Paying for public mental health care: crucial questions

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Mental disorders directly affect 15–20 percent of the U.S. population. These disorders range from the relatively mild to the totally debilitating, may be transient or last for a lifetime, and may develop unnoticed for years or strike suddenly. Certain disorders are, of course, more serious than others, requiring longer or more intensive forms of care. Prior to the 1950s, individuals with severe illnesses such as schizophrenia, depression, and organic brain syndromes were the primary recipients of mental health care, which was typically provided in large public hospitals. In the past thirty years, however, mental health care has expanded in communities, making help more widely available outside hospitals, both for individuals with serious disorders and for those suffering from milder mental health problems.

The nation’s specialty mental health system is gradually shifting from reliance on long-term residential institutions to emphasis on active treatment in community settings, supplemented by short-term, intensive hospital care. Today, the organized mental health care system is a diversified network of programs that, in 1986, served about seven million Americans at a cost of more than $18 billion. All levels of government and the private sector provide and fund treatment. Most patients receive relatively brief outpatient therapy or inpatient treatment from private practitioners, agencies, or hospitals in the community.

Since funds come from so many sources and go to so many varied practitioners and programs, it is particularly difficult to answer certain crucial questions: How much does mental health care cost? How many public dollars (federal, state, and local) are spent? For which patients and types of care does the public pay, and which rely on private sources?

National Data On Mental Health Expenditures

Most available national data relate to organized programs (both public and private), which provide care in hospitals, outpatient clinics, nonmed-
ical residences, or “partial care” (extended ambulatory care) programs. These programs make up the specialty mental health sector—the part of the organized health care system designed primarily to provide mental health services. The leading report of these statistics is the Mental Health, United States series, published biennially by the National Institute of Mental Health (NIMH). The NIMH figures, however, omit several important elements, such as individual office-based mental health professionals, family physicians, and other parts of the general health care and education systems that are not identified as “mental health organizations.” These costs, significant as they are, are not now captured in the regular effort to collect public mental health data.

The most recent edition of Mental Health, United States, published in 1987, covered data for 1983; more recent 1986 data have not yet been published. For 1986, expenditures for organization-based mental health care in the United States were estimated at $18.5 billion. The total funding effort has been remarkably stable over time in constant dollars per capita (Exhibit 1). However, the relative share of various organization types has changed. Most notably, during the 1970s, a significant decline in the proportion spent in state and county mental hospitals was paired with expansion in “other organizations” (community mental health centers, freestanding outpatient clinics and partial care organizations, multiservice mental health organizations, and residential treatment cen-

Exhibit 1
Expenditures Per Capita For Specialty Mental Health System, By Type Of Organization, 1969 Constant Dollars, Selected Years, 1969–1986

<table>
<thead>
<tr>
<th>Year</th>
<th>State and county mental hospitals</th>
<th>Private psychiatric hospitals</th>
<th>Nonfederal general hospitals with psychiatric services</th>
<th>Veterans Administration (VA) medical centers</th>
<th>Other organizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>1969</td>
<td>![Exhibit 1 Diagram]</td>
<td></td>
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<td></td>
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<tr>
<td>1975</td>
<td>![Exhibit 1 Diagram]</td>
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<tr>
<td>1979</td>
<td>![Exhibit 1 Diagram]</td>
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<td>1983</td>
<td>![Exhibit 1 Diagram]</td>
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<tr>
<td>1986</td>
<td>![Exhibit 1 Diagram]</td>
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</tbody>
</table>


Note: Data are for the U.S. civilian population. Years shown are the only years for which data are available.
ters for children). During the 1980s, these trends continued. State and county mental hospitals’ share continued to decline; the expansion came first in general hospitals with psychiatric services and then in private psychiatric hospitals.

Aside from its intrinsic importance, mental health care is an important component of the health care system as a whole. In 1986, mental health care accounted for approximately one-fifth of all hospital beds. Approximately eighty-four million days of hospital care were provided for mental disorders, compared to thirty-one million days for heart disease and twenty-two million days for cancer in 1986.

Sources Of Mental Health Revenues

States remain the primary source of funding for the mental health system. Exhibit 2 illustrates the distribution of revenues for 1986. As the exhibit shows, state governments are responsible for more than half of all funding for specialty mental health organizations, when their share of Medicaid is included. Local governments provided 7 percent of the total.

Exhibit 2
Distribution Of Revenues Of U.S. Specialty Mental-Health System, 1986

<table>
<thead>
<tr>
<th>Source: National Institute of Mental Health, unpublished data, November 1989.</th>
<th>State mental health agency funds 42.5%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other state government funds 5.6%</td>
<td>Contract funds from other nongovernment sources 0.7%</td>
</tr>
<tr>
<td>Client fees received 15.4%</td>
<td>Local government 7.8%</td>
</tr>
<tr>
<td>Other federal 10.3%</td>
<td>Other sources 4.3%</td>
</tr>
<tr>
<td>Medicaid 9.0%</td>
<td>Medicare 3.0%</td>
</tr>
<tr>
<td>Client fees reverted to state 1.3%</td>
<td>Medicaid 9.0%</td>
</tr>
<tr>
<td>Medicare 3.0%</td>
<td>Other state government funds 5.6%</td>
</tr>
</tbody>
</table>

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but 16–22 percent for outpatient-oriented organizations (freestanding outpatient psychiatric clinics and multiservice mental health organizations). The federal government, excluding Medicaid, provided approximately $2.1 billion (13.4 percent), including 100 percent of Veterans Administration (VA) medical center costs. Medicare provided about 3 percent and covered over 8 percent of private psychiatric hospital costs but less than 3 percent of costs for other organizations. Other programs, such as the Alcohol, Drug Abuse, and Mental Health Services Block Grant, account for the remainder. Client fees, including insurance, were the major source of funds for private psychiatric hospitals (67 percent) but provided only 4.3 percent for state hospitals and 10–15 percent for outpatient-oriented organizations.

The federal government has a direct influence on mental health care via extensive provision of services (through the VA) and funding of certain mental health services (through Medicaid and the Alcohol, Drug Abuse, and Mental Health Services Block Grant) and income support (Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI)). Indirectly, the federal presence pervades through federal rules for coverage under Medicare, CHAMPUS, and federal employees' health benefits, which often constitute a de facto model for other forms of insurance.

These national data provide an important measure of the system as a whole. To know what services are likely to be available in any given state or community, though, it is necessary to disaggregate them. The following facts reflect the status of state/community mental health services in 1985, according to the most recent state data available.6

1. State mental health agencies directly controlled and administered over $8 billion, of which 78 percent was provided by state government sources. 2. The federal government provided 15 percent of total state mental health agency revenues, of which 58 percent was for Medicaid. 3. State mental health agency expenditures per capita ranged from $90.12 to $8.38, with a national average of $34.70. 4. About 5 percent of all expenditures by state mental health organizations were for forensic care (criminal commitments). The bulk of these funds were for state mental hospitals. 5. The states spent 65 percent of their mental health agency budgets on inpatient care, primarily in state mental hospitals, 19 percent on ambulatory care, 5 percent on residential programs, and the balance on research and administration.

Some shift has occurred in recent years toward funding community based services. For example, from 1981 to 1985, total state mental health agency expenditures by community-based programs increased 50 percent (10 percent in constant dollars) to $2.65 billion. Also during that time,
total state mental health agency expenditures by state mental hospitals increased by over 30 percent (in constant dollars, a decrease of 4.8 percent) to $5.3 billion. However, the base of state hospital expenditures has so far outweighed community services that, to date, the change has not greatly altered the overall ratio of approximately two to one.

A primary difference in state hospital services is the shift toward acute care as opposed to long-term residential care. Proportionally more patients are receiving more active treatment for a shorter time. Exhibit 3 illustrates that the number of state hospital beds decreased by nearly 70 percent (from 413,000 to 130,000) from 1969 to 1984. The number of days of care provided by state mental hospitals decreased from 134 million in 1969 to 43 million in 1983 (68 percent). However, the number of inpatient additions (new admissions, readmissions, and returns) to state hospitals only decreased about 30 percent over the same time.

**Some Issues And Research Questions**

It is a daunting task to collect comparable statistics from the variety of organizations providing some form of mental health care, especially given the redefinition of terms occurring every few years. Because mental health patients are seen primarily in the community, many receive services and benefits from agencies outside mental health—some directly attributable to their mental illness, such as SSDI, and some more indirectly related, such as housing assistance based on their low income. How

| Exhibit 3 |
| Additions, Beds, And Days Of Care In State And County Mental Hospitals, Selected Years, 1969-1983 |

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>500</td>
<td>400</td>
<td>300</td>
<td>200</td>
<td>100</td>
</tr>
</tbody>
</table>

Additions (thousands)

Beds (thousands)

Days of care (millions)

Note: Years shown are the only years for which data are available. "Additions" refers to new admissions, readmissions, and returns.
can information be obtained about the experience of mental health clients in these other systems? What impact does a change in the SSI program have on the mental health services budget?

As an example of the variety of programs involving mental health, consider the following. In 1988, the federal government spent $3.8 billion for SSDI and $1.64 billion for SSI to support persons disabled by mental illness. Federal expenditures reached $151 million for special education for mentally and emotionally disturbed children in 1988-1989. Also, $42.7 million for housing subsidies went to persons handicapped by mental illness, under Section 202, in 1989.

At the state level, a host of other agencies provided services to clients of the mental health system as well as to persons who had never been identified as part of the mental health population: education, vocational rehabilitation, health, criminal justice, transportation, and social services, to name only a few. Initial attempts to trace these expenditures were presented in Mental Health, United States, 1985. In 1983, for example, twenty-six states spent $394 million from state special education funds for mentally ill clients; seventeen states spent $162 million from state social services funds; twenty-eight states spent $102 million in vocational rehabilitation funds; and thirty states spent $76 million in corrections and criminal justice funds.

**Medicaid and Medicare.** In 1986, Medicaid and Medicare together paid $4.9 billion for mental health care in general hospitals and $1.9 billion for mental health care in other organized facilities. Of the total for facilities other than general hospitals, approximately 80 percent came from Medicaid. A similar breakdown is not available for general hospitals, but given the severe limitations for mental health coverage under Medicare, the proportion of Medicare funding is likely to be similar or smaller. These numbers do not include separate payments for physician services.

The Medicaid program, jointly funded by the state and federal governments but administered by the states, obviously plays a major role in funding mental health services and in shaping the system of care. For the specialty mental health sector alone, Medicaid accounted for at least $1.4 billion (9 percent), of which the federal government share was over half, with the remainder from state and local governments. Medicaid paid 11.2 percent of state mental hospital costs (Exhibit 2).

Medicaid provides powerful incentives in favor of or against certain forms of care. For example, inpatient hospital services are part of mandatory coverage, but services in “institutions for mental disease” are not covered except as an option for persons over age sixty-four or under age twenty-two. Availability of this funding has encouraged the use of
general hospitals in the community for inpatient hospitalization. Since Medicaid coverage is largely limited to specific service incidents in health facilities, funding for the wide range of continuing supportive services needed by severely and persistently mentally disabled people living in the community is generally not available through this mechanism.

As a result of these and similar Medicaid characteristics, the program tends to drive the mental health service system toward an emphasis on episodic care rather than continuity, and toward use of acute care hospitals rather than community alternatives. The variation among state Medicaid programs' mental health coverage complicates efforts to determine how Medicaid is being used to support mental health services. Not surprisingly, states with more liberal eligibility and coverage policies have higher mental health utilization rates. Further, a relatively few individuals account for most of the costs.12

Deinstitutionalization and gaps in the system. Given the plethora of programs and funding sources, why do some individuals seem to fall through cracks in the system? An essential change that has come with deinstitutionalization is the fragmentation of budgetary as well as programmatic responsibility for persons served by the mental health system. Instead of going to a single source for services (and whatever funding was available), individuals now may go to one facility for mental health services, paid for by a combination of public and private funding sources, each perhaps with different eligibility criteria; to one or more other agencies for rehabilitation or employment assistance or social services, each dependent upon a wholly different public budget, and again with its own eligibility rules; and to still another Program (or combination of programs) to obtain income support under entitlement by one or several factors, ranging from poverty to military service to employment history. This fragmentation complicates service delivery and financing, both for clients and for providers, and vastly complicates the ability to determine program budgets.

Reinstitutionalization and the new asylum. As state mental hospitals have grown smaller and emphasized the provision of acute care, many seriously disabled persons have come to rely on community-based services for long-term support needs. The lack of adequate services in many communities is well documented. This situation has led some to advocate reversing the thirty-year trend away from state mental hospitals and encouraging their use as long-term residential settings, as in the past, or the creation of new residential facilities to perform their former function. Others argue that recreating the “asylum” would inevitably recreate the abuses that led to change thirty years ago.

In addressing such issues, it is important to know what in fact has
happened to the individuals who have left state mental hospitals over the past thirty years. How many have successfully adjusted to community life and “disappeared” from mental health statistics? How many have become clients of community-based services? How many have returned to the hospital for long or short stays? How many of the persons needing community-based treatment today are new (never hospitalized) patients? How much would it cost to expand institutional care for persons now living (some very marginally) in the community?

**Responsibility of public sources.** One of the more interesting current debates concerns the increasing responsibility taken by (or given to) local governments for funding mental health services, and how this is changing the traditional state authority and role. The role of Medicare, which has always largely excluded mental health, is also undergoing reexamination as an element of catastrophic coverage. The advent of acquired immunodeficiency syndrome (AIDS) has raised questions about public responsibility for the mental health component of services to people with AIDS and to their families. All of these are fertile areas of research to support policy decisions.

The author thanks Ronald Manderscheid, Division of Biometry and Applied Sciences, National Institute of Mental Health, and Kevin Marvelle, Mental Health Policy Resource Center, for their assistance in preparing this article.

NOTES

5. NIMH unpublished provisional estimates.
6. National Association of State Mental Health Program Directors, Funding Sources and Expenditures of State Mental Health Agencies: Revenue/Expenditure Study Results, Fiscal Year 1985 (Alexandria, Va., July 1987).
7. Derived from unpublished data provided by Office of the Actuary, Division of Statistical Analysis, Social Security Administration, November 1989.
10. NIMH unpublished provisional estimates.
11. Ibid.