7. Concluding Remarks: What Financing for Mental Health Care?

After having outlined the impact of mental health care financing arrangements against the backdrop of (mental health) policy tendencies which have arisen from the discourse analytical part, I will finally provide some concluding thoughts on the question how to finance mental health care. However, the aim of this chapter is not, as one might infer from the title, to present an alternative model for financing mental health care in Austria. Rather than ‘designing’ a financing model I will, firstly, seek to provide some suggestions concerning a potential process of developing an alternative financing approach. Put differently, some ideas will be offered as to how a process for developing such a model could be organised, and which issues would have to be taken into account.

The second aim of this chapter is to suggest some fundamental subjects to be covered in the discussions of such a development process. For that purpose I have tried to define core criteria which have evolved from the thesis, against which alternative financing arrangements can be assessed. The criteria are intended as a discussion tool for practitioners, planners and politicians. Most importantly, they should make the linkage between service provision, service financing and the overall political-economic context more transparent in future mental health policy discussions.

7.1. Recommendations for the Development Process

The most striking result of the thesis turns out to be the numerous scenarios and consequences which arise from more or less excluding financing issues in mental health care reform discussions and thus, missing to link questions of mental health care service provision with financing aspects. Regarding the major restructuring processes which have either occurred already or which are inevitably required, should the reform plans be fully implemented, it is indeed surprising that financing aspects have received so little attention. Neither the quantity of monetary resources required nor the mode of financing has been addressed in detail in most documents or in political discussions. Not addressing this issue, however, re-shapes the perception of what is regarded a priority in mental health care restructuring. It transports the impression that financing issues play a minor role, that financing is separated from mental health care or that financing is something that is predetermined and cannot be changed anyway.

The scenario which results from that is that restructuring of service provision takes place within the current mental health care financing structures. As a consequence of decentralisation and deinstitutionalisation, service provision
outside the hospital and even outside the health care sector will play an increasingly important role. By implication, financial responsibility will be based on different legal regulations, it shifts to different sectors and to different payers with an increasing focus on the sectors ‘family’ and ‘voluntary/community’. Not least, this is linked to growing responsibilities for individuals and/or their relatives. This is compounded by the introduction of several market-style instruments which particularly increase individual responsibility on various levels. Although the mental health care reform aims at social inclusion, for some persons affected this may actually result in social exclusion. Moreover, as it has been shown, the current financing system entails several incentives which run contrary to the reform goals. As a result, implementation of some specific reform aspects is hindered.

Overall, the analysis makes clear that mental health care reform processes lack substantial transparency in terms of financing and implications from various financing arrangements. It is therefore required to put the financing discussion on the (mental) health policy agenda and to strongly connect issues of service provision and financing. This is even more of relevance, as neuropsychiatric disorders account for 20% of disability adjusted life years and 43% of years lived with a disability in Europe (see chapter 2) and are associated with high individual and economic burden.

Besides discussing financing issues more generally, there are at least two reasons which may actually call for developing an alternative financing model: Restructuring mental health care financing will firstly be needed if social exclusion of people with mental illness is to be prevented or mitigated and it will secondly be required if full reform implementation is to be achieved. However, if a financing model is to be developed the question is how this will take place. In the expert dominated style of health and social policy formulation this matter sounds probably somewhat odd. Indeed, it seems to be self-evident that, similar to other recent projects such as the pension or health care reform, some expert(s) in the field need to be found to design a model. The answer to the question of how to develop a new model would then simply be to present a list of disciplines and experts to be considered.

Yet, I want to contest this approach for two reasons. The first one is based on my own experience with designing a ‘ready-made’ financing model for mental health care financing in Lower Austria. During the first stages of the development process, the commissioners of the project made clear that the financing issue should no longer be addressed in the remaining project period. Considering that an alternative financing model will inevitably address very sensitive questions of resource distribution and challenge existing power-relations, I doubt that any financing approach which will be developed on the initiative of single experts without a clear political mandate has a great chance to be implemented.

The second reason why I contest the expert-driven approach is simply to demonstrate that there may be other ways to find solutions for social problems in
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society than the one we have experienced over the recent decades. In other words, I want to challenge what has been taken for granted by arguing that it may be worth to experiment with unorthodox and even utopian sounding forms of developing a financing model.

Thus, my claim for an alternative way of planning is based on two lines of argument. The first one is a pragmatic one, which simply focuses on finding a mode which guarantees implementation, whereas the second one is a rather visionary one, which addresses not only mental health care financing issues per se but uses them as an example for discussing general social visions and ideas for mental health policy formulation.

For the development process, I basically propose to continue or adapt one of the outlined core aims of mental health care plans, which is the ‘participation principle’. In other words, I suggest developing a future financing model via a participatory approach, involving various actors and/or their representatives in the process. From the pragmatic point of view, this might be one option to find a financing method which has a broad majority among decision makers. The argument is based on general social planning literature which suggests that the best way to guarantee reform implementation is to involve those who will be affected by the reform in the planning process (e.g. Herrmann 2001; Markert and Wieseler 2001). Furthermore, as Hart and Pommerehne (1994) point out in context with ‘Nimbys’ 26 , acceptance of a solution is very often dependent on how the solution was found and how decisions were made.

However, it has been pointed out under 5.2. that ‘participation’ has several meanings. In contrast to the ‘consumerist approach’ which has been dominant so far, I suggest a participation approach on the other end of the continuum, which has been termed the ‘democratic approach’, thereby addressing the visionary dimension of my arguments. Concerning the level of participation, formulating a financing approach would address the strategic level of participation (see 5.2.). In contrast to the prevailing perception of participation, one requirement for organising an alternative participation process would firstly be that actors and/or their representatives are involved actively rather than passively. In the given case this means that participants develop the financing model together from scratch rather than being asked retrospectively whether or not they like an already finalised model. A second requirement would be that the project results in empowerment, education and emancipation of those involved. Thus, according to the empowerment definition by Kieffer (1984, 9), it would actually result in “the construction of multidimensional participatory competence“ in the form of a “development from socio-political illiteracy or ‘infancy’ to socio-political ‘adulthood’ “, or, as Nelson, Lord and Ochocka (2001, 127) have defined empowerment, it would create “opportunities for and conditions that promote

26 ‘Nimby’ means ‘not in my backyard’. ‘Nimby-goods’ are to the benefit of a large majority but the group which is affected by establishing them is rather resisting such an undertaking.
choice and control, community integration and valued resources.” Another requirement would be that the process is organised in a way which guarantees participation regardless of individual material or mental resources. This implies two challenges. Firstly, how can people be motivated to participate at all and secondly, how can it be guaranteed that, once people are part of the participation process, everybody has the same chances to influence decision making. In other words, how can it be avoided that the same power-relations which are pertinent in society in general are not simply transferred into the participation processes, thus, neglecting the views and claims of the traditionally more powerless.

Chapter 5 has shed some light to the problems of participation which may be helpful for this experiment of thoughts. In that context, the following issues are relevant to be taken into account. Firstly, people with low material resources must receive enough material support. This can range from support for transport, child care or income to adequate payment for the time they spend for participating. Secondly, during the actual discussions and dialogs, methods need to be used which make sure that less articulate or less educated participants have the same chance to express their views, to present their proposals and to be taken serious as the eloquent ones. In that respect, traditionally existing power-imbalances need to be taken into account such as gender relations (Lewis 2004). Furthermore, the language of those meetings needs to be comprehensible for all participants. In some cases this may simply require an interpreter, in other circumstances it may even be necessary to organise some lessons for knowledge transfer and education because if people should seriously discuss financing matters they need to understand the basic concepts and the context of financing. Overall, it will be paramount that experts who have internalised technical terms and specific disciplines’ languages prepare or ‘translate’ their inputs in a way so that it is understandable for every participant.

With respect to organising such a process, different types of ‘democratic participation’ are to be taken into account. According to Fichtner (1986), one can distinguish democratic participation along two lines which are firstly, formal types and, secondly, more informal types of participation. Both types include representative forms and more direct forms of involvement. When organising such a process in detail, representatives as well as direct forms of involvement may be necessary in different stages of development. However, there is no need to re-invent the wheel. A lot can be learned from the experience of such approaches in other areas. For example, increasing activity in terms of participation experiments can be observed in the area of budgeting where nationally and internationally some projects have been undertaken to involve the general public in budgeting (see for example BEIGEWUM 2000; BEIGEWUM 2002; Jäger, Leitner and Tomassovits 2002; Klatzer 2002). Furthermore, participation projects have been organised for local area management and urban planning in Austria and internationally (see for example Diebäcker 2004 for Austria).
Overall, the quality and success of such a project must not just be assessed in terms of its results, precisely whether or not the new financing model solves the problems, but also in terms of the process itself. The latter includes for example criteria concerning what people have learned both, ‘technically’ and ‘socially’ or concerning whether conflicts of interests have been discussed openly and transparently or whether they have been concealed. On a meta-level, the aim of such a process is in fact developing a new understanding of democracy.

7.2. Guidelines for Discussing Financing Options

In addition to the general process of developing a financing model, the final parts of this chapter address the subjects which will be important to be covered during such a project. Put differently, while 7.1. has been concerned with the procedure of how a financing concept can be established, this sub-chapter addresses issues which are concerned with financing options per se and their various characteristics. As I have mentioned earlier, I am not going to bring forward final versions of alternative financing arrangements for discussion at this stage, but I seek to summarise core issues which have evolved during the writing process and present them in the form of a ‘discussion guideline’ which can be used in the debates. The discussion tool is based on the following considerations.

In chapter 4 various forms of financing arrangements have been demonstrated. In particular, three case-studies have been presented. They have been selected and described according to the criterion of ‘overall health care system type’, which is a very common typological criterion. From a pragmatic point of view, this criterion could as well be used for discussing alternative mental health care financing arrangements for Austria. However, the empirical material shows that with respect to the effects on the macro and micro level of mental health care, broad trends and tendencies seem to be similar in all three countries, regardless whether the health care system is a ‘Beveridge’ or a ‘Bismarck’ type. Apart from various differences in detail (e.g. in terms of regressivity with respect to raising sources of financing), a common pattern in all of the three countries is that the more mental health services are provided within the health care sector, the higher is public financial responsibility. With the shift towards provision in community settings, services in all of the three countries 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 services provided outside the health care system. Similar to the Austrian case, in the remaining two countries the development is associated with some increasing private responsibility for the sectors ‘family’ and, ‘voluntary/community’ and, thus, for the individuals affected and/or their relatives (Zechmeister and Österle 2004a). Equally, in all three countries the role of the market is becoming more
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important, for example in terms of rising significance of private insurance such as in the UK or in terms of introducing market principles in the form of ‘Personal Budgets’ such as in Germany.

Consequently, the criterion ‘health care system type’ which mainly characterises differences in the sources of financing seems to bear some shortcomings for discussing alternative financing scenarios for mental health care. Furthermore, it is rather unrealistic that the health care system type would be changed if Austrian mental health care system representatives came to the conclusion that a tax based ‘Beveridge system’ should be preferred for financing mental health care.

Quite conversely, the previous chapters have shown that rather than the type of resources it is firstly the level of resources spent on mental health care, secondly, the way resources are allocated and thirdly, the mode how providers are reimbursed which primarily shapes the impact on the individual and on the macro level on the one hand and which creates incentives or disincentives for reform implementation on the other hand. In that respect, it is not uncommon that slight variations in regulations within the same method of financing can be associated with rather different impacts for the individuals. For example, variations in the level of ‘Personal Budgets’ in Germany are associated with substantial differences in terms of individual financial burden. Another example is the DRG system in Austria. The first generation was clearly related to disadvantages for providers who were treating patients with a psychiatric diagnosis, whereas this was avoided in the following generations by simply increasing the value for treating severe forms of illness. If such variations make a difference, this also means that there exist in fact many alternative ways of financing mental health care. Moreover, these alternatives may be more realistic in terms of implementation because they don’t necessarily require changes of the central type of health care system.

Taking these results into account, I have tried to summarise the core criteria on the resource allocation and reimbursement level which may be more appropriate to indicate implications of mental health care financing than the criterion ‘health care system type’. They may be helpful for discussing alternative financing scenarios, although I need to state that they are by no means exhaustive and can surely be extended to further criteria.

Overall, two different dimensions can be addressed in discussing financing options. The first one is the ‘content dimension’ which is concerned with questions about different elements of financing and their effects – in the given case the effects on the individual and macro level. The ‘content dimension’ mainly addresses ‘material’ issues. Yet, it has been found, that this dimension leaves several issues untouched. Therefore, a second dimension for discussing alternative financing arrangements has found to be important, which is the ‘process dimension’. In contrast to the ‘content dimension’, the ‘process dimension’ is concerned with issues of decision making and actor involvement in defined alternative financing scenarios.
7.2.1. Content Dimension

With respect to the content level, the following categories for addressing the effects of financing have been found to be useful. These are, firstly, the effect of financing on the nature of mental health care services, secondly, the consequence for the role of the beneficiaries, thirdly, the impact on service providers, fourthly, the impact on the role of the state and finally, the implication for the role of public administration. To explain how these variables can be used for discussions, I will demonstrate the concept by using financing examples from the thesis. One important issue in the financing discussions which has been neglected in debates so far will finally be to make transparent which political dimensions different financing scenarios reflect. For that purpose it has been tried to relate the core characteristics which have been described in earlier parts to general political ideologies which they seem to reflect. Table 18 provides a summary of these issues.

<table>
<thead>
<tr>
<th>Variables to consider: Effects of financing for the...</th>
<th>Characteristics observed</th>
</tr>
</thead>
<tbody>
<tr>
<td>...nature of mental health service</td>
<td>Form of ‘public good’</td>
</tr>
<tr>
<td>...role of beneficiaries</td>
<td>Users</td>
</tr>
<tr>
<td>...role of providers</td>
<td>(Uncoordinated) actors</td>
</tr>
<tr>
<td>...role of the state</td>
<td>Public responsibility</td>
</tr>
<tr>
<td>...role of public administration</td>
<td>Financier (and provider); Responsibility for providers and users</td>
</tr>
<tr>
<td></td>
<td>Purchaser; Guidance and control of providers</td>
</tr>
</tbody>
</table>

| -> Social democratic oriented mental health policy     | -> Liberal oriented mental health policy |

Table 18: Interdependency between financing and mental health policy; own table

With respect to the nature of services, it has been shown that financing can transform mental health care services into a form of ‘public good’ (e.g. in the case...
of financing universal benefits in kind) or into ‘buyable’ products (e.g. in the case of cash benefits only).

Correspondingly, through financing arrangements, beneficiaries are ascribed different roles which range from that of ‘users’ on the one hand to the role of ‘consumers’ on the other hand. In the latter case, beneficiaries may be free to choose between services, however their cash limit and the number of available providers restrict the quantity and/or quality of services to be ‘consumed’. Thus, if a ‘product-consumer’ character is constructed by mental health care financing using services is dependent on purchasing power. By contrast, the former role is more associated with collective provision of goods rather than products and using goods according to needs rather than buying them. An example for the former is the financing of hospital mental health care in Austria, whereas the latter situation results for instance from the ‘Personal Budgets’ in Germany.

Thirdly, financing arrangements shape the role of the providers which, according to chapter 6 has also an effect on affected individuals. Currently, the role of providers resembles those of uncoordinated actors on the one hand and those of competitors on the other hand. Examples for the latter are the DRG related reimbursement in Austrian hospital mental health care and the introduction of performance based contracting in the UK. An example for the former role is the traditional situation in Lower Austria, where different providers outside the health care field act in a rather uncoordinated manner. This pattern has been more common in bureaucratic and state-led forms of service supply.

This leads fourthly to how financing arrangements are linked with a certain role of the state. While there are some arrangements which represent full or at least high public responsibility there are others where the role of the state is reduced to that of providing support. High public responsibility is characteristic for benefits in kind which can be accessed universally according to needs rather than after means testing. Furthermore, in the case of cash benefits, public responsibility is higher the more costs can be covered with the public monetary transfer. An example for high responsibility of the state is hospital mental health care in the UK, whereas low public responsibility can for instance be observed in the case of psychotherapy in Austria or in the case of residential care.

The fifth criterion is the extent of public administration responsibility. Thus, different financing arrangements are associated with different public administration involvement within the whole process of financing and service provision. While involvement can on the one hand be related to responsibility sharing with different players who represent collective goals and interests, in other cases the role of public administration is reduced to guiding and controlling a market transfer similar to some fields of economic policy. The latter role is reflected in the approaches of performance based contracting which have been demonstrated earlier. The former has traditionally been the case where public financing has been linked with public provision of mental health care arrangements, for example nursing homes in Lower Austria.
Related to general mental health policy ideologies the observed characteristics seem to reflect two core strands, which is a more social democratic oriented mental health policy style on the one hand and a more liberal oriented mental health policy approach on the other. Notably, the term ‘social democratic’ is here to be understood in the sense of primarily rights-based entitlements to mental health care, whereas ‘liberal’ denotes a policy strand which is ruled by market principles with limited welfare rights. Of course this is only a crude typology, since features cannot always be clearly attributed to one specific ideology-type. For example, in the category ‘role of the state’ the feature ‘public support’ would also be typical for a conservative mental health policy ideology. Nevertheless, this form of portrayal fulfils the function of making the political dimension of financing more transparent.

From a historical perspective, the trends in mental health financing seem to mirror a mental health policy shift from a more social democratic oriented towards a more liberal oriented policy style in all three countries under investigation or vice versa, the liberal oriented policy discourse leads to a specific choice for mental health financing arrangements which support a liberal rather than a social democratic approach. In the Austrian case, the shift towards a liberal mental health policy discourse has been demonstrated in more detail in the discourse analysis which shows, once more, the interrelation between financing and discourse (see 5.2.). However, while I would describe the trend towards a liberal approach as being quite evident, typifying former approaches as clear cut social democratic is less obviously indicated. On the one hand, the argument is supported by the fact that hospital financing can traditionally be attributed to a social democratic policy strand in all three countries under investigation. Even in the UK, where the overall welfare system has always mirrored a liberal approach, the health care system has shown typical social democratic elements (Badelt and Österle 2001). With shifting mental health care from hospitals to other service elements, the social democratic elements become less apparent. Yet, especially in the Austrian case, I would say that there have always been other policy elements, especially more conservative ones. For example the role of the family in mental health care has always been important. Overall, these policy strands impact on individual responsibility in terms of organising and financing mental health care and on access to professional services. Needless to say that individual responsibility is higher and access is more likely to be restricted in a financing system which mirrors a liberal policy approach.

While the liberal mental health policy approach seems to increasingly dominate, it has to be noted that this is not something which needs to be taken for granted. Indeed, for a broad financing discussion, it will be paramount that the current development is not perceived as strict and exclusive. On the contrary, when discussing the effects of various financing arrangements, some alternative policy aims may be detected or vice versa, alternative policy aims can be
defined in the first place which may be achieved by other and even unprecedented forms of financing approaches. As an example I would like to mention a financing model which has been introduced as a pilot project in the Italian region of Campagnia. Notably, concerning the financing approach the model differs only slightly from the ‘Personal Budget’ model in Germany, yet the impact is a completely different one. Bifulco and Vitale (2004) describe this arrangement as a form of ‘Individual Health Care Budget’ which is intended for people affected by social disabilities derived from psycho-organic illnesses or socio-environmental marginality. The central aim of the financing strategy is to reduce hospital referrals. In order to achieve this, the costs of public expenditure for institutional services are transferred into individual budgets to be spent on the three basic functions of housing, work and socialization. In other words, the cost of a bed in an inpatients institution is converted into a budget which can be used by the individual person to develop his/her living and working capabilities. However, in contrast to the ‘Personal Budget’ in Germany, individuals do not receive the budget themselves, but it is managed by a non-profit organisation according to an individual care project. In order to choose the non-profit organisation and to develop the personal care plan, the individual is supported by a publicly financed interdisciplinary team of professionals. Furthermore, providers of services are involved in negotiating the care project. The professional support team is also responsible for observing the provider organisations’ compliance with the project. As an incentive for reducing the level of medical care, the care budget is increased by 10% at each step of decreasing medical intensity.

Applied to the framework in table 18, under such a financing arrangement, the nature of the mental health services would have to be characterised as public good because using services is not directly restricted to purchasing power. Furthermore, as Bifulco and Vitale (2004, 13) point out, “the beneficiary in this case is not recognized as a consumer, but as a player in his/her own individualized rehabilitation therapy plan, a player with his/her social ties and resources. ... Above all, the bargaining competence (and power) of the citizen is not considered as a starting-point, but as the intervention purpose. The idea is to support the ability of the frail citizen to choose on the project he/she is implied with, but without requiring that this capability should be fully developed [from] the beginning” (own emphasise). Additionally, with respect to providers, their role would be most correctly described as partners in a network rather than as competitors or uncoordinated actors. Finally, the role of public administration is also rather specific. Although it does not provide services themselves, it takes part in the whole process of service provision and responsibility is not just restricted to quality control. Related to mental health policy ideologies, this model does not really fit into traditional mental health policy approaches. It rather includes characteristics of several approaches or can even be described as an alternative one. In terms of individual responsibility, it resembles, however, a social democratic type.
Having demonstrated some subjects for discussion by using examples of financing from chapter 4, the final aim is to summarise the main issues for discussion. From my point of view the core question in any financing discussion needs to be which general mental health policy is actually wanted? Is the aim a continuation of the liberal approach, should it resemble the traditional policy approach in overall health care which has included many social democratic elements or is there another alternative? Once, there is consensus on that matter, finally those financing arrangements have to be selected, combined or even newly invented which support these aims. In summary, guiding questions for discussing alternative financing arrangements would therefore be:

What is the aim in terms of mental health policy?
Which financing arrangements support these aims by the way they shape

a) the nature of mental health services?
b) the role of the affected individuals?
c) the role of the providers?
d) the role of the state?
e) the role of public administration?

In contrast to traditional financing debates, in such a discussion, financing would not just be a technical means to increase efficiency within given resource-constraints but it would inevitably link mental health policy and financing issues and thus, mental health service provision and financing.

7.2.2. Process Dimension

While several core issues for the selection of a particular financing arrangement have been covered by addressing the content dimension, this still leaves an important aspect of financing unaddressed. The issue which has yet to be covered is concerned with the processes within a particular financing arrangement. Basically, from the process perspective, questions need to be asked which are mainly concerned with decision making in terms of resource allocation. These either address resource allocation directly, for example decision making about the level of hospital budgets, or they address resource allocation more indirectly in terms of criteria according to which resources are allocated. In that context, the first crucial question is where decisions about resource allocations or about indicators concerning resource allocation are to be made. For example the location can be the traditional parliamentary representative process but decision making about resource allocation can also be more directly transferred on to the mental health care arena where a committee is responsible for decision making. This leads to another vital issue for discussion namely who are the actors who make the decisions? The group of actors may involve politicians, civil servants on the administration level, experts, providers or representatives of users and/or their
relatives. Finally, discussions are required about what is being decided on which level? I will, again, demonstrate this more precisely by using several illustrations from the thesis which mirror different levels of decision making.

Take for instance the ‘Mental Health Care Budget’ which has been introduced in the German case study (see 4.3.). According to this arrangement, several monetary sources are pooled into a single mental health budget. While various expectations have been expressed how this arrangement allows more flexible choice between forms of treatments, no information has been provided concerning who actually decides about the resource use and where these decisions are made. The location of decision making could be the hospital but also some ‘independent’ location or it could even be the users’ place of living. Correspondingly, several alternatives in terms of decision makers are possible. One can think of a multiprofessional team including professionals from all provider types involved or the decision makers can be a form of representative board involving also users but it can also be a single psychiatrist. What I want to stress is that these decisions determine very much how resources will finally be distributed and to who’s benefit they are. If decision making is for example located at the hospital or if it is dominated by medical doctors, existing incentive structures will very likely result in using a higher proportion of financial resources for hospital mental health care.

Another example is the formulation of performance indicators for performance based contracting. Under 5.2. and subsequently under 6.3., it has been outlined that existing types of performance indicators are not always appropriate for mental health care. Moreover, they are very much related to technical efficiency concerns and thus, influenced or even defined entirely by managers and accountants. Defining these performance criteria will, again, have an impact on resource distribution. Most importantly, they determine quality and quantity of service supply and, consequently, costs of services. Not least, if people receive a cash benefit, spending these resources and, hence, final resource allocation will be considerably influenced by the quality and quantity of service availability. Principally, one can ask the same questions as in the above example, which is, firstly, which actors are involved in deciding about contract criteria and contract negotiations and, secondly, where do these negotiations take place?

The final example relates to resource allocation according to pre-determined formulae. By nature, the formulae determines very much the flow of resources to different areas and providers and, eventually, to users. Considering the problems which are associated with establishing formulae, I suggest that this must not be reduced to a mathematical task. Taking, additionally, into account the critical issues which have been raised under 5.2. concerning figures, it seems to be required that the mathematical task is accompanied by a political dialog, where it is not only explained what the figures are based on but where, additionally, amendments and adjustments are discussed publicly and transparently. Again, these debates can involve various actors and representatives.
Overall, this subject is closely related to 7.1. because the questions very much address the issue of participation and democracy. Thus, any approach which involves various actors and/or their representatives and, hence, transforms decision making on resource allocation more into a public process, reflects the ‘democracy-participation’ principle. Consequently, for details on organising such processes within a certain financing model the same issues will have to be taken into account as outlined earlier under 7.1. for the procedure of establishing a financing model.

To conclude, guiding questions for the process dimension within a specific financing approach would be:

a) Where are decisions about resource allocations made?
b) Who makes decisions on which issue of resource allocation?
c) How are decisions made?

7.3. Closing Statement

One of the central aims of the thesis has been to further integrate the fields of mental health care and social policy in an interdisciplinary manner for the Austrian context. The specific quality of this approach has been that it has made the interrelations between mental health care financing and reform more transparent. Additionally, it has indicated various challenges with respect to (future) financing approaches and their interdependencies with mental health care service provision. In providing, on the one hand, a description of mental health care financing arrangements in Austria and selected European countries, the thesis has shown that due to the specific characteristics of mental illness and mental health care, these financing arrangements are more complex than it is the case in overall health care financing. In the following in-depth analysis of the mental health reform discourse, it has, on the other hand, been demonstrated how central concepts of the reform are characterised by different meanings which is, for example the case for the ‘participation principle’. Moreover, although core objectives themselves have remained broadly unchanged, the underlying meaning has been transformed in the context of overall welfare state restructuring, notably resulting in a more liberal oriented mental health care approach. Within that processes of change mental health care financing has received little attention. Yet, even if not explicitly addressed, the analysis has demonstrated several examples how reform discourse and financing are implicitly linked to each other. Not least, the impact of these relations in terms of responsibility for (financing) mental health care on the level of the individual persons affected and on the general society level has been demonstrated. In summary, the trend seems to be that private responsibility for the societal sectors ‘family’ and ‘voluntary’ and thus for the affected individuals or their relatives is increasing while the state’s role in
terms of mental health care responsibility is on the decline. While reform concepts themselves may aim at social inclusion of persons with mental disorders, it has been shown that more subtle elements of change bear the danger of social exclusion. The thesis finishes with some suggestions for establishing an alternative mental health care financing approach including guidelines for discussing alternative financing scenarios.

Not least, this piece of research has just as well raised many more questions which are yet to be answered in future research projects. These questions are very much related to the currently developing sub-discipline ‘mental health economics’ at the European level. It remains to be hoped that, as one impact of the thesis, the specific Austrian situation will play an important role in future research activities on these issues. This should not least foster planning and development in Austrian but also international mental health care.
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