The Journal of Mental Health Policy and Economics
J Ment Health Policy Econ **6**, 111-112 (2003)

Editorial

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The articles in this issue consider the quality of schizophrenia pharmacotherapy in U.S. Veterans Administration facilities and in the private sector (Leslie & Rosenheck), the earning losses due to mental illness (Marcotte & Wilcox-Gok), and the financing of mental health care from the WHO project Atlas (Saxena *et al.*). The Saxena *et al.* article inspired two Commentaries (Hu and Mezzich).

Leslie & Rosenheck (p. 113) focus on the quality of pharmacotherapy for schizophrenia and compare outpatient care for schizophrenia in the U.S. Veterans Administration (VA) and in the private sector. For both groups, they evaluate the use of antipsychotic medication and construct measures of the quality of pharmacotherapy, including whether patients were prescribed any such medication at all; whether they were prescribed one of the newer, atypical antipsychotics; whether they were given multiple antipsychotic prescriptions; and whether dosing complied with the treatment recommendations developed by the schizophrenia Patient Outcomes Research Team (PORT). The authors compare a random sample from the national VA administrative database (including all outpatients diagnosed with schizophrenia who received at least one prescription of oral medication in fiscal year 2000) with a national sample from the private sector (1,318 patients diagnosed with schizophrenia in 2000 were identified using Medstat's MarketScan database). The results of the study show that antipsychotic medication was received by 82% of patients in the VA facilities and by 73% in the private sector. Overall, differences in the proportion of schizophrenia patients dosed according to the PORT recommendations were not statistically different across the two systems (60% for the VA and 58% in the private system). The authors report that the relatively low rates of compliance with treatment recommendations may be due to (i) lack of awareness of these recommendations among prescribing physicians or (ii) a belief that these recommendations are inadequate and are in need of further refinement.

Marcotte & Wilcox-Gok (p.123) analyze the impact of mental disorders on workers' earnings. They indicate that several factors may shape the extent to which illness impairs workers' ability to maintain employment or work effectively, including (i) the disparity in access to treatment that may cause important differences in the consequences of illness, and (ii) the differences in employment contracts (i.e. salaried workers versus those paid hourly rates), which may affect the likelihood of maintaining employment and earnings. The study re-examines the effects of mental illness on earnings from the assumption that the traditional focus on mean effects provides overly limited information. The authors use data from of the National Comorbidity Survey (NCS), a nationally representative survey designed to study the prevalence, causes and consequences of comorbidity between substance abuse disorders and non-substance abuse psychiatric disorders. The NCS contains data describing individuals' labor market experience, as well as other relevant economic and demographic information. The analysis is restricted to a sub-sample of 5,877 respondents to a questionnaire. The questionnaire was administered as Part II of the survey, and provides detailed information on individual and family history of mental illness. Respondents' annual personal income is used by the authors as a proxy measure for earnings, which would limit the analysis to those who report participating in the work force. The authors report that while average effects are often not large, mental illness more commonly leads to earnings losses at the lower tail of the earnings distribution, especially in women. They suggest that these results may be due to (i) the heavier impact of disease on poorer workers or (ii) the possibility that workers with more substantial illnesses are selected into the bottom of the distribution.

Saxena *et al.'s* study (p. 135) is part of the Atlas Project, launched by the World Health Organization in 2000, which aims to collect, compile and disseminate information on mental health resources throughout the world. The study seeks to describe the national health budgets and financing of mental health care. A questionnaire with glossary definitions aimed at quantifying the federal budget for mental health care and at evaluating policy, program and mental health resource indicators was sent to the focal point for mental health in the Ministry of Health of all WHO member countries. The authors report that 32% of the 191 countries that completed the questionnaire did not have a specified budget for mental health. Of the 89 countries that supplied the required information, 36% spent less than 1% of their total health care budget on mental health. In general, lower income countries spent a lesser proportion of the health care budget on mental health than did higher income countries. The authors stress the discrepancy between the 13% global burden of disease and the average allocation of 3.47% of the health care budget to mental health in 89 countries. The presence of mental health policies and programs in general was not associated with the proportion of the health care budget allocated to mental health. The authors recommend the establishment of national mental health care budgets

adequate to provide necessary services, training and research; the development of research on the financing of mental health care in order to inform policy and service planning; and the development of viable alternatives to out-of-pocket expenditure, which is crucial to financing mental health services in many low-income countries and to establishing mental health care in the community.

Hu (p. 145) and Mezzich (p. 149) have written Commentaries to the Saxena *et al.* paper.