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Access to Health Care for People with Mental Disorders in Europe

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Poverty and social exclusion continue to be serious challenges across the European Union and for health systems in Member States. People with mental disorders are at high risk of poverty, stigmatisation and social exclusion. They are also more likely to face physical health problems and to die prematurely. There is evidence that they do not receive the general health care that best responds to their needs. Improved access to general health care is therefore essential to minimising disadvantage for people with mental disorders. This Policy Brief outlines hurdles of access to health care for people with mental disorders and discusses policy implications.

The results presented are part of a research project on "Quality in and Equality of Access to Healthcare Services" (HealthQUEST) that was financed by the European Commission, DG Employment, Social Affairs and Equal Opportunities. This study analysed barriers of access to mainstream healthcare services for people at risk of social exclusion as well as policies in Member States to mitigate these barriers. The study had a focus on three groups at risk: people with mental disorders, migrants and older people with functional limitations. Eight countries were studied in depth: Finland, Germany, Greece, the Netherlands, Poland, Romania, Spain and the United Kingdom. A special case study analysed the situation of people with mental health problems in depth. This is based on a literature review and input from eight country reports.

What is the magnitude of the problem?

Mental disorders are common and relate to a continuum of symptoms, extending from transient adjustment disorders to the most severe and disabling mental disorders. More than one in four Europeans is affected by at least one mental disorder during any given year, and about 6 % of Europeans have been estimated to need mental health care. Moreover, there is evidence that early retirement and sick leave due to mental health disorders are increasing in the European Union.

Mental disorders are often gender-specific and more common among elderly people, among people living alone, among unemployed, among people with low education, and people with low socio-economic status. Important mental health differences in e.g. suicide and alcohol consumption rates and in access to care exist across the EU, especially between Nordic/Central and Southern countries and between Western and Eastern countries.

Mental disorders are associated with poor physical health.

Physical and mental morbidity often go hand in hand. Those with mental health problems have higher than average rates of physical illness including cardiovascular disease, diabetes, respiratory disease, sexually transmitted diseases, and poor oral health. Certain groups with multiple social disadvantages are at higher risk of mental health disorders and may face even greater barriers of access to health care than others. First, mental health problems are associated with socio-economic status: people who are poor, unemployed or have a low standard of living have more mental disorders. Second, poor mental health is common in many vulnerable groups with low access to health care, such as migrant groups and homeless people.

People with mental disorders are at risk to die earlier

There is consistent and considerable excess mortality among people with mental health disorders in Europe, even after accounting for deaths from suicide. The mortality due to diseases is two to three times higher among people with severe mental disorders than among the general population. The mortality is partly due to avoidable deaths caused by physical disor-

ders, such as cardiovascular, respiratory and metabolic disorders. Unambiguous data also shows a uniform excess mortality from avoidable natural causes in institutional settings. These avoidable deaths point to deficiencies in access to or quality of health care as well as unhealthy lifestyles among people with mental disorders.

Access to mental healthcare still needs improvement in many cases

Access to care for mental disorders has been consistently reported to be low, being provided for an average of 26% of individuals in Europe with a mental disorder. Not everyone with a mental disorder needs treatment, but still nearly half of Europeans in need of mental health care reported no formal health care use. For example, despite widespread need, only 3% of Europeans receive psychotherapy.

Policy developments

The Commission Green Paper "Improving the mental health of the population: Towards a strategy on mental health for the European Union" (2005) highlighted the close interrelation between mental and physical health. However, there is still a lack of awareness on the issue of access to general health care for people with mental disorders.

The importance of promoting mental health and well-being in the EU was recently acknowledged also by the European Pact for Mental Health and Wellbeing, adopted in 2008. The Pact focuses, among others, on the need for preventing depression and suicides; youth and education; workplace settings; older people; and stigma and social exclusion.

What are the most common access barriers for people with mental disorders?

Stigma is a widespread and well-documented major access barrier for people with mental health disorders. Mental disorders are connected to stigma and there are many misperceptions regarding mental disorders. Stigma is found in the general population, but perhaps more importantly in

the health service administrative staff, the health care staff, and also the mental health care staff.

Stigma associated with mental health disorders has many consequences. Perhaps most importantly, health care for people with mental health disorders tends to be underfunded all over Europe, which is partly due to stigma and discriminatory attitudes.

Evidence also suggests that stigma lessens the responsiveness of the health services, and that the fear of being labelled as having a mental health problem may cause individuals to delay or avoid seeking treatment altogether. If people with mental disorders are not treated respectfully and with dignity in general health care services, the perceived health benefit of seeking care may weigh less than the perceived harm in the form of shame and lowered self-esteem. Anticipated discrimination may then lead to self-stigmatisation, which in combination with previous bad experiences of health care (e.g. compulsory admissions or humiliating treatment) can raise the threshold to seek professional help.

In addition, mental disorder may also lead to limited capacity to organise and regularly pay for social health insurance in cases where this is an individual responsibility. In addition, cost-sharing requirements can negatively impact on the up-take of needed services, in particular for poor people. This is of particular concern in countries with a relatively high formal co-payment, widespread use of private health services or common use of informal "under the table" payment.

In general, there often seems to be poor awareness among health professions of the need for special measures in response to the health needs of people with mental disorders and their health outcome tends to be poor, despite usage of health services. Poor health literacy skills among some people with mental health disorders may create additional challenges for health systems. A certain degree of health literacy is usually important to navigate the health system, and health literacy problems may exclude people from health care benefits or have an impact on help-seeking behaviour.

What are the policy implications of these findings?

If mental health care is organised separately from other health care, difficulties to provide adequate services to people with both mental and physical health care needs frequently occur. However, evidence indicates that a general health policy supporting integration of health and social services and mainstreaming of mental health services can offer better access to general health care. For example, this has been reported for Germany and Greece.

Moreover, the HealthQUEST study has also shown that emerging best practice examples of responsiveness of services exist. There are examples of special integrated services that have been created to care for the complex needs of people with compound mental, physical and social problems. For example, health policies in the United Kingdom strive towards integrated services with good links between primary care and secondary mental health services. Health mediators for people with mental health problems, linking them to mainstream health services, is a promising approach as well.

The HealthQUEST study has identified the following health and social policy strategies and recommendations to address the high rates of co-morbidity and excess mortality of people with mental disorders.

Raising awareness is central

There is still a significant lack of awareness of the health care access problems for people with mental disorders. Policy should therefore acknowledge the specific needs of those with mental disorders and centrally target the needs of these groups in national health inequalities programmes, incentivising providers and performance managing to ensure targets are met. Specific treatment guidelines need to be developed where needed. Awareness of the problem needs to be supported by an improved evidence base. Sensitisation and capacity building programmes for health care staff are needed to better recognise the health care needs of people with mental disorders. Awareness raising is best achieved in close collaboration with users' groups, building on the experiences of users.

More needs to be done to reduce stigma and discrimination

Discrimination against people with mental health disorders within the health services cannot be tolerated. It is important that referral and health record systems are designed so that discrimination can be avoided. People with mental disorders should be empowered by involving users' representatives in health care decision-making. Regular monitoring of differences in waiting times between patients with mental health disorders and other patients should be carried out to highlight any discrimination. Anti-discrimination legislation should be enforced to ensure equal access to health care.

Targeted health promotion action is needed

Targeted health promotion action is needed for this highly vulnerable group. Current evidence indicates that health promotion among people with mental disorders is feasible and effective. Indeed it has even been reported that health gains may be larger than among people without mental health disorders. Health promotion has a wide spectrum of effects, not restricted to health status only, and health promotion should be seen as a valuable tool for achieving social inclusion.

Mainstreaming of mental health care is still lacking behind

Organisation of services is key to the success of meeting the needs of people with mental disorders, with integration, co-ordination, communication and seamless provision across health and social care sectors being of vital importance. A transformation of the mental health care system towards multidisciplinary, coordinated and holistic approaches is needed. Locating a primary health care team close to mental health services with good links between primary care staff and mental health staff is highly effective in improving the physical health of those with severe mental health problems.

Some progress has, however, been made with special outreach services, for example in England, where financial incentives for GPs were introduced to undertake annual health checks of people with mental disorders.

Actions to reduce inpatient mortality have become urgent

To reduce mortality rates at psychiatric institutions, measures to improve capacity of staff to recognise and treat physical disorders are needed. However, above all a radical change in attitudes of staff of institutions is

needed. Current evidence on the effectiveness of health promotion actions among people with mental disorders needs to be disseminated, and efforts should be made to bridge the gap between mental health care and general health care by closure of mental hospitals and initiation of psychiatric care within general hospitals. That progress is also feasible in, for example, reducing post-discharge suicides has been illustrated by the example of Finland.

Investment in research should have high priority

To succeed in the above-mentioned actions, a sound European research base is needed. Multidisciplinary research on stigma, anti-discrimination, health promotion, and integrated community-based services is crucial to bring the field forward. Clearly, the problem of access to health care for people with mental health disorders is not just a problem of health services; indeed it has wider ramifications: for attitudes within the European population, for defining the fundamental rights of every European; and for social cohesion and inclusion policies.

Conclusions

The HealthQUEST study has confirmed that people with mental health disorders are selectively affected by many common barriers of access to good quality health care. Among these, stigma is a major cause of access barriers for people with mental disorders. Besides, targeted actions to improve access to health care for this group are mostly lacking. This is also the case for targeted health promotion actions.

On the positive side, the HealthQUEST study has provided a number of illustrations for how general health policy measures can improve access. Among the more specific measures that appear promising are integrated care and psychiatric reform that has at the same time improved access to mainstream health care. But there is also clear evidence that more needs to be done in many cases, such as improving access to general health care within psychiatric institutions. In general, research in the question of access problems to mainstream health care for people with mental disorders is still in its infancy and this calls for further investment in the evidence for policy making.

Where to find more information

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For more information, and the full report, see:
http://ec.europa.eu/employment_social/spsi/studies_en.htm#healthcare

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