

Cornerstones of mental healthcare

The Dutch Association of Mental Health and Addiction Care's Chris Nas and Alex van Geldrop consider the changing face of mental healthcare in the Netherlands and Europe...

Mental disorders are among the main causes of the global burden of disease. The associated costs are immense; a conservative estimate is 3-4% of the GDP of the European Union.¹ Therefore, the European Commission (EC) and World Health Organization Regional Office for Europe (WHO/Europe) have recently published strategies to strengthen mental healthcare systems.^{2,3}

The Dutch answer is a market-based system

In the last decade, the Netherlands has executed a unique strategy to build a sustainable mental healthcare sector. In 2006, the government introduced regulated competition for healthcare, in which health insurers and service providers have to negotiate on costs as well as quality of care. In this marketplace, health providers that deliver cost-effective services will have a competitive advantage, which will stimulate innovation. However, improving performance is only possible if reliable and comparable information is available on both costs and quality of care (outcomes, client opinions, patient safety). For each cornerstone, data is collected individually, analysed, and reported nationally. Together, these four cornerstones will act as change drivers, in line with recent international recommendations (see table).

Now that change drivers are in place...

First, an activity and quality-based payment system for mental healthcare has been established to make costs transparent. There are currently 140 DBCs (the Dutch equivalent of diagnosis related groups) for treatment and seven for accommodation. The Dutch Healthcare Authority annually determines the maximum fee for all DBCs.

Because DBCs do not provide insight into quality, patient-reported outcome measurement is pivotal. These outcomes facilitate shared decision-making during treatment and thus empower clients, and also

contribute to professional reflection and governance. A national benchmark institute collects the anonymised data and publishes reports for stakeholders. Health insurers use these in their purchasing process.

The Consumer Quality Index (CQ-index) assesses client experiences. As of 2013, this system will be integrated into the outcome measurement system.

For patient safety, the Dutch Health Inspectorate decided to focus data collection on the priorities set in the national patient safety programme: medication safety, the perceived client-safety, and coercion (restraint, seclusion and forced medication).

...the next priority is redesigning the mental health system

Because implementation of these change drivers required a huge effort, Dutch mental healthcare has to catch up in other aspects. The National Agreement on the Future of Mental Healthcare 2013-2014 lists no fewer than 19 actions that reflect a major and necessary shift in the provision of mental healthcare.⁴

To achieve patient-centred and cost-effective mental healthcare, the government and representatives of clients, providers, health professionals and insurers agreed to continue the abovementioned policies and added these priorities:

- Strengthening primary mental healthcare for common mental disorders, including a new financing system for general practitioners, to reduce the number of patients in specialist mental healthcare by 20%;
- A shift from institution-based to community-based mental healthcare for severe mental illnesses, reducing the number of beds by 30% in 2020;
- A destigmatisation programme has started to facilitate social inclusion of people with mental disorders;
- A further reduction of coercive measures.

Change drivers identified by the EC and WHO	Current situation in the Netherlands
1 Strengthen governance for mental health (WHO)	Regulated competition in (mental) healthcare based on transparency of cost and quality
2 Create financial incentives by introducing activity and/or quality-based payment for DRGs (WHO and EC)	DBC's are fully implemented as payment system
3 Use health technology assessment systematically for decision-making processes, based on cost-effectiveness (EC)	N/A
4 Strengthen information systems, evidence, and research for mental health by improving data collection (WHO and EC)	Performance indicators on outcome monitoring, consumer quality and patient safety are implemented
5 Use financial incentives to encourage patients to register with a general practitioner and use a referral system to define a cost-effective path of care (EC)	Nearly all Dutch inhabitants are registered with a general practitioner, who acts as gatekeeper

Collaboration across health and social services is the next step

For patient-centred care, cooperation between youth care, social services, employment officers, housing societies and debt councillors is necessary. But cooperation outside of these traditional domains is also required. The Dutch Association of Mental Health and Addiction Care signed covenants with the national social benefits office to return employees with mental disorders to paid employment, and with the police to maintain public safety and security for patients and their environment.^{5, 6} Virtual 'safety houses' were set up locally, providing networks of legal aids, social and (mental) healthcare professionals and municipal civil servants to develop a transcending approach for complex cases in order to reduce severe nuisance and crime.⁷

Furthermore, special care and advice teams including mental healthcare professionals work in schools for prevention and early detection and treatment of psychosocial problems among children and adolescents.

These developments direct us towards long-term strategic objectives for mental healthcare: detect and treat psychosocial problems in an early stage, keep or return people to work, and social inclusion of clients suffering from severe mental illness.

Key for success: disseminating knowledge

These developments will fundamentally change the role of mental health practitioners. The transfer of knowledge to human resource departments and occupational physicians, teachers and sport coaches, general practitioners and nurses, community leaders and police officers will partly replace activities like treatment and support. All of these groups have to develop skills and awareness regarding mental health problems. Moreover, prevention, early detection and self-management will be facilitated by e-mental health applications on smartphones and the internet.

Change does not come easily – adoption of cost-effective health innovations takes about 17 years.⁸ So how can we stimulate acceptance of innovations in order to reap the substantial economic benefits? Aiming to shorten the implementation time to two or three years would be a good start.

Furthermore, healthcare practitioners will only change routines if doing so will deliver value for both patients and themselves. Transparency on outcomes will act as a change driver for motivated professionals and the market will drive innovation by rewarding organisations that perform better.

However, healthcare workers need to be able to find this information. Therefore, a European implementation programme is required that weighs the existing fragmented knowledge, breaks it down into bite-size modules and makes it accessible. In every country, mental health practitioners should find all the information they need on one website.

From an economic perspective, mental health should be foremost in the minds of Europe's decision-makers. A joint effort of mental health practitioners and policymakers is needed to provide European citizens with a smart, sustainable and innovative mental health system.

¹ Organisation for Economic Co-operation and Development (OECD), *Sick on the Job? Myths and realities about Mental Health and Work*, 2012, OECD Publishing

² European Commission, *Social Investment Package: Investing in Health*, 2013

³ World Health Organization, *Draft comprehensive mental health action plan 2013–2020*, 2013

⁴ *The National Agreement on the Future of Mental Health Care*, 2012

⁵ GGZ Nederland and UWV, *Convenant tussen Uitvoeringsinstituut Werknemers Verzekeringen en Geestelijke Gezondheidszorg Nederland (GGZ Nederland)*, 2012

⁶ GGZ Nederland and Politie, *Convenant Politie – GGZ 2012*, 2011

⁷ Ministerie van Veiligheid en Justitie, *Landelijk kader, Veiligheidshuizen, Vóór en dóór partners*, n.d.

⁸ Balas A. and S Boren, *Managing Clinical Knowledge for Health Care Improvement*, in *Yearbook of Medical Informatics 2000*, National Library of Medicine: Bethesda, MD, pp. 65-70



Chris Nas
Senior Policy Adviser

Alex van Geldrop
Junior Policy Adviser

Dutch Association of Mental Health and Addiction Care (GGZ Nederland)
CNas@ggz nederland.nl
www.ggz nederland.nl