4. Mental Health Care Financing

It has been outlined in the previous part that mental health care in Austria includes elements which are covered within and outside the health care system. Furthermore, historical issues and traditions as well as the federalist structure have led to the development of a specific scenery of public and private sector involvement. This is not only the case in Austria, but it is the traditional pattern in Western European countries. Given this complexity, it is not surprising that the financing structures of mental health care are also particularly complex.

In none of the Western European states there exists an explicitly defined mental health care financing system. Thus, mental health care financing always occurs within the context of the overall welfare state financing system and to a large extent within the context of general health care systems and financing arrangements. This might suggest that there is no point in specifically addressing mental health care financing. However, there are several reasons why the focus on mental health care financing is warranted.

Firstly, as Frank and McGuire (1999) point out, the spending on mental health care displays a different pattern than that found in the health care sector overall. When studying the situation in the USA they found that the most important difference is the role of government as direct funder of care. State and local government allocate more resources for mental health (41.1%) than for health services generally (23.3%). On the other hand, the federal government funds over 25% of health spending but less than 20% of mental health expenditures. Additionally, private spending for private health insurance and private out-of-pocket spending differ between health care and mental health care. Although European health care systems vary considerably from the US system, it is likely that European mental health care financing systems equally display specific patterns, simply because mental health care covers a wider range of services than general health care. Moreover, Dixon (2002) remarks that as a result of the shift away from institutionalised psychiatric to community care a diversification in mental health care financing has taken place in most of the countries. These specific characteristics may not least have implications for service delivery and for the individuals affected by mental disorders.

Secondly, even in domains where mental health care financing is identical with general health care financing, it is important to address financing arrangements. It has been outlined in the previous chapters that mental disorders differ from somatic illness in terms of aetiology, diagnosis and treatment as well as in terms of various social consequences which are related to mental illness. Serious disorders are associated with social disorders that can severely impair quality of life, including isolation from social networks, homelessness or inappropriate accommodation placements. Severe and chronic mental health problems are associated with unemployment and low income. Due to this specific nature of
illness and its consequences, the general health care financing system may have different implications for persons with mental disorders compared to those with somatic illnesses, for example in terms of (re-)distributional effects of a financing system or access to care.

Thirdly, since around 1980, all across Western Europe health care reforms have taken place. The majority of them were either directly or indirectly concerned with financing issues. Usually, implications of those changes for mental health care service provision and individuals affected by mental disorders have not been taken specifically into account in reform formulation and implementation processes. In other cases, mental health care has definitely been excluded from reforms. Both situations may have specific impacts for mental health care in general and for affected individuals in particular.

The purpose of this chapter is to describe mental health care financing in EU member states. Following this introduction is an overview about mental health care financing in Western European countries which is completed by three case-studies including the UK, Germany and Austria. The non-Austrian cases have been chosen according to the criteria of maximum similarity and maximum difference to the Austrian situation in terms of health care system type. In Germany, the overall financing principle is very similar to Austria, however, several specific arrangements (for mental health care financing) exist which differ from the Austrian case. It will be of interest to explore the effects of differences in details within overall similar systems in the subsequent parts of the thesis. In the UK, on the other hand, the general health care financing principle is different from Austria. The relationship between this type of financing and mental health care will also be an interesting issue, the more so, as considerable progress in the mental health care reform process in the UK can be observed.

The chapter will be of descriptive nature and provides an empirical source for the in-depth analysis in chapter 6 as well as for identifying alternative approaches to mental health care financing in chapter 7. In theory, this would include describing the overall health, social care and even other sectors’ financing system. However, due to the great variety of funding arrangements between countries and even within countries and regions, I will mainly restrict the description of financing arrangements to selected core-services for mentally ill rather than covering the sectors entirely. Particularly for the case studies the portrayal includes financing of hospital inpatient care, psychiatric specialist mental health care, residential care and mobile/ambulatory psychiatric services (MAPS). This raises terminological problems. Although terms used might be identical, they may cover different types of treatment/care in various countries or even within one country. Vice versa, providers offering similar types of activities may be termed differently. For the purpose of comparability I use the following definitions: ‘Hospital inpatient care’ relates to inpatient medical treatment, while ‘psychiatric specialist mental health care’ means psychiatric services offered by psychiatrists. ‘Residential care’ corresponds to all types of accommodation arrangements.
ranging from 24-hour staffed nursing homes to sheltered housing. Finally, the term ‘mobile/ambulatory psychiatric services’ stands for multidisciplinary teams which provide ‘come or go-structures’ for people with mental illness excluding employment related services. Only in the Austrian case, due to the Austrian focus of the thesis, the description of financing structures will cover some further elements of service provision. Furthermore, in the UK case, slightly more attention will be drawn to the financing procedure, as this will be of relevance for the remainder of the thesis.

4.1. An Overview of Mental Health Care Financing in Western European Countries

In the following, an overview about financing mechanisms in Western European countries which are relevant for mental health care services will be provided. This will firstly, include an overview about health care financing in Europe including sources of funding and resource allocation processes. However, similar to Austria, a lot of mental health care services are not provided within the health care system (as the term ‘mental health care’ might suggest) but in parallel sectors such as social care. In those cases, methods of financing and entitlement to services may differ considerably. Thus, the chapter also addresses the balance between health and social sector in mental health care and financing methods for core-services which are traditionally covered outside the health care sector in many countries. Empirical data for this description has been obtained via the ‘Mental Health Economics European Network (MHEEN)’ where research representatives from various European countries have collected information on financing mental health care (MHEEN 2004).

4.1.1. Sources of Funding

4.1.1.1. Funding Mental Health Care Services within the Health Care System

Sources of financing are relevant for several issues. Firstly, different sources can have different distributional effects. As Wendt (2003) remarks, individuals and their standard of living are considerably influenced by the way the health service is financed. Secondly, sources of financing often determine who makes decisions about resource allocation and broader planning aspects in the health care system (Wendt 2003).

11 The countries include Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, The Netherlands, Portugal, Spain, Sweden and the UK.
Usually, mental health care services within the health care system are funded in the same fashion as other health care services. Although there are many differences and variations between individual systems, there are four primary mechanisms for collecting funds for European health care systems which are taxation, social health insurance, out-of-pocket payments/user charges and private insurance. Taxes or social insurance money are public sources while user charges and payments by private insurances (which may be complementary or a substitute for public services) are private sources. Concerning public sources, each country tends to be dominated by one pattern, according to the general principle of organising and providing health services. ‘Beveridge-countries’ (e.g. UK, Scandinavian countries) base their health service financing on general taxation while the primary source of ‘Bismarck-countries’ (e.g. Germany and Austria) is social insurance money.

The sources can take different forms. Thus, taxation systems vary according to the source of taxes used (direct, indirect) and the collection level (national, local). Moreover, taxation can be earmarked or not. Social insurances, on the other hand, are based on pooling revenue through compulsory contributions by employees and (usually) employers. In some ‘social insurance-countries’ there exists an opting-out possibility for high-income groups which is the case in Germany. In the Netherlands, higher income groups are generally privately insured. Revenues can be collected by national or individual health insurance funds or by associations of funds. Usually, contributions are not risk-rated but dependent on income-levels. Contribution rates may either be uniform or they may vary according to funds. In some countries, individuals are able to choose between sickness funds, such as in Germany (Knapp et al. 2003).

Private health insurance plays a limited role for mental health care financing in all of the Western EU-countries. It can take a complementary form (such as in Germany or the Netherlands) or a supplementary form (such as in Austria or France). In most countries the majority of policies are bought at the discretion of an employer on behalf of the individual. Premiums are usually risk-rated (i.e. based on an assessment of individual risk), but may also be community-rated (based on an assessment of the average risk in a defined subgroup of the population) or group-rated (based on an assessment of average risk among the employees of a firm) (Mossialos and Thomson, 2002). Where supplemental insurance is available, coverage for mental health related services is often very limited. Due to the chronic nature and high cost of mental health treatments and interventions private insurers are likely to exclude mental health interventions from the benefits offered to enrollees. Psychiatric care and mental health problems are explicitly excluded in some European Union member states (Mossialos and Thomson, 2002). For instance the sole provider of private health insurance in Luxembourg does not cover mental health. Where treatments are covered, premia are likely to be high. In some cases private insurers are beginning to provide limited cover for some mental health problems, and in some countries this is
becoming significant. For example, employers may provide private health insurance as a non pecuniary employment benefit. A new phenomenon are insurance schemes providing employment protection. While these may not directly pay for mental health care, insurers can provide a cash benefit should an individual have to give up work because of a mental health related problem. In the UK such insurance schemes have funded counselling and other treatment for workers who have stress related disorders such as teachers.

Private contributions from users vary. In general, they play a minor role compared to public sources. However, trends can be observed which show a considerable increase in private contributions in some countries (Hofmarcher and Röhrling 2003a). User charges can be a percentage of cost or they can be a fixed amount. It is very common that user charges are levied on certain health services such as pharmaceuticals or primary care consultation. Introducing user charges can either be a way of raising revenue or a mean to discourge excessive or inappropriate utilization of services. Usually, specific groups are exempted from charges. Exemptions may be based on age, income, disease or functional status. For example, in Italy people with mental health problems are exempted from charges for using outpatient services. In Portugal exemptions to user charges have been applied for those with low family incomes, individuals with exceptional need for health care consumption such as the disabled and those with certain chronic conditions and for a range of special patient groups (e.g. pregnant women, children, drug addicts on recovery programs, chronic mental patients, etc.) (Pereira et al. 1999). In some cases private insurance may cover the cost of user charges.

OECD data indicate that public funding is the dominant source of health care financing in the countries observed. Concerning mental health care, this relates to those mental health care services which are provided within the health care system. Results from a global survey of mental health financing from the WHO (2001a) show that in the majority of Western European countries the primary source of financing mental health care within the health care system are taxes (figure 8).

There are only few situations where mental health care services within the health care system are financed differently from other health care sector services concerning sources of funding. One unusual case among social insurance based countries are the Netherlands. They have a separate insurance fund for long-term illness, as primary social health insurance only covers a one year period of either inpatient care and/or rehabilitation. After this period the ‘Exceptional Medical Expenses Act’ (AWBZ) comes into effect. The AWBZ is concerned with very severe financial burdens as a result of serious long-term illnesses or disorders. This insurance scheme is obligatory even for those with high income enrolled in private insurance schemes. Typically, long-term mental health problems are funded under this scheme. Overall, about 85% of the cost of mental health care
facilities is paid by the AWBZ, while 11% come directly out of the national budget. Additionally, there are out-of-pocket contributions for inpatient treatment, sheltered accommodation and psychotherapy which cover 4% of the costs of mental health care. Coverage under the AWBZ includes admission and stay in general hospitals, psychiatric hospitals and rehabilitation centres after the first 365 days, as well as funding nursing home care, home care, sheltered accommodation, counselling and outpatient psychiatric care (Ministry of Health, Welfare and Sports (VWS) and T. Institute 2000).

![Primary source of funding mental health care services within the health care sector (n=15)](image)

**Figure 8: Primary source of funding mental health care services within the health care sector; Source: WHO (2001a)**

Another special case is Belgium with respect to home care services for people with mental health problems as well as child and adolescent mental health outreach services. Although these services lie within the health care system they are not funded by social insurance but directly by the federal government, as these services currently operate on a pilot experimental basis.

Finally, some services for instance in Luxembourg, Spain and the UK may be supported by charitable groups. In some cases this type of funding is intended to supplement statutory services, in others it fills a gap where public funding is not available.
4.1.1.2. Funding Mental Health Care Services outside the Health Care System

As has been stated before, it is required to additionally investigate which core mental health care services are not part of the health care sector and may thus be funded in different ways. This is even more relevant as mental health care reforms have aimed at shifting mental health care from hospital based to community-based deinstitutionalised care and services of the latter are likely to be classified as ‘non-health care system’ services.

In general, there is much variation concerning which range of services are covered within or outside the health care system. Overall, few countries provide a fully comprehensive range of services within the health care system and even where they do the boundaries of responsibility and financing between the health and other sectors may be blurred. In the majority of countries, key services such as vocational rehabilitation or residential care are covered outside the health care system. Tables 11a/b present an overview of financing methods of those particular mental health care services.

Commonly, the primary sources of funding are taxes. In general, they are levied and/or administered on the regional or local level rather than on the national level. Notably, only in Sweden full public cost-coverage is provided. In any other country at least some forms of means-testing and out of pocket payment exist. Private payments can range from covering ‘hotel costs’ only such as in Denmark, Finland and Norway to high rates of private contributions according to the principle of subsidiarity. In the latter case, private money is used as the primary source of financing such as for some services in Portugal, Greece or Austria (MHEEN 2004a). Additionally, financing for services which are covered outside the health care sector is very often restricted to specific user groups in terms of access. For example, in Germany, access to several services depends on the severity of the illness and/or the grade of disability.

4.1.2. Transfer of Funds and Resource Allocation Processes

In this chapter a brief overview on the methods used in Western European countries to distribute mental health care resources is provided. In that respect, two processes can be distinguished. On the one hand, there is the process of resource distribution to different sectors and/or geographical areas of the mental health care system. On the other hand, resources are allocated to different providers of the mental health care system which takes place according to various reimbursement methods. The two processes are in some way dependent on each other. For example, the reimbursement method chosen may to a large extent determine the criteria for distributing overall resources.
<table>
<thead>
<tr>
<th>Source of Public Funding</th>
<th>Access restrictions</th>
<th>Out of pocket payment</th>
<th>Responsib. Level</th>
<th>Specific characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austria</td>
<td>Taxation</td>
<td>For some services</td>
<td>Yes for residential services</td>
<td>Regional</td>
</tr>
<tr>
<td>Belgium</td>
<td>Taxation</td>
<td>Means testing</td>
<td>For some services including long-term care</td>
<td>National</td>
</tr>
<tr>
<td>Denmark</td>
<td>Municipal/County taxation</td>
<td>No</td>
<td>Only hotel costs of long-term care</td>
<td>Local</td>
</tr>
<tr>
<td>Finland</td>
<td>National/Municipal taxation</td>
<td>Means testing and flat rate contributions</td>
<td>Flat income related housing cost contribution in municipal provided accommodation; subsidy for private accommodation</td>
<td>Local</td>
</tr>
<tr>
<td>France</td>
<td>National/Local taxation/Donations</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>Germany</td>
<td>Unemployment Funds/Taxation/Long-term care insurance/Donations</td>
<td>Access dependent on assessment of level of impairment</td>
<td>Yes for some services</td>
<td></td>
</tr>
<tr>
<td>Greece</td>
<td>Taxation/Insurance/EU support</td>
<td>Subsidiarity principle</td>
<td>No</td>
<td>National</td>
</tr>
</tbody>
</table>

Table 11a: Funding of mental health care services outside the health care system adapted from MHEEN (2004a)
<table>
<thead>
<tr>
<th>Source of Public Funding</th>
<th>Access restrictions</th>
<th>Out of pocket payment</th>
<th>Responsib. Level</th>
<th>Specific characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ireland</strong></td>
<td>Taxation/Donations</td>
<td>Means testing</td>
<td>Yes for most services</td>
<td>Regional</td>
</tr>
<tr>
<td><strong>Italy</strong></td>
<td>Taxation</td>
<td>?</td>
<td>?</td>
<td>Local</td>
</tr>
<tr>
<td><strong>Luxembourg</strong></td>
<td>Taxation</td>
<td>Housing requires referral from medical sector</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td><strong>Netherlands</strong></td>
<td>National taxation/Other sources</td>
<td>?</td>
<td>?</td>
<td>Local</td>
</tr>
<tr>
<td><strong>Portugal</strong></td>
<td>Taxation/Donations</td>
<td>Subsidiarity principle</td>
<td>Yes</td>
<td>National</td>
</tr>
<tr>
<td><strong>Spain</strong></td>
<td>Regional taxation</td>
<td>Certificate of disability required to access services/Discretionary provision</td>
<td>?</td>
<td>Regional</td>
</tr>
<tr>
<td><strong>Sweden</strong></td>
<td>Local taxation/National equalisation</td>
<td>No</td>
<td>No</td>
<td>Local</td>
</tr>
<tr>
<td><strong>UK</strong></td>
<td>Taxation/Donations</td>
<td>Subsidiarity principle</td>
<td>Yes for some services</td>
<td>Devolved administrations/Local</td>
</tr>
</tbody>
</table>

Table 11b: Funding of mental health care services outside the health care system adapted from MHEEN (2004a)
According to Rice and Smith (2002) four main modes of distributing overall health care funds can be found in Western European health care systems. Firstly, budgets can be set according to the size of a bid from providers. Secondly, the budget can be mainly based on political negotiation. Thirdly, the funds may be set according to historical patterns and, finally, they may be based on some independent measure of health care needs. Most Western European countries have introduced some type of needs based resource allocation method, mainly in the form of risk adjusted capitation formulae. In their empirical study, Rice and Smith (2002) found that from the Western European health care systems they analysed, only Austria, Greece, Ireland and Luxembourg had no elements of capitation. However, in most cases capitated budgets are still influenced by political negotiations and historical precedents, as it is for example evident in Portugal.

With respect to provider reimbursement within the health care system, three main methods of provider reimbursement can be envisaged along a spectrum of various arrangements. Firstly, providers can be reimbursed according to full retrospective reimbursement for all expenditure incurred. Secondly, reimbursement can be activity based according to a fixed schedule of fees as for example in the case of diagnosis related group systems. Finally, reimbursement may take place according to prospective funding based on a fixed budget which is determined on the basis of expected future expenditure. The main difference between method one and three is that the financial risk shifts increasingly from the payer to the provider of services. Rice and Smith (2002) point out that, not least because of increasing concerns with expenditure control, the trend within European health care systems has been a shift to the latter model. Particularly with the introduction of new forms of overall resource allocation such as needs based capitation, the ‘full retrospective reimbursement method’ has inevitably had to be abolished. However, very often explicit mechanisms of reimbursement may be influenced retrospectively by implicit mechanisms such as hidden subsidies. A case in point is the Austrian system where the prospective hospital budget combined with a diagnosis-related reimbursement of hospitals is traditionally subsidised in retrospect by taxes from provinces (see 4.4.). Not least, with changing reimbursement methods, particularly from retrospective to activity based and prospective reimbursement, the relationship between purchasers and providers has changed into a contractual relationship where various types of performance based contracts have been introduced.

Concerning the question whether specific characteristics in terms of resource allocation and reimbursement for mental health care services within the health care sector exist, some differences to somatic services can be envisaged. Most importantly, psychiatric hospital care may be exempted from the overall reimbursement scheme as for example in Germany, where psychiatric hospital services have been excluded from the diagnosis related group reimbursement system when it was introduced in January 2004 (see 4.3.).
Given that the majority of countries use risk adjusted capitation formulae for allocating resources, a crucial question is whether the factors used in the formulae account in any way for mental illness. There is hardly any information available on that matter. As Rice and Smith (2002, 258) note: “The selection of factors to be included in calculating health care capitation has been highly complex and controversial...”. Furthermore, once factors have been selected, weights must be attached in order to reflect the differences in needs. They are either based on individual data (e.g. age, sex, disability status etc.) or on aggregate data (e.g. demography, mortality etc.). Comprehensive individual data are hardly available. Thus statisticians are often forced to restrict weighing to very few individual criteria such as ‘age’ in France or they use aggregate data such as in Belgium or a hybrid model. With respect to mental illness, some of the factors (such as morbidity) may take specific needs more into account than others. In some cases, there may even be an explicit ‘mental illness factor’ which takes into account specific resource requirements for providing mental health care. An example for that will be described in more detail under 4.2.

Overall, allocations to mental health care are difficult to quantify. Some countries operate with a ‘ring fenced’ mental health care budget, while in others, the mental health care budget cannot be separated from the overall health care budget. According to a WHO (2001a) data base, twelve out of the fifteen Western European countries report that a specified mental health care budget exists. Out of these countries, seven have provided a percentage of mental health care spending. In one case (France) this accounts for 5 % of the total health care spending. Four countries (Belgium, Ireland, The Netherlands, UK) commit between 5.1 and 10% of their budget to mental health care, whereas only two (Luxembourg, Sweden) spend slightly more than 10% of total health care expenditure on mental health care.  

With respect to transferring funds and resource allocation for mental health services outside the health care system, even less detailed information is available. Principally, many of the described modes of distributing funds and reimbursing providers can also be found outside the health care system. However, funds for financing those services are more likely to be determined according to political negotiations and historical patterns. With respect to reimbursement, retrospective reimbursement has traditionally been used for various providers. More recently, reimbursement has shifted to activity based types of reimbursement and prospectively determined budgets, which is closely related to the shift from public subsidies to performance based contracting. Finally, it is common that similar to sources of funds, resource allocation and reimbursement processes for services outside the health care system differ within countries.

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12 The accuracy of the data depends on the definition of mental health care adopted in each country. In some countries the figure may also include financial resources for financing services outside the health care sector.
4.2. Case-Study: UK

4.2.1. Sources of Funding

4.2.1.1. Funding Mental Health Care Services within the Health Care System

From the services under investigation, hospital inpatient care, psychiatric specialist services and MAPS\(^{13}\) are covered within the health care system in the UK. Core elements of the latter are for example Community Mental Health Teams (CMHT)\(^{14}\) or Assertive Outreach Teams (AOT)\(^{15}\). In the following paragraphs sources for financing these services will be described.

The UK health care system belongs to the so-called ‘Beveridge-countries’ where the primary sources of health care funding are taxes and access to health care is universal (based on residency). The majority of health care in the UK is provided by the Department of Health (DoH) through the National Health Services (NHS). Apart from taxation, a small proportion of NHS expenditure is covered by national insurance contribution. For example, in England consolidated funds (general taxation) accounted for 77.7% of the NHS spending in 2000/2001 while 11.9% of the NHS spending was met by the national insurance (Department of Health 2002). It is worth noting that in 2003 hypothecated national insurance contributions for health care were introduced which increased insurance contributions for employers and employees by 1%. Concerning general taxation, direct taxes account for 44% (Wendt 2003). Overall, in 1995, taxes made up 84% of total health care expenditure while only 9.8% of the expenditure was financed through other public sources. On the whole, the public share of health care expenditure is high. In 2002, total expenditure on health accounted for 7.7% of the GDP from which 83.4% were publicly financed (OECD 2004).

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\(^{13}\) With re-structuring mental health care, the separation between health and social care has become increasingly blurred; thus, some resources (e.g. personnel) in MAPS may also be part of the traditional social sector. For example, formerly separate social work teams are merged with health teams to form ‘integrated services’. However, services are still regarded as health service led and mainly funded from health sector resources.

\(^{14}\) Community mental health teams are multidisciplinary teams which are responsible for coordinated service provision. The average size of those teams is 11 full-time equivalents which relates to 15 team members on average. The occupational group mostly represented are community psychiatric nurses (CPN) followed by social workers, medical personnel, psychologists and occupational therapists. The clientele are to a large extent people with serious mental disorders (57%) (Becker 1999).

\(^{15}\) Assertive Outreach teams are responsible for a specific target group, who have had frequent hospital admissions, present a substantial risk to themselves or others and have not engaged well with community mental health teams. The team works in patients’ living places (Johnson, Zinkler and Priebe 2001).
Private payments in the form of co-payments, self-payment or private insurance used to make up a relatively small contribution. In 1996, approximately £ 7,474 million (or 14.6% of total spending) were spent privately (Robinson and Dixon 1999). With respect to mental health care within the health care sector, co-payments only exist for prescriptions and, thus, play a role for services which are provided outside the hospital only. In terms of private insurance, private insurers are beginning to provide limited coverage for some mental health problems. However, these products have been criticised for being overly complex and variable which makes it difficult for the individual person to find out what is covered. For example of a sample of 203 policies available to a 50 year old provided by 7 insurance companies, 101 offered some inpatient psychiatric cover and 80 some outpatient psychiatric cover. Importantly, pre-existing conditions and treatment for ‘chronic conditions’ tend to be excluded from private health insurance coverage (Office of Fair trading 1996). While the number of individuals who purchase private insurance is small, private health insurance is increasingly offered by employers as an employment benefit.

Not least, the opportunity to provide services through private insurance rises with the increasing provision of mental health care by private companies (McDaid et al. 2004). As a recent market survey suggests, mental health is the fastest growing independent private health care sector, not least because the NHS increasingly outsources acute psychiatric care. For example, independent psychiatric hospital revenues were £ 336 million in total in 2001 which demonstrates an increase by 117% between 2000 and 2001 (Laing and Buisson 2003).

Furthermore, coverage with private health insurance is strongly income related. Data from a recent survey showed that 40% of those in the highest income decile have private insurance compared to just under 5% of those persons in the poorest four deciles. The correlation with high income also relates to the likelihood of an insurance paid for by an employer (Emmerson, Frayne and Goodman 2002).

Finally, in terms of self-payment, it may be relevant that the private sector is an important provider of psychological treatment such as psychotherapy (Johnson, Zinkler and Priebe 2001).

4.2.1.2. Funding Mental Health Care Services outside the Health Care System

Several core elements of community mental health care, namely residential care, employment support and leisure support are not covered within the NHS. Overall, Lien (2003) points out that in contrast to inpatient care where 96% of costs are covered within the NHS, for community care, over 50% fall on local health authorities, housing and education, voluntary organisations, social security, families of sufferers and other informal carers. For example, (financing)
responsibility for long-term care in residential or nursing homes and other accommodation arrangements is shared between several agencies such as local governments, the social services department and the NHS. To a large extent, the provision of services outside of the NHS is the responsibility of Local Authorities (LAs). Funding for these social care services is through the Personal Social Services (PSS) scheme. In contrast to the NHS, in the PSS locally raised revenues play a more important role while central DoH-money only accounts for a marginal proportion. In 2000/2001, spending by local authorities on PSS from DoH sources was £ 974 million (10%), while £ 9,752 (90%) million were funded from other sources (Department of Health 2002). Furthermore, many people have their residential care funded by housing benefits. While health care benefits available under the NHS are universal and free at the point of use, social care benefits are means tested and often subject to cost sharing. Thus, in the PSS-scheme, co-payments are common. For example, in 2002/2003, from £ 920 million total expenditure for the group ‘mentally ill adults’, private contributions from individuals accounted for £ 80 million (approx. 9%) in the English social service scheme (Department of Health 2004). As Goodwin (1997) points out, local authorities are increasingly using means tests for social care services in an attempt to control demand and raise resources.

Notably, the boundary between health and social care is blurred in mental health care. A person with a mental health problem who has accessed the system is assigned a care coordinator who is responsible for providing services based on the individual’s need. Services may be provided by the NHS but also by the social sector or other agencies. According to Dixon (2002), the shift to community mental health care has generally transferred responsibility for financing mental health care services from NHS budget to local social services budgets. Furthermore, the degree of integration between NHS mental health and social services varies. Although government policy requires plans to be made for social workers employed by local authority to work in joint teams with NHS mental health professionals, there is considerable variation in the extent to which these plans have been implemented so far (Johnson, Zinkler and Priebe 2001).

4.2.2. Transfer of Funds and Resource Allocation Processes

Since 1991, the structure of the UK health care system has been constantly changing which has particularly affected the resource allocation procedures in health and social care. Furthermore, the process of devolution has resulted in differences between England, Wales and Scotland. The following description should reflect the current situation as accurately as possible. Where relevant, the example of England is used. Additionally, figure 9 provides a graphical scheme of the financial structures and flows.
In the UK, the DoH budget is set annually in the overall political public expenditure planning process. It consists of a long-term fixed and a short-term (more flexible) treasury grant. Resources are allocated to the NHS and the PSS. In 2000/2001 total DoH Budget was £ 45,550 million from which 97% were allocated to the NHS and only 3% were allocated to the PSS (Department of Health 2002). The NHS budget is further broken down into funding for hospital and community care services (HCHS), family health services (FHS) and Central and Miscellaneous Services (CHMS) and is then transferred to the district level. To ensure that equity and efficiency goals are met, HCHS budgets are ideally set according to risk adjusted capitation methods. This means that allocation takes place according to a formula which was originally developed by the Resource Allocation Working Party (RAWP) in the 1970s. The formula takes into account the number of inhabitants, composition in terms of age and gender and weighted health status. Statistical methods of calculation have become increasingly sophisticated since then (Department of Health 2003). However, in several cases (especially when allocation is made to smaller catchment areas) budget allocation has mostly relied on historical patterns of costs and activity (Robinson and Dixon 1999). In contrast to the HCHS budget, allocation of the FHS budget has traditionally taken place according to historical patterns. Yet, with the development of new primary care structures, the establishment of formulae for primary care budget allocation seems to be under way.

Dixon (2002) points out that it has been recognised to include mental health as a separate risk factor in some resource allocation formulae. For example, in England the RAWP introduced specific needs indices for psychiatric hospital and community care in 1994 (Bindman et al. 2000). The commonly used index is the ‘Psychiatric Needs Index’. Some further allocation formulae for mental health care have been developed in the academic field. For example, Glover et al. (1998) developed the Mental Illness Needs Index (MINI) for special mental health care needs which is based on mathematical/statistical data on service utilisation, on socio-demographic variables and on expert interviews. The MINI is, however, not applied in practice.

Within the HCHS scheme of the NHS, England has an earmarked budget for mental health. It consists of a ‘general allocation for mental health’ and some smaller ‘special allocations’ such as the ‘old long stay allocation’, the ‘drug misuse allocation’ and the ‘mental health challenge fund’. While the ‘general allocation budget’ seems to be related to the Psychiatric Needs Index, such a relation is not observable with the ‘old long stay allocation’ indicating that the latter is mainly allocated on the basis of historical patterns (Bindman et al. 2000). On average, since 1997 around 12% of the HCHS budget has been allocated to mental HCHS (see table 12 for England). This corresponded to £ 2,911 million in 1996/1997 (Bindman et al. 2000) and to £ 5,368 million in 2003/2004 (Glover 2002).
Total amount and maximum/minimum proportion of PCT allocation to clinical areas in England for 2003/2004

<table>
<thead>
<tr>
<th>Clinical areas</th>
<th>Overall %</th>
<th>Max. %</th>
<th>Min. %</th>
<th>Total Allocation for England (£ 1000 )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute HCHS</td>
<td>70.87</td>
<td>73.14</td>
<td>64.04</td>
<td>32,112,793</td>
</tr>
<tr>
<td>Mental HCHS</td>
<td>11.85</td>
<td>20.13</td>
<td>8.04</td>
<td>5,367,596</td>
</tr>
<tr>
<td>Prescribing</td>
<td>14.01</td>
<td>16.81</td>
<td>9.02</td>
<td>6,346,694</td>
</tr>
<tr>
<td>GMSCL</td>
<td>2.59</td>
<td>3.32</td>
<td>2.02</td>
<td>1,174,531</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>0.69</td>
<td>5.79</td>
<td>0.07</td>
<td>311,217</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td></td>
<td></td>
<td>45,312,830</td>
</tr>
</tbody>
</table>

**Table 12: PCT allocation to clinical areas in England; Source: Glover (2002)**

Additionally, mental health receives a share of a dedicated budget for ‘Clinical Priorities’ which is funded through the ‘Centrally Funded Initiatives and Services and Special Allocation Fund’ (CFISSA). It is primarily spent on public mental health campaigns (Department of Health 2002).

Finally, within the PSS, mental health has a specific DoH grant. In 1999/2000, 5.3% (or £ 677 million) of local authority gross expenditure was spent for mentally ill adults (Department of Health 2002). In addition to these ‘earmarked’ allocations, money for mental health care is also allocated via other benefits (e.g. housing benefits), yet without addressing people with mental health problems in particular. Although overall government funding for social services has increased in recent years, the amounts available for mental health care have been constrained and the mental health grant given by central government to local authorities has not been raised at all in the latest period (Sainsbury Centre of Mental Health 2003).

Furthermore, with the process of devolution, significant differences in funding are beginning to appear within the UK. For instance in Wales all out of pocket charges for prescriptions are being phased out, while in Scotland personal as well as nursing costs of long-term care are now funded by the state. Incidentally, since devolution the amount of per capita resources devoted to mental health in Scotland is considerably higher than that in England (MHEEN 2004a).

Finally, resource allocation of the central budget is only one important matter. Another key issue is how resources are actually spent by the purchasing bodies. In other words, even if the allocation process is equitable, resources may not be invested in mental health care. In the UK, the expenditure procedure works as

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16 PCT is the abbreviation for Primary Care Trusts (see p. 63 for more details).
follows: Once broken down, the HCHS sub-budget is allocated to different bodies which function as purchasers of services. At first, the budget is transferred to Health Authorities (former District Health Authorities). Health Authorities (HA) transfer parts of the budgets further on to Primary Care Groups (PCG) with ‘Trust-status’ (PCT). The latter are groupings around GP practices in a geographical area which cover a population ranging from 50,000 to 250,000\(^{17}\). Both, Health Authorities and PCTs are responsible for commissioning and purchasing services from the providers based on the needs of the population. More recently, the function of HA has started to shift towards strategic planning, as PCGs increasingly move towards trust-status and assume responsibility for commissioning. The FHS sub-budget, on the other hand, is used for GP reimbursement and other primary care services.

Reimbursement for service providers is based on contracting arrangements which differ in detail between service types. Concerning methods of hospital funding, a contracting system was introduced under the 1991 reform. Providers of hospital services which have been given ‘Trust-status’ are expected to conclude performance based contracts with the purchasers. Contracts specify the type of service to provide and the terms on which they are to be supplied. The type of contract varies and has initially ranged from ‘block contracts’ to ‘cost-and-volume contracts’ and ‘cost-per-case contracts’. While block contracts define a sum of money for a range of services, cost-and-volume contracts specify a given number of treatments or cases at an agreed price. Cost-per-case contracts, on the other hand, link expenditure and activity explicitly on the individual patient level. Because of considerable transaction costs, the latter type was only used for specific arrangements. In practice, a new form of contract emerged which was called ‘sophisticated block contract’. Since 1998, the former short-term contractual relationship between purchasers and providers has been replaced by long-term service agreements emphasising collaboration rather than competition (Robinson and Dixon 1999).

In the field of mental health care, some specific service supply characteristics exist. Notably, some ‘Mental Health Trusts’ have been founded. ‘Mental Health Trusts’ are characterised as “large organisations with a range of local authority and PCT partners, operating from a multiplicity of sites” (Commission for Health Improvement 2003, 7). The foundation of ‘Mental Health Trusts’ enabled integration of health and social care through the delegation of social care services to NHS trusts. Thus, ‘Mental Health Trusts’ not only provide hospital care but also specialised community care services such as ‘Assertive Outreach’ or ‘Crisis Resolution’ (see 4.2.1.1.). They represent a collaboration between community mental health providers, hospital care providers and a range of voluntary and independent providers (Stevens et al. 2001). According to the Commission for

\(^{17}\) PCT only exist in England. In Wales and Scotland these bodies are called ‘Local Health Groups’ and ‘Local Health Care Cooperatives/Trusts’ respectively.
Health Improvement (2003), ‘Mental Health Trusts’ are at very different stages of development concerning the range of collaborating providers. Additionally, while trusts are formally established collaborations, mental health care services can also be provided through some flexible forms of health and social care integration. Furthermore, fairly recently ‘Care Trusts’ have been established. These are organisations that work in both health and social care. Local authorities can delegate health-related functions in order to provide integrated health and social care to their local communities. Care Trusts may carry out a range of services, including social care and mental health services. There are presently just four Care Trusts in England, however discussions are underway to set up more in the future (Henderson and Knapp 2003).

General practitioners are reimbursed via contracts with the NHS. The conditions of the contract are negotiated between the ‘General Medical Service Committee’ and the DoH. Reimbursement is made according to a mixture of fixed allowances, capitation fees and fees for a number of specific services (Robinson and Dixon 1999). With respect to mental health care on the primary level, primary health care teams providing social services, voluntary sector services and independent sector services exist which are commissioned by PCTs.

Mental health care services which have not been delegated to NHS trusts may be commissioned by PCTs in collaboration with local authority and commissioning teams of health authorities. Table 13 summarises the different types of commissioning and provision of mental health care services.

Viewed from a longitudinal perspective, it has been argued that the spending on adult mental health care has increased slower than spending in the general health and social care (Sainsbury Centre for Mental Health 2003). Adjusting for the effects of pay and price rise, expenditure on mental health services are estimated to increase at less than half the rate of total spending in the NHS and social services over the two years 2002/03 and 2003/04. Despite its status as a priority service, the share of mental health budgets is falling. This causes considerable pressures on budgets the more so, as government targets and new policies are to be implemented requiring substantial amount of service redesign and re-organisation. Since there are no savings available, a transitional problem exits, as setting up new services would require some additional funding in the short run.

Furthermore, Bindman et al. (2000) have shown that the ratio of actual expenditure to initial allocation varies considerable between the different spending bodies. This suggests that, given the allocation process is equitable, resources are not necessarily invested in mental health care by purchasers and providers. Indeed, the authors found that areas with greater levels of need tend to spend less than their allocation on mental health services. It appears that the redistributive nature of the psychiatric index has not been drawn to the attention of purchasing bodies. “They may fail to spend resources in line with the […] formula because it
has never been suggested that they should do so. Even if the implications of the formula have become apparent, they might be reluctant to divert resources to psychiatry from high-profile acute services” (Bindman et al. 2000, 272). Since it is national policy that the use of local resources is at the discretion of purchasing bodies, this issue can only be addressed locally.

### Commissioners and providers of mental health care in the UK

<table>
<thead>
<tr>
<th>Service</th>
<th>Commissioners</th>
<th>Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health provision in primary care</td>
<td>PCG/Ts responsible to health authorities</td>
<td>Primary care team with social services, voluntary sector and independent sector</td>
</tr>
<tr>
<td>Secondary and specialised community care</td>
<td>PCG/Ts in collaboration with health authority commissioning teams</td>
<td>Community mental health trusts and a range of voluntary and independent providers</td>
</tr>
<tr>
<td>Social care</td>
<td>PCG/Ts in collaboration with local authority and health authority commissioning teams</td>
<td>Local authority services, housing associations and private and voluntary sector</td>
</tr>
</tbody>
</table>

Table 13: Commissioners and providers of mental health care in the UK; Source: Stevens et al. (2001, 63)

4.3. Case-Study: Germany

4.3.1. Sources of Funding

4.3.1.1. Funding Mental Health Care Services within the Health Care System

In the German system, from the selected core-services only hospital inpatient and psychiatric specialist services are covered within the health care system. With respect to health care system type, Germany belongs to the so-called ‘Bismarck-group’ of countries where health care financing is based on social health insurance. Employers and employees have to pay mandatory ‘earmarked’ contributions into particular health insurance funds. Since the reforms in 1996, insurees have been free to choose between different sickness funds. With respect to freedom of choice between insurance funds, concern arose for two reasons,
Figure 9: Mental health care financing structures in England; own figure; adapted from Robinson and Dixon (1999)
firstly, the lack of mobility of chronically ill between funds and, secondly, the disincentive funds had to provide high quality care. According to Dixon (2002), of the 1.2 million people who changed funds in 2000 only 800 were chronically ill. Although social health insurance funds in Germany are required to accept all applicants, they may participate in more covert forms of risk selection such as exclusive internet marketing, which may deter certain patient groups. Since January 2002, funds that offer better care have received higher allocation through the ‘Risk Compensation Scheme’ for every member enrolled in a disease management programme. However, it has been criticised that there has not been put enough attention to the specific policy impact for mentally ill persons.

Contributions to the health insurance funds represent a percentage of the income up to a certain income ceiling. Persons whose income exceeds this ceiling are free to opt for full coverage via private health insurance. Currently, approximately 9% of the population has a full-cover private health insurance. Another 9% have taken out supplementary private health insurance in addition to social health insurance. According to the Verband der privaten Krankenkassen (2002), in 2001, 6% of the private health insurances’ expenditure was spent on mental health care. Overall, in 2002 around two thirds of the health care expenditures were financed by social insurance resources. The contribution of private health insurances was 8.4%.

In addition to the social and private insurance sources of health care, sources of funding are taxes which accounted for 7.9% in 2002 and, finally, private payments which covered a proportion of 12.16% of total health care expenditure (Statistisches Bundesamt 2002). In terms of private payments, co-payments have had a long tradition within the German health care system. With respect to mental health care, user charges particularly apply for inpatient care (fixed fee of € 9 per day for maximally 14 inpatient days per year), rehabilitation services (fixed fee of € 9 per day), prescription drugs (fixed fee of € 4-5 depending on package size for each drug prescribed) and primary care services (fixed fee of € 10 for visiting GPs or specialist psychiatrists). However, exemptions exist for persons under 18 years, for persons whose income is below € 500 and the maximal amount of user charges is limited to 2% of the p.a. gross income.

In social insurance systems, entitlements to health care is theoretically related to contributions made, however, the German system has been driven towards near universal coverage including the unemployed, non-working relatives, or people living on welfare benefits. Yet, for people with mental health problems entitlement is restricted in another sense: Only persons with acute conditions are entitled to hospital care. Once, long-term needs are detected, people are excluded from health care system and shifted to the social welfare system, the financing mechanisms of which will be described below.
4.3.1.2. Funding Mental Health Care Services outside the Health Care System

Several core-services of mental health care are not covered within the health care system in Germany. For the services under investigation, this relates to residential care. Furthermore, although MAPS (Sozialpsychiatrischer Dienst) legally belong to the health care system in some provinces, they are financed by different sources and methods which is why I also address them under ‘outside the health care system’. It needs to be noted that for many services outside the health care sector legal responsibility rests with the provinces. Due to the federalist structure, details of financing arrangements can vary considerably between provinces (Länder) or even within provinces.

Sources for residential care depend on the type of residence. The main public sources of funding long-term care for the mentally ill in nursing homes are resources from long-term care insurance and tax based social benefits. Long-term care insurance is organised as a compulsory insurance system (Nam 2003a). Thus, people who are covered under the social insurance system in health care and their employers pay income-related premia into the social long-term insurance system. Persons with a private health insurance need to complete a contract for long-term care with a private insurer. Other residential care facilities, such as sheltered accommodation are financed via tax based social benefits. Like in the British case, utilisation of these services is usually subject to cost-sharing (Con_sens 2000). Furthermore, access to living arrangements depends on the grade of impairment which is assessed by a public medical officer. The system differentiates between two levels of impairment. The first level is related to a 30% reduction of physical, intellectual or mental functioning while on the second level (‘severe impairment’), functioning is reduced by 50%. Most services are limited to persons with at least 30% impairment.

MAPS are usually funded by a mixture of sources. Rössler (1992) provides an overview about these sources which include tax-based subsidies from provinces, tax-based resources from communities, shares from private non-profit organisations and in some cases taxes from specific federal programs. Until recently, a small proportion of funding used to come from health insurances. However, the introduction of ‘Soziotherapie’ as a new service element has resulted in ‘earmarking’ social security money for ‘Soziotherapie’. This has reduced the resources for traditional activities of MAPS (Deutscher Berufsverband für Soziale Arbeit 2003). Additionally, some provinces have reduced their level of financing in the recent past and communities are expected to follow the same route. According to an expert in the field, the future existence of MAPS in Germany is rather at risk (Salize 2004). Overall, MAPS are entirely publicly funded, however, access is restricted to persons with severe mental illness only, as outlined in the directive of the German Social Ministry (Sozialministerium 2002).
4.3.2. Transfer of Funds and Resource Allocation Processes

Available data from Germany do not allow for quantifying the resources which are allocated to mental health care. Nevertheless, allocation processes will be described in a qualitative manner. For an overview of monetary flows see figure 10. For services which are covered within the health care system, a fundamental characteristic in terms of resource allocation is the sharing of decision making between the federal government, the provinces and the social insurance bodies. Germany does not have one budget for funding health care, but there are several tax-based budgets and several hundred sub-budgets from sickness funds. Tax based budgets are determined by individual parliaments acting on a proposal from their respective government (Busse and Riesberg 2000). Health care funds do not have predetermined health budgets but budgets depend on total contributions, which in turn are related to contribution rates, employment rate and other economic parameters. Funds have to cover all the expenses of their insured members. Theoretically, if income does not match expenditure, contribution rates have to be adjusted. In order to avoid constantly rising contribution rates, sectoral budgets or spending cups were introduced. This measure should limit expenditure growth to the growth rate of contributory income. In contrast to the former case of the UK, budgets for hospital and primary care are mainly based on activity and historical patterns rather than on some kind of needs formulae.

Regarding hospital reimbursement, historically, reimbursement took place according to per diem flat rates which were paid in retrospect for each hospital. Over the last ten years several reforms have taken place which changed the reimbursement methods considerably. Since January 2004, reimbursement has taken place according to a diagnosis-related-group principle (DRG). This method links administered diagnoses with a prospectively determined lump sum of money which should reflect different costs for treating different diagnoses. However, psychiatric hospital reimbursement has been excluded from the DRG system. Thus, psychiatric hospital services are still reimbursed by a two-tier per diem system. It consists of a hospital-wide flat rate covering non-medical costs and a department specific charge covering medical costs (Busse and Riesberg 2000). The flat rate is based on calculations from the ‘Federal directive on staffing in inpatient psychiatric services’ (Psychiatrie Personalverordnung). This was introduced in 1991 in order to increase the number of personnel and, thus, quality of mental health care in hospitals (Aktion Psychisch Kranke 1998). The method calculates personnel needs according to the number and type of patients in an institution multiplied with a defined time requirement.

There have been discussions in Germany whether mental health care should be included into the DRG system in future. While there are proponents of the inclusion strategy, others have started to discuss an alternative reimbursement method which is based on the ‘Federal directive on staffing in inpatient
psychiatric services'. The idea is to generally allocate the ‘psychiatric budget’
according to results of the calculation. In other words, the criterion for resource
allocation would be time and personnel requirements for different types of
treatment and care rather than diagnoses (as in the DRG system).

DRG-fees and per diem fees are all part of the budget of the hospitals. However, these budgets are not budgets in the sense of prospective budgets. They are rather based on predetermined targets established in negotiations between the sickness funds and the hospitals. If the activity of the hospital is above or below the target, some financial adjustments are made.

Payment of specialist psychiatrists is subject to a two-tiered process of
physician reimbursement. The physicians association receives an overall budget
based on capitation which is distributed to the members of the physician
association according to a ‘Uniform Value Scale’. At the end of each quarter
physicians invoice the association for the total number of service points delivered
(Busse and Riesberg 2000). Actual reimbursement is subject to several control-
mechanisms which should prevent excess utilisation and false claims.

Resource allocation of taxes for services which are covered outside the health
care system is primarily based on political negotiations and historical spending
patterns and is, thus, subject to the public budget process. Long-term care
insurance benefits are allocated according to the person’s needs. However, unlike
the health insurance, long-term care insurance benefits are restricted to a
maximum level. Cost differences and ‘hotel costs’ have to be borne privately or
may be borne by social assistance after means testing (Nam 2003a). Furthermore,
reimbursement for mental health services outside the health care system varies
considerably between the regions. The most common reimbursement method for
MAPS and residential arrangements are annual public subsidies and daily flat
rates respectively.

Apart from these general financing arrangements some new forms of financing
have been introduced on an experimental base in Germany. Firstly, in some
regions, people are allocated a ‘Personal Budget’ (derived from tax based social
assistance sources). In some cases people can spend the money completely freely
and need not necessarily buy professional services. In other areas, the arrangement
resembles a ‘voucher principle’ where people receive a cash benefit which is valid
for using services from accredited service providers and, thus, allows them to
choose freely between different service providers (Hagelskamp 2004; Schröder
2004). Usually, the overall service package involves different service elements
from various providers. The level of the personal budget is based on an individual
needs assessment procedure (Krüger and Kunze 2004). In some cases the level of
the budget is determined by multiplying the individual service needs (expressed in
professional caring hours) with the wages/hour from the cheapest service
provider. This has been termed ‘cold benefit in kind’ (kalte Sachleistung)
Mental Health Care Financing

(Speicher 2004). Overall, this financing model demonstrates a shift from benefit in kind to cash benefit.

Secondly, a ‘Regional Budget for Clinical Psychiatry’ has been introduced on a 5-year project base in the region of Schleswig-Holstein. The budget integrates sources from all health insurance funds in the region in a ‘Managed Care’ approach. The size of the budget is based on historical spending patterns for hospital mental health care and outpatient mental health care according to the number of treated patients. The aim of the regional budget is to allow a more flexible choice between various treatment settings which include ‘inpatient care’, ‘outpatient care’ and ‘medical home treatment’ in the first stage. In the long run, the goal is to reduce hospital care and, additionally, to reduce costs (Deister, Zeichner and Roick 2004). The project is being evaluated and may be extended to covering the whole range of mental health care services and payers in a second phase.

4.4. Case-Study: Austria

Similar to the former two countries, the financing structures of the Austrian mental health care are complex (figure 11). In resemblance to Germany, legal competence for services covered outside the health care system mainly rests with the provincial levels. Hence, differences in financing structures between the provinces occur. Where this is the case, the situation in the province of Lower Austria will be referred to. In terms of types of services, the portrayal will be slightly more detailed than the previous ones as it is the Austrian situation which will be paid primary attention to in the remainder of the thesis.

4.4.1. Sources of Funding

4.4.1.1. Funding Mental Health Care Services within the Health Care System

From the services under investigation, hospital inpatient care and psychiatric specialist services are covered within the health care system. Additionally, the Austrian description will include psychotherapy which is also attributed to the

17 ‘Managed Care’ is a management concept for health care system which transfers leadership and control to payers (Arnold, Lauterbach and Preuß 1997).
Figure 10: Mental health care financing structures in Germany; own figure.
Mental Health Care Financing

health care system. Like Germany, Austria belongs to the so-called ‘Bismarck group’ of countries where health care financing is based on health insurance. Austrian employers and employees as well as the self-employed and pensioners have to pay mandatory ‘earmarked’ payments into particular health insurance funds. Yet, in contrast to Germany, the number of existing funds is considerably lower. In Austria, these funds finance about 42% of the health care system, with most of the rest coming from tax funds invested by the federal and provincial governments (27%) and from out-of-pocket payments (30%) in the form of co-payments (e.g. prescription fees, daily flat rates for hospital stays), private payments for certain services (e.g. private specialist psychiatrists), or private insurance. Private insurance takes a complementary form in Austria. Nevertheless, private insurance coverage is rather high with around 32% of the population covered in 1999 (Badelt and Österle 2001). In the year 2000 overall expenditure for health care in Austria came to 8.2% of GDP (OECD 2002). While public expenditure is on the decline (corresponding to 67.3% of total health care expenditure in 2001), private expenditure has risen over the last years with an average annual increase of 4.5% since 1997 (Hofrnarcher and Röhrling 2003).

Similar to Germany, the premium for Austrian health insurance funds is adjusted to one’s income level up to a certain income ceiling and it is independent of the payer’s health status. Moreover, access to health care and the type of service to which individuals are entitled bear no relation to the premium paid. However, unlike Germany, people cannot choose between insurance funds and opting out to private insurance is only possible for a very small minority of the population. Nevertheless, eligibility to health care is organised similarly to Germany. It depends strongly on the definition of illness according to the ‘General Social Security Act’ (Allgemeines Sozialversicherungsgesetz, ASVG) which takes a curative approach (Resch 2001). Thus, the potential for cure via medical intervention is the prerequisite for service payment by the health insurance fund. By implication, mentally ill people who develop chronic illnesses are excluded from the health insurance system.

4.4.1.2. Funding Mental Health Care Services Outside the Health Care System

In contrast to medical services, responsibility for residential care and MAPS rests with provincial governments whereas for employment related services (which are also included in the Austrian case study) it rests partly with the provincial and partly with the federal government. The legal basis of the former is constituted by provincial ‘Social Assistance Acts’ (Sozialhilfegesetze) which stipulate that financing of social services is based on the principle of subsidiarity. For the provision of several services, pensions and long-term care allowances, according to the ‘Federal and Provincial Long-Term Care Allowance Acts’ (Bundespflege-
Mental Health Care Financing

geldgesetz, Landespflegegeldgesetze) are the primary source of financing. The difference with respect to full coverage of costs is financed via taxes, and may in retrospect be re-covered from the private savings of clients and of close relatives. The laws allow a rather broad interpretation which results in a considerable variety as to the implications for individual patients even within the same province (Pfeil 2001). Mental health care services which are funded via these financing arrangements are nursing homes and other forms of residential care. MAPS, on the other hand, belong to the very few specific social services which are entirely publicly funded. In these cases the financier is the provincial government using tax-money. For employment related services (which are publicly funded) financiers are the federal and the provincial government, the employment insurance fund and the supranational European Social Fund. Current availability of data does not allow for a quantification of total funding for mental health care. To get a rough overview of overall social care expenditure for social services and living arrangements, in 1998 from 1.4 billion € gross expenditure by provinces, private payments made up 481.1 million € which corresponds to 34%. In 2001, the private share was 37%, rising to 39% in 2002. In total, private payments in 2002 accounted for 698.1 million € (Statistische Nachrichten 2000; Statistische Nachrichten 2004).

4.4.2. Transfer of Funds and Resource Allocation Processes

Like in Germany, resource allocation within the health care system is separated between hospital and primary care. In the 1997 reform, central provincial institutions were established in each of the nine provinces which are allocated a prospectively determined global budget for financing all publicly funded hospitals. All public financiers pay into these provincial funds (in Lower Austria the ‘Niederösterreichischer Gesundheits- und Sozialfonds/ Bereich Gesundheit’). Around 40% is covered by the health insurance funds in the form of a prospectively determined flat rate which is based on the annual growth rate of social insurance income. In addition, predetermined payments are made by the federal government, the local governments and the communities via turnover taxes. Their contribution is determined legally as a fixed percentage of tax income. The procedure for negotiating overall aggregates of the hospital budget is linked with the periodic negotiations on intergovernmental transfers between the federal government and the provinces (Hofrnarcher and Rack 2001). Any hospital-deficit which arises due to expenditure that exceeds the allocated budget is borne by the providers. Thus, the hospital reform has transferred the financial risk from the payer to the provider. Since provinces and communities are major providers of hospital services, they often have the final financial responsibility.

The reimbursement of providers is organised in rather variegated fashions. Hospitals are reimbursed via a diagnosis-related hospital reimbursement system.
Mental Health Care Financing

(Leistungsorientierte Krankenanstaltenfinanzierung). It was introduced in 1997 in order to limit further increase in costs and replaced the retrospective reimbursement that was based on flat rates per day. In the Austrian DRG-system, hospitals ‘earn points’ for every diagnosis they administer and some specific specialised services they provide. The monetary value of each point is determined in retrospect and depends on the total points earned by all hospitals in a province. In contrast to Germany, psychiatric hospital interventions are reimbursed via the DRG system.

According to the Austrian audit court (Rechnungshof 1998), total costs for hospital mental health care accounted for around 291 million € in 1990 and rose to roughly 400 million € in 1995. In other words, costs for inpatient care rose by 37.5 % between 1990 and 1995. The average cost per beds accounted for around 33,430 € in 1990 and rose to 81,394 € in 1995 which reflects an increase of more than 70 percent (table 14). In relation to the overall expenditure for health care, mental hospital care costs accounted for around 3% of the total health care expenditure in 1995. In addition to the general Austrian situation, data from the province of Lower Austria show that the amount of money which was allocated to hospital mental health care in 1999 has been estimated to roughly 32.3 million € (figure 14).

It needs to be noted that none of these figures include expenditure for those people with a psychiatric diagnosis who were treated in non-psychiatric wards. As Katschnig et al. (2001) have shown, these patients account for a rather high proportion of discharged persons. For example, in 1997, almost half of the persons with a psychiatric diagnosis were discharged from non-psychiatric wards in Austria. Thus, actual expenditure for hospital mental health care will in fact be considerably higher than the figures presented.

<table>
<thead>
<tr>
<th>Costs for hospital mental health care 1990-1995</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Total cost (in million €)</td>
</tr>
<tr>
<td>Cost per bed occupied (in €)</td>
</tr>
</tbody>
</table>

Table 14: Costs for hospital mental health care 1990-1995; Source: Rechnungshof (1998)

For General Practitioners (GPs) and psychiatric specialists who usually work in solo practices, separate regulations exist. Negotiations on a corporatist basis are
the common norm. The medical association and the health insurance funds agree on fees for those GPs and specialist doctors who are in a contractual relationship with the health insurance funds. Remuneration follows a mixed reimbursement system with a combination of flat rates and fee-for-service. For services rendered by private, non-contract specialists patients pay on an out-of-pocket basis and are partially refunded by health insurance funds or private insurance (Hofmarcher and Rack 2001). While figures of total expenditure for primary mental health care treatment by psychiatrists and general practitioners are not available, costs for medication show at least a proportion of the expenditure. Between 1995 and 2002, the total number of prescriptions which concerned psychotropic medication paid for by health insurance rose from 4.77 million to 6.5 million prescriptions (or 7% of all prescriptions) (figure 11). In 2002, they cost 167.3 million € and accounted for 9.4% of total public drug expenditure. Then, over 50% of the prescriptions were for antidepressants, less then 25% for tranquilizers and 15% for antipsychotics. Prescriptions for antidepressants and antipsychotics have risen while costs for tranquilizers are on the decline (BMFG 2003) (figure 12). Antipsychotics accounted for one quarter of the total costs. On the contrary, tranquilizers, making up 25% of prescriptions, accounted for only 4% of the costs. In total, in 2003 costs for psychotropic medication were three times higher than in 1995 (Katschnig, Denk and Scherer 2004).

Psychotherapy has, until recently, been mainly privately financed by patients. They have been able to apply for a partial refund (21.80 €/hour of therapy; 5.09 € for a group therapy session) from the social insurance. Over the last years, a variety of financial arrangements for publicly funded psychotherapy has been established on provincial level with the social insurance bodies and the provinces being the public funding bodies. Contracts differ considerably between the nine provinces and resource-allocation as well as selection of patients are intransparent (Zechmeister, Meichenitsch and Hagleitner 2004). A recent study shows that there exist seven different types of financing arrangements in Austria (ÖBIG 2004). Resource allocation and reimbursement arrangements are, thus, subject to individual negotiations between providers and financiers. Consequently, access to services for users varies considerably.

In 1999, social insurance expenditure for psychotherapy services was 27.3 million €. Two third (17.4 million €) from those were paid in the form of partial refunds and around 9.9 million € were allocated to full-cost funded psychotherapy provided either by medical doctors (4.3 million €), by provincial organisations (4.6 million €) or by ambulatories owned by the social insurance fund (1 million €) (Katschnig et al. 2001). Financial resources from health insurance slightly increased to roughly 28.8 million € in 2001 (ÖBIG 2004). Furthermore, public resources for provincial organisations were estimated to roughly 12.21 million € in 2003. Nevertheless, despite rising public expenditure for psychotherapy, these make up only around one fifth of the expenditure for pharmacotherapy.
Prescriptions of psychotropic medication 1995-2002

Figure 11: Prescription of psychotropic medication 1995-2002; Source: BMFG (2003)

Costs of out-patient prescriptions of psychotropic medication 2002 by type of medication, 100%=167,331 €

Figure 12: Costs of outpatient prescriptions of psychotropic medication 2002 by type of medication; Source: BMFG (2003)
Compared to public expenditure, private expenditure is rather high for psychotherapy services. In 2001, overall private expenditure was estimated to approximately 47.5 million €. This is more than 1.5 times higher than total psychotherapy expenditure by the social insurance funds (ÖBIG 2004).

As it has been outlined earlier, residential care and MAPS are financed via the social care system where responsibility rests on the provincial level. The total amount of resources allocated to the services varies between the nine provinces and is usually subject to annual public expenditure planning processes. Negotiations are mainly based on former costs and activity. Mental health care plans which have been established in all of the nine provinces serve as an additional basis for negotiations. For example, in Lower Austria extension of MAPS including their scope of financing is based on the ‘Lower Austrian Mental Health Care Plan’.

For financing social care services in Lower Austria, the provincial ‘Social Care Fund’ (Niederösterreichischer Gesundheits- und Sozialfonds/ Bereich Soziales) acts as a counterpart to the provincial ‘Health Care Fund’. However, financial flows are much more complex in social care (see figure 14). For each type of social service provision there are specific funding mechanisms that result in segregated monetary flows. Hence, the role of the provincial ‘Social Care Fund’ as a central institution for resource distribution and allocation for social service providers has so far been rather marginal. Major regulatory competence rests with different departments in the provincial government. Quantitative figures on resource allocation can only be roughly estimated. According to figure 14, the highest amount of money has been allocated to public nursing homes (160.4 million €), followed by other forms of residential care (23.4 million €) and MAPS/crisis phone (547,672 €). However, it needs to be taken into account that the public share from provinces and communities for public nursing homes and other forms of residential care is much lower in reality, as the figure includes private sources from the users. Furthermore, with respect to nursing homes the figure shows gross expenditure for all nursing home residents, because a separation between mentally ill and other residents in terms of expenditure is not possible. Consequently, the figures overestimate factual public expenditures for these types of mental health services.

As with the overall resource allocation, considerable provincial variations exist with respect to reimbursement of services. In Lower Austria, nursing homes are reimbursed via flat rates per day and expenditure is then recovered from residents and close family members. Other types of residential care, such as staffed group homes or sheltered housing as well as day structure centres are financed via flat rates per patient and year. MAPS, on the other hand are financed via annual budgets. Finally, services promoting employment and labour market integration are funded via a combination of annual budgets and subsidies from the federal and provincial governments and by the Labour Market Service (Arbeitsmarktservice)
(Zechmeister and Österle 2001). Not least, recently, performance based contracting between private providers and public payers have become an increasingly prominent issue in the financing discussions. Equally to the UK, this means that resources are allocated according to the results of negotiations between providers and the public payers. Concluded contracts stipulate the quantity and quality of services that are to be provided (Schneider and Trukeschitz 2003).

4.5. Conclusion

This chapter has provided descriptive data on mental health care financing in Western Europe with some detailed information for Austria, Germany and the UK. It has been shown that financing arrangements for mental health care services are rather complex involving various actors and being based on different regulations. Furthermore, it has been demonstrated that mental health care financing displays a different pattern than that found in the health care sector overall. The main reasons for that are the special characteristics of mental illness which require provision of several core-services of mental health care outside the health care sector or which have led to specific financing regulations for mental health care services within the health care sector. Compared to somatic illness, financing of mental health care is often related to another government level where revenues for financing are raised or administered and/or to a different share of funding for payers. Additionally, resource allocation and reimbursement methods in mental health care differ from those of general health care either because specific methods have been determined for mental health care or simply because processes of allocation and reimbursement outside the health care sector are different from those within the health care sector. The chapter has also shown that exact quantitative data are not always available. Especially the Austrian data illustrate rough dimensions of financing rather than correct figures. Concerning qualitative dimensions, information on financing regulations for services within the health care system has been available in more detail than for those outside the health care system where the regulations often vary between different regions within one country.

In the following chapter the focus shifts to reform processes and reform objectives and attempts to analyse the broader reform discourse within mental health care planning initiatives with a focus on the Austrian situation. The results will be linked with the empirical data on financing from this chapter in the final analysis in chapter 6.
Figure 13: Mental health care financing structures in Lower Austria; own figure
Figure 14: Quantification of monetary flows from public payers in Lower Austria, year 1999; Sources: NÖGUS, Province of Lower Austria, own calculation
Legend to Figure 14

1) Amount for total number of residents including private payments (amount for mentally ill only and for private proportion not available)
2) Amount includes private and public sources (private proportion not available)
3) Legally determined sources from provinces
4) Legally determined sources from communities
5) Sources from hospital providers including deficit spending
6) Legally determined federal sources
7) Legally determined social insurance sources
8) Amount not available
9) Calculated, according to administered LKF-points; amount only includes treatment in mental hospitals and in psychiatric departments in general hospitals; figures for treatment of people with diagnosis of mental illness in other departments not available