

Managing Mental Health Service Provision in the Decentralized, Multi-layered Health and Social Care System of Germany

Anke Bramesfeld,^{1*} Matthias Wismar,² Kai Mosebach³

¹M.D., MPH, Health Policy Working Group, Department for Epidemiology, Social Medicine and Health System Research, Hanover Medical School, Hanover, Germany

²Ph.D., Political Scientist, Research Fellow, Health Policy Working Group, Department for Epidemiology, Social Medicine and Health System Research, Hanover Medical School, Hanover, Germany

³Political Scientist, Research Fellow, Health Policy Working Group, Department for Epidemiology, Social Medicine and Health System Research, Hanover Medical School, Hanover, Germany

Abstract

Background: The effective coordination of mental health service provision is a requirement for successfully reforming mental health care from a hospital-focused system towards a more decentralized, community-oriented one. Implementing such coordination is particularly challenging in a decentralized, multi-layered health and social care system such as exists in Germany.

Aim of the Study: (i) To investigate the coordination and planning of mental health service provision performed at and between the local, Länder and federal political levels in Germany; (ii) to outline the disparities in coordination and planning of mental health service provision that exist between the different political levels and locate key-authorities; (iii) to determine whether a decentralized, multi-layered health and social system such as Germany's allows for adequate coordination.

Method: (i) Analysis of mental health legislation and policy documents; (ii) guided interviews with officers and consultants of the government units responsible for mental health affairs of the 16 Länder and the federal Ministry of Health and Social Security; (iii) submission of results to the interviewed experts for verification.

Results: Multi-professional boards and posts for coordinating and planning mental health services are widely implemented on local state and federal level in Germany. Most of them operate without being required by legislation. The sickness and pension funds are represented in less than half of the boards on state level. Boards on local and on state level are mainly concerned with coordinating social mental health care and have little influence on medical mental health care. Mental health policy documents exist federally and in most Länder. All but one of the mental health legislations of the Länder (present in 12 out of the 16 Länder) also considers regulations concerning coordinating and planning mental health services. The key-authorities for mental-health policy, legislation and service implementation is with the 16 Länder. The federal

government however plays an important frame setting role. Actual service provision is a local responsibility.

Discussion: Since the beginning of mental health reforms 25 years ago and in particular in recent years, structures for the coordination and planning of mental health service provision have been established countrywide at local, Länder and federal levels. However, there are hardly any structures that connect the Länder and local levels and act as a source of independent quality assurance. The coordination boards at the Länder level include almost all the parties involved in mental health care, with the exception of sickness and pension funds that are, for the most part, absent. Thus the coordination boards are mainly restricted to governing social services in mental health care. Despite this, the countrywide establishment of diverse boards for the structured coordination of mental health service provision can be regarded in itself as a success, although little is known of the processes and impact of this framework. There are, however, indications that coordination is still restricted to the traditional interfaces and dividing lines of the mental health care system, which they seem unable to overcome.

Implication for Health Policies: The reform of mental health service provision towards a more community-orientated approach requires sophisticated coordination. The countrywide establishment of structures for the coordination and planning of mental health service provision has been largely possible in Germany. It does, however, require further analysis, since coordination beyond the traditional boundaries seems unlikely. Therefore, incentives are needed in order to encourage "adequate coordination" as well as integration with other parts of the mental health care system.

Received 24 April 2003; accepted 28 January 2004

Introduction

The efficient coordination of mental health services is believed to be important to the success of mental health care reforms that reach beyond the de-hospitalization of long-term patients.¹⁻³ This study investigates how structures for the coordination and planning of mental health service provision are implemented in the German health and social care system.

* **Correspondence to:** Dr. Anke Bramesfeld, Abteilung für Epidemiologie, Sozialmedizin und Gesundheitssystemforschung, Medizinische Hochschule Hannover, Carl-Neuberg-Strasse 1, 30625 Hanover, Germany
Tel.: +49-511-532 8425
Fax: +49-511-532 5347

E-mail: Bramesfeld.anke@mh-hannover.de

Source of Funding: None declared.

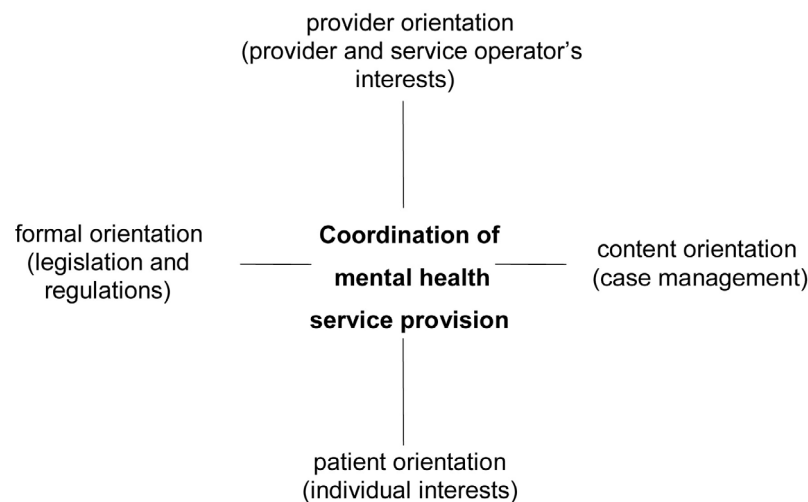


Figure 1. Tension in the Coordination of Mental Health Service Provision.

Background

The Significance of Coordination in Community-Oriented Reform

The way that different health care services are coordinated and integrated is of growing interest with respect to general health care reforms in most European countries,^{4,5} especially those trying to shift an inpatient-focused health care system towards a more ambulatory one. Service coordination and integration is expected to result in greater organizational efficiency, higher service quality and improved response to local needs.⁶

The mental health sector is one of the prime examples, having long been involved with reforms aimed at restructuring services from an inpatient focus towards a community-based approach. In many European countries the mental health service reform movements of the last few decades have led to continuous de-hospitalization of psychiatric patients.^{7,8} However, reducing the number of hospital beds bears the risk of under-serving psychiatric patients unless it is paralleled by the implementation of alternative treatment and care structures in the community.² Also worth noting is that community-oriented mental health services are more decentralized and diverse than a uniquely hospital-focused system.⁹ Thus, financial and organizational responsibilities and accountability are shifted from the health care to the social care system.^{2,10,11} To avoid fragmentation of services – as a side effect of decentralization^{12,13} – it is essential to ensure that providers, responsible bodies and services are adequately coordinated.^{1,7}

Coordination is understood in this context as a tool, in that benefits, care, services and policies are coordinated through explicit structures across the various sectors of the health and social care system that are involved in mental health service provision. It aims to reduce points of friction, confusion and discontinuity among the various structures, organizations and

bodies.¹⁴ Coordination of mental health service provision thereby takes place in a zone of tension between the individual and local management of each particular patient and a public health approach that is manifested in legislation and regulations (**Figure 1**). On the other hand, there is also tension between the interests of patients who demand the best treatment possible and the interests of service providers, such as hospital and hostel administrators, who are required to operate under financial constraints.

In Germany the coordination of mental health service provision is challenged not only by mental health reforms, but also by a health and social care system whose organization is multi-layered and decentralized. This results in a system of multiple, often fragmented, and sometimes redundant providers, cost carriers and responsible organizations that makes planning and coordination particularly difficult¹⁵ (see **Figure 2**).

Mental Health Service Provision in Germany

Today's mental health service provision in Germany is the result of reforms that started in the 1970s.*¹⁶ It led to a change in German mental health policy that was followed and paralleled by the following changes on the service provision side:

- The number of psychiatric hospital beds was cut by about 50%, reducing the number of beds per 100,000 population from 160 in 1971 to 73 in 1996. Thus, the average hospital size decreased from 1200¹⁵ to the current average of 167 beds (range: 958 to 8 beds).¹⁷ Psychiatric units in general hospitals were established (about 170 today), along with day clinics (now about 280).¹⁷ The average inpatient

* After German reunification these reforms were also implemented in the new Länder.

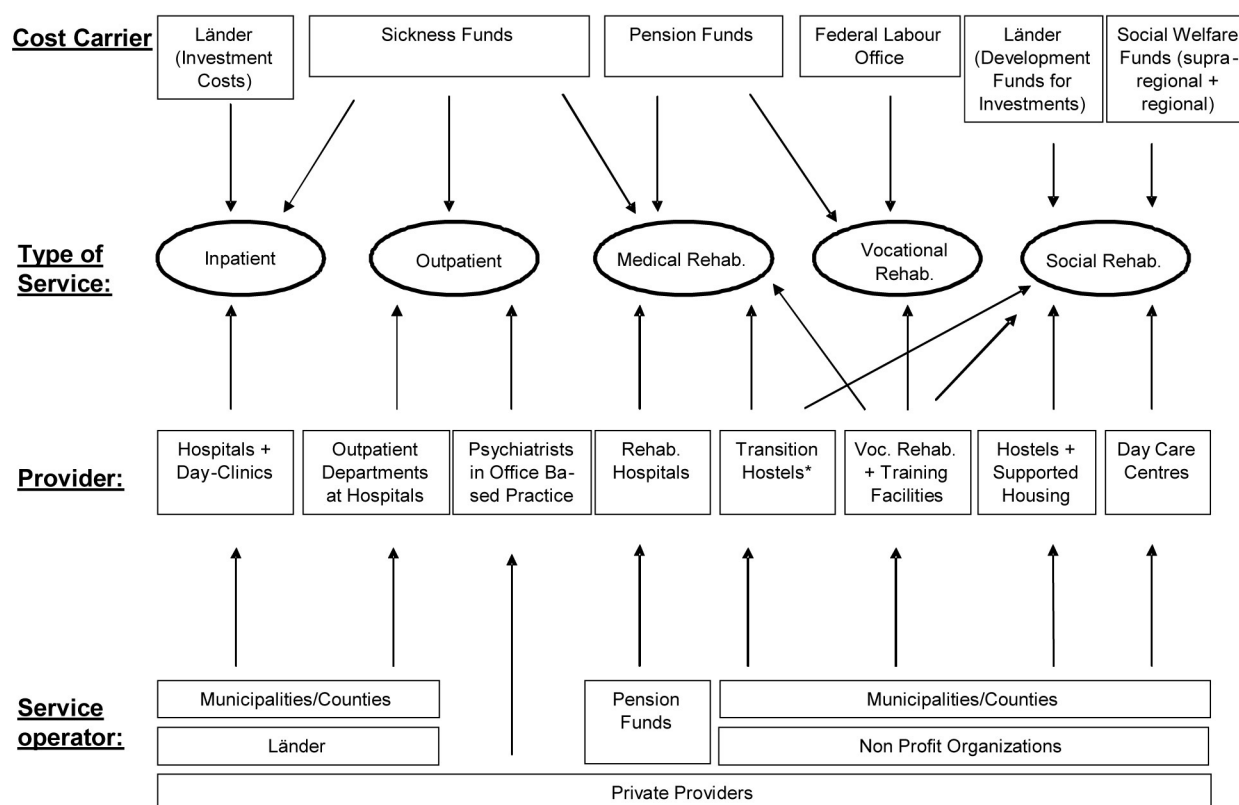


Figure 2. Structure and Organization of Mental Health Service Provision in Germany.

Note: Transition hostels/group homes offer more intense rehabilitation activities than ordinary hostels and group homes. Residents living in transition hostels/group homes are expected to stay a maximum of two years and then move into a less institutionalized environment or, if this is not possible, to a more permanent hostel or staffed group home.

treatment time is down from almost a year in the 1960s to 23 days in psychiatric units of general hospitals and 34 days in psychiatric hospitals.¹⁵

- The number of office-based psychiatrists, who provide most of the outpatient care in Germany, has increased from one per 100,000 population in the 1960s to six per 100,000 today.
- Long-term patients have been de-hospitalized and are now mostly living in some sort of sheltered housing.
- Ninety percent of catchment areas have residential care services and provide some day care and structured activities.
- Workshops for persons with long-term mental illness exist in two out of three catchment areas.¹⁵

The availability of mental health services differs among the 16 Länder as well as among the different regions within the Länder. An overview of the availability of key services per 100,000 population in the Länder is given in **Table 1** and should serve as a rough indicator of the status of service provision.

Critics of current mental health service provision in Germany are often concerned about the following points:

- Inpatient treatment in most regions is still focused on mental hospitals (only one hospital has been closed in over

25 years of mental health care reform). Many of them are located in rural areas. Day-clinics are locally available, but not countrywide. The catchment areas can be rather large, so hospitals are difficult to reach by patients not living nearby.⁷

- Most sheltered housing for chronic patients is provided in hostels rather than supported housing or family-like group homes.^{17,7} Some critics state that many hostels have simply replaced the former long-term mental hospitals instead of providing a place to live in the community.¹⁸
- Specific training and rehabilitation centers are not available countrywide.¹⁵

On the organizational side, mental health service provision in Germany is characterized by a situation outlined in **Figure 2**, which shows the different sectors involved in mental health care. It groups service operators, providers, and cost carriers around the different types of mental health care services. Five types of service are provided by eight types of provider, operated by five types of service operator and financed by six types of cost carrier. The situation is even more complex since there is no exact match between service operators and providers, on the one hand, and cost carriers on the other. Moreover, some of the services for mental health care patients are financed through various cost carriers while

Table 1. Mental Health Services in the 16 German Länder

Land	Population*	Population per km ² *	Psychiatric beds**	Treatment places in day-clinics**	Office based psychiatrists***	Living places in hostels****	Living places in supported housing****
per 100,000 inhabitants							
Baden-Württemberg	10,426,000	298	63	3	6	40	20
Bavaria	12,086,500	176	65	4	6	40	20
Berlin	3,398,800	3,804	85	22	13	2	80
Brandenburg	2,590,400	88	66	10	3	41	10
Bremen	668,000	1,638	87	15	16	34	70
Hamburg	1,700,100	2,289	82	14	12	43	50
Hesse	6,035,100	288	63	7	6	39	50
Mecklenburg-Western Pomm.	1,798,700	75	49	5	5	28	10
Lower-Saxony	7,865,800	168	63	7	5	48	10
North Rhine-Westphalia	17,975,500	530	84	8	6	44	30
Rhineland-Palatinate	4,025,000	204	48	3	5	76	40
Saarland	1,074,200	415	55	14	7	25	20
Saxony	4,489,400	236	57	12	5	19	20
Saxony-Anhalt	2,674,500	125	48	15	4	19	20
Schleswig-Holstein	2,766,100	179	63	6	6	80	10
Thuringia	2,462,800	148	52	7	4	37	40
Total	82,036,900	231	67	8	6	41	30

* Federal Statistical Office Germany,³⁶ 1998 data.** Federal working group of the operators of psychiatric hospitals (BAG),³⁷ own calculation, 1999 data.*** Federal Association of Statutory Health Insurance Physicians (KBV),³⁸ own calculation, 2001 data.**** Brill,³⁹ 1999 data.

others are offered by various providers. The overlapping and mismatching is often difficult to unravel for patients, managers and policy makers alike.

The following circumstances also shape the organization of mental health service provision in Germany.

The implementation of health care is the autonomous responsibility of the 16 Länder.* Social care (such as sheltered housing for the handicapped or subsistence money for the indigent) is partly the responsibility of the municipalities (for ambulatory services) and partly that of supra-regional authorities that are closely connected to the Länder (for stationary services). The federal government has the authority to define legally the services that are covered by the social insurance and welfare system (health care: Social Code Book [SGB] V; rehabilitation and participation of handicapped persons: SGB IX; nursing care: SGB XI; social welfare: Federal Social Support Act [BSHG]).

As outlined in **Figure 2**, psychiatric outpatient and inpatient services are provided by institutions that are administratively and financially separate from each other, but financed from the same source: like all health care, mental health care is paid for by the patient's sickness fund.† Inpatient mental health care is reimbursed in the form of per-diems, and outpatient care (mainly provided by office-based psychiatrists) is funded under a system that is something like fee-for-service but limited by a certain budget. The investment costs of hospitals, such as construction, are the financial responsibility of the Länder.

The change from hospital- to community-based mental health care results in more services that are provided by the social system. These services (housing, work rehabilitation, etc.) are administratively separate from the health care system. As shown in **Figure 2**, they are operated by non-profit and charity organizations, municipalities, counties (?) and private providers.

Everything that concerns social rehabilitation, such as housing in supported facilities, is a social welfare benefit. The responsibility, however, is split between the supra-regional body (a Länder authority) that pays for stationary housing* like hostels or staffed group homes and the regional body (municipalities and counties) that finances ambulatory housing.† Investments, such as the construction of sheltered housing,* are often subsidized with development funds from the Länder.

* The Federal Republic of Germany consist of 16 Länder. Three of them, Bremen, Berlin and Hamburg, are city-states, while five – Saxony, Saxony-Anhalt, Brandenburg, Thuringia and Mecklenburg-Western Pomerania – constitute the former East Germany and are referred to as the “new Länder”.
† Ninety-eight percent of the German population is health insured.¹⁹

* Municipalities and counties are the smallest administrative and political entity in a Land. Larger cities form municipalities (*kreisfreie Städte*), while in rural areas the organization of a county serves as the equivalent (*Landkreise*).

† Accommodation for a group of residents with 24-hour staffing.

* Single or small-group accommodation with no permanent staffing.

The development of modern community psychiatry in recent decades has caused the financial burden to shift from the sickness funds toward the social welfare funds.¹⁰ The amount of money that is ultimately spent for treatment, rehabilitation and care of the mentally ill cannot, however, be specified with routine data since the expenditures for mental health services are an integral part of the concerned bodies' budgets. Expenditures for mental health are thus largely unknown. A recent study, in any case, estimated that in the year 2000 the “statutory” health insurance (in Germany self regulating bodies under public law, not state bodies) spent about € 8.7 mn per 100,000 population for mental health care (€ 151.5 mn per 100,000 for health care in general) and the welfare funds about € 4.0 mn per 100,000 (€ 28.4 mn/100,000 for social welfare in general).^{20,21}

Due to these organizational quirks, the German mental health system is a challenge to coordinate. The existence of separate bodies that are responsible for financing hospital, outpatient and community care is detrimental to any cooperation and coordination effort.²² The reimbursement for hospital care on a per diem basis and for outpatient services on a fee-for-service basis provides little incentive to integrate and coordinate with other services.^{23,24} Such incentives, however, are believed to be particularly important in a decentralized, multi-layered system.²⁵ In the light of the particular organization of mental health care provision in Germany, it is even more important for the coordination and planning of structures to be well implemented and executed.

Research Queries

Given the decentralized and multi-layered structure of the German health and social care system, the following queries about the planning and coordination of mental health service provision are relevant:

- (i) How is the coordination of mental health service provision organized at the different political levels and how do these levels interact?
- (ii) How far do the differences between the various political levels reach, and where are the key-authorities for planning and coordination located?
- (iii) Can a decentralized, multi-layered health and social system such as Germany's allow for adequate coordination?

By “adequate coordination” we mean that it:

- is implemented countrywide and not only in some regional pilot scheme;
- works across the interfaces and dividing lines of the German health and social system to reduce friction, confusion and discontinuity among the different structures, organizations and bodies involved;
- considers the four dimensions of coordination that are outlined in **Figure 1** (provider and service operator's interests versus individual interests, case management versus legislation and regulations);
- works towards a mental health care system that is as community-based as possible in order to make a life as normal as possible for the mentally ill and handicapped.

Method

The investigation focuses on structures for the coordination and planning of medical and social services in general mental health care. Structures for coordinating child and adolescent mental health services and forensic psychiatry are not considered.

The following subjects were investigated:

- boards and working groups that are specialized in coordinating and planning mental health services on a federal, Länder and local level (municipality/county, district, catchment area);
- the leading persons that are involved in the boards and working groups at the federal and Länder level;
- the policy documents that concern planning and coordinating mental health services at the federal and Länder level;
- the considerations that go into mental health service planning and coordination in federal and Länder legislation.

Information on the coordination and planning structure was sought using the following methods.

Analysis of Legislation and Policy Documents

Federal and Länder legislation referring explicitly to mental health were analyzed for information on the coordination and planning of mental health services. We considered content reaching beyond the taking of precautions for mental health emergencies and the regulation of compulsory admission and involuntary treatment. In addition, we evaluated federal and Länder policy documents for dealing with the structures that coordinate and plan mental health service provision.

Expert Interviews

Guided interviews²⁶ were conducted with experts. They were guided by the subjects specified above. Experts were officers with the units of the 16 Länder governments and of the federal Ministry of Health and Social Security (MoH) that are responsible for mental health affairs. A total of 25 experts were consulted. All interviews were held by telephone, those with the Länder governments from August to October 2002. The interviews with the officer of the mental health affairs unit at the federal MoH and with the chairman of the Psychiatry Task Force at the general conference of the Länder ministers of health were conducted in January and February 2003.

Verification of Results

The results of the interviews at the units responsible for mental health affairs at the Länder governments were processed, tabulated and sent back to the units for content verification. The results of the interview at the mental health affairs unit at the federal MoH were summarized in text-form and sent back to the ministry for confirmation.

Results

Mental-Health-Specific Coordination Boards

The Federal Level

A unit for mental health affairs is part of the federal MoH in Bonn. In addition, two boards at the federal level are of importance for mental health policies in Germany:

- (i) The Psychiatry Task Force at the general conference of the Länder ministers of health, a permanent panel that meets twice a year. It consists of the representatives of the units responsible for mental health affairs at the Länder MoH. The representatives of the mental health affairs unit at the federal MoH and of the federal ministry of justice participate as guests. The task force builds a platform for exchange between the Länder on mental health issues. It deals with current problems regarding mental health care in the Länder (such as budget cuts) as well as coordination issues (such as under-serving in forensic psychiatry in certain Länder). It also works on proposals for federal legislation. On a conceptual level, the Psychiatry Task Force is the most influential board concerning mental health policy in Germany.
- (ii) The working group for the further development of psychiatry reform, recently re-established by the mental health affairs unit at the federal MoH. This group works on specific subjects for a limited time span only and is not a permanent body. It consists of representatives from many parties, including physicians, professional associations, social insurance carriers, and patient and family delegates. It includes representatives from the Psychiatry Task Force at the conference of the Länder ministers of health and representatives from the "Action of the Mentally Ill" [*Aktion psychisch Kranke*], an influential lobby for mentally ill and disabled persons.

The Länder Level

A central agency for mental health policy in all 16 Länder is a unit at the Länder MoH that is in charge of mental health affairs. With the exception of North Rhine Westphalia, however, planning of psychiatric hospital services is not assigned to these units. Instead, this is usually the responsibility of the units that are planning hospital services in general. The planning and coordination of supported housing, hostels, staffed group homes, etc. for the mentally ill is also rarely included in the responsibilities of the units in charge of mental health affairs, but dealt with in the units that address social welfare issues, housing and social support for the disabled in general.

Eleven out of 16 German Länder have an advisory board or equivalent structure, such as a topical- oriented expert group (Schleswig-Holstein), in operation at the Länder level. At the time of investigation, Bremen and Hesse were about to implement an advisory board. The boards' tasks entail the defining of concepts, standards and a framework for mental health policy in the Länder. They also advise the Länder MoH. Usually, these boards are chaired by the mental health representative of each Land's MoH. In Lower Saxony only,

the board is an institution that is independent from the ministry, although it is appointed by it and the ministry is a member thereof.

The advisory boards of the Länder are usually composed of representatives of psychiatric medical care provider groups (psychiatrists in office based practice, hospitals and psychiatric associations); providers of psychiatric social care, such as non-profit and charity organizations; the social psychiatric services [*Sozialpsychiatrischer Dienst**]; and representatives of the social welfare agencies for the Länder and municipalities. Except in Hamburg, Berlin and Saxony-Anhalt, the board also includes representatives of the patient families and patients themselves. Pension funds are regular members of the boards in five Länder, and the sickness funds in seven Länder.

In addition to these boards at the Länder level, working groups of local “psychiatry coordinators” help plan and coordinate mental health services in the Länder of Berlin, Hesse, Mecklenburg-Western Pomerania and Lower-Saxony. The advisory boards are defined in mental health legislation only in the Länder of Rhineland-Palatine and Berlin. Bremen, Lower-Saxony, Saxony and Saxony-Anhalt provide additional committees that visit all institutions that treat, care for and/or house the mentally ill. They report their findings to the public. These commissions are all defined in the mental health legislations of these Länder.

The Local Level

In all Länder, permanent local boards for the coordination of mental health services exist for the smallest administrative and political entity, the counties and municipalities. Only Mecklenburg-Western Pomerania uses the catchment areas of the psychiatric hospitals and departments as the geographical basis for these local boards. Brandenburg and Bavaria have established additional boards at the district level, which lies between the municipality/county and the Länder. In many municipalities/counties, more than one board deals with mental health affairs at a local level. An example is an advisory board that works more conceptually on service organization and coordination. There may also be a “psycho-social working group” that deals with the coordination of services in respect to more individual cases.

The position of a “psychiatric coordinator,” who coordinates all mental health services in a region, exists in almost all municipalities/counties of eight Länder. However, the method of filling this position differs considerably not only among the Länder but also from one region to another within a Land. For example, in Hesse the job of a psychiatric coordinator can be carried out by a fully employed person at the municipality or by an honorary psycho-social working group. In eight Länder, mental health or public health legislation defines locally operating coordination structures such as boards, working groups or psychiatric coordinators (see **Table 2**).

* A visiting outpatient service.

Policy Documents Concerning the Planning and Coordination of Mental Health Service Provision

The Federal Level

The main documents setting guidelines for German mental health policy (these date to the debut of the mental health reform more than 25 years ago and still form the baseline for mental health policy) are the report to the German Parliament by the Enquête Commission about the situation of psychiatry in the Federal Republic of Germany¹⁶ and the report of the expert commission of the German Federal Government for the reform of mental health services.²⁷ In the latter document the coordination of mental health services is named as a major requirement for mental health reforms, alongside the community orientation of services, access to mental health services by all in need, and the equal status of somatic and psychiatric patients.

The Länder Level

Thirteen out of 16 Länder have a policy document that describes the ethical, political and structural basis on which mental health policy should be performed in their territory along with the actual status of services and planning for the future. These documents are not legally binding but serve as guidelines for mental health policies (see **Table 2**).

The Local Level

Some counties/municipalities have authored their own psychiatric plans, describing service structures and plans in detail.

Legislation Concerning the Planning and Coordination of Mental Health Service Provision

The Federal Level

The federal government’s influence on mental health relevant legislation comprises the legal regulation of staffing ratios for nursing personnel in psychiatric departments and hospitals [*Psychiatrie Personal Verordnung*: Psych-PV] and laws that specify the provision of services through the social and welfare programs. In the Social Code Book V dealing with health care services, some sections refer explicitly to psychiatric services, such as the section regulating the opening of psychiatric outpatient units [§ 118 SGB V] or the one on socio-therapy [§ 37 a SGB V]. Other statutes from the social legislation of health care [SGB V], rehabilitation [SGB IX], nursing care [SGB XI] or social welfare [BSHG] concern the interests of patients suffering from mental illness, but are not designed explicitly for mental health purposes.

The Länder Level

The Länder are responsible for legislating involuntary treatment and compulsory admission. Except for Hesse, Baden-Württemberg, Bavaria and Saarland, all Länder have enacted additional mental health legislation dealing with therapeutic aids and preventive measures for the mentally ill. These laws – except for Hamburg’s – also regulate the

Table 2. Organizations and Policy Documents that Relate to the Coordination and Planning of Mental Health Service Provision in the 16 German Länder.

Land	Mental health affairs unit at the Länder MoH	Länder Advisory board or equivalent working group	Länder commission for visiting mental health institutions	Länder working group of the local psychiatric coordinators	Post of local psychiatric coordinator	Local boards and working groups	Mental health policy document and year of publication
Baden-Württemberg	X	X				X	X 2000
Bavaria	X					X	X 1990
Berlin	X	X (§)		X	X	X (§)	X 1997 + statistical update 2001
Brandenburg	X				X	X (§)	X 1997
Bremen	X	X **	X (§)			X	X 1996
Hamburg	X	X				X	X 1997
Hesse	X	X **		X	X*	X*	X 1982 (update in progress)
Mecklenburg-Western Pomm.	X	X		X	X	X (§)	X 1994
Lower-Saxony	X	X	X (§)		X	X (§)	X 1993
North Rhine-Westphalia	X	X		X	X	X (§)	
Rhineland-Palatinate	X	X (§)				X (§)	
Saarland	X	X				X	
Saxony	X	X	X (§)		X	X (§)	X 1993 + update on substance abuse 1998
Saxony-Anhalt	X		X (§)		X	X	X 1998
Schleswig-Holstein	X	X				X (§)	X 2000
Thuringia	X	X				X	X 1994 + update 2002

* of non-homogeneous design

** about to be established at the time of investigation

§ defined in the Länder's mental health or public health legislation

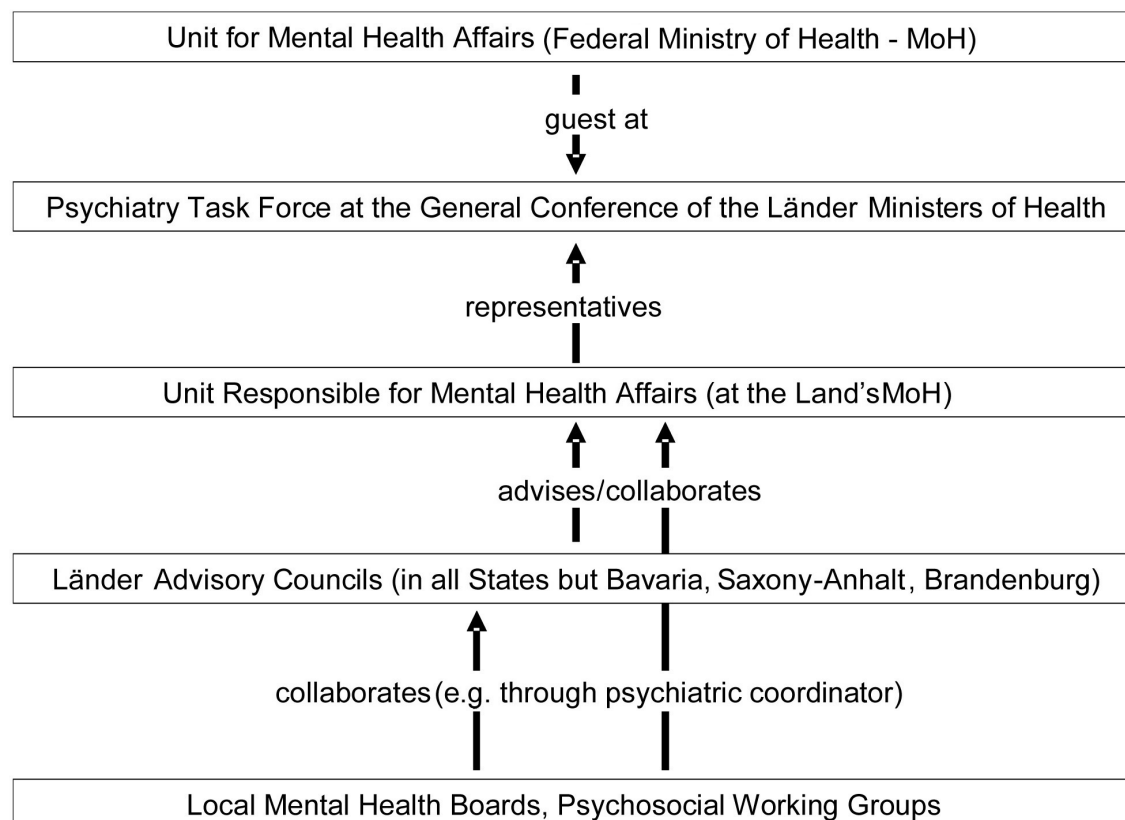


Figure 3. Interplay of the Various Organizations Concerned with Coordinating and Planning Mental Health Service Provision in Germany at the Federal, Länder and Local Levels.

coordination and planning of mental health services. All of the legislation has been enacted or renewed during the past 10 years, half of it in the past five years. The public health legislation of Bremen, Hamburg, North Rhine Westphalia and Saxony-Anhalt also regulates the coordination and planning of mental health care.

The Local Level

The counties/municipalities do not have the authority to enact laws.

Discussion

More than 25 years since the start of mental health reforms toward more community-based care in West Germany, and 13 years since these policies were transferred to East Germany, boards and working groups for coordinating and planning mental health services have been set up at all political levels. The same is true for policy documents and legislation on coordination and planning.

How is the Coordination of Mental Health Service Provision Organized at the Different Political Levels and How do these Levels Interact?

For the coordination of mental health service provision, various institutions and bodies have been established at the local, Länder and federal levels. The organization of these institutions across the political levels is outlined in **Figure 3**.

At the local level, boards and working groups for mental health issues now operate in every Land, whether or not they are defined by law. This is an improvement since 1988 when local boards and working groups existed in a few regions only.²⁸ This success may owe to the report of the National Expert Commission for Reforms in Psychiatry in 1988, which recommended the implementation of coordinating structures.²⁷ The availability today in many counties/municipalities of more than one coordinating group with diversified tasks indicates the dynamics of coordination there. A positive impact on local service provision should be expected from these activities.²⁹

The types of bodies involved in coordinating and planning mental health service provision in the Länder are listed in

Table 2. Every Land has a specialized mental health unit in its MoH. Thirteen out of 16 Länder have or are about to implement an advisory board. However, structures that interconnect the Länder level with the local level (e.g. psychiatric coordinators or coordination working groups) exist only in some places and are of varying official status.³⁰ By neglecting the role of the local psychiatric coordinator as a spokesperson and liaison to the other municipalities/counties and to the Land's government, important opportunities for service coordination, exchange of experience, and policy formation might be missed by the municipalities/counties and the Land.

Communication and coordination between the Länder is carried out by the mental health affairs unit at the Land's MoH. Their representatives meet at the "supra-Länder" level in the Psychiatry Task Force at the general conference of the Länder ministers of health. The federal MoH is represented by its mental health affairs unit, which sits on the task force as a guest. This forms the connection between the Länder and the federal level.

The working group on the further development of psychiatry reform is a parallel advisory structure at the federal level. It is not permanent and has no direct executive and implementation authority. Thus, it is not part of the coordination and planning network but can more accurately be described as a think-tank at the federal level.

How Extensive are the Differences Between the Various Political Levels, and Where are the Key Authorities for Planning and Coordination Located?

The differences between the local, Länder and federal levels are significant. At the local level (communities and municipalities), coordination structures are concerned with the development and operation of local services. At the Länder level they deal with the organization of mental health service provision, while at the "supra-Länder" and federal levels the coordination boards are concerned more with setting frameworks for form and content. The key authorities for planning and coordination are with the Psychiatry Task Force at the "supra-Länder" level and with the Länder units responsible for mental health affairs and their advisory boards.

The county and municipal levels play a crucial role in the coordination and actual operation of mental health care services.^{31,32} For example, although the SGB V has allowed the operation of outpatient departments at mental hospitals for quite some time, many hospitals have only recently opened such departments. Since hospitals operate independently, they cannot be forced but only urged to open an outpatient facility. Consequently, no mental health policy can be implemented without consent and cooperation at the local level.⁶ Thus, the coordination structures described above can play a significant role.

Although the policies concerning mental health care and legislation and the organization of hospital and hostel care are shaped by the Länder, their influence on the scope of

psychiatric medical service provision is weak, since the financing of medical care is regulated federally. This is reflected in the composition of the Länder's advisory boards, which consist mainly of psychiatric social care organizations (funded by supra-regional and regional welfare funds) and are under-represented by sickness and pension funds.²⁸ Therefore, coordination between the medical and social sectors, which is so important for the implementation of community-oriented mental health services,²² is not enforced.

Quality assurance and data collection for further planning is the responsibility of the Länder, but only four Länder have set up independent commissions that visit all mental health institutions and report their findings to the public. These commissions serve as an important tool for collecting information for planning and for keeping mental health care transparent.³³ The fact that the commissions are defined in the mental health legislation of these Länder may reflect the significance accorded them.

The influence of the federal government on the implementation of structures necessary for community-based mental health care is of a more indirect, frame-setting character. It operates through policy papers that have been major trendsetters for German mental health policies.^{16,27} In drafting these documents, the mental health affairs unit at the federal MoH has often put mental health reforms high on the national agenda. In addition, and as a consequence of these papers, the federal government has executed pilot schemes on several aspects of the provision of mental health services, such as their coordination and planning. These pilot schemes have served as major impetus for mental health services throughout the country and worked to drive mental health reforms in Germany.^{28,34}

There is controversy over the role of legislation in influencing mental health service provision and coordination. Some authors see the lack of a mental health act in Hesse as being responsible for the striking regional differences in the provision of mental health care and in the coordination of such services.³⁰ Others believe that mental health legislation is more a formal expression of reform activities than a tool for directly influencing structures.³⁵

Can a Decentralized, Multi-layered Health and Social System Such as Germany's Allow for "Adequate Coordination"?

We have shown in this paper that institutions for coordination and planning are structurally available in Germany at the local, Länder, and federal levels. This means that boards as well as working and advisory groups are widely established as a framework for coordination. This in itself is a major achievement, and satisfies one of the criteria for "adequate coordination". However, it is not known how successfully this framework has been implemented. There

* The federal pilot schemes have been terminated recently due to financial constraints.

are no data available to evaluate how these boards are performing, or information that assesses their actual impact on mental health care in Germany.

In theory, the performance of the various coordination boards relates to the following three aspects:

- (i) The institutions that are represented on the coordination boards. At the Länder level they comprise almost all players in mental health care. This should be viewed as an adequate approach to the composition of such boards. Sickness and pension funds, however, are under-represented. Thus the biggest financial power in mental health care (as far as the sickness funds are concerned) is not participating in the coordination process. It is a likely assumption that the Länder boards do not negotiate much medical mental health care, which is financed by the sickness funds. The boards will rather be concerned with coordinating service provision outside the financial responsibility of the sickness and pension funds. This refers mainly to social services, which are predominantly a social welfare benefit. Furthermore, the structures that connect the local and Länder levels, such as psychiatric coordinators, are not widely enough available. To summarize, the composition of the Länder boards and the scarce availability of structures connecting the local and Länder levels makes it questionable whether the coordination of mental health service provision operates across the interfaces and boundaries of the German health and social system. Consequently, its capacity is weakened and it is unlikely that “adequate coordination” can take place in this regard.
- (ii) The individual board members, whose personal input and dedication to achieving better and more “adequate” mental health care is directly related to the performance of the coordination boards at all levels. This personal input can be reinforced through official recognition of the board’s activities. Examples of this are the definition of local and Länder coordination boards in either mental or public health legislation or in mental health policy documents. This is not the case in all Länder. Furthermore, psychiatric coordination is upgraded by its professional implementation. Berlin, for example, has a full time psychiatric coordinator for every local region, but many other Länder do not.
- (iii) The structural composition of the health and social system and its ability to set incentives for “adequate coordination.” In Germany, some of the structures in the health and social system counteract “adequate coordination” and cooperation. One example is the variety of financing bodies for medical and social mental health services.²² Furthermore, the methods of reimbursing hospital care (per diems) and outpatient care (fee-for-service) sets little incentive for integration and coordination with other services.^{23,24} Likewise, there is little financial incentive for hostels (reimbursed by hostel budgets) to have their residents placed in rehabilitation programs so that they can eventually move out of the hostel. The reimbursement system for

mental health care effectively satisfies isolated institutional interests instead of promoting a comprehensive approach that favors the needs of the mental health care client/patient.²⁰ It follows that any form of coordination will be met with unwillingness by all organizations that benefit from the current reimbursement system.

Conclusions and Implications for Health Policies

The example of Germany demonstrates that the implementation of structures for the coordination of mental health service provision is generally possible at all political levels, even in a highly decentralized, multi-layered, and disjointed health and social care system. Little is known, however, about the processes and effects of coordination and planning within the established organization. There are hints that such coordination remains limited to the traditional interfaces and boundaries of and between the health and social system and has not managed to overcome them. As such, problems usually arise in service provision as well, concerning the structure of services for the case management of the individual patient. On the basis of this study and prior investigations in other health systems,⁶ it seems unlikely that coordination alone is capable of improving the health and social system in this regard. Beyond the implementation of “adequate coordination” and its evaluation, attention should therefore be paid to incentives within the mental health care system that facilitate the coordination and integration of the various sectors of mental health care²². This should be the direction for future research in mental health service provision. The outcome of such research would help determine ways to augment the implementation of community-based mental health care.

Acknowledgements

We are very grateful to the officers at the Länder and the Federal Ministries of Health for their kindness in sharing their expertise with us. In particular, we would like to thank Dr. Güntert (Baden-Württemberg), Dr. Dick and Dr. Neft (Bavaria), Mrs. Weise and Mr. Beuscher (Berlin), Mr. Mosch (Bremen), Mr. Lengefeldt and Mr. Georg-Wiese (Hamburg), Mrs. Noecker (Hesse), Mr. Köpke (Mecklenburg-Western Pomerania), Dr. Kersting and Dr. Schöpfer (Lower-Saxony), Mrs. Slawski-Haun and Mr. Walintowicz (North Rhine-Westphalia), Mrs. Steinfurth and Mr. Maibaum (Rhineland-Palatinate), Mr. Both (Saarland), Dr. Pfortner (Saxony), Dr. Wille, Mr. Maervoet and Dr. Naumann (Saxony-Anhalt), Dr. Müller-Lucks (Schleswig-Holstein), Mrs. Stoofs (Thuringia) and Dr. Brockmann (Bonn). We are also grateful to Dr. Holler (Hannover Medical School) and Dr. Höfer (Sozialpsychiatrischer Dienst Hildesheim) for their technical advice and support, to Daniela Albrecht for assisting in the literature search and to Götz Bramesfeld for revising the language.

References

1. Becker T, Vázquez-Barquero J. The European perspective of psychiatric reform. *Acta Psychiatr Scand* 2001; **104**: 8-14
2. Thornicroft G, Bebbington P. Deinstitutionalisation - from hospital closure to service development. *Brit J Psychiatry* 1989; **155**: 739-753.
3. Munk-Jorgensen P. Has deinstitutionalisation gone to far? *Europ Arch Psych Clin Neuroscience*. 1999; **249**: 136-143.
4. Mur-Veeman I, van Raak A, Paulus A. Integrated care: the impact of governmental behaviour on collaborative networks. *Health Policy* 1999; **49**: 149-159.
5. Fleury MJ, Mercier C. Integrated local networks as a model for organizing mental health services. *Adm Policy Ment Health* 2002; **30**: 55-73.
6. Fleury MJ, Mercier C, Denis JL. Regional planning implementation and its impact on integration of a mental health care network. *Int J Health Plan Management* 2002; **17**: 315-332.
7. Haug H, Rössler W. Deinstitutionalisation of psychiatric patients in central Europe. *Europ Arch Psych Clin Neuroscience*. 1999; **249**: 115-122.
8. Sturm R, Bao Y. Psychiatric care expenditures and length of stay: Trends in industrialized countries. *Psych Services*. 2000; **51**: 295.
9. WHO/ OMS. *Rapport sur la santé dans le monde 2001: La santé mentale: Nouvelle conception, nouveaux espoirs*. Genève: World Health Organisation, 2001.
10. Salize H-J, Rössler W, Reinhard I. Kostenermittlung in einem fragmentierten psychiatrischen Versorgungssystem. *Gesundheitswesen* 1996; **58**: 10-17.
11. Rothbard AB, Kuno E, Schinnar AP *et al*. Service utilization and cost of community care for discharged state hospital patients: A 3-year follow-up study. *Am J Psychiatry* 1999; **156**: 920-927.
12. Saltman RB, Figueras J. Reorganizing the system: decentralization, recentralization and privatization. *European Health Care Reform*. Copenhagen: World Health Organization Regional Office for Europe, 1997.
13. Lehman AF. Public health policy, community services, and outcomes for patients with schizophrenia. *Psych Clin North America* 1998; **21**: 221-+.
14. Leutz WN. Five laws for integrating medical and social services: Lessons from the United States and the United Kingdom. *Milbank Q* 1999; **77**: 77-110.
15. Bauer M, Kunze H, v Cranach M *et al*. Psychiatric Reform in Germany. *Acta Psychiatr Scand*. 2001; **104** (Suppl. 410): 27-34.
16. Deutscher Bundestag. *Bericht über die Lage der Psychiatrie in der Bundesrepublik Deutschland - zur psychiatrischen und psychotherapeutisch/psychosomatischen Versorgung der Bevölkerung (Psychiatrie Enquete)*. 1975.
17. Bramesfeld A. Wie gemeindenah ist die psychiatrische Versorgung in der Bundesrepublik Deutschland? *Psychiatr Prax* 2003; **30**: 256-265.
18. Dörner K. Die Kommunalisierung der Psychiatrie ist überfällig oder: Die Psychiatrie ist schon längst kommunal. *Soziale Psychiatrie* 2000; **87**: 1.
19. Beske F, Halauer JF. *Das Gesundheitswesen in Deutschland*. Deutscher Ärzte-Verlag, 1998.
20. Melchinger H, Machleidt W, Rössler W. Psychiatrische Versorgung, Ausgaben auf dem Prüfstand. *Deutsches Ärzteblatt* 2003; **44**: C 2227-C 2228.
21. Statistisches Bundesamt. Gesellschaft, Wirtschaft, Staat im Spiegel der Statistik. www.destatis.de. 2002. Datenreport 2002.
22. Lien L. Financial and organisational reforms in the health sector; implications for the financing and management of mental health care services. *Health Policy* 2003; **63**: 73-80.
23. Dewa CS, Hoch JS, Goerin P. Using financial incentives to promote shared mental health care. *Can J Psychiatry* 2001; **46**: 488-495.
24. Frick U, Barta W, Binder H. Krankenhaus Finanzierung der stationären Psychiatrie über DRG bezogene prospektive Zahlung: Salzburger Erfahrung. *Psychiatr Prax* 2002; **28**: 55-62.
25. Sturm R. What type of information is needed to inform mental health policy? *J Ment Health Policy Econ* 1999; **2**: 141-144.
26. Meuser M, Nagel U. 1991. Expert Inneninterviews - vielfach erprobt, wenig bedacht. Ein Beitrag zur qualitativen Methodendiskussion. In: Garz D, Kraimer K, eds. *Qualitativ-empirische Sozialforschung*. Opladen: Westdeutscher Verlag.
27. Bundesministerium für Jugend Familie Frauen und Gesundheit. *Empfehlungen der Expertenkommission der Bundesregierung zur Reform der Versorgung im psychiatrischen und psychotherapeutischen/ psychosomatischen Bereich*. 1988; Bonn: Bundesministerium für Jugend Familie Frauen und Gesundheit.
28. Kruckenberg P, Kunze H, Brill KE *et al*. *Von institutions- zu personenzentrierten Hilfen in der psychiatrischen Versorgung*. Baden-Baden: Nomos Verlagsgesellschaft, 1999.
29. Foster-Fishman PG, Salem DA, Allen NA *et al*. Facilitating interorganizational collaboration: The contribution of interorganizational alliances. *Am J Comm Psychology* 2001; **29**: 875-905.
30. Schröder WF, Rehberg W, Zich K. *Psychiatrische Versorgung in Hessen. Entwicklung bis 2007*. Berlin: IGES-Eigenverlag, 2002.
31. Bahle T, Pfenning A. *Angebotsformen und Trägerstrukturen sozialer Dienste im europäischen Vergleich*, Mannheimer Zentrum für Europäische Sozialforschung, Arbeitspapiere - Mannheimer Zentrum für Europäische Sozialforschung, Nr. **34**, 2001.
32. Thornicroft G, Tansella M. *The mental health matrix*. Cambridge University Press, 1999.
33. Böcker FM, Jeschke F, Brieger P. Psychiatrische Versorgung in Sachsen-Anhalt: Einrichtungen und Dienste im Überblick. *Psychiatr Prax*. 2001; **28**: 393-401.
34. Holler G, Schnabel R, Marx M. *Aufbau von gemeindepsychiatrischen Versorgungsstrukturen in ausgewählten Modellregionen in den neuen Ländern. Abschlußbericht der Modellerprobung*. Baden-Baden: Nomos Verlagsgesellschaft, 1995.
35. Golmer E. Erfahrungen mit dem Nordrhein-westfälischen PsychKG am Beispiel der Stadt Münster. *Gesundheitswesen* 1999; **61**: 553-559.
36. Statistisches Bundesamt. *Statistisches Jahrbuch 2001. Für die Bundesrepublik Deutschland*. Wiesbaden: Metzler Poeschel, 2001.
37. BAG - Bundesarbeitsgemeinschaft der Träger Psychiatrischer Krankenhäuser. *Verzeichnis der psychiatrischen Krankenhäuser/ Abteilungen in der Bundesrepublik Deutschland*. Köln, 1999.
38. KBV (Kassenärztliche Bundesvereinigung). Grunddaten zur Vertragsärztlichen Versorgung in der Bundesrepublik Deutschland 2001. <http://www.kbv.de/publikationen/190.htm>. 2002.
39. Brill KE. Zum Stand der Entwicklung komplementärer Angebote. *Psychosoziale Umschau* 2000; **4**: 4-7.