percentage of total sources of finance or level of importance)

BUD = Budget
FFS = Fee for Service
CAP = Capitation
TAR = Target payments
CAPR = Capitation risk adjusted
DAY = Daily fee for attendance
OTH = Other, please specify
ABF = Activity based funding (e.g. DRG)
FLA = Flat rate per attending patient for a defined time period

7.4.1.6b Other types of care

DAY = psychiatric day care
AMB = psychiatric ambulatory care
MOB = psychiatric mobile care
TEL = telephone, internet and computer-based services
OTHER (for instance also inpatient care might be provided)

Elaborating on information provided in Table 7.4 – columns 7.4.1.5 to 7.4.1.6

7.4.1.5 Who pays for consultation/liaison psychiatric service structures?

In the table you were asked to indicate how common any purchaser-provider split was in providing funds for consultation/liaison psychiatric services. Please elaborate further, on the different sources of payment stating whether these cover the national area, or a different focus, such as a specific sub national area or insurer (note user charges are enquired separately). If there are different payers and they use different payment mechanism this should be described below.

7.4.1.6a and b Payment mechanisms used for one or several types of specialist psychiatric outpatient care

Services providing specialist consultation/liaison psychiatric services (C/L) may also provide other outpatient services, such as psychiatric ambulatory care (AMB), psychiatric day care (DAY), psychiatric mobile care (MOB) or telephone, internet, and computer-based services (TEL). See also sections 7.1, 7.2, 7.3 and 7.5 for the other four types of psychiatric outpatient services. Specify if the specific service provider also provides inpatient care (see section 8).

When commenting on payment mechanism used, please consider that a payment mechanism may relate to several types of specialist psychiatric outpatient care (or even also to inpatient care). If this is the case, please describe the respective mechanism(s) of payment (e.g. ring fenced payment for each of the provided services or global budget for some of them or for all).

You were already asked, not only to identify the different types of mechanism that are used to pay consultation/ liaison psychiatric services but also their relative importance in terms of total revenue for these services.

Please provide any further comment here that you think may be useful, including any comment on gaps in information or difficulties in quantifying the balance between different types of service structure in your country.

Please note in relation to target payments (TAR), that this can cover a number of different mechanisms. In essence payment is made conditional on the achievement of pre-specified goal including quality of outcomes achieved. Different countries will use different names for this type of payment mechanism, for instance pay-for-performance (P4P) or performance related payment (PRP). In commenting on target payments, please describe – after consulting the glossary – what the term covers in your country context in the subsequent comments section.

Please provide information on the principal risk adjustment mechanisms that are used.

Please indicate whether there are any specific eligibility requirements or patient characteristics that may influence the use of different payment mechanisms.

Where relevant it would be helpful to know whether payments are made retrospectively or prospectively, and how often payments are made. If there are substantial differences in the use of payment mechanisms by different consultation/liaison psychiatric service structures can you provide a commentary on why this may be the case?

Can you provide any information about contracts or other regulatory devices that influence the use of payment mechanisms?

For instance are there limits on the amount of activities that are funded by specific payment mechanisms – do these differ by different consultation/liaison psychiatric service organisational structures? Also, is there a minimum amount/frequency of different types of outpatient activities defined, which has to be definitely provided over a certain time period by the service in question (might concern financing mechanism budget/capitation).

For capitation payments please briefly describe how these payments are made and indicate if these are adjusted to reflect differences in population characteristics – e.g. linked to age, gender, socio-economic deprivation. Please indicate if any unspent money can be retained at the end of the financial year.

In the case of global budgets please briefly explain how these are normally set, e.g. based on historical use/activity patterns. Are any adjustments made for population need? Please indicate if any unspent money can be retained at the end of the financial year.

Please describe any flat rate budgets not linked to diagnosis or clinical need that may be used for consultation/ liaison psychiatric services.

For fee for service payments, please indicate if a national/regional standard set of tariffs are set or alternatively if these are determined in specific contracts with service providers.

Please indicate if service users can pay for consultation/liaison psychiatric service through individual budgets that they may have been allocated by the state or health insurance fund.

Please indicate if service users receive cash budgets or vouchers that can be used to purchase care.

Please describe any other significant ways in which consultation/ liaison psychiatric services receive money. This for instance could include charitable donations, faith group support, payments from other government departments, foreign aid or lottery support.

Table 7.4, Part 3 of template to map consultation/liaison psychiatric services (C/L)

Where appropriate, please insert several codes into one box.

7.4.1.1a Provider type	7.4.1.1b Provider subtype	7.4.1.7 User charges	7.4.1.8 User payment reimbursement
7.4A Consultation service provided by psychiatric services based in the same hospital			
7.4B Consultation service provided in a hospital by psychiatrists who are not based at the same hospital: e.g. working in a community mental health service or another hospital with psychiatric services or based in an independent practice			
7.3C Other, please describe			

NOTES:

7.4.1.7 User charges

0 = none
1 = yes, for visits by consultation/liaison psychiatric service (paid at future point in time)
2 = yes, for additional medications prescribed for psychiatric needs

7.4.1.8 User payment reimbursement

1 Reimbursement for visits	1.1 = 100%
	1.2 = less than 100%
	1.3 = no reimbursement
2 Reimbursement for medications	2.1 = 100%
	2.2 = less than 100%
	2.3 = no reimbursement

Elaborating on information provided in Table 7.4 – columns 7.4.1.7 to 7.4.1.8

7.4.1.7 User charges for consultation/ liaison psychiatric service structures

You were asked to specify whether user charges are made. For any consultation/ liaison psychiatric service organisational structure are there any user changes? If so can you provide more information? If there are any charges can you provide examples of the typical charges for the receipt of consultation/liaison psychiatric services and whether there are exemptions or ceilings on these payments? Can you indicate whether there are any additional charges for any additional medications prescribed by consultation/liaison psychiatric services? Please indicate if there are any ceilings on total payments or if specific groups of the population are exempt from co-payments.

7.4.1.8 Reimbursement of user charges

Please elaborate further on the way in which any user charges are reimbursed and whether or not they are fully reimbursed. If less than 100% are reimbursed can you indicate the exact proportion? Are there different levels of reimbursement for different types of consultation/ liaison psychiatric services? Are any user charges for mental health services delivered by consultation/liaison psychiatric services treated in a different way to user charges for additional consultation/ liaison services for physical health needs by physical health specialists?

Table 7.4, Part 4 of template to map consultation/liaison psychiatric services (C/L)

Where appropriate, please insert several codes into one box.

7.4.1.1a Provider type	7.4.1.1b Provider subtype	7.4.1.9 Restrictions/ incentives on number of services	7.4.1.10 Types of care provided
7.4A Consultation service provided by psychiatric services based in the same hospital			
7.4B Consultation service provided in a hospital by psychiatrists who are not based at the same hospital: e.g. working in a community mental health service or another hospital with psychiatric services or based in an independent practice			
7.3C Other, please describe			

NOTES:

7.4.1.9 Restrictions/incentives on number of specialist consultation/liaison psychiatric services in a geographical area

0 = none
1 = restrictions only
2 = incentives only
3 = restrictions and incentives

7.4.1.10 Types of care provided

1 = Acute psychiatric care need
2 = Chronic care
3 = Palliative care support
4 = Accident & emergency department
5 = Other

Elaborating on information provided in Table 7.4 – columns 7.4.1.9 to 7.4.1.11

7.4.1.9 Restrictions/incentives on number of consultation/ liaison psychiatric services in a geographical area

Are any restrictions due to regulations stipulating the maximum number of consultation/liaison psychiatric services that can be provided or specifications set out in some national or local plan or needs assessment? What incentives are provided to encourage the provision of consultation/liaison psychiatric services in some areas of a country e.g. in socially deprived communities which might have a high rate of people with mental health problems/substance use disorders or in rural areas?

Please indicate if there is a specified list of consultation/liaison psychiatric service providers that service users can choose from if they are to receive publicly funded consultation/liaison psychiatric services.

7.4.1.10 Types of care provided by consultation/liaison psychiatric services

Please describe further the typical types of care provided by consultation/liaison psychiatric service structures, for instance consultation for acute psychiatric care needs, consultation for chronic psychiatric needs in patients admitted for physical health problems, psychiatric consultation required following presentation at accident and emergency department of a hospital, psychiatric consultation for a patient living with a life changing injury or terminal condition.

7.4.1.11 Other comments

Please provide any additional comments you might wish to make. In particular we are interested in relevant information that you feel is not adequately captured by our template.

7.4.2 Financial and non-financial incentives and disincentives concerning consultation/liaison psychiatric services for people with mental health needs

Please collate detailed information on the existence of financial and non-financial incentives and disincentives concerning consultation/liaison psychiatric services. Please consider that financial incentives and disincentives may be of a general nature (e.g. it is generally assumed that fee-for-service incentivises a higher number of services to be provided whereas capitation is assumed to be a disincentive for this), or of a specific nature relating to mental health care (e.g. specific fee-for-service tariffs for mental health care, specific target payments for achieving specific mental health goals, and similar results-based/performance or quality related financing mechanisms).

For each of the different psychiatric mobile care service providers that you identified in Table 7.4, look now in further depth and briefly indicate whether financial or non-financial incentives have a significant impact on access to, and utilisation of consultation/liaison psychiatric services for mental health problems.

7.4.2.1 Incentives related to performance related payment schemes

Please briefly describe how any performance related payment systems may work. This may be based on individual factors or a weighted or non-weighted composite measure of factors such as individual productivity, patient satisfaction, impact on hospital admissions, quality of life measures, etc. Please also state if fines apply in the case of poor performance. Performance related systems may be associated with the introduction of systems of monitoring and inspection. How is performance monitored – is this a function of any outside regulatory body or other procedure? Are the results of any performance assessment made public? If so how? Could this influence demand for services by service commissioners and/or patients?

7.4.2.2 Incentives related to complex activity based payment systems

Please describe where relevant how any DRG or other needs-linked activity based payment systems deals with consultation/liaison psychiatric services. If not linked to diagnosis, please explain how the system works. Please give an indication of whether tariffs are set at national, regional, sickness fund or other level. Please indicate if tariffs are linked to a primary diagnosis or some other indicator of need (e.g. linked to symptom profile). Please indicate if tariffs vary depending on co-morbidity.

Please indicate any broad categories of psychiatric diagnosis or psychiatric patient population groups that are excluded from any DRG system. Please indicate how payment is actually made (i.e. a defined amount of money or allocation of "points", whose monetary value will be determined retrospectively).

7.4.2.3 Incentives related to population sub-groups

If subtypes of consultation/liaison psychiatric services deal with different groups of patients with mental health problems can they select specific patients? If so how is this done (e.g. by waiting list management)? Are there financial incentives and disincentives in place for the different service subtypes to take on or refuse specific patients? For instance is there any cream-skimming occurring whereby mobile services deal with easier to manage individuals? Do severity of disorder and troublesomeness of patients play a role?

7.4.2.4 Non-financial incentives and disincentives and other incentives and disincentives

Please describe any other important financial and/or non-financial incentives or disincentives that might be in place. For instance are there any public ranking systems etc. – these can be quite powerful, e.g. if a service has poor performance can staff might lose their jobs.

Are there specific non-financial incentives/disincentives that impact on the use of consultation/liaison psychiatric services?

Are there any non-financial incentives for consultation/liaison psychiatric services to carry out cooperative/shared care with other mental health services or other services in the health or the social sector?

Is stigma a barrier for the use of consultation/liaison psychiatric services?

Does the availability of the consultation/liaison psychiatric services play a role on service use? Availability in the same village, town, city?

Is there any indication that extrinsic motivations (norms, reputation, feedback and profiling), intrinsic motivations (professional ethics, altruism), regulations (guidelines, audit) shape provider behaviour?

7.5 Telephone, Internet and Computer-based Mental Health Care Services

7.5.1 Organisation, structure, payment and regulation – telephone, internet and computer-based mental health care services

Please **complete Table 7.5 which helps provide a brief description on the organisation and role of telephone, internet and computer-based specialist mental health services in your country.** Focus on organisational structures and payment mechanisms that are representative of what is provided in your country – experimental approaches or those which are only intended for small specialist client groups (for instance in some countries this may include military health care services) are not of interest here. While there is no strict cut off point for guidance it is suggested that if a structure or payment mechanisms is likely to account for less than 5% of all structures or all payment mechanisms then consider carefully whether it is worth spending much time on its documentation. A key factor when thinking about such mechanisms will be the issue of innovation – it may be that a mechanism is very new and perhaps only being piloted in a small area of the country, but if this is being done with a view to roll out across the whole of the country then this is a payment mechanism that would be worth documenting. The innovative or experimental nature of a payment mechanism could be described in the supplemental narrative descriptions to the Table that is set out later in this section.

Table 7.5 requests information on the typical configuration of infrastructure and payment mechanisms in your country, in this case on different internet and phone based services.

In addition to completing this table, please **draft a supplementary text providing a brief description** of the psychiatric telephone, internet and computer-based specialist mental health care system and its place within the health care system in the country or region. The text should then go into more detail on some of the responses you have made to Table 7.5. Each of these issues is now considered in turn.

Table 7.5, Part 1 of template to map the structure of telephone, internet and computer-based care structures (TEL)

Where appropriate, please insert several codes into one box.

7.5.1.1a Provider type	7.5.1.1b Provider subtype	7.5.1.2 Frequency 0=absent 1=occasional 2=common	7.5.1.3 Volume of care L=large M=medium S=small	7.5.1.4 Legal status/ownership PUB-DI PUB-INDIR PR-PROF PR-NOTPROF
7.5A Organisationally part of a specialist psychiatric unit				
7.5B Organisationally part of a community mental health team				
7.5C Organisationally a stand alone specialist service				
7.5D Organisationally part of local/regional/national government services				
7.5E Other, please describe				

NOTES:

7.5.1.1b Provider subtype

If subtypes of 7.5.1.1a providers exist name and describe the most common here (and others in the Elaborating information section using the categories provided in this table).

7.5.1.3 Volume of care

Give a crude estimate of the volume of care (in terms of number of patients, visits, etc.) for each provider type in relation to the total care provided by telephone, internet and computer-based services.

7.5.1.4 Legal status/ownership

PUB-DI = Direct public provision by national/local government or mandatory social health insurance

PUB-INDIR = Public indirect provision by a separate/independent structure e.g. a national health service organisation, public enterprise/company or similar

PR-PROF = For profit private sector

PR-NOTPROF = Not for profit private sector

Elaborating on information provided in Table 7.5 – columns 7.5.1.1 to 7.5.1.4

If subtypes of the 7.5.1.1a provider type exist, please describe here the subtype(s) existing in addition to the one described in the table by using the categories 7.5.1.2 to 7.5.1.11 for this/these additional subtype(s).

7.5.1.1a and b Telephone, internet and computer-based care structures

Please provide examples of the typical names in your own language given to each type of telephone, internet and computer-based specialist mental health care structure that you have indicated. These services for instance, might involve remote synchronous or asynchronous counselling or psychological therapies, or access to bibliotherapy.

7.5.1.2 Frequency of different telephone, internet and computer-based care structures

You were already asked for information on the frequency of different models of telephone, internet and computer-based care. Please provide any further comment here that you think may be useful, including any comment on gaps in information or difficulties in quantifying the balance between different types of service structure in your country. Ideally provide a percentage breakdown on the balance between different service structures.

7.5.1.3 Volume of care handled by different telephone, internet and computer-based care structures

Please provide a commentary for the estimate of volume of care you have provided for each type of telephone, internet and computer-based care, including any comment on gaps in information or difficulties in quantifying the balance between different types of service in your country. Given the nature of these services, provide also the number of contacts with these types of services as well as the numbers of services.

7.5.1.4 Legal status/ownership

Please provide any clarifications on the legal status of each type of telephone, internet and computer-based care structures that you have identified. Please also provide the local language name for this legal status.

Table 7.5, Part 2 of template to map telephone, internet and computer-based services (TEL)

Where appropriate, please insert several codes into one box.

7.5.1.1a Provider type	7.5.1.1b Provider subtype	7.5.1.5 Who pays? Purchaser-provider split: No/Yes	7.5.1.6a Payment mechanisms	7.5.1.6b Does this specific TEL service provide any of the other types of care?
7.5A Organisationally part of a specialist psychiatric unit				
7.5B Organisationally part of a community mental health team				
7.5C Organisationally a stand alone specialist service				
7.5D Organisationally part of local/regional/national government services				
7.5E Other, please describe				

NOTES:

7.5.1.1b Provider subtype

If subtypes of 7.5.1.1a providers exist name and describe the most common here (and others in the Elaborating information sections using the categories provided in this table).

7.5.1.5 Who pays for TEL services? Who is the contractor of the service?

Please state the name(s) and legal status of organisations that pay for telephone, internet and computer-based services either at country or regional level as appropriate. Note: user charges to the provider are covered below in 7.5.1.7

7.5.1.6a Payment mechanisms (specify percentage of total sources of finance or level of importance)

BUD = Budget
CAP = Capitation
CAPR = Capitation risk adjusted
OTH = Other, please specify
FFS = Fee for Service
TAR = Target payments
ABF = Activity based funding (e.g. DRG)
FLA = Flat rate per attending patient for a defined time period

7.5.1.6b Other types of care

DAY = psychiatric day care
AMB = psychiatric ambulatory care
MOB = psychiatric mobile care
C/L=consultation/liaison psychiatric care
OTHER (for instance also inpatient care might be provided)

Elaborating on information provided in Table 7.5 – columns 7.5.1.5 to 7.5.1.6

7.5.1.5 Who pays for telephone, internet and computer-based service structures?

In the table you were asked to indicate how common any purchaser-provider split was in providing funds for telephone, internet and computer-based services. Please elaborate further, on the different sources of payment stating whether these cover national area, or a different focus, such as a specific sub national area or insurer (note user charges are enquired separately). If there are different payers and they use different payment mechanism this should be described below.

7.5.1.6a and b Payment mechanisms used for one or several types of specialist psychiatric outpatient care

Services providing specialist telephone, internet, and computer-based services (TEL) may also provide other outpatient services, such as psychiatric ambulatory care (AMB), psychiatric day care (DAY), psychiatric mobile care (MOB) or consultation/liaison psychiatric services (C/L). See also sections 7.1, 7.2, 7.3 and 7.4 for the other four types of psychiatric outpatient services. Also, specify if the specific service provider also provides inpatient care (see section 8).

When commenting on payment mechanism used, please consider that a payment mechanism may relate to several types of specialist psychiatric outpatient care (or even also to inpatient care). If this is the case, please describe the respective mechanism(s) of payment (e.g. ring fenced payment for each of the provided services or global budget for some of them or for all).

You were already asked, not only to identify the different types of mechanism that are used to pay for telephone, internet and computer-based services but also their relative importance in terms of total revenue for these services.

Please indicate whether there are any specific eligibility requirements or service user characteristics that may influence the use of different payment mechanisms.

Please note in relation to target payments (TAR), that this can cover a number of different mechanisms. In essence payment is made conditional on the achievement of pre-specified goal including quality of outcomes achieved. Different countries will use different names for this type of payment mechanism, for instance pay-for-performance (P4P) or performance related payment (PRP). In commenting on target payments, please describe – after consulting the glossary – what the term covers in your country context in the subsequent comments section.

Where relevant it would be helpful to know whether payments are made retrospectively or prospectively, and how often payments are made. If there are substantial differences in the use of payment mechanisms by different telephone, internet and computer-based care structures can you provide a commentary on why this may be the case?

Can you provide any information about contracts or other regulatory devices that influence the use of payment mechanisms?

For instance are there limits on the amount of activities that are funded by specific payment mechanisms – do these differ by different psychiatric telephone, internet and computer-based care organisational structures? Also, is there a minimum amount/frequency of different types of outpatient activities defined, which has to be definitely provided over a certain time period by the service in question (might concern financing mechanism budget/capitation).

For capitation payments please briefly describe how these payments are made and indicate if these are adjusted to reflect differences in population characteristics – e.g. linked to age, gender, socio-economic deprivation. Please indicate if any unspent money can be retained by the service provider at the end of the financial year.

Please describe any flat rate budgets not linked to diagnosis or clinical need that may be used for telephone, internet and computer-based services.

For fee for service payments, please indicate if a national/regional standard set of tariffs are set or alternatively if these are determined in specific contracts between purchasers and service providers.

Please indicate if service users can pay for telephone, internet and computer-based care through individual budgets that they may have been allocated by the state or health insurance fund.

Please indicate if service users receive cash budgets or vouchers that can be used to purchase care for telephone, internet and computer-based services.

Please describe any other significant ways in which telephone, internet and computer-based care services receive money. This for instance could include charitable donations, faith group support, payments from other government departments, foreign aid or lottery support.

Table 7.5, Part 3 of template to map telephone, internet and computer-based services (TEL)

Where appropriate, please insert several codes into one box.

7.5.1.1a Provider type	7.5.1.1b Provider subtype	7.5.1.7 User charges	7.5.1.8 User payment reimbursement
7.5A Organisationally part of a specialist psychiatric unit			
7.5B Organisationally part of a community mental health team			
7.5C Organisationally a stand alone specialist service			
7.5D Organisationally part of local/ regional/national government services			
7.5E Other, please describe			

NOTES:

7.5.1.7 User charges

0 = none
1 = yes, on use of internet, phone and computer-based services (including costs of premium rate calls)
2 = yes, on use of internet, phone and computer-based services (paid at future point in time)
3 = yes for any hardware, software or self-help materials paid at point of use
4 = yes for any hardware, software or self-help materials paid at future point in time
5 = yes for any internet access or telephone calls paid at point of use
6 = yes for any internet access or telephone calls paid at future point in time

7.5.1.8 User payment reimbursement

1 Reimbursement for visits	1.1 = 100% 1.2 = less than 100% 1.3 = no reimbursement
2 Reimbursement for medications	2.1 = 100% 2.2 = less than 100% 2.3 = no reimbursement
3 Reimbursement for internet access or telephone calls	3.1 = 100% 3.2 = less than 100% 3.3 = no reimbursement

Elaborating on information provided in Table 7.5 – columns 7.5.1.7 to 7.5.1.8

7.5.1.7 User charges for telephone, internet and computer-based service structures

You were asked to specify whether user charges are made, and whether these are at point of service use or retrospective. For each different type of telephone, internet and computer-based service structure that you have identified where users must make a contribution to the costs of care, can you provide more information? Can you provide examples of the typical charges for each session or course of treatment and whether there are exemptions or ceilings on these payments? Can you indicate whether there are any charges for any hardware, software or self-help materials provided by these services? Are there charges for phone calls or use of the internet? Can you cite any information locally on how user charges have influenced use of these services? Please indicate if there are any ceilings on total payments or if specific groups of the population are exempt from co-payments.

7.5.1.8 Reimbursement of user charges

Please elaborate further on the way in which user charges are reimbursed and whether or not they are fully reimbursed. If less than 100% are reimbursed can you indicate the exact proportion? Are there different levels of reimbursement for different types of telephone, internet and computer-based services?

Table 7.5, Part 4 of template to map telephone, internet and computer-based services (TEL)

Where appropriate, please insert several codes into one box.

7.5.1.1a Provider type	7.5.1.1b Provider subtype	7.5.1.9 Restrictions/ incentives on number of services	7.5.1.10 No of service users per service	7.5.1.11 Types of care provided
7.5A Organisationally part of a specialist psychiatric unit				
7.5B Organisationally part of a community mental health team				
7.5C Organisationally a stand alone specialist service				
7.5D Organisationally part of local/regional/national government services				
7.5E Other, please describe				

NOTES:

7.5.1.9 Restrictions/incentives on number of phone, internet and computer-based services
0 = none
1 = restrictions only
2 = incentives only
3 = restrictions and incentives

7.5.1.10 Number of service users per service

Insert Min to Max number of service users for different telephone, internet and computer-based services for a specified time period and specific geographical location

7.5.1.11 Types of care provided
1 = Diagnosis
2 = Prevention
3 = Psychological interventions
4 = Online consultations
5 = Crisis intervention
6 = Other

Elaborating on information provided in Table 7.5 – columns 7.5.1.9 to 7.5.1.11

7.5.1.9 Restrictions/incentives on number. of specialist telephone, internet and computer-based services

Are any restrictions due to regulations stipulating the maximum number of telephone, internet and computer-based services that can be provided or specifications set out in some national or local plan or needs assessment? One restriction may for instance be the proportion of services that are provided in real time with mental health professionals over the internet or phone.

If services are not provided at a national level only what incentives are provided to encourage the provision of these services in some areas of a country e.g. in socially deprived communities which might have a high rate of people with mental health problems/substance use disorders or in rural areas? Please indicate if there is a specified list of telephone, internet and computer-based providers that service users can choose from if they are to receive publicly funded services.

7.5.1.10 Number of service users accessing telephone, internet and computer-based services

Please provide some information on the minimum and maximum number of service users that access telephone, internet and computer-based services, specifying the time period for this service use. It would also be helpful to get a sense of how many sessions/ contacts service users have with these services.

7.5.1.11 Types of service provided by telephone, internet and computer-based services

Please describe further the typical types of service provided by telephone, internet and computer-based services, for instance diagnosis of mental health problems, provision of psychological and psychosocial therapies, access to self-help materials, online consultations or other purposes.

7.5.1.12 Other comments

Please provide any additional comments you might wish to make. In particular provide relevant information that you feel is not adequately captured by our template.

7.5.2 Financial and non-financial incentives and disincentives concerning telephone, internet and computer-based services for people with mental health needs

Please collate detailed information on the existence of financial and non-financial incentives and disincentives concerning telephone, internet and computer-based services. Please consider that financial incentives and disincentives may be of a general nature (e.g. it is generally assumed that fee-for-service incentivises a higher number of services to be provided whereas capitation is assumed to be a disincentive for this), or of a specific nature relating to mental health care (e.g. specific fee-for-service tariffs for mental health care, specific

target payments for achieving specific mental health goals, and similar results-based/performance or quality related financing mechanisms).

For each of the different telephone, internet and computer-based services providers that you identified in Table 7.5, look now in further depth and briefly indicate whether financial or non-financial incentives have a significant impact on access to, and utilisation of telephone, internet and computer-based services e for mental health problems.

7.5.2.1 Incentives related to performance related payment schemes

Please briefly describe how any performance related payment systems may work. This may be based on individual factors or a weighted or non-weighted composite measure of factors such as individual productivity, patient satisfaction, impact on hospital admissions, quality of life measures, etc. Please also state if fines apply in the case of poor performance. Performance related systems may be associated with the introduction of systems of monitoring and inspection. How is performance monitored – is this a function of any outside regulatory body or other procedure? Are the results of any performance assessment made public? If so how? Could this influence demand for services by service commissioners and/or patients?

7.5.2.2 Incentives related to complex activity based payment systems

Please describe where relevant how any DRG or other needs-linked activity based payment systems deals with telephone, internet and computer-based services. If not linked to diagnosis, please explain how the system works. Please give an indication of whether tariffs are set at national, regional, sickness fund or other level. Please indicate if tariffs are linked to a primary diagnosis or some other indicator of need (e.g. linked to symptom profile). Please indicate if tariffs vary depending on co-morbidity.

Please indicate any broad categories of psychiatric diagnosis or psychiatric patient population groups that are excluded from any DRG system. Please indicate how payment is actually made (i.e. a defined amount of money or allocation of "points", whose monetary value will be determined retrospectively).

7.5.2.3 Incentives related to population sub-groups

If subtypes of telephone, internet and computer-based services deal with different groups of patients with mental health problems can they select specific patients? If so how is this done (e.g. by waiting list management)? Are there financial incentives and disincentives in place for the different service subtypes to take on or refuse specific patients? For instance is there any cream-skimming occurring whereby telephone, internet and computer-based services deal with easier to manage individuals? Do severity of disorder and troublesomeness of patients play a role?

7.5.2.4 Non-financial incentives and disincentives and other incentives and disincentives

Please describe any other important financial and/or non-financial incentives or disincentives that might be in place. For instance are there any public ranking systems etc. – these can be quite powerful, e.g. if a service has poor performance can staff might lose their jobs.

Are there specific non-financial incentives/disincentives that impact on the use of telephone, internet and computer-based services?

Are there any non-financial incentives for telephone, internet and computer-based services to carry out cooperative/shared care with other mental health services or other services in the health or the social sector?

Is stigma a barrier for the use of telephone, internet and computer-based services?

Does the availability of the telephone, internet and computer-based services play a role on service use? Availability in the same village, town, city?

Is there any indication that extrinsic motivations (norms, reputation, feedback and profiling), intrinsic motivations (professional ethics, altruism), regulations (guidelines, audit) shape provider behaviour?

Section 8: Inpatient Mental Health Care

PRELIMINARY REMARK: Section 8 is called "Inpatient Mental Health Care" rather than "Inpatient Specialist Mental Health Services" or "Inpatient Specialist Psychiatric Services". This distinction is relevant, because it is well documented for many countries that people with mental health problems are not only admitted to specialist psychiatric inpatient facilities but also to non-psychiatric inpatient units in general hospitals. The reasons for this are not entirely clear; co-morbidity between physical and mental disorders certainly plays a role, easier geographical accessibility is another factor. Since the financing mechanisms for individuals staying in non-psychiatric inpatient units might be different from those in specialist mental health inpatient units Section 8 also covers financing mechanisms as well as incentives and disincentives for admitting individuals with mental health problems to non-psychiatric beds in general hospitals.

Inpatient care services for people with mental health needs involve overnight stays. This includes inpatient care in psychiatric beds in psychiatric and general hospitals, as well as care provided in long-term nursing care homes, whose primary function is the medical management of residents. In the case of nursing homes, services may be provided to individuals in nursing homes whose primary purpose is to support people with organic mental health problems such as dementia. The size of these inpatient facilities is not defined – in theory an inpatient facility might only cater for one individual if it provides residential care which is paid for mainly by the public purse rather than individuals. Not only services publicly funded by health budgets or social health insurance, but also services funded from other budgets such as local or national government social welfare

8.1 Specialist Inpatient Psychiatric Care (SIC)

budgets, even if the services are owned privately are of interest. In many countries some of these services may be provided and funded from outside the health sector. This includes the funding of long stay care services that are not the responsibility of the health care system. They may be subject to very different rules on entitlement and out of pocket costs compared to long term care services provided within the health care system.

8.1.1 Organisation, structure, payment and regulation - Specialist Inpatient Psychiatric Care

Please complete Table 8.1 which helps provide a brief description on the organisation and role of psychiatric inpatient care in your country. Focus on organisational structures and payment mechanisms that are representative of what is provided in your country – experimental approaches or those which are only intended for small specialist client groups (for instance in some countries this may include military health care services) are not of interest here. While there is no strict cut off point for guidance it is suggested that if a structure or payment mechanisms is likely to account for less than 5% of all structures or all payment mechanisms then consider carefully whether it is worth spending much time on its documentation. A key factor when thinking about such mechanisms will be the issue of innovation – it may be that a mechanism is very new and perhaps only being piloted in a small area of the country, but if this is being done with a view to roll out across the whole of the country then this is a payment mechanism that would be worth documenting. The innovative or experimental nature of a payment mechanism could be described in the supplemental narrative descriptions to the Table that is set out later in this section.

Table 8.1 requests information on the typical configuration of infrastructure and payment mechanisms in your country, in this case on different inpatient and long stay care structures. For instance this will help give a sense of whether most of this care is provided in stand-alone psychiatric facilities, within general hospitals or in facilities outside of the health care system.

In addition to completing this table, **please draft a supplementary text providing a brief description** of the inpatient psychiatric care system and its place in the health care system in your country or region. The text should go into more detail on some of the responses you have made to Table 8.1. Each of these issues is now considered in turn.

A key factor when thinking about such mechanisms will be the issue of innovation – it may be that a mechanism is very new and perhaps only being piloted in a small area of the country, but if this is being done with a view to roll out across the whole of the country then this is a payment mechanism that would be worth documenting. The innovative or experimental nature of a payment mechanism could be described in the supplemental narrative descriptions to the Table that is set out later in this section.

Table 8.1, Part 1 of template to map the structure of specialist inpatient psychiatric care services (SIC)

Where appropriate, please insert several codes into one box.

not in word doc, but in other similar tables

8.1.1.1a Provider type	8.1.1.1b Provider subtype	8.1.1.2 Frequency 0=absent 1=occasional 2=common	8.1.1.3 Volume of care L=large M=medium S=small	8.1.1.4 Legal status/ownership PUB-DI PUB-INDIR PR-PROF PR-NOTPROF
8.1A Stand-alone psychiatric facility – acute care				
8.1B Stand-alone psychiatric facility – long-term care				
8.1C Stand-alone psychiatric facility – long-term and acute care				
8.1D Part of a psychiatric centre / community mental health centre				
8.1E Psychiatric departments in general hospitals (non-university)				
8.1F Psychiatric departments in general hospitals (university)				
8.1G Psychiatric beds in long stay residential care homes (non-organic conditions)				
8.1H Psychiatric beds in long stay residential care homes (organic conditions)				
8.1I Other, please describe				

NOTES:

8.1.1.1b Provider subtype

If subtypes of 8.1.1.1a providers exist name and describe the most common here (and others in the Elaborating information section using the categories provided in this table).

8.1.1.3 Volume of care

Give a crude estimate of the volume of care (in terms of number of patients, visits, etc.) for each provider type in relation to the total care provided by specialist psychiatric inpatient care services.

8.1.1.4 Legal status/ownership

PUB-DI = Direct public provision by national/local government or mandatory social health insurance

PUB-INDIR = Public indirect provision by a separate/independent structure e.g. a national health service organisation, public enterprise/company or similar

PR-PROF = For profit private sector

PR-NOTPROF = Not for profit private sector

Elaborating on information provided in Table 8.1 – 8.1.1.1 to 8.1.1.4

If subtypes of the 8.1.1.1a provider type exist, please describe here the subtype(s) existing in addition to the one described in the table by using the categories 8.1.1.2 to 8.1.1.10 for this/these additional subtype(s).

8.1.1.1a and b Inpatient psychiatric care structures

Please provide examples of the typical names in your own language given to each type of inpatient psychiatric care structure that you have indicated. It may be helpful to indicate if these are commonly considered to be 'hospitals' or are given other names e.g. mental health units. What are the names commonly used for long stay facilities not in the health system?

8.1.1.2 Frequency of different psychiatric inpatient care structures

You were already asked for information on the frequency of different models of psychiatric inpatient care. Please provide any further comment here that you think may be useful, including any comment on gaps in information or difficulties in quantifying the balance between different types of service structure in your country. Ideally provide a percentage breakdown on the balance between different service structures.

8.1.1.3 Volume of care handled by different psychiatric inpatient care structures

Please provide a commentary for the estimate of volume of care you have provided for each type of psychiatric inpatient care, including any comment on gaps in information or difficulties in quantifying the balance between different types of service in your country.

8.1.1.4 Legal status/ownership

Please provide any clarifications on the legal status of each type of psychiatric inpatient care structure that you have identified. Please also provide the local language name for this legal status. Please indicate if any inpatient services are owned by governmental bodies outside the health sector, e.g. by social welfare services (if provided separately).

Table 8.1, Part 2 of template to map psychiatric inpatient care services (SIC)

Where appropriate, please insert several codes into one box.

8.1.1.1a Provider type	8.1.1.1b Provider subtype	8.1.1.5 Who pays? Purchaser-provider split: No/Yes	8.1.1.6a Payment mechanisms	8.1.1.6b Does this specific SIC service provide any of the other types of care?
8.1A Stand-alone psychiatric facility – acute care				
8.1B Stand-alone psychiatric facility – long-term care				
8.1C Stand-alone psychiatric facility – long-term and acute care				
8.1D Part of a psychiatric centre / community mental health centre				
8.1E Psychiatric departments in general hospitals (non-university)				
8.1F Psychiatric departments in general hospitals (university)				
8.1G Psychiatric beds in long stay residential care homes (non-organic conditions)				
8.1H Psychiatric beds in long stay residential care homes (organic conditions)				
8.1I Other, please describe				

NOTES:

8.1.1.1b Provider subtype

If subtypes of 8.1.1.1a providers exist name and describe the most common here (and others in the Elaborating information sections using the categories provided in this table).

8.1.1.5 Who pays for SIC services? Who is the contractor of the service?

Please state the name(s) and legal status of organisations that pay for psychiatric inpatient care either at country or regional level as appropriate. Note: user charges to the provider are covered below in 8.1.1.7

8.1.1.6a Payment mechanisms (specify percentage of total sources of finance or level of importance)

BUD = Budget
CAP = Capitation
CAPR = Capitation risk adjusted
OTH = Other, please specify
FFS = Fee for Service
TAR = Target payments
ABF = Activity based funding (e.g. DRG)
FLA = Flat rate per attending patient for a defined time period

8.1.1.6b Other types of care

DAY = psychiatric day care
MOB = psychiatric mobile care
OTH = Other, please specify
AMB = psychiatric ambulatory care
C/L = consultation/liaison psychiatric care
TEL= telephone, internet and computer-based services

Elaborating on information provided in Table 8.8 – 8.1.1.5 to 8.1.1.6

8.1.1.5 Who pays for psychiatric inpatient care structures?

In the table you were asked to indicate how common any purchaser-provider split was in providing funds for psychiatric inpatient care. Please elaborate further, on the different sources of payment stating whether these cover the national area, or a different focus, such as a specific sub national area or insurer (note user charges are enquired separately – do not discuss here). If there are different payers and they use different payment mechanism this should be described below.

8.1.1.6a Payment mechanisms used to pay providers

You were already asked, not only to identify the different types of mechanism that are used to pay for psychiatric inpatient care but also their relative importance in terms of total revenue for these services.

Please provide any further comments here that you think may be useful, including any comment on gaps in information or difficulties in quantifying the balance between different types of psychiatric inpatient care structure in your country.

Please note in relation to target payments (TAR):

Sometimes the terms pay-for-performance (P4P), payment by results (PbR) or performance related payment (PRP) are used in a similar way as target payments (TAR). In case this might be relevant in commenting on target payments, please describe - after consulting the glossary - the meaning of these terms in your comments below.

Please provide information on the principal risk adjustment mechanisms that are used.

Please indicate whether there are any specific eligibility requirements or service user characteristics that may influence the use of different payment mechanisms.

Where relevant it would be helpful to know whether payments are made retrospectively or prospectively, and how often payments are made. If there are substantial differences in the use of payment mechanisms by different psychiatric inpatient care structures can you provide a commentary on why this may be the case?

Can you provide any information about contracts or other regulatory devices that influence the use of payment mechanisms? For instance are there limits on the amount of activities that are funded by specific payment mechanisms – do these differ by different psychiatric inpatient care structures?

For capitation payments made directly to service providers please briefly describe how these payments are made and indicate if these are adjusted to reflect differences in population characteristics – e.g. linked to age, gender, socio-economic deprivation. Please indicate if any unspent money can be retained by the service provider at the end of the financial year.

In the case of global budgets please briefly explain how these are normally set, e.g. based on historical allocations of resources, based on maintaining specific rates of bed occupancy, adjustments for population need, case-mix adjustments to take account of differences in population and past activity in terms of severity of cases treated etc. Please indicate if any unspent money can be retained at the end of the financial year.

Please describe any flat rate payments not linked to diagnosis or clinical need that may be used for psychiatric inpatient care

Please indicate if service users can pay for inpatient care services through individual budgets (cash or vouchers) that they may have been allocated by the state or health insurance fund. Please indicate if there is a specified list of inpatient service providers that service users can choose from.

Please discuss issues around performance related payment and DRG tariff systems in more detail in section 8.2.

Please describe any other significant ways in which psychiatric inpatient care services receive money. This for instance could include charitable donations, faith group support, payments from other government departments, foreign aid or lottery support. Please indicate, for instance, if any significant revenues might also be received from different central and/or local government departments, e.g. ministry of justice for some forensic patients; local authority budgets for social care.

Please indicate if there are any significant additional 'under the table' or informal payments made to hospitals for inpatient care.

Please also indicate if inpatient service providers are entitled to subsidise their operations, through raising revenue from private sector patients or engaging in other revenue raising activities e.g. charging for car parking, renting premises etc.

8.1.1.6b Provision of other type of specialist psychiatric outpatient care

It might be possible that in addition to inpatient care the provider also offers specialist outpatient services. In this case please specify if the service provides psychiatric ambulatory care (AMB), psychiatric day care (DAY), psychiatric mobile care (MOB), consultation/liaison psychiatric services (C/L) and/or telephone, internet, and computer based services (TEL). If this is the case please describe the mechanism of payment, e.g. ring fenced for each of the provided specialist outpatient services or global budget for some of them or for all. See also sections 7.1, 7.2, 7.3, 7.4 and 7.5 for the different types of psychiatric outpatient services.

Table 8.1, Part 3 of template to map psychiatric inpatient care services (SIC)

Where appropriate, please insert several codes into one box.

8..1.1.1a Provider type	8.1.1.1b Provider subtype	8.1.1.7 User charges	8.1.1.8 User payment reimbursement
8.1A Stand-alone psychiatric facility – acute care			
8.1B Stand-alone psychiatric facility – long-term care			
8.1C Stand-alone psychiatric facility – long-term and acute care			
8.1D Part of a psychiatric centre / community mental health centre			
8.1E Psychiatric departments in general hospitals (non-university)			
8.1F Psychiatric departments in general hospitals (university)			
8.1G Psychiatric beds in long stay residential care homes (non-organic conditions)			
8.1H Psychiatric beds in long stay residential care homes (organic conditions)			
8.1I Other, please describe			

NOTES:

8.1.1.7 User charges
0 = none
1 = yes, for stays in inpatient care services
2 = yes, for meals in inpatient care services
3 = yes for medications received

8.1.1.8 User payment reimbursement

1 Reimbursement for each stay	1.1 = 100% 1.2 = less than 100% 1.3 = no reimbursement
2 Reimbursement for meals	2.1 = 100% 2.2 = less than 100% 2.3 = no reimbursement
3 Reimbursement for medication	3.1 = 100% 3.2 = less than 100% 3.3 = no reimbursement

Elaborating on information provided in Table 8.1 – 8.1.1.7 to 8.1.1.8

8.1.1.7 User charges for psychiatric inpatient care structures

Please describe any user charges for inpatient hospital and other long term care facilities. These for instance may be fixed fees per stay or daily fees. Do they, vary by type of ward or diagnosis? Please indicate if there are any ceilings on total payments or if specific groups of the population are exempt from co-payments.

You were asked to specify whether user charges are made, and whether these are at the point of service use or retrospective. For each different type of specialist psychiatric inpatient care organisational structure where users must make a contribution to the costs of care, can you provide more information? Can you provide examples of the typical charges for stays in psychiatric inpatient care services and whether there are exemptions or ceilings on these payments? For instance are there daily charges for each day of a stay or a fixed charge per stay in the facility? Can you do the same for examples of other services for which service users must make a contribution e.g. meals or medications when receiving psychiatric inpatient care? Please indicate if payments are prospective or retrospective.

Please indicate if service users may be able to cover these co-payments through additional insurance. If service users receive a public pension or disability benefits it may be the case that most if not all of this pension goes towards the costs of care; please indicate if this is the case.

Can you cite any information locally on how user charges have influenced use of psychiatric inpatient care? Are family members liable to pay any charges if the service user cannot pay?

Please indicate if user charges apply to stays in long stay care facilities that are not part of the health system?

8.1.1.8 Reimbursement of user charges

Please elaborate further on the way in which user charges related to psychiatric inpatient care are reimbursed and whether or not they are fully reimbursed. If less than 100% are reimbursed can you indicate the exact proportion? Are there different levels of reimbursement for different types of psychiatric inpatient care service? Are any user charges for psychiatric inpatient care services for mental health problems treated in a different way to inpatient care for physical health problems? Please describe the main differences in liability for and level of user charges between any psychiatric inpatient care services funded by the health system and services that are funded from outside the health system, such as from local municipalities or from different government departments such as social welfare.

Table 8.1, Part 4 of template to map psychiatric inpatient care services (SIC)

Where appropriate, please insert several codes into one box.

8.1.1.1a Provider type	8.1.1.1b Provider subtype	8.1.1.9 Restrictions/ incentives on number of services	8.1.1.10 Number of beds per inpatient care service	8.1.1.11 Types of service user
8.1A Stand-alone psychiatric facility – acute care				
8.1B Stand-alone psychiatric facility – long-term care				
8.1C Stand-alone psychiatric facility – long-term and acute care				
8.1D Part of a psychiatric centre / community mental health centre				
8.1E Psychiatric departments in general hospitals (non-university)				
8.1F Psychiatric departments in general hospitals (university)				
8.1G Psychiatric beds in long stay residential care homes (non-organic conditions)				
8.1H Psychiatric beds in long stay residential care homes (organic conditions)				
8.1I Other, please describe				

NOTES:

8.1.1.9 Restrictions/incentives on number of psychiatric inpatient services in a geographical catchment area

0 = none
1 = restrictions only
2 = incentives only
3 = restrictions and incentives

8.1.1.10 Number of beds per inpatient care service

Insert Min to Max number of places in inpatient care services

8.1.1.11 Types of service user

0 = all
1 = rather less severely ill (including compulsory)
2 = rather less severely ill (excluding compulsory)
3 = rather severely ill (including compulsory)
4 = rather severely ill (excluding compulsory)
5 = other (please state)

Elaborating on information provided in Table 8.1 – 8.1.1.9 to 8.1.1.11

8.1.1.9 Restrictions/incentives on number of psychiatric inpatient care service providers in a geographical area

Are any restrictions due to regulations stipulating the maximum number of psychiatric inpatient care services that can be provided or specifications set out in some national or local plan or needs assessment? What incentives are provided to encourage the provision of inpatient care services in some areas of a country e.g. in socially deprived communities which might have a high rate of people with mental health problems/substance use disorders or in rural areas etc?

Please indicate if there is a specified list of psychiatric inpatient care service providers that service users can choose from if they are to receive publicly funded psychiatric inpatient care services.

8.1.1.10 Restrictions/incentives on number of psychiatric inpatient care beds in a geographical area

Please elaborate further as appropriate on the number of beds available in psychiatric inpatient care service (minimum number of places – maximum number of places) for a geographical area. Please elaborate on any incentives / disincentives facilities may have to change alter the number of beds that they provide

8.1.1.11 Types of care provided

Please briefly describe the typical types of care provided seen in each type of psychiatric inpatient care service structure.

8.1.1.12 Other comments

Please provide any additional comments you might wish to make. In particular provide relevant information that you feel is not adequately captured by our template.

8.1.2 Financial and non-financial incentives and disincentives concerning Specialist Psychiatric Inpatient Care Services for people with mental health needs

Please collate detailed information on the existence of financial and non-financial incentives and disincentives concerning psychiatric inpatient care services. For each of the different service providers that you identified in Table 8.1, now look in further depth and briefly indicate whether financial or non-financial incentives have a significant impact on access to, and utilisation of inpatient care. Some issues to consider include:

8.1.2.1 Incentives related to population sub-groups

If subtypes of psychiatric inpatient care services deal with different groups of people with mental health problems can they select specific service users? If so how is this done (e.g. by waiting list management)? Are there any financial incentives and disincentives in place for the

different psychiatric inpatient care service providers to take on or refuse specific service users? For instance is there any cream-skimming occurring whereby psychiatric inpatient care services deal with easier to manage individuals? Does severity of disorder and troublesomeness of service users play a role?

8.1.2.2 Incentives related to performance related payment schemes

Please briefly describe how any performance-related payment systems use for psychiatric inpatient care services may work. This may be based on individual factors or a weighted or non-weighted composite measure of factors such as individual productivity, patient satisfaction, impact on hospital admissions, quality of life measures, etc. Please also state if fines apply in the case of poor performance.

Performance-related systems may be associated with the introduction of systems of monitoring and inspection. How is performance monitored – is this a function of any outside regulatory body or other procedure? Are the results of any performance assessment made public? If so how? Could this influence demand for psychiatric inpatient care service by service commissioners and/or service users?

8.1.2.3 Incentives related to complex activity based payment systems

Please describe, where relevant, how any DRG or other needs-linked activity-based payment systems deal with psychiatric inpatient care services. If not linked to diagnosis, please explain how the system works. Please give an indication of whether tariffs are set at national, regional, sickness fund or other level. Please indicate if tariffs are linked to a primary diagnosis or some other indicator of need (e.g. linked to symptom profile. Please indicate if tariffs vary depending on co-morbidity.

Please indicate any broad categories of psychiatric diagnosis or psychiatric patient population groups that are excluded from any DRG system for psychiatric inpatient care services. Please indicate how payment is actually made (i.e. a defined amount of money or allocation of "points", whose monetary value will be determined retrospectively). Please indicate whether the DRG tariff includes resources for follow up outpatient or ambulatory care (including community mental health care).

8.1.2.4 Incentives to use inpatient care rather than outpatient care

Please describe any other important financial and/or non-financial incentives or disincentives that might encourage/discourage the use of psychiatric inpatient care service instead of the different outpatient services discussed in section 7.

8.1.2.5 Other incentives and disincentives

Please describe any other important financial and/or non-financial incentives or disincentives that might be in place re the provision of inpatient services. E.g. are there any financial advantages or

disadvantages for psychiatric inpatient care services that are part of universities.

8.2 Non-psychiatric beds in acute general hospitals used for patients with mental health needs (GEN)

8.2.1 Does this type of utilisation of non-psychiatric beds in acute general hospitals exist in your country?

This phenomenon may be known in your country already. However, it might be worthwhile to obtain more information by asking clinicians working in general hospitals, by searching publications and by analysing hospital discharge data for the occurrence of primary or secondary mental health diagnoses.

- ☐ This is definitely the case: please provide an estimate of the percentage of discharges from such beds with a psychiatric diagnosis (primary or secondary)
- ☐ Unclear
- ☐ Definitely not the case

8.2.2 Financing mechanisms

If the phenomenon exists: Please describe briefly how the care of people with mental disorders, who are admitted to non-psychiatric beds in acute general hospitals, is paid to the provider. Please use – where appropriate – the categories of the tables in Section 8.1. Please note whether and how these mechanisms are different from (a) those relating to patients admitted to specialised psychiatric inpatient facilities (b) those for patients without mental health needs (i.e. only with physical disorders) treated in non-psychiatric beds

8.2.3 Please name possible reasons for psychiatric patients with a main psychiatric diagnosis being admitted to a non-psychiatric bed?

- ☐ Longer distance to psychiatric hospitals/departments
- ☐ Physical co-morbidity
- ☐ Stigma avoidance
- ☐ Financial incentives: please describe …
- ☐ Non-financial incentives: please describe …
- ☐ Other: describe

8.2.4 Additional comments

Section 9: Selected additional services for housing, employment and vocational rehabilitation

Other key services for people with mental health needs include help with housing needs, support to remain in and/or return to employment and support with education and training needs. All services, including those that are privately owned, as long as they receive some of their funding from the public or charitable sources, are of interest. In many countries many of these types of services will be funded and delivered outside the health sector.

Not only in services publicly funded by health budgets or social health insurance should be considered, but also services funded from other budgets such as local or national government social welfare budgets, even if the services are owned privately. In many countries some of these services may be provided and funded from outside the health sector.

The following sections consider these issues:

9.1. HOU Housing Support

9.2. EMP Individual Employment Support

9.3. VOC Vocational Rehabilitation

9.1 Housing Support

9.1 Housing Support

9.1.1 Organisation, structure, payment and regulation – Housing Support

Please complete Table 9.1 which helps provide a brief description on the organisation and role of support for independent housing for people with mental health needs in your country. Support for independent housing can take different forms including houses or flats for one or more people without any on-site support, or blocks of houses or flats for single or shared use with an on-site manager or support worker providing support. In some cases residence will be time limited while in other instances it will be seen as a potential permanent dwelling.

Provide information on organisational structures and payment mechanisms that are representative of what is provided in your country – experimental approaches or in those which are only intended for small specialist client groups (for instance in some countries this may include services for military veterans) are not of interest. While there is no strict cut off point for guidance it is suggested that if a structure or payment mechanisms is likely to account for less than 5% of all structures or all payment mechanisms then it is suggested that you consider carefully whether it is worth spending much time on its documentation. A key factor when thinking about such mechanisms will be the issue of innovation – it may be that a mechanism is very new and perhaps only being piloted in a small area of the country, but if this is being done with a view to roll out across the whole of the country then this is a payment mechanism that would be worth documenting. The innovative or

experimental nature of a payment mechanism could be described in the supplemental narrative descriptions to the Table that is set out later in this section.

Table 9.1 requests information on the typical configuration of infrastructure and payment mechanisms in your country, in this case for different means of providing help with housing for independent living. For instance this will help give a sense of whether most of this care is provided in dedicated supporting houses or through other financial support to help people to pay their rent.

In addition to completing this table, **please draft a supplementary text providing a brief description** of housing support for people with mental health needs and its place within the housing support system in the country or region. If supported housing is available to allow people with health needs to live independently, briefly indicate the principal ways in which supported housing services for people with health needs are paid for. For instance is this through contracts which specify levels of funding from local/national purchasers of housing to subsidise or fully cover the costs of rent.

Please indicate which government body has responsibility for oversight of this service. The text should then go into more detail on some of the responses you have made to Table 9.1. Each of these issues is now considered in turn.

Table 9.1, Part 1 of template to map the structure of services to support independent housing (HOU)

Where appropriate, please insert several codes into one box.

9.1.1.1a Type of housing support	9.1.1.1b Service subtype	9.1.1.2 Frequency 0=absent 1=occasional 2=common	9.1.1.3 Volume of service L=large M=medium S=small	9.1.1.4 Legal status/ownership PUB-DI PUB-INDIR PR-PROF PR-NOTPROF SU
9.1A Time limited provision of housing for independent living for a single person/family without onsite support				
9.1B Non time limited provision of housing for independent living for single person/family without onsite support				
9.1C Time limited provision of housing for independent living for single person/family with onsite support				
9.1D Non time limited provision of housing for independent living for single person/family with onsite support				
9.1E Independent group living housing without onsite support				
9.1F Independent group living housing with onsite support				
9.1G Financial benefits to help support rent/mortgage payments				
9.1H Other, please describe				

NOTES:

9.1.1.1b Provider subtype

If subtypes of 9.1.1.1a providers exist name and describe the most common here (and others in the Elaborating information section using the categories provided in this table).

9.1.1.3 Volume of service

Give a crude estimate of the volume of care (in terms of number of patients, visits, etc.) for each provider type in relation to the total care provided by services to support independent housing.

9.1.1.4 Legal status/ownership

PUB-DI = Direct public provision by national/local government or mandatory social health insurance
PUB-INDIR = Public indirect provision by a separate/independent structure e.g. a national health service organisation, public enterprise/company or similar
PR-PROF = For profit private sector
PR-NOTPROF = Not for profit private sector
SU = Owned by service user

Elaborating on information provided in Table 9.1 – 9.1.1.1 to 9.1.1.4

If subtypes of the 9.1.1.1a provider type exist, please describe here the subtype(s) existing in addition to the one described in the table by using the categories 9.1.1.2 to 9.1.1.11 for this/these additional subtype(s).

9.1.1.1a and b Types of supports for independent living arrangements

Please provide examples of the typical names in your own language given to each type of support for independent living that you have indicated.

9.1.1.2 Frequency of different supports for independent living arrangements

You were already asked for information on the frequency of different models of support for independent living arrangements. Please provide any further comment here that you think may be useful, including any comment on gaps in information or difficulties in quantifying the balance between different types of support for independent living service structures in your country. Ideally provide a percentage breakdown on the balance between different service structures.

9.1.1.3 Volume of care handled by different supports for independent living arrangements

Please provide a commentary for the estimate of volume of care you have provided for each type of housing support, including any comment on gaps in information or difficulties in quantifying the balance between different types of service in your country.

9.1.1.4 Legal status/ownership

Please provide any clarifications on the legal status of each type of support for independent living structure that you have identified. Please also provide the local language name for this legal status.

Table 9.1, Part 2 of template to map services to support independent housing (HOU)

Where appropriate, please insert several codes into one box.

9.1.1.1a Type of housing support	9.1.1.1b Service subtype	9.1.1.5 Who pays? Who is the contractor of the service? Purchaser-provider split: No/Yes	9.1.1.6 Payment mechanisms
9.1A Time limited provision of housing for independent living for a single person/family without onsite support			
9.1B Non time limited provision of housing for independent living for single person/family without onsite support			
9.1C Time limited provision of housing for independent living for single person/family with onsite support			
9.1D Non time limited provision of housing for independent living for single person/family with onsite support			
9.1E Independent group living housing without onsite support			
9.1F Independent group living housing with onsite support			
9.1G Financial benefits to help support rent/mortgage payments			
9.1H Other, please describe			

NOTES:

9.1.1.1b Provider subtype

If subtypes of 9.1.1.1a providers exist, name and describe the most common here (and others in the Elaborating information sections using the categories provided in this table).

9.1.1.5 Who pays for HOU services? Who is the contractor of the service?

Please state the name(s) and legal status of organisations that pay for housing support either at country or regional level as appropriate. Note: user charges to the provider are covered below in 9.1.1.7

9.1.1.6 Payment mechanisms (specify percentage of total sources of finance or level of importance)

BUD = Budget

FLA = Flat rate per attending patient for a defined time period

OTH = Other, please specify

Elaborating on information provided in Table 9.1 – 9.1.1.5 to 9.1.1.6

9.1.1.5 Who pays for supports for independent living arrangements?

In the table you were asked to indicate how common any purchaser-provider split was in providing funds for independent housing for people with mental health needs. Please elaborate further, on the different sources of payment stating whether these cover the national area, or a different focus, such as a specific sub national area, (note user charges are asked for separately). If there are different payers and they use different payment mechanism this should be described below.

9.1.1.6 Payment mechanisms used to pay providers

You were already asked, not only to identify the different types of mechanism that are used to pay for support for independent living but also their relative importance in terms of total revenue for these services.

Please provide any further comments here that you think may be useful, including any comment on gaps in information or difficulties in quantifying the balance between different types of supported independent living arrangements in your country.

Please indicate whether there are any specific eligibility requirements or service user characteristics that may influence access to independent living arrangements.

Where relevant it would be helpful to know whether payments are made retrospectively or prospectively, and how often payments are made. If there are substantial differences in the use of payment mechanisms by different supported housing structure can you provide a commentary on why this may be the case?

Can you provide any information about contracts or other regulatory devices that influence the use of payment mechanisms?

In the case of global budgets for support for independent living arrangements in a locality please briefly explain how these are normally set, e.g. based on historical allocations of resources, adjustments for population need etc. Please indicate if any unspent money can be retained at the end of the financial year.

Please indicate if service users can pay for supported housing services through individual budgets (cash or vouchers) that they may have been allocated by the state or health insurance fund. Please indicate if there is a specified list of supported housing services that service users can choose from.

In addition to national and local taxes and contributions from social protection systems and service users please describe any other significant ways in which supported housing services receive money. This for instance could include charitable donations, faith group support, payments from other government departments, foreign aid or lottery support.

Table 9.1, Part 3 of template to map services to support independent housing (HOU)

Where appropriate, please insert several codes into one box.

9.1.1.1a Type of housing support	9.1.1.1b Service subtype	9.1.1.7 User contributions to housing costs 0 = no 1 = yes	9.1.1.8 Support for user payments 0 = no 1 = Means tested support for user payments for rent available
9.1A Time limited provision of housing for independent living for a single person/family without onsite support			
9.1B Non time limited provision of housing for independent living for single person/family without onsite support			
9.1C Time limited provision of housing for independent living for single person/family with onsite support			
9.1D Non time limited provision of housing for independent living for single person/family with onsite support			
9.1E Independent group living housing without onsite support			
9.1F Independent group living housing with onsite support			
9.1G Financial benefits to help support rent/mortgage payments			
9.1H Other, please describe			

Elaborating on information provided in Table 9.1 – 9.1.1.7 to 9.1.1.8

9.1.1.7 User charges towards the cost of housing

Please describe any contribution by residents towards the costs of housing. Do householders have to pay rents at market rate or are there any ceilings on total payments? Are specific sub-groups of the population exempt from having to make a contribution?

Can you cite any information locally on how the need for individuals to make contributions towards the costs of housing has influenced use of psychiatric inpatient care? Are family members liable to pay any charges if the service user cannot pay?

Please indicate if there is a specified list of housing services and housing service providers that service users can choose from.

9.1.1.8 Support to reduce the burden of user contributions

Please elaborate further on the way in which any user contributions towards the costs of housing may be offset, for inset by the receipt of income-dependent financial support. Are there different levels of contributions towards the costs of housing for different types of supported housing service? Are there any differences in user charges for people with mental health needs living in supported housing compared to people with physical health problems living in similar circumstances? Please describe the main differences in liability for and level of user contributions between any housing services funded by the health system and services that are funded from outside the health system, such as from local municipalities or from different government departments such as social welfare.

Table 9.1, Part 4 of template to map services to support independent housing (HOU)

Where appropriate, please insert several codes into one box.

9.1.1.1a Type of housing support	9.1.1.1b Service subtype	9.1.1.9 Restrictions/ incentives on number of supported housing services in a geographical catchment area	9.1.1.10 Types of service user
9.1A Time limited provision of housing for independent living for a single person/family without onsite support			
9.1B Non time limited provision of housing for independent living for single person/family without onsite support			
9.1C Time limited provision of housing for independent living for single person/family with onsite support			
9.1D Non time limited provision of housing for independent living for single person/family with onsite support			
9.1E Independent group living housing without onsite support			
9.1F Independent group living housing with onsite support			
9.1G Financial benefits to help support rent/mortgage payments			
9.1H Other, please describe			

NOTES:

9.1.1.9 Restrictions / incentives on number of supported housing services in a geographical catchment area
0 = none
1 = restrictions only
2 = incentives only
3 = restrictions and incentives

9.1.1.10 Types of service user
0 = all
1 = rather less severely ill
2 = rather severely ill
3 = other (please state)

Elaborating on information provided in Table 9.1 – 9.1.1.9 to 9.1.1.10

9.1.1.9 Restrictions/incentives on number of supported housing service providers in a geographical area

Are any restrictions due to regulations stipulating the maximum number of supported housing services that can be provided or specifications set out in some national or local plan or needs assessment? What incentives are provided to encourage the provision of services for independent housing in some areas of a country e.g. in socially deprived communities which might have a high rate of people with mental health problems / substance use disorders or in rural areas etc?

Please indicate if people with mental health needs have the same rights of entitlement to supported housing services as other population groups with health care needs.

Please indicate if there is a specified list of support for independent housing service providers that service users can choose.

9.1.1.10 Types of service user supported

Please briefly describe the typical types of services users supported in each type of supported housing structure.

9.1.1.11 Other comments

Please provide any additional comments you might wish to make. In particular look for relevant information that you feel is not adequately captured by our template, e.g., whether flats for people with mental health problems are mixed with flats for other user groups such as substance abusers or elderly, whether there is resistance from neighbours, etc.

9.1.2 Financial and non-financial incentives and disincentives concerning Housing Support for people with mental health needs

Please collate detailed information on the existence of financial and non-financial incentives and disincentives concerning services to support independent living. For each of the different service providers that you identified in Table 9.1, look in further depth and briefly indicate whether financial or non-financial incentives have a significant impact on access to, and utilisation of supported housing services. Some issues to consider include:

9.1.2.1 Incentives related to population sub-groups

If subtypes of supported housing services deal with different groups of people with mental health problems can they select specific service users? If so how is this done (e.g. by waiting list management)? Are there any financial incentives and disincentives in place for the different supported housing service providers to take on or refuse specific service users? For instance is there any cream-skimming occurring whereby supported housing services deal with easier to

manage individuals? Are there differences in financial services between time-limited and non-time-limited services?

9.1.2.2 Incentives related to performance related payment schemes

Please briefly describe how any performance related payment systems use for supported housing services may work. Performance related systems may be associated with the introduction of systems of monitoring and inspection. How is performance monitored – is this a function of any outside regulatory body or other procedure? Are the results of any performance assessment made public? If so how?

9.1.2.3 Other incentives and disincentives

Please describe any other important financial and/or non-financial incentives or disincentives that might be in place re the provision of supported housing services.

9.2 Individual Employment (Intermediation) Services

9.2.1 Organisation, structure, payment and regulation – Individual Employment (Intermediation) Services

Please complete Table 9.2 which helps provide a brief description on the organisation and role of employment support services for people with mental health needs in your country. The focus is on 'individualised' intermediation services' to support (or 'activate') unemployed or inactive jobseekers with mental health problems to find and maintain employment. 'Individualised' refers to there being a personal service dimension as opposed to more generic provisions such as standardised training programmes. At minimum, these involve information provision services, employment guidance counselling, and job searching. Perhaps less common are services related to employability or skills assessment, job coaching and supported employment, job matching and individualised career or job planning. Many of these services will be provided by mainstream employment services that focus on the employment needs of the whole population, but employment intermediation services for people with mental health problems and physical disabilities may also be provided by specialist organisations. In nearly all cases the funding for all services will come from general and local government revenues.

Only organisational structures and payment mechanisms that are representative of what is provided in your country are of interest – experimental approaches or in those which are only intended for small specialist client groups (for instance in some countries this may include services for military veterans) are not asked for. While there is no strict cut off point for guidance it is suggested that if a structure or payment mechanisms is likely to account for less than 5% of all structures or all payment mechanisms then you are urged that you consider carefully whether it is worth spending much time on its documentation. A key factor when thinking about such mechanisms will be the issue of innovation – it may be that a mechanism is very new and perhaps only being piloted in a small area of the country, but

if this is being done with a view to roll out across the whole of the country then this is a payment mechanism that would be worth documenting. The innovative or experimental nature of a payment mechanism could be described in the supplemental narrative descriptions to the Table that is set out later in this section.

Table 9.2 requests information on the typical configuration of infrastructure and payment mechanisms in your country, in this case for different means of providing employment support. For instance this will help give a sense of whether most of these services are mainstreamed and provided by public employment services or alternatively are provided by specialist employment services.

In addition to completing this table, **please draft a supplementary text providing a brief description of employment services to support people with mental health needs** and its place within the employment support system in the country or region. Please briefly indicate the principal sources of funding for employment, for instance through contracts with the Ministry of Labour or public employment services. Please indicate which government body has responsibility for oversight of these services. The text should then go into more detail on some of the responses you have made to Table 9.2. Each of these issues is now considered in turn.

Table 9.2, Part 1 of template to map employment intermediation services (EMP)

Where appropriate, please insert several codes into one box.

9.2.1.1a Type of employment service	**9.2.1.1b Service subtype**	**9.2.1.2 Frequency** 0=absent 1=occasional 2=common	**9.2.1.3 Volume of service** L=large M=medium S=small	**9.2.1.4 Legal status/ownership** PUB-DI PUB-INDIR PR-PROF PR-NOTPROF
9.2A Services provided by public employment services (mainstreamed)				
9.2B Services provided by specialist public employment service				
9.2C Services provided by private sector employment services under contract (mainstreamed)				
9.2D Services provided by private sector specialist mental health employment services under contract				
9.2E Other, please describe				

NOTES:

9.2.1.1b Provider subtype

If subtypes of 9.2.1.1a providers exist name and describe the most common here (and others in the Elaborating information section using the categories provided in this table).

9.2.1.3 Volume of service

Give a crude estimate of the volume of care (in terms of number of patients, visits, etc.) for each provider type in relation to the total care provided by services to support independent housing.

9.2.1.4 Legal status/ownership

PUB-DI = Direct public provision by national/local government or mandatory social health insurance
PUB-INDIR = Public indirect provision by a separate/independent structure e.g. a national health service organisation, public enterprise/company or similar
PR-PROF = For profit private sector
PR-NOTPROF = Not for profit private sector

Elaborating on information provided in Table 9.2 – 9.2.1.1 to 9.2.1.4

If subtypes of the 9.2.1.1a provider type exist, please describe here the subtype(s) existing in addition to the one described in the table by using the categories 9.2.1.2 to 9.2.1.9 for this/these additional subtype(s).

9.2.1.1a and b Types of supports for employment intermediation services

Please provide examples of the typical names in your own language given to each type of employment intermediation service that you have indicated.

9.2.1.2 Frequency of different employment intermediation services

You were already asked for information on the frequency of different models of employment intermediation services. Please provide any further comment here that you think may be useful, including any comment on gaps in information or difficulties in quantifying the balance between different types of employment intermediation services in your country. Ideally provide a percentage breakdown on the balance between different service structures.

9.2.1.3 Volume of support handled by different employment intermediation services

Please provide a commentary for the estimate of volume of care you have provided for each type of employment intermediation service, including any comment on gaps in information or difficulties in quantifying the balance between different types of service in your country.

9.2.1.4 Legal status/ownership

Please provide any clarifications on the legal status of each type of employment intermediation service that you have identified. Please also provide the local language name for this legal status.

Table 9.2, Part 2 of template to map employment intermediation services (EMP)

Where appropriate, please insert several codes into one box.

9.2.1.1a Type of employment service	9.2.1.1b Service subtype	9.2.1.5 Who pays? Who is the contractor of the service? Purchaser-provider split: No/Yes	9.2.1.6 Payment mechanisms
9.2A Services provided by public employment services (mainstreamed)			
9.2B Services provided by specialist public employment service			
9.2C Services provided by private sector employment services under contract (mainstreamed)			
9.2D Services provided by private sector specialist mental health employment services under contract			
9.2E Other, please describe			

NOTES:

9.2.1.1b Provider subtype

If subtypes of 9.2.1.1a providers exist, name and describe the most common here (and others in the Elaborating information sections using the categories provided in this table).

9.2.1.5 Who pays for EMP services? Who is the contractor of the service?

Please state the name(s) and legal status of organisations that pay for housing support either at country or regional level as appropriate.

9.2.1.6 Payment mechanisms (specify percentage of total sources of finance or level of importance)

BUD = Budget

ABF (P) = Activity based funding

ORF = Outcome related funding. (Fees paid when clients enter paid employment for minimum specified time period)

TAR = Additional payments made based on achievement of specific employment goals

OTH = Other, please specify

Elaborating on information provided in Table 9.2 – 9.2.1.5 to 9.2.1.6

9.2.1.5 Who pays for employment intermediation services?

In the table you were asked to indicate how common any purchaser-provider split was in providing funds for employment intermediation services for people with mental health needs. Please elaborate further, on the different sources of payment stating whether these cover the national area, or a different focus, such as a specific sub national area. If there are different payers and they use different payment mechanism this should be described below.

9.2.1.6 Payment mechanisms used to pay providers

You were already asked, not only to identify the different types of mechanism that are used to pay for employment intermediation services but also their relative importance in terms of total revenue for these services.

Please provide any further comments here that you think may be useful, including any comment on gaps in information or difficulties in quantifying the balance between different types of employment intermediation services in your country.

Please indicate whether there are any specific eligibility requirements or service user characteristics that may influence access to employment intermediation services

It would be helpful to know whether payments are made retrospectively or prospectively, and how often payments are made. In the case of employment services contracts may stipulate a certain mix of clients; there may also be an element of performance related payment, whereby employment services are paid for clients who successfully enter employment for a minimum specified period of time. If there are substantial differences in the use of payment mechanisms by different employment intermediation services can you provide a commentary on why this may be the case?

Can you provide any information about contracts or other regulatory devices that influence contracts and payment mechanisms?

In the case of global budgets for employment intermediation services in a locality please briefly explain how these are normally set, e.g. based on historical allocations of resources, adjustments for population need etc. Please indicate if any unspent money can be retained at the end of the financial year.

Please indicate if service users can pay for employment intermediation services through individual budgets (cash or vouchers) that they may have been allocated by the state or health insurance fund. Please indicate if there is a specified list of employment intermediation services that service users can choose from.

In addition to national and local taxes and contributions from social protection systems please describe any other significant ways in which employment intermediation services receive money. This for instance could include charitable donations, faith group support, payments from other government departments, foreign aid or lottery support.

Table 9.2, Part 3 of template to map employment intermediation services (EMP)

Where appropriate, please insert several codes into one box.

9.2.1.1a Type of employment service	9.2.1.1b Service subtype	9.2.1.7 Restrictions /incentives on number of employment intermediation services in a geographical catchment area	9.2.1.8 Number of places per employment service provider in a catchment area	9.2.1.9 Types of service user
9.2A Services provided by public employment services (mainstreamed)				
9.2B Services provided by specialist public employment service				
9.2C Services provided by private sector employment services under contract (mainstreamed)				
9.2D Services provided by private sector specialist mental health employment services under contract				
9.2E Other, please describe				

NOTES:

9.2.1.7 Restrictions/incentives on number of employment intermediation services in a geographical catchment area

0 = none

1 = restrictions only

2 = incentives only

3 = restrictions and incentives

9.2.1.8 Number of places per employment service provider in a catchment area

Insert min to max number of places in a geographically defined area

9.2.1.9 Types of service user

0 = all

1 = rather less severely ill

2 = rather severely ill

3 = other (please state)

Elaborating on information provided in Table 9.2 – 9.2.1.7 to 9.2.1.9

9.2.1.7 Restrictions/incentives on number of employment intermediation service providers in a geographical area

Are any restrictions due to regulations stipulating the maximum number of employment intermediation service providers set out in some national or local plan or needs assessment? What incentives are provided to encourage the provision of employment services in some areas of a country e.g. in socially deprived communities which might have a high rate of people with mental health problems / substance use disorders or in rural areas etc?

Please indicate if people with mental health needs have the same rights of entitlement to employment intermediation services as other population groups with health care needs.

Please indicate if there is a specified list of support for employment intermediation service providers that service users can choose.

9.2.1.8 Restrictions / incentives on number of places in employment intermediation service providers in a geographical area

Please elaborate further as appropriate on the number of places available in employment intermediation service providers for independent living for a geographical area. Please elaborate on any incentives / disincentives that may affect the number of places provided.

9.2.1.9 Types of service user supported

Please briefly describe the typical types of services users supported in different types of employment intermediation service.

9.2.1.10 Other comments

Please provide any additional comments you might wish to make. In particular provide relevant information that you feel is not adequately captured by our template.

9.2.2 Financial and non-financial incentives and disincentives concerning Employment Intermediation Services for people with mental health needs

Please collate detailed information on the existence of financial and non-financial incentives and disincentives concerning services to support independent living. For each of the different service providers that you identified in Table 9.2, look in further depth and briefly indicate whether financial or non-financial incentives have a significant impact on access to, and utilisation of supported housing services. Some issues to consider include:

9.2.2.1 Incentives related to population sub-groups

If subtypes of employment intermediation services deal with different groups of people with mental health problems can they select specific

service users? If so how is this done (e.g. by waiting list management)? Are there any financial incentives and disincentives in place for the different employment intermediation services to take on or refuse specific service users? For instance is there any cream-skimming occurring whereby employment intermediation services deal with easier to manage clients?

9.2.2.2 Incentives related to performance related payment schemes

Please briefly describe how any performance related payment systems used employment intermediation services may work. What time periods for instance, must an individual remain in employment before a payment is made? Are there different rates of payment for successfully helping to employ people with different physical or mental health needs. Performance related systems may be associated with the introduction of systems of monitoring and inspection. How is performance monitored – is this a function of any outside regulatory body or other procedure? Are the results of any performance assessment made public? If so how?

9.2.2.3 Other incentives and disincentives

Please describe any other important financial and/or non-financial incentives or disincentives that might be in place re the provision of employment intermediation services.

9.3 Vocational Rehabilitation Services

9.3.1 Organisation, structure, payment and regulation - Vocational Rehabilitation Services

Please complete Table 9.3 which helps provide a brief description on the organisation and role of vocational rehabilitation services for people with mental health needs in your country. The focus is on training services and other supports to help provide individuals with the skills to subsequently re-enter competitive employment. These services can include organisations that offer opportunities for sheltered work for a wage. Many of these services will be provided by specialist, often not for profit organisations as well as faith groups. Funding may come from a variety of sources, potentially including contributions from service users.

Only organisational structures and payment mechanisms that are representative of what is provided in your country are of interest – experimental approaches or in those which are only intended for small specialist client groups (for instance in some countries this may include services for military veterans) are not of interest here. While there is no strict cut off point for guidance it is suggested that if a structure or payment mechanisms is likely to account for less than 5% of all structures or all payment mechanisms then you are urged that you consider carefully whether it is worth spending much time on its documentation. A key factor when thinking about such mechanisms will be the issue of innovation – it may be that a mechanism is very new and perhaps only being piloted in a small area of the country, but

if this is being done with a view to roll out across the whole of the country then this is a payment mechanism that would be worth documenting. The innovative or experimental nature of a payment mechanism could be described in the supplemental narrative descriptions to the Table that is set out later in this section.

Table 9.3 requests information on the typical configuration of infrastructure and payment mechanisms in your country, in this case for different means of providing vocational rehabilitation. Given the diverse nature of vocational rehabilitation models please add additional rows for different models of service provision as appropriate.

In addition to completing this table, **please draft a supplementary text providing a brief description of vocational rehabilitation services** to support people with mental health needs and its place within the wider vocational rehabilitation system in the country or region. Please very briefly indicate whether vocational rehabilitation services, including pre-work training, work-like activities, clubhouses and sheltered workshops are available for people with health needs. Please indicate which government body has responsibility for this service. Please indicate if people with mental health needs have the same rights of entitlement to these services as other groups with health needs/disabilities and if possible any overview on the use of these services. Please briefly indicate the principal sources of funding for employment and indicate which government body has responsibility for oversight of these services. The text should then go into more detail on some of the responses you have made to Table 9.3. Each of these issues is now considered in turn.

Table 9.3, Part 1 of template to map the structure of vocational rehabilitation services (VOC)

Where appropriate, please insert several codes into one box.

9.3.1.1a Type of vocational rehabilitation service	**9.3.1.1b Service subtype**	**9.3.1.2 Frequency** 0=absent 1=occasional 2=common	**9.3.1.3 Volume of service** L=large M=medium S=small	**9.3.1.4 Legal status/ownership** PUB-DI PUB-INDIR PR-PROF PR-NOTPROF
9.3A Vocational rehabilitation services provided by specialist public employment services				
9.3B Vocational rehabilitation services provided by specialist rehabilitation service				
9.3C Services provided by a clubhouse or similar organisation				
9.3D Other, please describe				

NOTES:

9.3.1.1b Provider subtype

If subtypes of 9.3.1.1a providers exist name and describe the most common here (and others in the Elaborating information section using the categories provided in this table).

9.3.1.3 Volume of service

Give a crude estimate of the volume of care (in terms of number of patients, visits, etc.) for each provider type in relation to the total care provided by services to support independent housing.

9.3.1.4 Legal status/ownership

PUB-DI = Direct public provision by national/local government or mandatory social health insurance
PUB-INDIR = Public indirect provision by a separate/independent structure e.g. a national health service organisation, public enterprise/company or similar
PR-PROF = For profit private sector
PR-NOTPROF = Not for profit private sector

Elaborating on information provided in Table 9.3 – 9.3.1.1 to 9.3.1.4

If subtypes of the 9.3.1.1a provider type exist, please describe here the subtype(s) existing in addition to the one described in the table by using the categories 9.3.1.2 to 9.3.1.12 for this/these additional subtype(s).

9.3.1.1a and b Types of supports for vocational rehabilitation services

Please provide examples of the typical names in your own language given to each type of vocational rehabilitation service that you have indicated.

9.3.1.2 Frequency of different vocational rehabilitation services

You were already asked for information on the frequency of different models of vocational rehabilitation services. Please provide any further comment here that you think may be useful, including any comment on gaps in information or difficulties in quantifying the balance between different types of vocational rehabilitation services in your country. Ideally provide a percentage breakdown on the balance between different service structures.

9.3.1.3 Volume of support handled by different vocational rehabilitation services

Please provide a commentary for the estimate of volume of care you have provided for each type of vocational rehabilitation service, including any comment on gaps in information or difficulties in quantifying the balance between different types of service in your country.

9.3.1.4 Legal status/ownership

Please provide any clarifications on the legal status of each type of vocational rehabilitation service that you have identified. Please also provide the local language name for this legal status.

Table 9.3, Part 2 of template to map vocational rehabilitation services (VOC)

Where appropriate, please insert several codes into one box.

9.3.1.1a Type of vocational rehabilitation service	9.3.1.1b Service subtype	9.3.1.5 Who pays? Who is the contractor of the service? Purchaser-provider split: No/Yes	9.3.1.6 Payment mechanisms
9.3A Vocational rehabilitation services provided by specialist public employment services			
9.3B Vocational rehabilitation services provided by specialist rehabilitation service			
9.3C Services provided by a clubhouse or similar organisation			
9.3D Other, please describe			

NOTES:

9.3.1.1b Provider subtype

If subtypes of 9.3.1.1a providers exist, name and describe the most common here (and others in the Elaborating information sections using the categories provided in this table).

9.3.1.5 Who pays for VOC services? Who is the contractor of the service?

Please state the name(s) and legal status of organisations that pay for housing support either at country or regional level as appropriate. Note: user charges to the provider are covered below in 9.3.1.7

9.3.1.6 Payment mechanisms (specify percentage of total sources of finance or level of importance)

BUD = Budget

DAY = Daily fee

FFC = Fixed Fee per Client

ORF = Outcome Related

INC = Income from sales etc from sheltered work

OTH = Other, please specify

Elaborating on information provided in Table 9.3 – 9.3.1.5 to 9.3.1.5

9.3.1.5 Who pays for vocational rehabilitation services?

In the table you were asked to indicate how common any purchaser-provider split was in providing funds for vocational rehabilitation services for people with mental health needs. Please elaborate further, on the different sources of payment stating whether these cover the national area, or a different focus, such as a specific sub national area. If there are different payers and they use different payment mechanism this should be described below.

9.3.1.6 Payment mechanisms used to pay providers

You were already asked, not only to identify the different types of mechanism that are used to pay for vocational rehabilitation services, but also their relative importance in terms of total revenue for these services.

Please provide any further comments here that you think may be useful, including any comment on gaps in information or difficulties in quantifying the balance between different types of supported independent living arrangements in your country.

Please indicate whether there are any specific eligibility requirements or service user characteristics that may influence access to employment intermediation services.

Please elaborate on payment mechanisms used. For instance are contracts established with service providers to pay them on a fee per client basis, or fee per attendance basis? It would be helpful to know whether payments are made retrospectively or prospectively, and how often payments are made. In the case of vocational rehabilitation contracts may stipulate a certain mix of clients; there may also be an element of performance related payment or bonuses, when clients successfully acquire new skills or subsequently go on to and/or obtain employment on the open labour market?

If there are substantial differences in the use of payment mechanisms by different vocational rehabilitation services can you provide a commentary on why this may be the case?

Can you provide any information about contracts or other regulatory devices that influence contracts and payment mechanisms?

In the case of global budgets for vocational rehabilitation services in a locality please briefly explain how these are normally set, e.g. based on historical allocations of resources, adjustments for population need etc. Please indicate if any unspent money can be retained at the end of the financial year.

Please indicate if service users can pay participation in vocational rehabilitation services through individual budgets (cash or vouchers) that they may have been allocated by the state or health insurance fund. Please indicate if there is a specified list of vocational rehabilitation services that service users can choose from.

In addition to national and local taxes and contributions from social protection systems please describe any other significant ways in which vocational rehabilitation services receive money. This for instance could include charitable donations, funding from faith groups, payments from other government departments, foreign aid or lottery support.

In respect of sheltered workshops and enterprises another source of funding may be the revenues raised from sales of good and services. Please indicate if this type of income is a significant source of funding.

Table 9.3, Part 3 of template to map vocational rehabilitation services (VOC)

Where appropriate, please insert several codes into one box.

9.3.1.1a Type of employment service	9.3.1.1b Service subtype	9.3.1.7 User payments 0 = no 1 = yes	9.3.1.8 Salaries and wages	9.3.1.9 User payment reimbursement
9.3A Vocational rehabilitation services provided by specialist public employment services				
9.3B Vocational rehabilitation services provided by specialist rehabilitation service				
9.3C Services provided by a clubhouse or similar organisation				
9.3D Other, please describe				

NOTES:

9.3.1.8 Salaries and wages

0 = No

1 = Yes market rate wages are paid

2 = Yes minimum wage rates are paid

3 = Clients receive some payment but this is below minimum wage rates

9.3.1.9 User payment reimbursement

0 = No

1 = Means tested support for user contributions available

2 = Reimbursement from social health insurance available

Elaborating on information provided in Table 9.3 – 9.3.1.7 to 9.3.1.9

9.3.1.7 User charges for vocational rehabilitation services

Please describe any user charges for vocational rehabilitation services. Do these charges cover meals and/or transport? Please indicate if there are any ceilings on total payments or if specific groups of the population are exempt from co-payments.

9.3.1.8 Salaries/ wages

Please describe systems for paying salaries or wages to clients who may be placed in sheltered workshops, business and similar structures. Do they receive a regular salary and if so is this at competitive market rates, the national minimum wage rate (if this exists) or at a lower level?

9.3.1.9 Reimbursement of client charges

Please elaborate further on any ways in which client charges related to vocational rehabilitation services may be offset or reimbursed. For instance are there are mean tested exemptions to payments? Can clients of these services have any out of pocket costs reimbursed through social insurance or other insurance products.

Table 9.3, Part 4 of template to map vocational rehabilitation services (VOC)

Where appropriate, please insert several codes into one box.

9.3.1.1a Type of employment service	9.3.1.1b Service subtype	9.3.1.10 Restrictions/ incentives on number of vocational rehabilitation services in a geographical catchment area	9.3.1.11 Number of places per vocational rehabilitation service provider in a catchment area	9.3.1.12 Types of service user
9.3A Vocational rehabilitation services provided by specialist public employment services				
9.3B Vocational rehabilitation services provided by specialist rehabilitation service				
9.3C Services provided by a clubhouse or similar organisation				
9.3D Other, please describe				

NOTES:

9.3.1.10 Restrictions / incentives on number of vocational rehabilitation services in a geographical catchment area

0 = none

1 = restrictions only

2 = incentives only

3 = restrictions and incentives

9.3.1.11 Number of places per vocational rehabilitation service provider in a catchment area

Insert min to max number of places in a geographically defined area

9.3.1.12 Types of service user

0 = all

1 = rather less severely ill

2 = rather severely ill

3 = other (please state)

Elaborating on information provided in Table 9.3 – 9.3.1.10 to 9.3.1.12

9.3.1.10 Restrictions/incentives on number of vocational rehabilitation service providers in a geographical area

Are any restrictions due to regulations stipulating the maximum number of vocational rehabilitation service providers set out in some national or local plan or needs assessment? What incentives are provided to encourage the provision of employment services in some areas of a country e.g. in socially deprived communities which might have a high rate of people with mental health problems / substance use disorders or in rural areas etc?

Please indicate if people with mental health needs have the same rights of entitlement to vocational rehabilitation services as other population groups with health care needs.

Please indicate if there is a specified list of support for vocational rehabilitation service providers that service users can choose.

9.3.1.11 Restrictions/incentives on number of places in vocational rehabilitation service providers in a geographical area

Please elaborate further as appropriate on the number of places available in vocational rehabilitation service providers for independent living for a geographical area. Please elaborate on any incentives / disincentives that may affect the number of places provided.

9.3.1.12 Types of service user supported

Please briefly describe the typical types of services users supported in different types of vocational rehabilitation service.

9.3.1.13 Other comments

Please provide any additional comments you might wish to make. In particular provide relevant information that you feel is not adequately captured by our template.

9.3.2 Financial and non-financial incentives and disincentives concerning Vocational Rehabilitation Services for people with mental health needs

Please collate detailed information on the existence of financial and non-financial incentives and disincentives concerning vocational rehabilitation services to support independent living. For each of the different service providers that you identified in Table 9.3 look in further depth and briefly indicate whether financial or non-financial incentives have a significant impact on access to, and utilisation of vocational rehabilitation services. Some issues to consider include:

9.3.2.1 Incentives related to population sub-groups

If subtypes of vocational rehabilitation services deal with different groups of people with mental health problems can they select specific service users? If so how is this done (e.g. by waiting list management)?

Are there any financial incentives and disincentives in place for the different vocational rehabilitation services to take on or refuse specific clients? For instance is there any cream-skimming occurring whereby vocational rehabilitation services deal with easier to manage clients?

9.3.2.2 Incentives related to performance related payment schemes

Please briefly describe how any performance related payment systems used vocational rehabilitation services may work. What outcome measures are used and over what time period, for instance, must an individual return to open employment before a payment is made? Are there different rates of payment for successfully helping to rehabilitate people with different physical or mental health needs. Performance related systems may be associated with the introduction of systems of monitoring and inspection. How is performance monitored – is this a function of any outside regulatory body or other procedure? Are the results of any performance assessment made public? If so how?

9.3.2.3 Other incentives and disincentives

Please describe any other important financial and/or non-financial incentives or disincentives that might be in place re the provision of vocational rehabilitation services.

Section 10: Prescription medicines

10.1 Out of pocket payments for prescription medicines

In this section some of the issues in the reimbursement of pharmaceuticals dispensed via prescription and, in particular, whether any costs fall on service users are briefly considered. Reimbursement of medications delivered received in inpatient or outpatient facilities where prescriptions are not issued are not covered. These are covered earlier in FINCENTO.

Please briefly provide some information on how pharmaceuticals dispensed by prescription are reimbursed considering the following points:

Please indicate if there is a positive list of pharmaceuticals that can be reimbursed if dispensed via prescription.

Please indicate if there is a negative list of pharmaceuticals that cannot be reimbursed, even if dispensed via prescription.

What out of pocket payments do patients have to make for prescriptions dispensed from primary care? Does this consist of a flat fee, a proportion of the cost of the product or determined in another way?

Are pharmaceuticals dispensed via prescription reimbursed at different rates? If so what are the principal determining criteria. Is there any difference in the reimbursement rules governing the prescription of drugs for mental health problems compared to drugs for other health issues?

Please indicate if there are any classes of drugs for mental health problems can only be prescribed by specialists?

Is there a ceiling on any out of pocket payments by service users for pharmaceuticals?

What are the main categories of exemption for service users from out of pocket payments?

10.2 Incentives and disincentives related to prescription medicines

Consider briefly whether there are any financial or other incentives that influence the use of generic or branded drugs on prescriptions.

Do pharmacists have any financial or other incentives to switch from branded products to generics when dispensing prescriptions? If so, please describe.

Do physicians have any financial or other incentives to prescribe generics rather than branded products? If so, please describe.

Do service users pay lower out of pocket charges if they receive generic rather than branded products?

Can service users take out insurance policies against out of pocket payments for prescribed medications? If so, please describe.

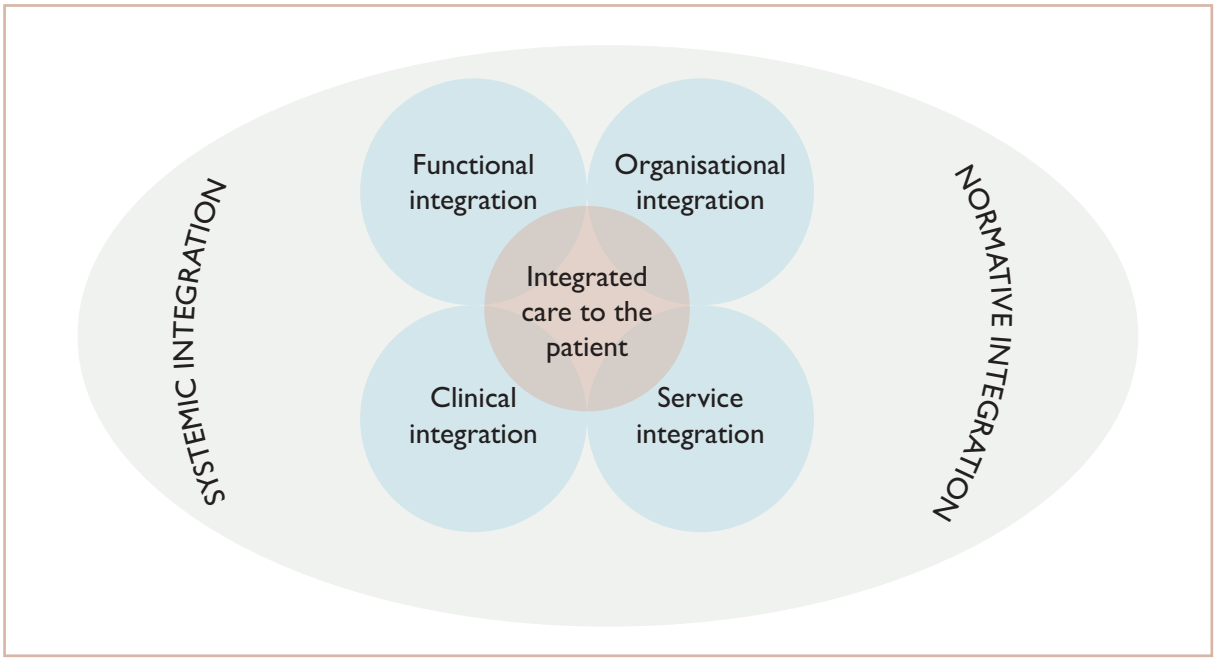
If there are restrictions on the number of pharmacists that can operate in any geographic catchment area, does this have any impacts on the availability and use of prescribed medications for mental health needs?

Section 11: Financial barriers and facilitators for the coordination of care

11.1 Introduction

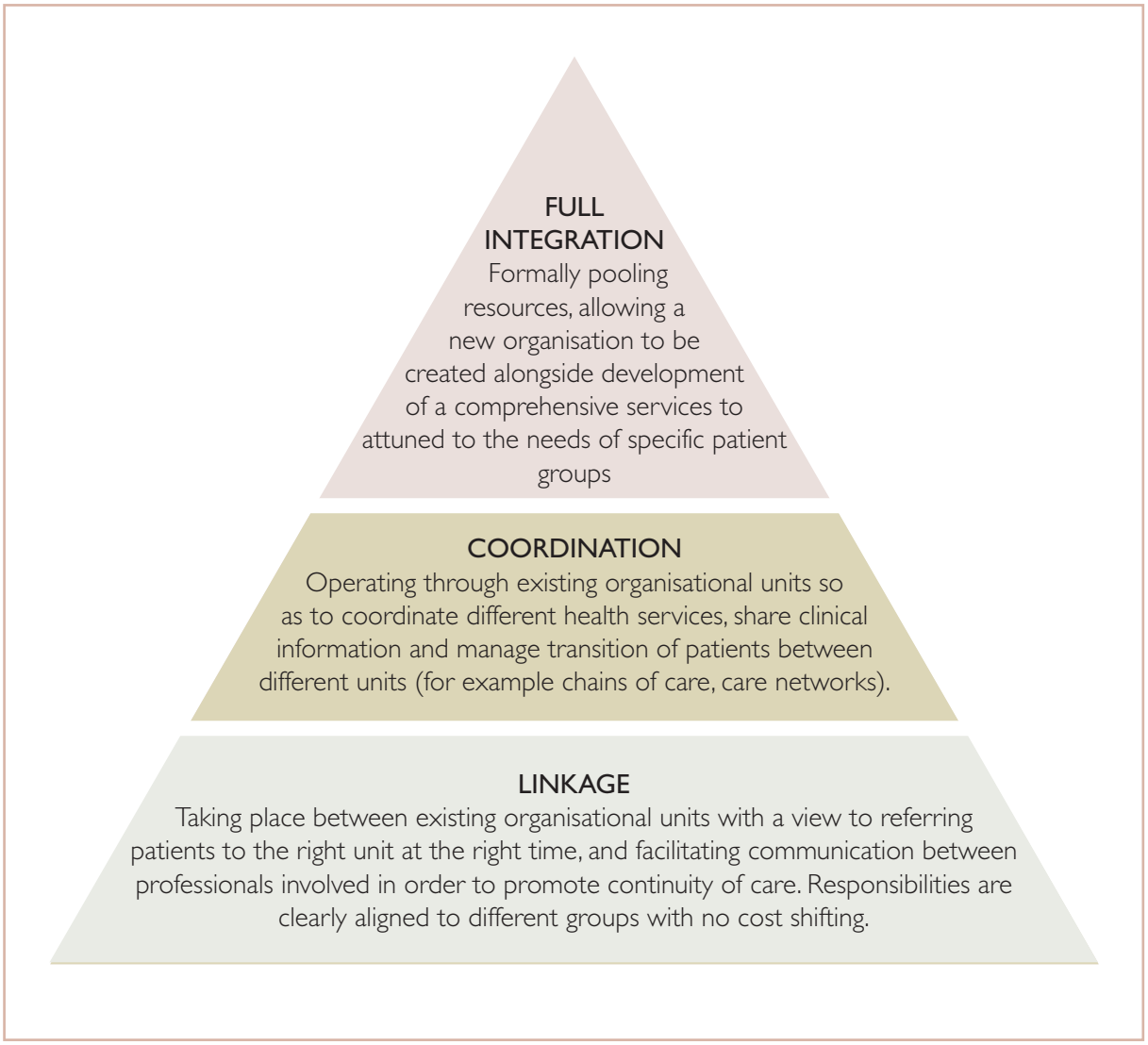
This final section is concerned with understanding the role of financial and non-financial incentives to ensure the continuity and better coordination of care. This potentially can lead towards what is generally known as a more integrated system of care. The concepts of coordination and integration are contested terms and we do not try and cover all of this literature here; we take a pragmatic view of these issues concentrating on identification of financing obstacles and facilitators for better coordination. One conceptualisation of integration covers the notion of full organisational integration, as well as more limited views of the concept of integration, including functional integration where some shared functions such as electronic patient records are fully integrated, or service integration where different clinical services are integrated at an organisational level, such as through multi-disciplinary early intervention teams for first episode psychosis. It also speaks of clinical integration through shared clinical guidelines and protocols (Figure 11.1). The authors further distinguish between systemic integration, with common rules and policies, and normative integration where there is an ethos of shared values and commitment to coordinating work.

Figure 11.1 Typologies of integrated care (From Fulop et al 2005, adapted by Shaw et al 2011)



It is also important to recognise that the intensity of integration and coordination can also vary, as Figure 11.2 shows ranging from loose linkage arrangements between independent organisational structures, through formal coordination arrangements and full integration through the pooling of resources within a single organisational structure (Shaw 2011). The interested reader can access a wealth of literature on this topic; one good introduction is work undertaken by the Kings Fund (Addicott 2014).

Figure 11.2 The intensity of integration. (Shaw 2011 – adapted from Leutz 1999)



At its most fundamental level coordination is about bridging /managing the interfaces between different types of services or sectors that are involved in the production of mental health care, such as inpatient/outpatient care, mental and physical health care or mental and social care. A more detailed list of possible interfaces is given below in Box 11.1.

Box 11.1: Examples of coordination interfaces involving mental health care

Managing mental health needs identified in accident and emergency units of general hospitals

Transitions between specialist inpatient care and different forms of outpatient care and ambulatory care.

Transitions between primary care and specialist inpatient, outpatient or ambulatory care

Transitions between child and adult services or between adult and old-age services

Parallel or sequential use of primary and specialist outpatient services

Parallel or sequential use of substance abuse and mental health services

Managing risks to mental health as a result of physical health problems & vice versa

Managing risks to mental health of parents following childbirth

Coordinating wider aspects of recovery making use of wider services, e.g. employment support, education support, housing, access to social welfare benefits

The need for coordination is a recognition that mental health, social care and other sectors can sometimes be difficult to access, navigate and may be inefficient in supporting people with severe and persistent mental illness (SPMI) and complex care and support needs. Seamless care over extended periods of time and across sectors and care settings is required. Individuals with poor mental health will typically make use of many different services at different points in time depending on their needs. If care is not well planned and coordinated it can become inefficient.

Resources can also be wasted due to duplication of services, while there might also be a danger of gaps emerging in service provision or in access to services. Examples of challenges include managing the high risks of multi-morbidity arising from physical health problems and the need to ensure access to stable accommodation in the community after discharge from inpatient services. Better care coordination has therefore become an explicit objective of health and social care system reform in many countries (McKee and Nolte, 2009).

Optimum use of services may be enhanced through coordination mechanisms that help promote coordination and continuity of care; these mechanisms will be of particular points at key interfaces where individuals are making a transition between different services, such as the transition from inpatient hospital care to outpatient or mobile community mental health teams, or the relationship between primary

care services and the use of specialist mental health services. There may also be a parallel use of services where coordination and mutual exchange of information is required, e.g. where a primary care physician might manage physical health issues while mental health care remains the responsibility of specialist services. Across the life course there may be transitions where coordination is required, for instance between child and adolescent mental health services and adult mental health services. Box 11.1 also highlights coordination interfaces with social care services and non-health services such as housing or employment support.

While we focus on financial facilitators and barriers, there are many different aspects of coordination that go beyond the scope of this tool. It is important to recognise that other key elements of coordination include governance arrangements that influence the relationships between different services within any health system, as well as rules governing the roles and responsibilities of the workforce. Coordination will also be enhanced through the availability of good information systems, including electronic health record systems, which track the use of services, including use of pharmaceuticals, within the mental and general health systems etc. The extent to which the system is currently fragmented will also play an important role; in a system where all services are funded and provided by a single organisation there may be fewer financial barriers to coordination.

Coordination can mean different things, in a narrow sense, it can refer to a specific role within a system for coordination of service provision, for instance at a micro level through the concept of a case manager who might be responsible for developing and implementing a care plan, at a meso level coordinating inputs from different elements within a mental health system as well as other relevant actors, who might for instance provide accommodation or employment support, as well as much broader aspects of integration across the health system as a whole at the macro level.

11.2 Coordination and financing arrangements

Budgeting mechanisms can be used to promote better coordination within and across sectors; there are many different approaches to doing this (see examples in Box 11.2) (McDaid 2012), including different ways of pooling resources to reduce disincentives to shared working and the establishment of common goals and aims. In the area of mental health these approaches have been used in some countries to promote better coordination between mental health and employment services for example. Another approach is to link funding directly to an individual rather than to a service, such as personal budgets, so that the money goes with the service user, regardless of what service this has used. This can help overcome the challenge of different sector budgets, but it will not stop different elements of the mental health system potentially competing to maximise their share of total funding that is available.

Box 11.2 Different approaches to joint budgeting (McDaid 2012)

Budget alignment: Budgets may be aligned rather than actually joined together. For instance, a health commissioner can manage both a health budget and a separate local authority budget to meet an agreed set of aims.

Dedicated joint funds: Departments may contribute a set level of resources to a single joint fund to be spent on agreed projects or delivery of specific services. This may often be a time-limited activity. There is usually some flexibility in how funds within the budget can be spent. A variant of this in the United Kingdom is the individual budget which pools funds from several sectors, but leaves it to discretion of service users as to how funds should be spent.

Joint-post funding: There may be an agreement to jointly fund a post where an individual is responsible for services and/or attaining objectives relevant to both departments. Theoretically this can help ensure cooperation and avoid duplication of effort.

Fully integrated budgets: Budgets across sectors might become fully integrated, with resources and the workforce fully coming together. One partner typically acts as the 'host' to undertake the other's functions and to manage all staff. To date this has largely been restricted to partnerships between health and social care organizations, or for the provision of services for people with mental health needs.

Policy-orientated funding: Central or local government may set objectives that cut across ministerial and budget boundaries and the budget system. Money may be allocated to specific policy areas, rather than to specific departments, as has been seen in Sweden and England.

Another way in which finances can be used to influence coordination and continuity of care is through contracting arrangements between different actors on a care pathway, including mental, physical and social care. Detailed contracts with a range of financial incentives and disincentives are increasingly being used to address some of the challenges associated with more integrated care, including in the area of mental health. New models of contracting are also being developed (see example re mental health services in London page 27 Addicott 2014). Legal and administrative mechanisms to encourage coordination and continuity of care across sectors and along the care pathway can include financial incentives and penalties for instance to reduce delays in discharge from hospitals.

11.3 Issues to be considered in identifying and describing barriers and facilitators for coordinated care

These are examples of questions to be considered when thinking about coordination of care; they are not exhaustive but are intended to guide the reader to better understand how financial facilitators and barriers work in relation to coordination of mental health care. They also help in understanding how prominent different financial mechanisms are within different systems.

We would like to know more about the local context and how this impacts on use of financial mechanisms to promote coordination. Please consider the following issues:

Do financial mechanisms for care coordination exist, especially relevant if care by the same provider is not available?

Are there single or multiple payers responsible for mental and physical care?

Is the same administrative structure responsible for financing health and social care?

Is there are single payer or multiple payers responsible for specialist inpatient, specialist outpatient and primary care?

Do provider payment mechanisms for inpatient, specialist outpatient and primary care help facilitate or impede coordination of care

Has there been any development of disease management programme – sometime known as 'bundled payments' – for treating mental disorders?

Do out of pocket payments act as a barrier to coordinated care?

Are contracts frequently used to improve coordination between different providers of mental health care? Please give examples.

To what extent are private for-profit and not-for-profit providers involved in the delivery of services?

11.3.1 Examples of use of financial facilitators and barriers to coordination

Describing all possible interfaces which are potentially relevant for mental health care is beyond the scope of this toolkit. Therefore we have chosen to focus on two typical interfaces in mental health care where coordination is essential and where inappropriate financing mechanisms may contribute towards a lack of coordination, despite the best intentions of all players. These two examples are extensively covered in the Refinement Pathway Tool REPATO (see section 1 on "Primary and specialist mental health care" and section 2 on "Continuity of mental health care").

Looking at the two examples in REPATO please try to identify and describe the financial barriers/obstacles and facilitators to better coordination/continuity of care.

Example 1: the interface between primary and specialist mental health care.

Are there different payers for primary and specialist outpatient mental health care?

Are there different payers for primary and specialist inpatient mental health care?

Describe how specific payment mechanisms for primary (Section 6) and specialist outpatient mental health care (Section 7) facilitate or hinder coordination of care?

Describe how specific payment mechanisms for primary (Section 6) and specialist inpatient mental health care (Section 8) facilitate or hinder coordination of care?

Example 2: the interface between hospital care and appropriate follow-up care.

Which specific payment mechanisms for hospital stays and specialist ambulatory mental health care facilitate or impede coordination between these two types of service once a person has been discharged from hospital?

Which specific payment mechanisms for hospital stays and primary health care facilitate or impede coordination between these two types of service once a person has been discharged from hospital?

References

Addicott R. *Commissioning and contracting for integrated care*. London: The Kings Fund, 2014.

Fulop N, Mowlem A and Edwards N. *Building Integrated Care: Lessons from the UK and elsewhere*. London: The NHS Confederation, 2005

Leutz WN. Five laws for integrating medical and social services: lessons from the United States and the United Kingdom. *Milbank Quarterly* 1999; 77(1): 77–110

Lewis R, Rosen R, Goodwin N, Dixon J. *Where next for integrated care organisations in the English NHS?* London, Nuffield Trust, 2010.

McKee M and Nolte E. Chronic care. In: Smith Peter C, Mossialos E, Papanicolas I and Leatherman S (eds.), *Performance measurement for health system improvement: experiences, challenges and prospects* pp. 406–425). Cambridge: Cambridge University Press, 2009

McDaid D. Joint budgeting: can it facilitate intersectoral action? In: McQueen D, Wismar, M, Lin, V Jones C and Davies M (eds), *Intersectoral Governance for Health in All Policies: Structures, actions and experiences, Observatory Studies Series 26,* London: European Observatory on Health Systems and Policies, 2012.

Pike B, Mongan D. *The integration of health and social care services.* Dublin: Health Research Board, 2014.

Shaw S, Rosen R, Rumbold B. *What is integrated care?* London, Nuffield Trust 2011.

The REFINEMENT Project

Research on Financing Systems' Effect on the Quality of Mental Health Care

FINCENTO

Financing & INCENtive TOol

A tool mapping health and other services for adults with mental health needs and identifying details of related financing systems