6. Mental Health Care Financing in the Light of Reform Objectives and Discourse

The previous chapter has shown that the mental health reform discourse mirrors a transformation process of mental health policy which is part of a larger process of welfare state transformation. In this chapter it will be analysed which role mental health care financing plays in both reflecting and shaping this development and vice versa which role discourse transformation plays in influencing and shaping (future) financing arrangements. Additionally, it will be shown how the inter-dependency between financing and discourse impact on the overall mental health care structure and on individuals affected by mental illness and/or their relatives. In doing so, not least the interrelation between financing and service provision will become more transparent.

The chapter is based on the approach that mental health care financing is a political process and bears considerable potential to shape societal structures and relationships. Thus, any mental health care financing system mirrors a specific social-policy concept of mental health and illness by the way, mental health care is financed in quantitative and qualitative terms and by the way, mental health care financing is embedded in the overall welfare state context.

The objective of this chapter is to make the central role of financing for mental health policy formation and processes of policy development more visible and to make transparent processes of transformations which are already taking place or which are likely to occur. It is to be expected that the link between financing and discourse and their impact on the mental health care structure are not always obviously visible, the more so if no major mental health financing reforms are taking place. Therefore, attention will particularly be paid to more subtle elements of change and the role of financing herein.

6.1. Analytical Framework

In order to make the complexity more tangible an analytical framework is required which allows for a structured analysis of mental health care financing and its policy dimensions. The analytical framework which will be used has been adapted from Daly and Lewis (2000) who have developed a framework for the purpose of analysing social care (financing) arrangements (table 17). Similar to their concept of social care, mental health care takes place at the intersection of state, market, family and the voluntary sector and is, as Daly and Lewis (2001, 286) put it for social care, “an activity that crosses spheres”. In mental health care, this is not least due to the encounter of traditionally separated policy domains of health and social care with their individually characteristic involvement of
different societal sectors (see chapter 3 and 4). It is precisely the complexity resulting from that which is at the centre of the framework.

Overall, the analysis focuses on three dimensions of ‘mental health care’ which are found to be closely linked to financing and discourse. The first one is the ‘responsibility dimension’, which draws attention to how financing arrangements and discourse reflect responsibilities and obligations for mental health care. This brings also in a normative element concerning social relations in mental health care and the state’s role in shaping these relations. The second dimension is ‘labour’ which draws attention to how financing and discourse are linked to the nature of work and activity (paid or unpaid work, formal or informal work). Finally, the third dimension is the ‘cost-dimension’ which addresses the question how financing arrangements are linked to the division of costs between families, individuals and within societies at large.

The analytical framework used addresses two levels as demonstrated in the two columns of table 17. Firstly, it will be analysed how financing shapes a specific mental health care system landscape on the macro-level. Thus, I seek to examine how financing arrangements form the division of mental health care between the sectors ‘state’, ‘market’, ‘family’ and ‘voluntary/community’. Secondly, the framework addresses the micro-level and analysis effects for individuals by who I mean people who are affected by a mental illness and/or their relatives. Furthermore, as it is outlined in the two rows of table 17, the framework addresses the current situation as well as the dynamics of change by analysing the shifting of boundaries on both, the macro-and the micro-level. Thus, it will be identified if relationships within mental health care are shifted between the sectors on the macro-level and between individuals on the micro-level. For this task, I will specifically use the results from the discourse analysis in chapter 5 as an empirical indicator of processes of change. Overall, the empirical material for answering the analytical questions will be used from the sources provided in the previous chapters 3, 4 and 5, as outlined in the third row of table 17.

The framework has been found appropriate for several reasons. Firstly, it puts mental health care financing at the centre of interest rather than following traditional differentiations into either health or social care financing. Consequently, it draws particular attention to the balance between the health and social sector in mental health care and financing. It has additionally been found adequate because it enables me to capture the broad spectrum of financing arrangement and is, for example, not restricted to one selected form such as cash benefits or to one financing element such as sources of financing. Even more, it makes transparent the interplay between certain elements of financing arrangements and their effects on mental health service provision.
## Analytical Framework

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<th>Implications of mental health care financing on...</th>
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<th>Micro-level</th>
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<tr>
<td>...the division of mental health care (labour, responsibility and cost) between the state, market, family and community</td>
<td>...the distribution of mental health care (labour, responsibility and cost) among individuals within the family and community and the character of state support for the mentally ill and for carers</td>
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<tr>
<th>Trajectories of change</th>
<th>More/less: state market family community</th>
<th>Alteration in the distribution of mental health care activity</th>
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<td></td>
<td>- alteration in the identity of carers</td>
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<td>- alteration in the relations between mental health care giver and receiver</td>
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<th>Empirically indicated by</th>
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<td>- the mental health care reform discourse</td>
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<td>- mental health care financing arrangements</td>
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<td>- the distribution of expenditure and costs between sectors</td>
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<td>- the distribution of provision between sectors</td>
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<tr>
<th>chapter 3, 4 and 5</th>
<th>- who performs mental health care?</th>
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<tr>
<td>- who is the recipient of which type of mental health care benefits and services that are available</td>
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<tr>
<td>- who has access to which type of mental health care - which kind of relations exist between the mental health care giver and receiver? (e.g. who bears the costs, what is the discursive context)</td>
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Table 17: Analytical framework; own table adapted from Daly and Lewis (2000)
Most importantly, the framework allows for addressing how mental health care financing shapes the complex relationships between state, market, family and the voluntary sector in mental health care or vice versa how financing is shaped by this relation. Thus it makes visible the social and political economy within mental health care financing and service provision are embedded. Similar as Daly and Lewis (2001) have observed for social care, I argue that this issue has remained underdeveloped in mental health care so far. Notably, the framework incorporates the role of the informal sector which has all too often been neglected in current welfare state reforms and their analyses (Österle 2001). Not least, the framework’s beauty lies in the fact that it connects the changes on the macro level with the micro level, thus making visible the relationship between financing arrangements and individual social relations within mental health care provision. In that respect it allows for example for making transparent the gendered nature of these relations. Overall, the framework furnishes a rich picture about possible directions of mental health policy, thus eventually reflecting the policy dimension of the financing-reform discourse conglomerate.

6.2. Mental Health Care Financing and Impacts on the Macro Level

6.2.1. The Changing Role of the State

Chapter 3 has shown that in terms of service provision, the role of the state has decreased while the sectors ‘private non-profit’, ‘private for-profit’, ‘family’ and ‘voluntary/community’ have played an increasingly important role over the last decades. Furthermore, within the health care sector, the state’s role as a provider is mainly restricted to hospital mental health care. Outside the health care system provision is to a large extent carried out by various private sector providers.

However, those who provide services need not necessarily to be identical with those who are financially responsible. Data from chapter 4 gives an insight into this issue. When analysing the data, it turns out that mental health services which are provided within the health care system in Austria are characterised by relatively high public financial responsibility. This is shared between the state and the social insurance funds. Although some private responsibilities in the form of co-payment for the identified health care sector services exist, they are rather moderate in size compared to other services. Yet, co-payments have been raised over the last years and some new forms of out-of-pocket payments have been introduced but it needs to be noted that exemptions from co-payments for low income groups exist which may particularly apply to the mentally ill. An exception to this financing pattern is the financing of psychotherapy which is
characterised by a relatively high overall private share. In general, the described public-private payment pattern is not only characteristic for Austria but can also be observed in a similar form in the German or the UK case, although responsibility of the private sector in the form of private insurance seems to be higher or even expanding in these countries.

Furthermore, within the health care sector public responsibility is highest for hospital mental health care in the Austrian model. For mental health care services which are provided within the health care sector but outside hospitals such as psychiatric specialist services, private financial responsibility for the sector ‘family’ tends to be more likely (e.g. in the form of prescription fees or travel-costs etc.). In that respect, Austria does not differ much from the German or the UK case. For example, according to the Mental Health Foundation (1995), in the early 1990s, it was estimated that on average 80£ per person per day was spent publicly on those in English mental hospitals and just £ 1 per person per day was spent on those in the community. Likewise, in a review of costs in one area in Germany in 1983 it was found that of the amount paid from social insurance sources, around 70 percent went towards the costs of hospital mental health care (Cooper and Bauer 1987). However, the gap may have narrowed with ongoing reform processes.

For mental health care services which are covered outside the health care sector, the state’s financial responsibility is tendentially lower. The Lower Austrian case has shown that public responsibility is more likely to be restricted to coverage of only a proportion of costs with the person affected or even his/her relatives having to pay for the other share. Moreover, when the principle of subsidiarity is applied, private sources account for the primary basis of funding, while only the remainder is covered publicly (e.g. in the case of residential care). In summary, the extent to which the state bears financial responsibilities for mental health care services in Austria correlates very much with the extent to which mental health care services are covered within the health care system, more exactly, within hospitals. Again, this is also a typical pattern in the two other countries which have been described.

In addition to the range of services covered, one has to take into account the level of coverage which is quantitatively indicated by the level of expenditure and its development (in relation to other expenditure). Unfortunately, specific quantitative empirical data on that matter are hardly available for Austria. Nevertheless, some data which I have presented earlier seem to indicate that overall expenditure for mental health services within the health care system has increased which is for example demonstrated by rising health insurance expenditure on psychotropic drugs and on psychotherapy. Increasing expenditure is also suggested by the figures on rising costs for psychiatric hospital care (at least until 1995) or by the increasing number of specialist psychiatrists. However, most of the data cannot be segregated into public and private expenditure shares
or they are available for one point in time only. In that respect, the general health care expenditure trend for Austria may provide a rough picture (see 4.4.). It shows increasing health care expenditure in absolute terms. In relative numbers, public expenditure has decreased while private expenditure has increased at an annual rate of 4.5% over the last years (Hofmarcher and Röhring 2003).

For mental health services outside the health care system, currently available Austrian data doesn't allow for a calculation of the share of expenditure levels. Generally, chapter 5 has provided some evidence that public financial responsibility is more subject to discretionary decisions and, thus, rather volatile and that private responsibility can be substantial. A case in point is the unstable public subsidy of specific services in the self-help sphere which can be associated with high individual private investments. A rough indicator concerning the public-private share for services outside the health care system is the data on social assistance expenditure. In that respect, since 1998 the increase of gross expenditure has been accompanied by a constantly rising private share (see 4.4.).

Apart from that, it is important to address the development over time in terms of service structure and organisation of mental health care as outlined in the planning documents. As demonstrated in the framework in table 17, it will be asked how these changes affect the relationships between different societal sectors. One common feature of all documents is the aim of deinstitutionalisation. Although this is related to major restructuring processes, financing issues are hardly addressed. For example with respect to sources of financing, the reform discourse does not explicitly address any changes in the payer-relationship, be it the relationship between different public payers, between public and private payers or between various private payers. Yet, given the Austrian payer scene and the legal responsibility patterns, the community care paradigm with its increasing service provision outside the health care sector makes a change in the payer relationship inevitable.

A shift to service provision outside the health care system, firstly incurs changes within public sector responsibilities with growing local or provincial public responsibilities. Secondly, due to the different legal situation (e.g. characteristic of cost-sharing), it also involves higher private responsibilities for the sectors ‘family’ and ‘voluntary/community’. This has been a general concern. To quote Goodwin (1997, 62): “What the shift towards community care does allow for is increased scope for the shifting of the costs of care from the state on to informal carers. It also allows for the neglect of at least some patients, who, following discharge, my not receive any community support services whatsoever. Community care policy creates the possibility of cutting costs in a way that institutional care does not allow, and, there is some evidence of governments having chosen this route.”

Notably, increasing mental health care obligations for service providers outside the health care system do not necessarily correspond to equally increasing
resource allocations. The UK example shows that, although government funding for general social services has increased in recent years, the amounts available for mental health have been constrained and the mental health grant given by central government to local authorities has not been increased at all in the latest period, despite the fact that mental health care had been given a priority status (Sainsbury Centre for Mental Health 2003). Furthermore, the empirical data from chapter 4 demonstrates that in absolute terms, the mental health budget which is allocated to the health care sector is significantly higher than that transferred to the social sector in the UK.

Although Austrian data are not available for a similar investigation, there are some indications for an analogous pattern. Firstly, the amount of money which was used in 1997 for financing long-stay wards has been ‘frozen’ and has since then been used for financing the rising number of other psychiatric services outside the hospital (Zechmeister and Österle 2001). Hence, even though financial sources for some services have been increased (e.g. for MAPS in Lower Austria), this is mainly due to a re-allocation from former long-stay wards which had been financed by the same payer. Secondly, many of the former ‘long-stay’ mentally ill have been transferred to long-term care institutions which are paid much lower daily flat rates than the original hospital wards. What there is no evidence for, is an official transfer from resources stemming from within the health care system to payers which are responsible for services outside the health care system. Although without doubt the number of services outside the health care sector has been increased, it is unlikely that the overall amount of resources has increased to the same extent.

Furthermore, raising resources in the ‘non-health care sector’ has been particularly difficult, as the scope of action in terms of public budgets and the resources available have been considerably restricted for provinces and communities and, thus, for those payers which are primarily responsible for mental health services outside the health care sector. The financial situation of provinces and communities has been severely affected by federal measures of zero-budgeting in context with the EU-stability pact (Smutny 2002). Thus, shifting public responsibility to the provincial and/or local level seems not least to be associated with less flexibility for raising additional resources for mental health care.

Considering that an aim of the reform has been to primarily locate treatment and care not only outside the hospital but to a high extent outside the health care system, a resource allocation debate which addresses re-allocation of former health care resources is vital. In other words, if overall resources are not increased for the non-health care services, increasing service capacity will have to be financed with the same amount of money which raises the question of who has to bear the financial burden? As mental health care services are very personnel-intensive, it seems obvious that cost-containment measures will primarily affect
the workforce. Highly qualified people might be paid less or their salary may stagnate, jobs might as well be increasingly carried out by less qualified personnel or by an increasing number of voluntary workers. The latter has been characteristic for many of the non-profit organisations which are involved in mental health care outside the health care sector. This may as well impact on the quality of care. As the study by Denk and Weibold (2002) has demonstrated, despite the high number of persons with mental illness in nursing homes, only a small number of specifically qualified psychiatric nurses has been available to care for these persons so far.

Another scenario is that the diversity of services provided will be reduced, thus concentrating financing on some singly priorities. Indeed, while MAPS in Lower Austria have been expanded over the last years (related to the quantitative figures of the mental health care plan), employment related services have received increasingly lower financing priority (Durstberger 2004), which may not least be related to the fact that the latter have received only minor attention in mental health care planning documents (see 5.2.). Notably, the criteria for focussing on MAPS rather than employment related services have neither been made transparent nor discussed publicly nor have there been research activities which would legitimise such a prioritisation from an academic point of view.

Not least, the development has to be embedded into the context of overall health and social care sector restructuring. Firstly, it has been demonstrated in chapter 5 that the political context has changed from a social liberal to a more market-liberal ideology. Similar to other Western European countries, a key issue in the Austrian social policy discourse has been the cost containment aim which has also an impact on mental health care. In the international debate it has been noted that the desire to save public money has been key to the process of deinstitutionalisation. For example, Ungerson (1995, 39) remarks: “In many European countries these policies [deinstitutionalisation] are driven largely by ideas of reducing expenditure – namely that it is cheaper and more cost-effective to care for people in the ‘community’”. Although professional arguments have played an important role for framing the deinstitutionalisation goal, the cost-containment context has probably been another factor of influence. Yet, as it has been shown, the term ‘cheaper’ is likely to be related to public sector costs only, while in terms of overall economic costs, deinstitutionalisation needs not necessarily to be cheaper (Fakhoury and Priebe 2002), but in some cases simply masks a shift of costs from the sector ‘state’ to the sectors ‘family’ and ‘community’.

In conclusion, though not explicitly made transparent in restructuring processes, the financial impact in terms of payer relationship and financial responsibility within society at large can be substantial and it seems almost paradoxical that there is only token acknowledgement of this particular financing issue in the mental health care discourse. There may be one specific explanation
why the question of financial responsibility has been mostly neglected so far. In chapter 5, it has been outlined that several dimensions of the discourse reflect a social engineering type of governance which suggests a positivist approach to mental health care, stressing the logical relationship between means and ends. Transferred to financing, this approach perceives financing primarily as a technical instrument which is located somewhat outside the mental health care sphere and its actors. Thus, the notion of what the subject ‘mental health care financing’ covers is actually restricted to allocation of available resources. Mental health care financing, from that point of view, is then mainly concerned with increasing allocative efficiency within given resource constraints but widely ignores the more political dimensions such as distributional effects.

6.2.2. The Rising Position of the ‘Market’

Shifting of boundaries on the societal level in context with mental health care financing can also be observed in another, more subtle, form. It has been demonstrated in chapter 5.2., that, even where sources of funding are public, the role of the ‘market’ has become increasingly important. This trend has been termed ‘economisation of the social’ referring to the transfer of market principles, their logic and concepts to the public sector. Some of these discourse developments are closely linked with financing issues. They are particularly related to the reimbursement level of financing and require some fundamental discussion of reimbursement methods in mental health care.

According to the discourse, financing instruments to be preferred are those which support commodification and individualisation, thus allowing for the consumer-concept to be implemented. In order to establish conditions for ‘buying’ services according to individual preferences, cash benefits rather than benefits in kind are to be preferred. Examples for such a transformation are the ‘Personal Budget’ or the ‘Voucher System’ which have been described in the German example. The role of the state is in that case perceived as one of enabling or supporting rather than providing and being fully responsible. This can either mean that provision of services is left to ‘free market forces’, hence, services are expected to evolve according to market principles of demand and supply. Such a situation has been described in the area of long-term care after the introduction of monetary long-term care allowances (Hammer 2002). For mental health care specifically, the mentally ill would receive some type of cash benefit which they can use autonomously to buy their preferred services. As the German example has shown, this is a realistic future scenario and discussions of that model have also started in Austria, specifically in context with disability allowances. Notably, ‘Personal Budgets’ do not necessarily change the overall level of resources allocated to mental health care. In the German examples budgets are legally based
on the social assistance act and are thus, related to the same patterns of cost-sharing as in traditional financing arrangements (Schröder 2004). Hence, unless the level of the cash benefit is high enough to cover total costs of professional care, the sectoral shift to ‘family’ and ‘voluntary/community’ equally occurs with ‘Personal Budgets’ or any other modified type of cash-benefit.

Another less radical scenario might be that services are continued to be regulated publicly. This means that public and/or private service provision is planned and legally regulated on the provincial or on the federal level, thus ensuring adequate distribution of services. In that case, it is likely that the overall aim of cost-containment requires some form of rationing. Considering the discourse, a typical approach would be that experts in the field of mental health care establish a pre-defined service catalogue without much public discussion about priorities. Responsiveness, in such a model, would be assured via assessing individuals’ needs using an elaborate type of assessment instrument.

Furthermore, the economisation model requires that the financing system needs to support competition in mental health care. With the introduction of the LKF-reimbursement system in 1997, this has already happened in the Austrian hospital sector (see chapter 4.4.). In contrast to other countries with DRG systems, in Austria psychiatry is included in the LKF-system. Yet, the competitive element of the LKF system may have some specific effects for the treatment of persons with mental illness. In that respect, several critical arguments have been raised in context with DRG reimbursement for mental health care. Firstly, the criterion which is used for the level of reimbursement is the diagnosis. This is inappropriate in mental health care because the same diagnosis can be related to considerably differing severities of a mental illness and, consequently, to different lengths of stays and resource needs (e.g. Lercher 1998; Lien 2003). As a result, the money providers receive is not always related to actual costs. Reimbursement may either be less than costs (when treating severe cases) or income exceeds actual costs (in less severe cases). The incentive works in a way that providers need to prefer less severe cases in order to avoid deficit spending. In other words, the method bears the potential of ‘cream skimming’. This is specifically related to small scale providers which are not able to pool risks. Secondly, DRGs show shortcomings for long-term diseases, as financing is to the advantage of shorter episodes rather than longer stay periods. In turn, this bears the incentive for repeated re-admissions known as the ‘revolving door effect’ (Lien 2003). Thirdly, DRGs in mental health care bear the risk to reduce quality of care which may not appear at the point of discharge but rather in the long run (Frick and Cording 2004). Whether these effects occur will not least depend on the details of the single systems. For example, the first generation of the Austrian LKF system was heavily criticised by psychiatrists because treatment of people with severe mental illness was related to considerable financial disadvantages for hospital providers (Meise and Hinterhuber 1998). One reason for that was that only data from one
mental hospital was used for calculating average resource needs per diagnosis. As a consequence, the first generation of the ‘LKF system’ has been remodelled by introducing a ‘severity-factor’ which means that reimbursement does not solely depend on the diagnosis but also on the severity of the diagnosed illness (Katschnig, Denk and Scherer 2004). This has been regarded as more appropriate for mental health care (Lercher 1998). Yet, in some cases the incentive has now the reverse effect. As the admission of persons with severe psychiatric diagnoses is currently associated with quite high income, providers have an interest in high admission numbers. This can even have the side-effect that the existence of a psychiatric ward in a general hospital prevents hospital providers from closure of hospital wards (Gross 2000). As public providers on the community level increasingly need to justify the existence of their hospital in numerous discussions about hospital closure, the competitive element of DRGs is not least associated with highly political dimensions.

That the DRG system makes profitable parts more visible, thus reflecting the market-logic, may not just be interesting in terms of deficit spending. As Pelizzari (2003) remarks, it can also be related to other consequences. Given that there is an overall tendency in favour of privatisation which is also increasingly being discussed for the health care sector (Davis and Fairbrother 2003; Wirtschaftsblatt 2003; Rümmele 2005), full privatisation of profitable parts of mental health care services becomes a realistic option, as those become attractive for capital investment. Consequently, only those parts of mental health care which are non-profitable may then remain publicly provided and financed. Indeed, the UK case in chapter 4 has shown evidence for that development.

Systematic empirical data of the long-term DRG impact in mental health care have been rare for the Western European context. In terms of short term effects for psychiatry in Austria, Frick, Barta and Binder (2001) demonstrated for the province of Salzburg that the ‘revolving door effect’ did not occur as a consequence of the LKF system in the first two years. Furthermore, they showed that LKF reimbursement was not the primary factor of influence for length of stay and hospital frequency. On the other hand, the Austrian mental health report from 2004 (Katschnig, Denk and Scherer 2004) states the average length of stay in psychiatric hospitals and/or departments has decreased considerably since the hospital reform. Thus, it dropped from 41.2 days in 1996 to 27.2 days in 2002. Furthermore, Katschnig et al. (2001) remarked that constantly increasing hospital admissions are to a large extent due to re-admissions. One explanation for that contradiction could be that the effects have been triggered by the prospective budget rather than by the LKF system. Overall, the issue is generally discussed controversially. As scholars have pointed out, research from other countries shows that many effects may only be visible in the long run (Kunze 2001; Russel 1989; Theurl 1996). Notably, there have been countries such as the USA, where DRG reimbursement has been abolished for psychiatric hospital services after a 4-year
period with the justification of inappropriateness. Furthermore, the German case has shown that in some countries psychiatry has been excluded from DRGs per se. On the other hand, Lien (2003) points to the rather contradictory concern that the exemption of mental health care will in the long run draw funds away from the mental health care sector. There is also some apprehension that mental health care might become an idiosyncratic service with its own rules and regulations if it is exempted from general health care reforms. In summary, what all these debates make clear is that there is a lot more research required with respect to the specific impact of health sector reimbursement reforms on mental health care.

Concerning competition, the introduction of competitive elements by means of financing is not restricted to the hospital sector but there is some evidence that a similar transformation process has also started in other fields including services outside the health care system. Thus, even where service provision remains primarily publicly financed, the form of financing is likely to change. Indeed, as Gerlinger (2002) has shown for the German health care sector, an increasing tendency to introduce a type of DRG-related reimbursement in the ambulatory sector might be a reasonable future scenario.

Another example for such a transformation process is demonstrated by the shift from public subsidies to performance-based contracts for privately provided social services (e.g. Schneider and Trukeschitz 2003). With respect to mental health care, a US-study has demonstrated some advantages of performance-based contracting showing that this type of reimbursement has reduced the possibilities for non-profit organisations to select patients. In particular, the contracts forced providers to supply integrated services for persons with complex needs (Smith and Lipsky 1993). Put differently, performance-based contracting has supported the implementation of community care especially for severely ill persons or people with long-term illness. However, others have demonstrated that performance-based contracting in mental health is also associated with several problems. For instance, Ashton (1998) has identified that negotiation for mental health services was more complex than in other cases. Compared to other fields of health care, this not least resulted in higher transaction costs leaving eventually less resources for treatment and care. Additionally, Simpson (1998) remarks for the British context that difficulties with contracting arose in the field of mental health care because performance criteria are much more difficult to define than in other fields of health care. For example, there exists an irreducible uncertainty about treatment results. Furthermore, most contracts are 'activity-based' which is inadequate for mental health care. For instance, rather than the number of treated persons, optimal coordination of services for persons is relevant for the outcome. Additionally, contracts don't guarantee adequate spending levels. As the UK case shows, the ratio 'actual expenditure/initial allocation for mental health' varies considerably between the different spending bodies and is not necessarily related to the needs index of the various regions (see 4.2.). This suggests that in the
contracts some providers haven’t received the same proportion of money which has originally been allocated to mental health care. As the Ashton (1998, 358) summarises: ”When transactions involve highly specific assets and are associated with considerable uncertainty and/or problems of measurement, contracts between purchasers and providers tend to be incomplete and therefore open to opportunism. Because this increases the costs of monitoring and enforcement, some form of vertically integrated organisational arrangements tends to be more efficient than markets”.

For the Austrian case, several critical issues can be raised in context with contracting for mental health care services outside the health care sector. It has been shown that non-profit providers in mental health care have usually a quasi-monopsonist status which means that very few single providers are responsible for a large population and for providing a large number of services. It has been criticised that this gives providers considerable power to choose ‘their own’ patients. All in all, this constellation constitutes an obstacle for person-oriented community based care as it makes supply of adequate services for people with complex needs particularly difficult (Zechmeister et al. 2002). As a matter of fact these people have been likely to be cared for in nursing homes because this is the location where all service elements can easily be provided in one place. With performance-based contracts, similar to the US case, providers could be influenced as to provide integrated services especially for people with complex needs. For example a contract with the ‘Caritas’ as one of the main providers in Lower Austria would then stipulate that service provision has to integrate accommodation, labour oriented and treatment oriented services via mobile and flexible teams. There could even be a specific clause in the contract in order to guarantee that persons with complex needs are not automatically referred to long-term care institutions. However, several problems appear when addressing the issue in more detail.

Firstly, although responsibility for most of the services affected rests on the provincial level, it is split between different administrative areas. For example, the administrative part which is responsible for nursing home issues differs from the one which covers matters of MAPS (see 4.4.). Thus, several contracts would have to be concluded with several purchasers. This seems to be as much an obstacle for coordination and integration of services as it would be a means to enhance coordination.

Another crucial question is, whether it is actually in the interest of the purchasers to enable community care for severely ill patients with complex needs, as these people will require considerably more resources than persons with common mental disorders (Beecham, Fenyo und Knapp 1991; Kavanagh 1996). Facing the pressure of cost-containment it seems unlikely that purchasers on the public administration level are advocating the treatment and care of severely mentally ill in the community. This financing mechanism can therefore as well
encourage a segregation of patients into ‘re-institutionalised’ and ‘marketable’ (Priebe 2003) ones, the more so, as the demand for community integration has traditionally come from professionals or users rather than from the political or public administration level. Moreover, the issue of defining adequate performance criteria which has been described earlier is equally true for Austria.

To sum up, the economisation processes which are observable in the discourse and its consequences for financing show, as Daly and Lewis (2000, 295) outline, that “welfare state transformation is more complex than is generally conceived and that state support may be in the process of taking a new form rather than being appropriately characterized as being ‘cut-back’“. Detailed consequences for mental health care have yet to be analysed in further empirical research.

6.3. Mental Health Care Financing and Impacts on the Micro Level

This part of the analysis focuses on impacts of financing arrangements on the individuals affected and the changes of these effects over time which can be observed. When analysing the effects of financing arrangements on the micro-level, the nature of mental illness and the related characteristics of people with mental illness need to be remembered. To sum up the information from previous chapters, these are firstly, the high prevalence of poverty, secondly, the high degree of unmet needs, thirdly, the high degree of stigma, and, finally, the often lifelong nature of the mental diseases. Additionally, people with mental illness also have poorer physical health than the general population (e.g. Harris and Barraclough 1998). Due to these characteristics the impact from financing arrangements for individuals with a mental illness differs from that for people with a somatic illness. In the following parts these specific features will be addressed.

6.3.1. Shifting of the Financial Burden on the Individual Level

It has been outlined in the previous part that the private expenditure share for services which are provided within the health care system is low compared to those covered outside the health care sector, suggesting that the burden on the individual level is also low. However, the micro-level needs to be addressed in a more differentiated way. Firstly, individuals may be affected differently by the way public sources for financing health care are levied. Drawing attention to the Austrian health care system, social insurance premia are regressive which means that people with lower income have to pay a disproportionately higher rate than those in higher income groups (Guger 1996; Wendt 2003). Given that there is a
high prevalence of low income among individuals with mental illness, regressive revenue raising places a higher burden on this group.

Furthermore, although user charges for health care services are low compared to services provided outside the health care sector they still can have some significant effects for individuals with mental disorders. To quote Dixon (2002, 27): “Most studies show that charges deter access particularly amongst the low income, the unemployed, the elderly and the chronically ill. Any increase in user charges or individual risk rated private insurance is likely to adversely affect access for those with mental health problems, due to a combination of their chronic state, the stigma attached to their illness and the impact on their employment opportunities and earning capacity.” In that context, Frank and McGuire (1999) found in their empirical study that demand for outpatient mental health care is more sensitive to cost-sharing than for outpatient care in somatic medicine. In Austria, cost-sharing is particularly characteristic in the outpatient sector. Notably, it is exactly the outpatient sector which is to receive higher priority in mental health care as treatment in primary care settings and by specialist psychiatrists and other professionals in the field are to be prioritised according to the reform aims. Yet, if user charges deter individuals from service utilisation, it may compound the documented low utilisation of services attributed in part to the stigma associated with mental health problems. Due to the comparatively poorer physical health status of people with mental illness, the financial burden of user charges is even more substantial.

Access-problems associated with cost-sharing are even more virulent for services which are provided outside the health care sector. As it has been outlined earlier, the likelihood for private cost-sharing is considerably higher for those services. Since these services have become more significant during the reform process, individual financing responsibility plays an ever more important role. For the affected individuals this is related to a specific distribution of costs. While treatment is primarily borne by the state, caring is ‘off-loaded’ by placing people in cheaper residential accommodation or discharging them into the local community. This is often related to higher private financial responsibilities as well as caring responsibilities for relatives or friends. As Goodwin (1997, 85) remarks: “The result is an increasingly stark divide in the pattern of expenditure on mental health services. Statutory financing of services has tended to be concentrated upon the provision of treatment services, while financial responsibility for the care of people with mental health problems concerning their need for accommodation, employment, transport, and so on, has tended to be delegated to non-statutory and informal sources of care.”

As this shows, the individual financial burden has also an impact on relatives. For example, in a German study-population 63% of spouses and 69% of parents of people with schizophrenia had to bear private costs which result from the illness only (Mory, Jungbauer and Angermeyer 2002). Although objectively the
existing burden is very often marginalized, not addressed or played down, burden
is explicitly expressed by parents who have children with early onset of illness
and who still live with them as well as by spouses with low income. Moreover,
the higher private costs for professional care, the higher the incentive for informal
care. Not only is this related to further costs for the carer (loss of income, loss of
qualification, loss of long-term social security) but carers may develop mental
disorders themselves (e.g. depression) resulting in some further need for mental
health care resources (e.g. Rainer et al. 2002; Wittmund, Wilms and Angermeyer
2002; Wittmund and Killian 2002). While in some countries, carers’ support has
been established, this has only marginally been the case in Austria.

From a gender perspective it has to be noted that informal care is largely
carried out by women. Similar to the case of long-term care for elderly or child
care, associated loss of financial independency and reduced social security may
constitute a long-term risk factor for female poverty. Moreover, another scenario
may be that the high private costs for professional carers result in black or grey
market arrangements with illegal employment. In the case of long-term care for
elderly people this is a known phenomenon (Hammer and Österle 2001). Not only
is this arrangement related to precarious financial situations for the carer but it
also may impact on the employment situation in the formal labour market.
Professional carers who are again mainly women (Zechmeister 2004) may face
increasing pressure concerning wage levels. Especially for the lower qualified this
may result in difficulties to find an adequately paid formal employment
arrangement. In summary, these scenarios demonstrate – as outlined in the
framework in table 17 – how financing arrangements strongly influence the nature
of work and activity. Although the reform discourse does not particularly address
this issue, with unchanged financing structures, unpaid and informal work will
inevitably have to play an important role in future caring relations.

More generally, it needs to be noted that the individual financial responsibility
is distributed rather unevenly among individuals, which results from the patchy
distribution of professional service provision and the diversity of financing
arrangements. Thus individual responsibility is higher in those areas where no
(publicly funded) professional services are available. This is for example the case
in areas where few specialist psychiatrists with a social insurance contract are
available or in provinces with lower public funding of psychotherapy. Thus, even
if public expenditure is rising overall, financial responsibility for some individuals
will remain high.

From an economic point of view, the individual financial burden and its
consequences for service utilisation do not least have an impact on the overall
economic costs. For example, poor mental health of adults can have consequences
for their children and they can have a negative impact on social capital in the
community. Thus, not treating mental problems and guaranteeing access to
services is likely to result in various negative externalities. In the case of mental
health problems further adverse impacts can include loss of productivity and poor long-term health outcomes, as well as impacts on education or on criminal justice. As Dixon (2002, 4) puts it: “Any positive externalities of mental health service utilisation by those with mental health problems cannot therefore be ignored when evaluating the extent to which different health care financing arrangements affect the mental health sector. The incentives for people with mental health problems to utilise mental health care under different financing arrangements may have crucial implications for achieving levels of use that more closely reflect a socially efficient resource allocation.” [original emphasise]

Another possible effect may be that individuals eventually use those services which are related to the lowest financial burden. So far, this has been hospital mental health care. Moreover, this is compounded by other issues. Firstly, the analysis of reform documents and interviews in chapter 5.2. has shown that hospital mental health care holds either implicitly or explicitly a priority status in the perception of various actors in the mental health care field. Additionally, Zechmeister et al. (2001) have shown that several incentives in the financing system result in hospital focused mental health care. Firstly, although the hospital reimbursement system sets incentives to reduce lengths of stays, it still contributes to hospital-centred provision of services by simultaneously setting incentives to increase admission rates. The more cases a single hospital administers the more ‘points it can earn’, hence the more income it can generate. Although the prospectively fixed hospital budget means that a higher number of overall administered points decreases the value of a single point for each hospital, it has been shown that hospitals effectively tend to employ a point-maximising strategy (Lercher 1998; Stepan and Sommersguter-Reichmann 2001). Furthermore, the health insurance has no interest in setting incentives against this hospital-based supply of services, since any service consumed in the primary care sector means additional expenditure for the insurance fund, whereas hospital over-expenditure has to be born by hospital providers themselves. Many of these are provincial or local public bodies who do not exercise strict budget limits. Thus, although mental health care is de facto shifted to other services and durations of single hospital episodes for the mentally ill have decreased substantially since the 1997 hospital financing reform, hospital care is likely to remain the highest priority in referral processes and treatment decisions. This may firstly, not always meet the real preference of the individual person and secondly, it is actually contrary to the core aims of the reform according to which deinstitutionalised care should receive the highest priority.

A final financial issue on the individual level is implicitly raised with the ‘participation discourse’. The discourse analysis has demonstrated that involvement of representatives of user groups or self-help groups in planning is primarily viewed as support in a market research type of assessment. Consequently, their contribution is not regarded as type of work equivalent to the
professionals’ one and these persons need not necessarily be allocated remuneration. Hence, those people either will have to work voluntarily or may be given some symbolic monetary recognition. Evidence for such a development is provided by the draft of the ‘Upper Austrian Equal Opportunity Act’ (Chancengleichheitsgesetz Oberösterreich), which outlines that participation of user representatives in planning bodies has to take place on a voluntary basis (Landesregierung Oberösterreich 2002a).

6.3.2. ‘Consumers’ of Mental Health Care: Opportunities and Pitfalls

The discourse analysis has shown that the mental health service users are ascribed a ‘new’ role in the mental health care field which is the role of a mental health service consumer or customer. Under 6.2.2., it has already been mentioned that the ‘consumer approach’ in mental health care requires new forms of financing arrangements, in particular a shift from benefit in kind to cash benefit, for example in the form of a ‘Personal Budget’. Undoubtedly, such financing arrangements transform persons with mental illness into ‘consumers’ who buy the ‘mental health product’ on the ‘mental health market’. On the one hand, this type of financing arrangement may increase freedom of choice, empowerment and self-determination. Additionally, Speicher (2004) remarks in context with ‘Personal Budgets’ that they are a means to enhance participation, which transforms the person with a mental disorder into a citizen. On the other hand, however, some deficits of cash-benefits have been found. Firstly, access to care is not guaranteed for the individual person by providing a cash benefit only. Hammer and Osterle (2001) noticed for the area of long-term care that unlike an ideal market, the supply-demand mechanism does not work in the field of social care. Unless supply of services (especially in deprived areas) is assured by legal stipulations, access to care will be distributed unequally and in some (particularly rural) areas there may not be services available at all. Furthermore, access to services is dependent on the level of the budget. If the level is too low to cover at least a high proportion of costs for professional care, access to high quality mental health care is not guaranteed. Indeed, as Speicher (2004) observes for the German case of ‘Personal Budgets’, only a small proportion of people with mental illness can afford professional services.

Secondly, even if people can afford services, individual cash benefits do not guarantee that the services offered meet their needs. In analysing a similar case in the Italian region Lombardy, Bifulco and Vitale (2004) note that in the existing arrangement providers are not obliged to offer services for any of their ‘customers’. They can as well refuse requests without facing some form of sanctions. As the scholars put it: ”The position of the citizen-consumer is asymmetrical regarding the provider. There is a strong power disparity, grounded
in the consumer condition of hardship, urgent need, or deprivation” (Bifulco and Vitale 2004, 14). Thus, services are not tailored to individual needs but users can only ‘consume’ pre-defined service elements. Regarding freedom of choice, this is a freedom of exit but not a freedom of voice which would allow users to co-define services according to their needs (Bifulco and Vitale 2004 referring to Berlin). Considering the Austrian mental health care situation in particular, it needs to be noted that the monopsonic status of providers in the field of social and employment related services contradicts the notion of freedom of choice. Unless the number of service providers increases considerably, freedom of choice for those services (which are expected to play an increasingly important role) exists only in theory and would largely be restricted to urban areas.

In terms of service provision, responsibility of the state is reduced to quality control of accredited providers but the state does not bear responsibility for service users in terms of support for choice and decision making and in terms of guaranteeing that users receive services according to their needs. This part of mental health care is either left to relatives or other informal support or – if such forms of help are not available – individuals have to make decisions on their own and also are left to themselves to find services which best meet their needs, if such services exist at all. Considering the numerous psychological and material barriers mentally ill people can face, it is questionable if such an arrangement will be to the benefit of the affected persons.

A crucial question in that context seems to be, if and how affected individuals or representatives are involved in the diverse contracting processes between providers and payers. More general, which actors define performance criteria, service quality and quantity and where do these negotiations take place? As Simpson (1998) has criticised for the British case, contracting negotiations between providers and payers primarily take place between the responsible purchasers and the managerial boards of the providers. Usually, they don’t involve those professionals who actually carry out the service and have direct contact with users, nor do they systematically involve user representatives. Furthermore, due to the focus on market logic and related technical efficiency it is to be expected that quantitative indicators will play an important role, especially those which allow calculations and discussions of technical efficiency issues (see chapter 5). In such circumstances it is highly questionable whether services will really meet the needs of service users. Related to the Austrian situation, the consumerist participation approach in the reform discourse seems to result in a similar tendency on the individual level as mentioned for the British case.
6.4. Conclusion

With the shift towards provision in community settings, services have been increasingly provided outside the health care sector. While medical mental health care is usually associated with universal or almost universal access, this is not the case for non-medical services. The trend seems to be that private responsibility for the sectors ‘family’ and ‘voluntary/community’ and, thus, for the individuals affected and/or their relatives is increasing. However, the analysis has shown that apart from expenditure levels and financial responsibility some more subtle changes can be observed when analysing developments in terms of resource allocation and reimbursement methods. Regardless of the source of finance, ‘privatisation’ occurs in terms of introducing market principles into the public and family sector which is related to various financing scenarios with their own specific consequences for the affected individuals. In general, methods used tend not to take into full account the specific characteristics of mental disorders. However, empirical research which addresses the impact of these changes in reimbursement and resource allocation has been very limited so far. Apart from that, the analysis has shown that mental health care (financing) – because of its complexity – is an interesting example for indicating broader welfare state developments.

With regard to the situation for the mentally ill and their relatives, the picture which has been drawn appears to be rather bleak. This should not leave the impression of pessimism but should rather motivate and stimulate further debates, in particular, discussions about alternative approaches to finance mental health care in Austria. The following and final chapter intends to conclude the thesis with some material for a structured discussion on those issues which have turned out to be most relevant.