Evropská unie
Evropský sociální fond
Operační program Zaměstnanost

MERRPS international workshop on mental health economics

Meeting minutes of the second day

BASIC INFORMATION

Date: 28th November, 2019

Place: Kaiserštejnský palác, Malostranské náměstí 23/37110 00 Praha 1

Attendees: Petr Winkler, Hana Marie Broulíková, Helena Rögnerová, Bertalan Németh, Pavla Čermáková, Lucie Kondrátová, Matyáš Müller, Dana Chrtková, Alexandr Kasal, Tomáš Formánek, Karolína Mladá, Zbyněk Roboch, Dita Protopopová, Martin Dlouhý

Program: see here

BERTALAN NÉMETH: HEALTH ECONOMICS OF MENTAL HEALTH ISSUES WITH SPECIAL FOCUS ON CENTRAL AND EASTERN EUROPE

- see the presentation

Summary

- CEE countries have worse health status, more limited health care resources, fewer trained health economists, lower public budget for health economics and health policy research and they pay more penalties for inappropriate health policy
- myth concerning mental health were presented – mental health as neglected problem – extremely costly and huge burden – despite this they are not priority for the health system
- use of health economics - two examples
    - first – cost of negative symptoms of schizophrenia
        - systematic review showed that negative symptoms of schizophrenia generate considerable cost despite the general assumption that they do not
        - testing new drug in different settings - transferability of cost-effectiveness findings is limited – results different for different countries despite the same methodology (with key factor being the hospitalization costs – using new drug, they spend less time in hospital, it saves money; the cost of hospitalization is different across countries)
    - second – smoking cessation (EQUIPT study)
        - model of three states smokers – former smokers – death
        - looking at 4 main diseases
        - outcomes of social marketing campaign, doubling of therapy and their combination compared → combination had biggest health benefit and saved money

Discussion

- in Hungary they have functioning HTA agency but it only rarely includes psychosocial interventions – mostly pharmaceuticals
- Bulgaria smoking rate compared to other countries?
- equity implications should be included
    - smoking banned in restaurants – effect on pregnancies and new born children of waitresses was investigated – it had more positive effect on waitresses of lower socioeconomic classes because those of higher status had already known about the harm, so they left the environment
- education of policy makers – health economics is not just about saving
    - they often fear initial costs that can be too big
    - example of infamous Phillipe Morris study in the Czech republic – included initial costs – people who smoke die younger - before retirement – thus the campaigns against smoking do not save money
    - we should not expect cost savings but cost-effectiveness

MARTIN DLOUHÝ: MENTAL HEALTH FINANCINGIN THE CZECH REPUBLIC

- see the presentation

Summary

- Structure of expenditures: Public health insurances (80%) + private expenditures (15%) + regional budgets (5%)
- Health expenditures in CZ is below OECD average (7 to 8%)
- According to EHCI 2018, CZ system is more effective than others, functioning better (even it is cheaper)
- Health insurance is compulsory (based on a permanent stay or if a person is employed in the country), government pays insurance for children, unemployed, retired, prisoners etc.
- 7 public health insurance funds in the country
- Reimbursement mechanism
    - No specific budget for MH
    - No special reimbursement system for mh, no special regulations
    - Outpatient care: Fee-for-services system (no direct prices, fee is being prised)
    - Inpatient care: per-day system (not in psychiatric institutions only)
    - Acute care: DRG (mean duration of stay is about 20 days)
- Psychiatric wards usually do not admit acute patients, the reform processes aim to motivate them to work with them and do not refer acute patients directly to psychiatric hospitals
- Reimbursement Decree is being changed every year, is very complicated, most of the providers cannot understand the formulas
    - Reimbursements negotiated between associations of providers and ministry, the ministry makes the final decision (embedded in law)
- Mental Health Centres established recently, mh care is still largely based on inpatient care
    - From Jan 2020 MHCs should be paid from health insurance and regional social budgets
    - The network of regional services is updated once a year, a complicated political process, long-term planning is needed, sustainability is not being assured neither for the current services
- NGOs providing services ask for grants from different sources (ministries, municipalities, national councils, public health insurance funds etc.)
    - The structure of financing is more stable
- Mental Health Expenditures (MHE)
    - The calculations vary from 3 to 4, 14 % (below the EU average)
    - The majority of MHE go to inpatient care/mental health hospitals (more than 50 %)
    - Source of financing – health insurance is the most important
    - A third of MHE goes to schizophrenia treatment
    - Personal costs – reach up to 65 % of MHE

Discussion:

- The discussions to leave the per-day system have not been started yet, starting next year the incentives for people hospitalized for more than 180 days will be decreased
- An effort to speed up the process of deinstitutionalization (number of beds decreased by 50 psychiatric beds in the last 5 years), a lot of work with hospital managers is being done (transformation teams in each psychiatric hospital)
- Positive change in attitudes of those working in psychiatric hospitals is seen (more constructive cooperation)
- Efficiency is being monitored by individual outcomes as well as macro indicators (readmission rate etc.)
- Experience with care measures? Regular survey among mh care users is conducted
    - Anonymous, data may be linked back to a facility
    - Experience with care is always system-specific
- Rowena Jacobs: a recent study focusing on factors which drives an experience with care

CONCLUDING DISCUSSION

- the question of how to make assessment of services in a systematic way in the Czech Republic was discussed
- **How to introduce health economics?**
    - experience from Canada (INESSS)
        - there is a need for building platform at the political, governmental perspective to support such a movement
        - big driver was the understanding at the minister level that the system will be unable to sustain without capacity to decide what is good and bad practice – readdressing in the way that is not political – not only compromise between stakeholders
        - they invited people from NICE for inspiration – building capacity for methodological and economical experts – mixed with consideration of participation, citizenship
        - since the beginning they had troubling with financing but INESSS wasn't cut down
    - Hungarian experience
        - it is good to have a special HTA institution – often cost-effectiveness is not written in the law, government can pretend it does not exist
        - capacity building is necessary – using established institution – programs at universities
        - what is challenging – you have to convince not only clinicians but also politicians, decision-makers – they mistrust
- **What is the attitude of medical doctors? Here they fear that it will take power from them.**
    - Canada
        - they were afraid there would be department that will decide what is and is not good for the population – they struggled – it was important for them that the institute is outside ministry of health – processes are completely independent
        - they understood their members would be needed for those processes
        - they had to make sure it will be done with ethical principles – no physician could be part of expertise or deliberative committee if they had ethical issues
        - Quebecian physicians give priority to the therapeutic value – component of health economist is important but not mixed with other process
    - UK
        - doctors in the UK welcome it, there were health economists in contact with doctors and persuaded them - they now train doctors at medical schools in health economics
        - psychiatry specifically is a bit different
        - over the years people are accepting the idea of cost effectiveness more
        - NICE attitude: don't give a measure to someone if it's harmful; you don't penalize clinicians when they use other treatment than the recommended one
    - Netherlads

        - first reactions were against health economics – they perceived it like just about reducing budget
        - generally doctors now perceive it as useful in the context of quality guidelines
- **Contextualization of evidence**
    - there was an agreement that that the evidence has to be contextualized because there are different results in every country due to specific socioeconomic factors – for this reason it is necessary that there are HTA agencies specific for a given country
    - there is often an objection to HTA: it is so expensive, so why we don't just use NICE guidelines → systems in countries that did this collapsed – if we don't contextualize, it will lead to unsustainable system
    - it is possible to contextualize guidelines for CZ – possible collaboration with NICE, INESSS
    - currently the evidence for pharmaceuticals and other interventions is from abroad – the decisions are already made, we need to know how to improve it
    - example from NICE in Turkey developing clinical guideline for schizophrenia: NICE offered training, helped them to review evidence, recruit people but the data were gained by Turkish researchers with their context and they got different results
    - NICE international
    - similarly INESS operates in Kazachstan, Tunisia...
- **Should we create new HTA institution for mental health or join some existing one (like SUKL – state institute for drug control – HTA for pharmaceuticals)?**
    - it would be too ambitious to establish such an institution for all health sector but it might be possible to develop and pilot it for mental health (within the MHC reform, with insurance companies)
    - possibility to have one pilot for MH and one for other health interventions
    - we have good example with SUKL for controlling medicine – it is financed separately from ministry
    - we have in our law special cases for paragraph 16 when somebody needs extra care (not recommended by guidelines), we can ask insurance company to follow one case and finance this special care
- **Who should be the partner of the Czech agency – should it be connected to NIMH or university or established as a whole new body (which would be demanding)? How to build capacities?**
    - health economists were drawn from universities to NICE at the beginning
    - now universities offer them more indirectly – they provide methods
    - lack of health economists – the only way forward is to have training for health economists at university – at the moment it is necessary to go abroad - we should start with making lectures within existing programs
    - health economics should be supported by science funding institutions
    - importance of collaboration of ministry of health and education
- **How to establish regular collaboration of HTA and government?**
    - Canadian experience – it should be given by the law - components of INESSS worked before law as well, but the law reinforced it and helped to maintain it
    - Nethernads - government has now more interest in HE and is more demanding that new technologies are supported by evidence
- **What would you dream of for the Czech Republic in terms of health economics within 5 years?**
    - the evidence is respected by insurance companies and translated to practice
    - health and social care providers understand the principles of HE and value it
    - minister of health has a special commission board – list of recommendations can be taken there – the minister of health is doing things for future, there is chance to do something

Minutes written by Matyáš Müller