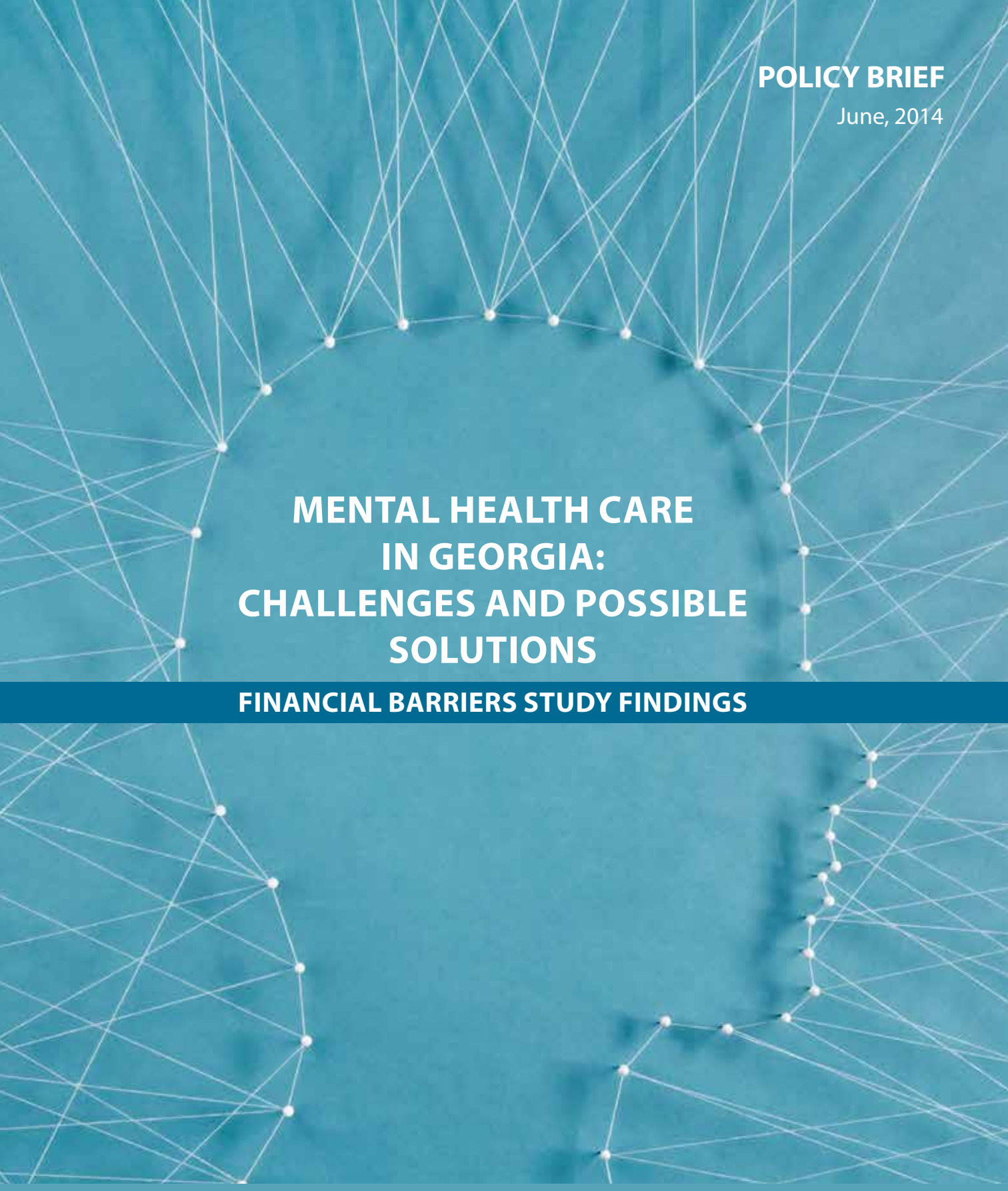


POLICY BRIEF

June, 2014

MENTAL HEALTH CARE IN GEORGIA: CHALLENGES AND POSSIBLE SOLUTIONS

FINANCIAL BARRIERS STUDY FINDINGS

20 CURATIO INTERNATIONAL FOUNDATION
Years of Challenging Transition

Global Initiative on Psychiatry

Significance of the Issue

The following key issues highlight significance of Mental Health for the Health Care and National Policy:

- Mental health is essential for the overall health and well-being as emphasized by the World Health Organization's definition – "A state of complete physical, mental and social well-being, and not merely the absence of disease."

- High burden of neuropsychiatric disorders in Georgia (22.8% of the global burden of diseases)[1] calls for adequate management and attention.

- Mental health problems have considerable and negative impact on the quality of life – especially, among the economically active part of the population, that have negative reflection to the country's economy.

About the Research

In 2014 Curatio International Foundation conducted a study on financial barriers of the mental health system. The study employed qualitative research methods, as well as literature review and secondary data analysis.

The document presents main barriers existing at the different levels of the system creating access problems to adequate and quality services for the population.

Policy Brief has been developed by Lela Sulaberidze, Maia Uchaneishvili, Nino Gamkrelidze under the guidance of Ivdity Chikovani. Curatio International Foundation would like to especially thank Nino Makhashvili (Global Initiative in Psychiatry – Tbilisi; Ilia State University) and David McDaid (London School of Economics and Political Science). The research team would also like to thank all the participants who agreed to dedicate their time and effort to the study.

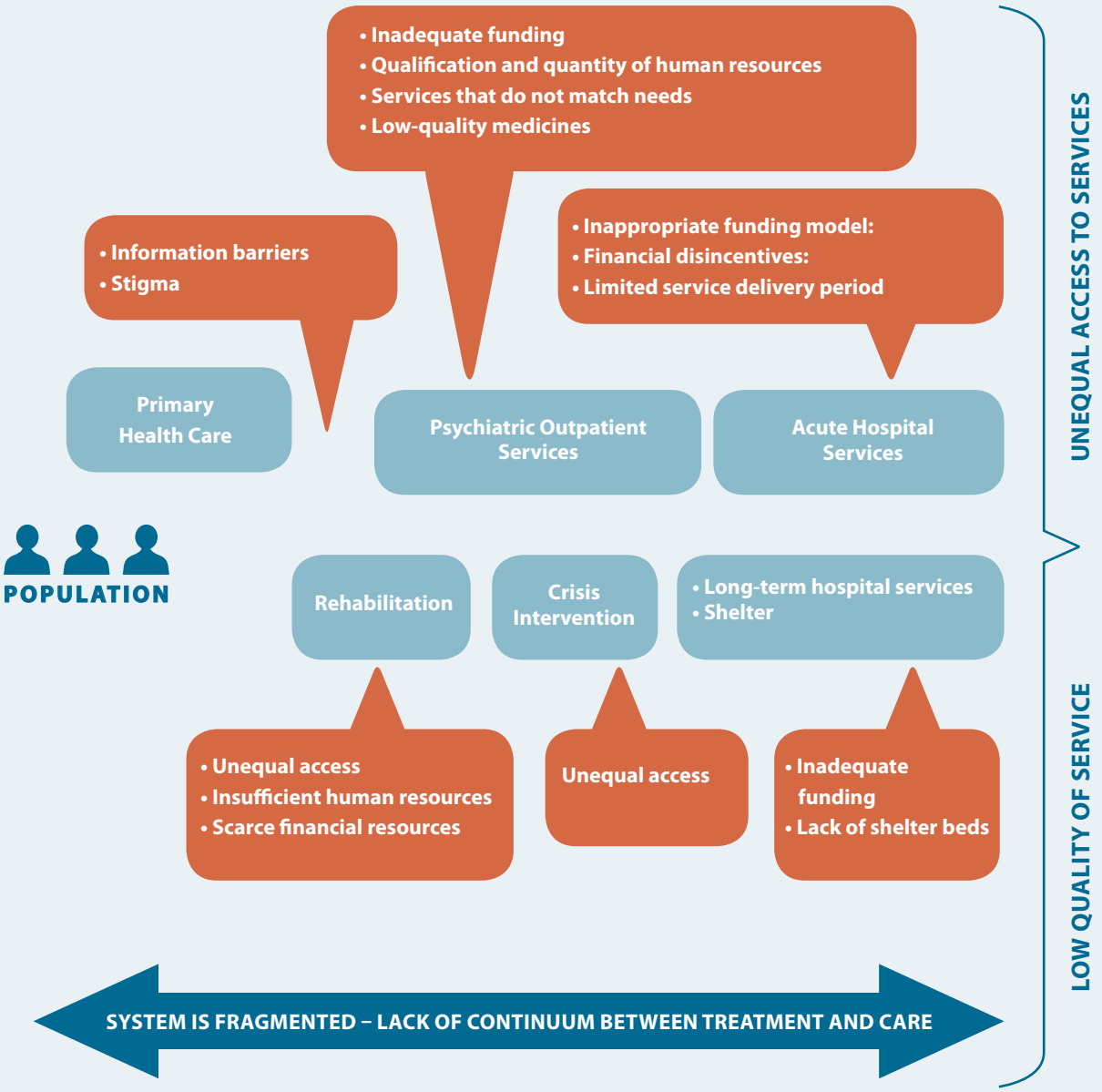
The study was carried out under the UNDP financial support. The views expressed in this publication are those of the author(s) and do not necessarily represent those of the UNDP.

Empowered lives.
Resilient nations.

1 WHO, Mental Health Atlas 2011

Context:

- Scarce financial and human resources
- Inadequate resource distribution
- Limited evidence base
- Management/supervisory gaps
- Poor interaction between different state programs services

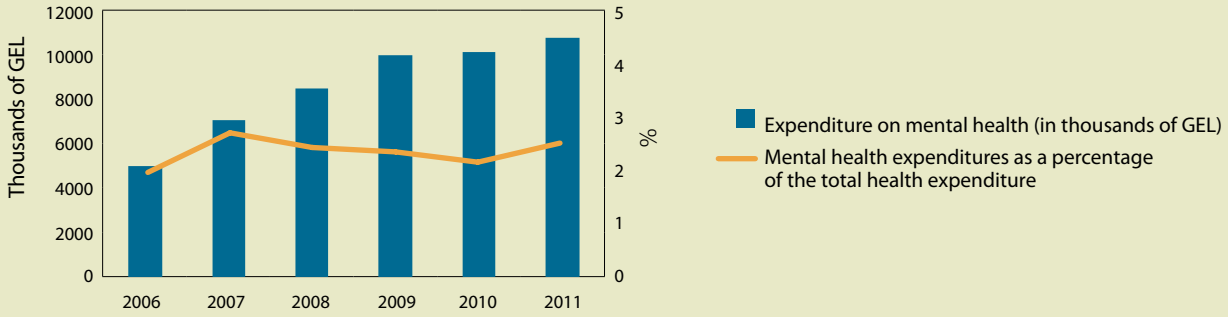


Funding and allocation of resources

MENTAL HEALTH EXPENDITURES

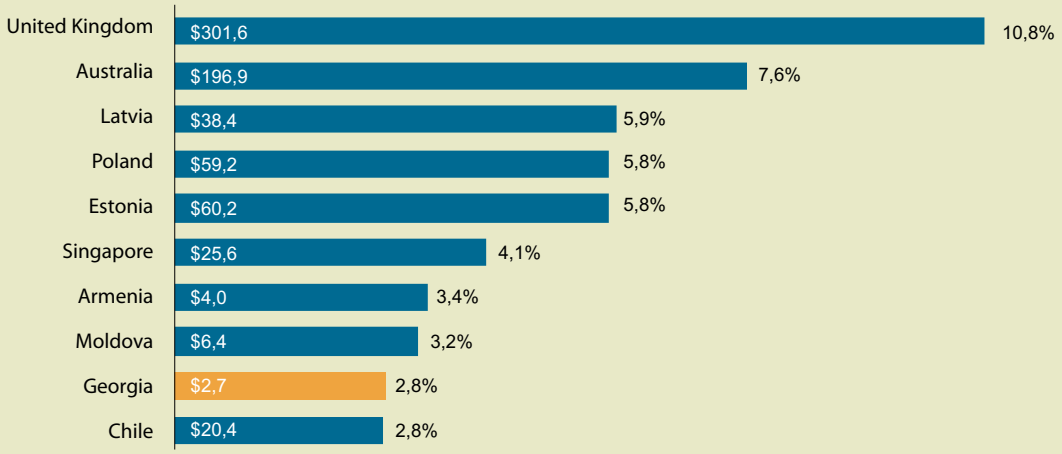
Public Health allocations on mental health in Georgia had a tendency to increase during 2006-2011, however the share of mental health expenditures (%) in the total public health expenditures has not experienced substantial change and stays at about 2.5%,[2] which is much lower than the same indicator of the countries with the similar economic development.

Figure 1. Mental Health Expenditure in 2006-2011



At the same time Per capita expenditure on the mental health in Georgia significantly differs from that of the countries with the similar development level, where more money is spent on mental health services.

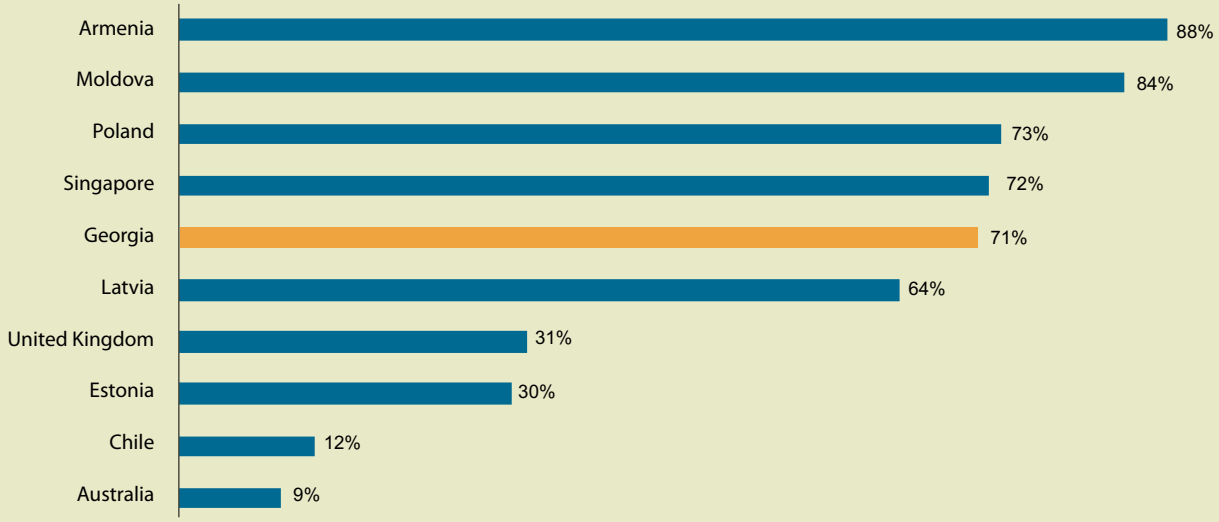
Figure 2. Mental health expenditure as % of public health expenditures and per capita expenditure on mental health[3,4]



2 National Health Accounts
3 WHO, European Health for All database
4 WHO, Mental Health Atlas 2011

A large portion of the funds allocated to the mental health care is spent on inpatient mental health services (71 %) in Georgia and this figure has remained stably high over the years (from 2006 to present). The developed European countries spend 9-31% on the inpatient mental health services, while having much higher expenditures on community services. It is worth mentioning that the deinstitutionalization process and the development of community-based services is a result of long-term endeavor in these countries, and Georgia will need decades to achieve the same level, however the first steps should be taken today. For example, Australia began to implement similar reforms as far back as in 1950s, and the United Kingdom has been implementing the reforms since 1980s.

Figure 3. Mental hospital expenditures as a percentage of all mental health spending[5]



In Georgia, the high share of expenditures on the inpatient services poses a significant problem to the development of outpatient services: a) Existing resources for satisfying outpatient programs needs are scarce, b) Until 2014, funds among service providers were distributed according to a "historic budget", which put institutions in unequal conditions – per registered beneficiary expenditures varied from 4 to 17 GEL. Weakness of the patient registration system is considered one of the causes of the above-mentioned inequality.

Overall scarcity of the financial resources allocated from the budget to the Mental Health

"... DURING LAST SEVERAL MONTHS WE'VE RECEIVED A LARGE NUMBER OF ADDITIONAL PATIENTS IN THE OUTPATIENT CLINIC, AND WE ARE EXPERIENCING LOSSES..."

A FACILITY MANAGER

"...WHEN I VISIT THE DOCTOR, HE/SHE GIVES ME 10 PILLS. THE DOCTOR DOES NOT TELL ME: I'LL GIVE YOU A PRESCRIPTION AND YOU CAN GET THE DRUG AGAIN. I'D RATHER BUY THE DRUG MYSELF - 100 PILLS COST 7 GEL- THAN PAYING 40 GEL FOR A VISIT AND GET THE DRUG FREE OF CHARGE...."

A CARE-GIVER

5 WHO, Mental Health Atlas 2011

Care fail to create a favorable environment for service providers for delivering better services. Namely, the competence of outpatient facilities is basically limited to prescription and distribution of drugs, which are of poor quality, and, in some cases, fails to comply with quantitative requirements. As demonstrated by the study findings, some facilities experience drug shortages for a certain period of a month that result in out-of-pocket expenditures by the patients.

FAIRNESS OF RESOURCE ALLOCATION AND ACCESS TO PROGRAM SERVICES

Currently 18 outpatient mental health care providers operate throughout the country, while only five are authorized to provide psychosocial expertise to persons with disabilities. According to the established procedure of granting the status, repeated assessment is carried out with a pre-determined frequency, that creates geographical barrier to the service accessibility and affects the patient's financial state. It should also be noted that the facility does not receive additional financial benefit for providing expertise service.

"... NOTHING CHANGES IN A PATIENT'S LIFE AFTER THE TREATMENT, STABILIZATION AND ACHIEVED IMPROVEMENT. THE ABOVE MENTIONED MUST BE ACCOMPANIED BY SOCIAL REHABILITATION. OFTEN THE PATIENT'S CONDITION IS EXACERBATED AND HE/SHE COMES BACK."

A PSYCHIATRIST

In light of the scarce resources, there is a certain type of service – a crisis intervention component, which absorbs 20% of the budget allocated for the outpatient clinics and is available only in 4 regions, while some districts are not covered even by basic outpatient services.

The psycho-social rehabilitation service, which, in its essence, is aimed to maximally promote the social integration and adaptation conditions for persons with mental disorders, is presently limited to only three institutions and the number of beneficiaries does not exceed a few dozen.

Long-term hospital beds are occupied by the patients that require shelter or community residential services. Therefore, in some cases, the access to necessary services becomes limited for the beneficiaries.

"... SOMETIMES THE HOSPITAL IS FULL, AND THEY TELL YOU TO CALL LATER SO THAT THEY COULD HOSPITALIZE YOU. YOU ARE PUT ON A WAITING LIST AND WAIT FOR YOUR TURN..."

A PATIENT

FUNDING MODELS

It is known that the funding models create financial incentives for service providers. The existing funding models on one hand stimulate reduction of length of stay and high bed utilization (acute hospitalization), while on the other hand - maximum bed occupancy (long-term hospitalization), that ultimately leads to an inefficient use of the program funds.

Analysis of cases of 10 months from 2013 program data demonstrates that length of stay in acute inpatient service provider institutions is 14-20 days, consequently, the bed turnover rate is high. Data from the developed countries shows that acute beds length of stay fluctuates in approximately the same range as in Georgia.[6,7] However, these countries have a developed unified system of treatment/care, the most important components of which are the non-hospital based services. The latter ensures the treatment continuation and constant supervision of the patient's health. It is interesting that in such systems re-hospitalization is estimated at 30 days and is used as an indicator for the quality of the non-hospital based services[8]. In Georgia the setting is different. In particular, the system in Georgia is fragmented - there is no close interaction between hospitals and outpatient services, while the re-hospitalization term of 7 days is considered a problematic issue among the psychiatrists.

Based on the international experience, it can be stated that the re-hospitalization term of 7-days is inappropriate under such a fragmented system. It does not fulfill its purpose. Furthermore, this regulation might encourage an institution to manipulate with a patient's hospitalization date.

„... I DON'T KNOW WHERE THIS DURATION OF 7 DAYS HAS COME FROM…I NEITHER CAN SAY A PATIENT'S STATE WON'T DETERIORATE WITHIN THESE 7 DAYS, AS THERE ARE NO EXTRA-HOSPITAL SERVICES AND A POORLY PREPARED FAMILY AND SOCIETY AWAIT THE DISCHARGED PATIENT OUTSIDE.."

A PSYCHIATRIST

The program design does not consider involvement of a hospital in patient's supervision after discharge. As a result of inadequate outpatient services, some patients return to the hospital. Within the 'conditional' time-frames established under the influence of the financial model, some patients' health state cannot be improved sufficiently to enable them to return to the society, therefore, after receiving acute hospitalization services, these patients become beneficiaries of the long-term hospital service. All these factors result in additional costs to the program. The funding of hospital services is unevenly distributed, for example, the funding of long-term services fails to cover the existing needs, while the acute hospitalization services are relatively adequately funded. The issue is exacerbated by the lack of criteria for acute and long-term hospitalization at the regulations level.

Management and Supervision

Mental health requires specific approach in terms of management/supervision. The existing supervision requirements of the public programs are standardized for the overall health care system and are not tailored to specific needs of the mental healthcare.

"… THIS REQUIRES DIFFERENT METHODS OF THE QUALITATIVE MONITORING; A MONITOR SHOULD RATHER BE A BETTER SPECIALIST THAN A BUREAUCRAT, WHO ONLY REVIEWS THE PASSPORT DATA... "

AN EXPERT

6 Australia, the duration of the acute hospitalization is 12-19 days. Australian hospital statistics 2009–10. Health services series no. 40. Cat. no. HSE 107. Canberra: AIHW

7 Canada - the duration of the acute hospitalization is 12-27. Statistics Canada, Acute care hospital days and mental diagnoses, http://www.statcan.gc.ca/pub/82-003-x/2012004/article/11761-eng.htm

8 Unplanned hospital re-admissions for patients with mental disorders. Health at a Glance 2013OECD Indicators

"... IF I AM OUT OF DRUGS IN THE AMBULATORY, BUT THERE ARE SOME LEFT IN THE HOSPITAL, I CANNOT MOVE FROM ONE TO ANOTHER..."

A FACILITY MANAGER

"... THE LAW ON PROCUREMENT DOES NOT ALLOW US TO PURCHASE MEDICINES OF HIGHER QUALITY..."

A FACILITY MANAGER

In addition, the supervision does not consider the quality monitoring and is directed only towards financial expenditure control. There is no monitoring and evaluation framework that would measure the program effectiveness. The existing funding models do not involve the indicators contributing to the quality improvement of the performed work.

The administration procedures for public programs create a so called "silo budgeting" barrier, which implies limitations in the transfer/reallocation of program funds between the program components (for example, the same implementer cannot move the program resources from one component to another in order to optimize the work and use the resources more efficiently).

The evidence-based decision-making process requires the mobilization of adequate informational, financial and human resources. To date, the country has developed an electronic system of beneficiaries of the public programs, which is a very good step forward and allows collecting and analyzing the program data by specific components. However, the system does not provide a unified database for conducting a comprehensive analysis in order to evaluate beneficiary's movement within the system, allow the timely identification of a problem and response to it. There is a lack of the financial and human resources as well.

"...THE ONLY PRECEDENT THAT WE ARE AWARE OF (THOUGH HAVE NOT USED) IS THE DIRECTIVE OF THE TENDER TO PURCHASE ONLY THE MEDICATION REGISTERED WITHIN THE RECOGNITION REGIME... THIS, OF COURSE, SIGNIFICANTLY INCREASES THE TENDER VALUE, AND THERE ARE NO FINANCIAL RESOURCES FOR IT, SO WE HAD TO REJECT IT AT THIS POINT..."

A FACILITY MANAGER

"... IF A PATIENT HAS TO BE TRANSPORTED FROM RUSTAVI TO TBILISI, HE IS REQUIRED TO PAY 70 GEL..."

FOCUS GROUP OF A SERVICE PROVIDER S

Shortages in qualified personnel were also identified in the field of public procurement.

"...IN THE INSTITUTIONS, THE POLICY IS DETERMINED BY THE MINISTRY OF HEALTH, WHILE MANAGEMENT IS IMPLEMENTED BY THE MINISTRY OF ECONOMY. WELL, HERE WE HAVE THE SITUATION WITH A SERVANT OF TWO MASTERS. THE MINISTRY OF HEALTH ASKS TO DO SOMETHING, WHILE THE MINISTRY OF ECONOMY DEMANDS SOMETHING ELSE. THIS BECOMES MORE PROBLEMATIC FOR A DECISION-MAKING..."

A FACILITY MANAGER

In order to avoid difficulties associated with the procurement requirements, due to lack of knowledge of terms and conditions and also, financial resources, the outpatient institutions are unable to purchase high-quality medicines.

Bureaucratic obstacles complicate the use of various public programs (e.g., universal health care) for beneficiaries of the inpatient component of the mental health program. The state-owned service providers are accountable to two state bodies for economic and financial indicators: The Ministry of Economy and Sustain-

able Development and the Ministry of Labor, Health and Social Affairs. This fact also raises substantial challenges in the financial management.

Human Resources

The mental health system in Georgia is experiencing a severe shortage of human resources. The quantity of the psychiatrists is half of the average European rate that makes a deficiency of at least 250 psychiatrists, when expressed in absolute figures. The situation with regard to other staff is even more dramatic.

Table 1. Psychiatric personnel per 100,000 population (2011)[9]

	GEORGIA	AVERAGE EUROPEAN RATE	HOW MANY PEOPLE NEEDS GEORGIA
Psychologist	12.8	22.2	422
Nurse	7.7	45.3	1688
Social worker	2.9	60	2564

The staff are heavily overloaded due to the shortage of human resources. At the outpatient level, beneficiaries indicate the existence of long queues, while at the hospital level the major part of the doctors' working time is devoted to such routine activities as maintaining of patients' medical records and preparation of various supplementary documents. Computerization of these functions, or delegation of those to the low-skilled staff would help to decrease the existing deficit in human resources.

"... I AM THE ONLY DOCTOR SERVING 65 PATIENTS PER DAY IN THIS HOSPITAL, AND PROCESSING THEIR DOCUMENTATION EVERY DAY IS A VERY LABORIOUS, IT REQUIRES A QUITE SIGNIFICANT PART OF MY WORKING TIME..."

A PSYCHIATRIST

"... THERE IS A PROBLEM WITH THE STAFF, BASICALLY, WITH SOCIAL WORKERS, REHABILITATION SPECIALISTS, PSYCHOLOGISTS; THE EDUCATION OF NURSES IS NOT ADEQUATE... THE NUMBER OF THE PSYCHIATRISTS IS ENOUGH, BUT THERE IS A NEED OF FURTHER RE-TRAINING. YOU CAN INCREASE THE NUMBER OF NEW SPECIALISTS, BUT THEIR INTEREST IS LOW AND LATER THERE MAY BE A PROBLEM TO GET THEM EMPLOYED..."

A FACILITY MANAGER

Lack of the personnel on one hand and limited financial resources on the other result in the absence of multidisciplinary services at the outpatient level. Again, there are problems with the personnel qualification, especially in the regions, and particularly with psychologists and nurses. Due to lack of financial incentives, the psychiatric field is not attractive to young doctors. Also the existing funding models do not contribute to the work quality improvement.

9 WHO, Mental Health Atlas 2011

> **"... THE FAMILY DOCTOR (FD) SENT US TO THE NEUROLOGIST. THE FD DID NOT MENTION A PSYCHIATRIST AT ALL..."**
>
> **A CARE-GIVER**

The above mentioned problems are further exacerbated by the fact that the state has not yet developed a vision/strategy for supplying the field with human resources in the future, which would encourage young medical staff to work in this field.

Weakness of the primary health care system in identifying and referring the patients with mental disorders shall be especially underlined. The study conducted among the IDPs demonstrated that in cases of the most common mental disorders,[10] 43% of the patients visit family doctors and 55% - neurologists, while utilization of specialized mental health services is very low (4%). The reason for this is that the family doctors do not or cannot identify the cases, or incorrectly refer the patient to a neurologist. The stigma associated with seeking of medical attention at separate specialized mental health facilities also plays a decisive role.

Proposed Problem Solutions

To improve the current situation in the mental health system, it is important to make rational and weighted steps, evidence-based decisions and, at the same time, develop funding models that take into account the country's socio-economic status and is focused on the system development.

As shown by the international experience, the deinstitutionalization is a long, but necessary process for the field development. It requires the consistent and stage-by-stage introduction of changes in the current mental health program components. The country has developed the Mental Health concept,[11] and also the development process of a strategic plan that should define system changes for the next 5-10 years is underway.

In order to address challenges revealed by the study the following approaches are proposed:

1. RESULTS BASED FINANCING

Introduction of a Results Based Financing model that creates financial-economic incentives for the development of community services. This model should be directed towards the creation and maintenance of a continuation between the treatment/care services, thus contributing to achieve the final outcome – improved patient's health condition through quality and efficient services. The model envisages the promotion of facilities with financial bonuses (which shall be directly reflected on the staff salary) based on special indicators, in order to develop the services that would be oriented on the deinstitutionalization of a patient and his/her return to the society. The model should allow a facility to use funds according to its needs. It is necessary to allocate additional funding from the program budget for financial incentives.

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10 Depression, Post-Traumatic Stress Disorder, Anxiety disorder

11 The Parliament of Georgia resolution on approval of the "Mental Health State Concept", 11 December, 2013

2. NON-HOSPITAL BASED SERVICES

Increase funding for outpatient services in order to satisfy basic needs of the program beneficiaries. Determine a fair budget in accordance with the number of registered beneficiaries at the outpatient facilities. Place the mental health staff in the primary healthcare centers in order to attract the patients who do not see specialists due to the stigma or an informational barrier.

The program shall have a geographic view, which will enable elimination of the geographic availability barriers within the non-hospital based mental healthcare services in a particular area, and will maintain continuity among different service levels. To provide the latter, it is necessary to introduce the practice of sharing the patient-related information between the agencies implementing different types of services.

3. MONITORING AND EVALUATION

Implementation of the independent monitoring and evaluation of the program based on pre-designed, specific, clear, measurable and quality-oriented indicators that shall be directed towards supporting supervision and not focused on punitive measures. For instance quality indicators could be: timely inclusion (7 days) of the patients discharged from the hospital in the outpatient services; Continuous supervision of the discharged patients by the outpatient services; Proportion of re-hospitalization of the patients discharged from the hospital during a specific period of time.[12] As a result of the analysis of the independent monitoring and evaluation, identification of program deficiencies will be simplified and measures for their correction will be planned.

4. INFRASTRUCTURAL CHANGES

Implementation of infrastructural changes both to modernize the existing facilities and develop new services.

Additional buildings are needed to be assigned /constructed for residential facilities of communities, which will release hospital beds currently occupied by shelter beneficiaries.

The proposed approaches will allows us to overcome the following barriers:

- Ensuring continuation of services: the facility will be motivated to reduce unnecessary costs (e.g. timely discharge of patients from the facility, if not otherwise required) and develop the outpatient services focused on community needs.

- Optimal/targeted use of the budget – possibility of spending funds for their intended purpose in the absence of a "silo budget".

12 Selecting Indicators for the Quality of Mental Health Care at the Health Systems Level in OECD Countries, OECD Health Technical Papers No. 17, 2004

- Currently existing prejudicial financial incentives and obstacles will gradually decrease (and, probably, disappear).

- Financial incentives for the personnel will help to create competitive environment for recruiting new personnel.

- In order to identify persons with mental disorders, incentives will be created to establish close links with the primary health care system.

- Access of population to necessary services will be improved.

5. UNIFIED PROCUREMENT SYSTEMS FOR MEDICINES

Voluntary combination of forces of the facilities regulated by the Public Law in order to implement unified drug procurement, which could be accomplished with the help of a hired group of experts.

What barriers will be surmountable?

- As a result of the increased volume of medicines to be purchased the unit price may be reduced and/or the quality of medicines to be purchased may be improved, and/or the quantity of medicines to be purchased may be increased. Eventually, significant drug price-and quality-related problems will be solved.

- Hiring an expert group in order to implement a unified procurement will eliminate operational challenges associated with the knowledge and management of the state procurement regulations (such as the challenges associated with the possibility of inclusion of additional conditions related to the quality of medicines).

6. HUMAN RESOURCES DEVELOPMENT

- Elaboration of the vision and strategy on human resources development in the mental health care system;

- Labor division. Because of the professional staff shortages in the facilities, distribution of responsibilities to the less qualified staff is recommended (e.g., processing documents, etc.) or releasing time by the computer automation of the process, for example, automation of drug prescriptions in outpatient clinics;

- Creating motivations to attract and retain younger staff members (e.g., results-oriented bonus system), hiring residents/junior doctors, etc.