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Mental Health Reform: the Greek Experience

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Mental Care Reform: the Greek Experience

- Why is mental care (and mental care reform) important?

  - mental illnesses associated with social costs: unemployment, homelessness, violence, crime
  - mental illnesses increase risk of communicable and non-communicable diseases; co- & multi-morbidity (Prince *et al*, 2007)
  - large savings in hospital costs have resulted from treatment improvements (Buxton *et al*, 2004)

→ reforming mental care may lead to substantial economies of health expenditure (see KCL, KI study on dementia)

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❑ Why look at stakeholders, and their engagement in reform?

- ‘programme’ or ‘project environment’ of healthcare infrastructure and/or service reform programmes: several stakeholders, e.g. int’l organisations, national government, practitioners, patients, communities play a part in reform (‘change’)
- stigma associated with (mental) health conditions :: relevant to delivering community-based care and rehabilitation
- consensual and pluralist national policy systems
- the role of civil society.

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- Reform programme 1984-1995: EEC/815/84 Programme B
  - mental care prior to reform: institutional care for virtually all pathologies, ten overcrowded hospitals, uneven geography, lack of alternative services and qualified staff
  - reform prompted upon entry of Greece to the EU (EEC)
  - a 4-year programme designed with input from EC, WHO to:
    - replace institutional care with primary & acute care;
    - offer care to long-stay hospital patients in extramural, social, vocational rehabilitation structures in communities;
    - upgrade hospital infrastructure, provide care staff training.
  - Finance: yearly matched funding, national and EU at 55%.

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- Reform programme 1984-1995: EEC/815/84 Programme B
  - → irregular stakeholder engagement led to:
  - (a) delays in site selection for new service infrastructure;
  - (b) very slow progress with construction;
  - (c) slow progress with care staff completing training;
  - (d) absence of programme monitoring.
  - → these were not addressed by the national government, or other stakeholders
  - → (a) – (c) persisted → funding withdrawal → reform at risk

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- ❑ Reform programme 1984-1995: EEC/815/84 Programme B

  → in 1989: EC intervened, introduced own expertise and rallied other stakeholders:

  - monitoring and evaluation established, uninitiated projects cancelled; three expert groups introduced to review progress

  → national gvt presented special actions, a revised programme

  → expert groups working with national gvt and care staff to deliver primary and acute care services, new legislation, balancing the geographic distribution of new services

  → programme completed in 1995 :: due to active stakeholder engagement after 1989.

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- Reform programme of 1995-1999: Psychargos A
  - a further programme to broaden de-institutionalisation, community-based, extramural and primary care;
  - financed by national, EU Structural Funds: ERDF, ESF
  - stakeholder engagement promoted by the EU:
    - support for concerted actions in psychiatric hospitals;
    - emphasis on developing motivated, qualified staff;
    - stakeholder participation formalised through programme Monitoring Committees (EC/1260/99), reviewing progress periodically.
  - improvements in the legal and administrative framework requested by the EU

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- Reform programme of 1995-1999: Psychargos A
  - provided financial support to new care structures
  - enhanced knowledge of frontline practitioners through training, interaction with international experts invited by the Greek government
  - prepared the ground for a larger scale de-institutionalisation after 2000

→ However:

  - legal and administrative improvements introduced in 1999
  - delays with launching the national autism care centres through regional programmes suggest these may not be the optimum instrument for delivering specialist care

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❑ Reform programme 2000-2008: Psychargos B

→ programme foci:

- de-institutionalisation of mental hospital patients;
- expansion of community-based and primary mental care, integration with acute care;
- illness prevention, solidarity, labour market inclusion;
- training for care practitioners.

→ Law 2716/1999 set out the framework of implementation:

- service design based on population-based needs assessment;
- community psychiatry, emphasis on primary, extramural care;
- de-institutionalisation, social rehabilitation, continuity of care;

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- Reform programme 2000-2008: Psychargos B

  Law 2716/1999 (cont'd):
  - information dissemination, growth of volunteerism;
  - launch of a Committee for the Protection of Patients' Rights;
  - hospitals entitled to launch new care structures & services: *mental care centres, child care centres, mental care surgeries for adults and children, specialised care centres, rehabilitation, mobile care structures, home-based services*;
  - private actors entitled to launch new care structures & services: *day care centres, protected flats, hostels, social rehabilitation and employment centres, communal limited liability partnerships with local government*.

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- Reform programme 2000-2008: Psychargos B
  - → delineation of *mental health sectors* according to geography and population: fifty two prefectures of Greece as basis
  - → new care services to be managed and monitored by *Sectoral Mental Care Committees* (SMCCs), staffed by senior practitioners working in mental care hospitals and private structures in Greek prefectures
  - → absence of *a priori* distinction at programme level among types of mental illness and services to be provided
  - → epidemiological data collection and analysis lacking as basis for designing specialist care structures: reliance on mental hospital patient data

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- Reform programme 2000-2008: the role of SFs

→use of the ERDF and ESF <u>*in combination*</u>:

- ERDF: infrastructure build and equipment - €21.5mio;
- ESF: care staff training, salaries, property rent costs - €182.6mio;
- National funding - €51.1mio.

→ traditional focus of ESF: development of human resources

→ "Psychargos B" designed as an intervention relevant to human resources, social inclusion, and the labour market:

- patients accessing the labour market - rehabilitation, job training;
- patient family members free to access the labour market;
- growth of community-based mental care services;
- career opportunities for care practitioners.

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Reform programme 2000-2008: the process

Programme Scoping

Action Plan put together by MoH, communicated to stakeholders → Scope of New & Deferred projects assessed and approved by MoH → OP, Programming Complement texts finalised and published by the MA

Prospective Beneficiaries Certification

Prospective beneficiary organisations invited to obtain certification by the MA → Organisations prepare and submit their certification dossiers to the MA → Certification dossiers assessed, results published by the MA

Project Approval

Project ToR developed by MoHPD → Mature project ToR sent to MA for approval → Mature project ToR finalised, published by MoHPD → Tenders submitted within timeframe set → Submitted tenders assessed, winning bid selected → Contract prepared by MoHPD

Project Implementation

Project start put together by the MA → Funding claim sent to PA by MA → Contract signed betw. beneficiary, project contractor → Payment approved, drawn on ERDF, ESF, national accounts, sent to beneficiary by PA → Beneficiary submits monthly expenses to MA → Beneficiary submits 6-month report to MA

New Structure Operation

Further infrastructure, equipment procurement managed by beneficiary → Staff hiring, patient profiling, further prep steps managed by beneficiary → Structure begins operation funded by Psychargos B for 12, 18 months → Operation funded by ordinary MoH budget

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- Reform programme 2000-2008: issues

→ intermittent stakeholder engagement in the design and implementation of the programme led to these deficiencies:

(a) priority on patients exiting hospitals prior to expanding capacity of extramural & primary care service network;

(b) finance plan disproportionately reliant on EU funding: lack of additional funding, irregularity of national funding;

(c) no care quality guidelines or control developed *a priori*;

(d) little, unsuccessful engagement of local stakeholders;

(e) weak project maturation and management in regions.

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- Reform programme 2000-2008: performance

→care delivery problems after 2005, putting reform at risk:

(a) patient safety incidents;

(b) inconsistent quality of care;

(c) new private structures came to be underfunded after 2005, compromising care quality further;

(d) loss of commitment to reform on the part of practitioners;

(e) negative reaction by local residents towards new services.

→ 2009: EU and Greek government secured funding, established a care quality control system.

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- Conclusions

  → patient de-institutionalisation may ensue once primary and extramural network, care quality control are in place;

  →mode and regularity of stakeholder engagement matter: roles and expertise contributions important to agree, map, communicate and evaluate at every stage of reform;

  → periodic, or exception reporting seemingly not suitable: need for other more appropriate PM methods

  → finance supporting reform may affect continuity of care: multiple funding channels required to sustain reform;

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❑ Structuring a new healthcare market:

- patient de-institutionalisation leads to demand for launching new services
- demand sees new structures launched, care practitioners gain employment
- patient family members released to access the labour market;
- patients themselves enter the labour force.

→ Care quality control; complementary funding channels; career development pathways; active stakeholder engagement needed.

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Your questions

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