

# Incentives in Financing Mental Health Care in Austria

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## Abstract

**Background:** In Austria, financing health care -and even more so mental health care- is characterized by a mix of federal and provincial responsibilities, lack of uniformity in service provision and service providers, and diverse funding arrangements. The division between financing structures for health care and social care makes the situation even more complex. This state of affairs results in various, partly counterproductive and sometimes paradoxical financial incentives and disincentives for the providers, recipients and financiers of mental health services. In several provinces of Austria, recent reform plans in mental health care have focused strongly on establishing community-based and patient-oriented mental health care. One of the main challenges in implementing this new policy is the re-allocation of resources.

**Aims of the Study:** The authors hypothesize that the existing structure of mental health care financing, with its incentives and disincentives, constitutes an obstacle to patient-oriented community-based mental health care. Analyzing the characteristics of the overall mental health care financing system in one Austrian province, Lower Austria, will provide a better understanding of actor-relationships and inherent incentives and highlight implications for the process of deinstitutionalization.

**Method:** The authors used an analytical framework based on the principal-agent theory, empirical evidence, and information on financial, organizational and legal structures to identify the characteristics of actor-relationships and the position of single actors within the system.

**Results:** The article shows how incentives are linked to existing constellations of actors involved in mental health care financing and identifies significant power relations. As a consequence, incentives and disincentives within the financing system result in hospital-centered and supply-oriented mental health care in Lower Austria.

**Discussion:** The current system of financing mental health care provides an obstacle to the provision of patient-oriented and community-based mental care. This is due to existing constellations and power relations among the actors where, most importantly, patients are the weakest party in the patient-payer-provider triangle. Balancing power relations will be a significant prerequisite for alternative financing systems.

**Implications for Health Policies and Further Research:** If a community and needs-based mental health care system is to be established in Austria, the financing structures have to be changed accordingly. Applying a principal-agent framework is useful for identifying key aspects in mental health care financing in relation to the provision of services. Further research is needed to help develop alternative financing mechanisms that support community-based and patient-oriented mental health care systems.

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## Introduction

Austria is a federal country with nine provinces (Länder). Mental health care financing is characterized by a mix of federal and provincial responsibilities, heterogeneous service elements and service providers, and diverse funding arrangements. The mix of incentives embedded in this complex system results in specific actor behaviors and, most importantly, has shaped particular forms and characteristics of service provision.

Recently, a number of Austrian provinces have taken steps toward mental health care reform. The common philosophy, which can be identified in "reform plan documents," is to transform mental health care systems from centralized inpatient care to decentralized, community- and needs-based systems of service provision. One key determinant for successful implementation of the reform efforts is information on the existence and the creation of incentives in mental health care financing, the role these play in mental health care provision and their implications for the patients.

This paper aims to investigate the implications of incentives arising from mental health care financing schemes for the process of deinstitutionalization. The authors hypothesize that incentives in the current structures constitute an obstacle to patient-oriented and needs-based community psychiatric care. They use evidence from one Austrian province (Lower Austria, population 1.5 million) to exemplify the effects of such incentives and to discuss requirements for the successful re-allocation of resources.

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The body of this paper begins with a theoretical and conceptual analysis of incentives. The following part describes the current mental health care financing system in Austria as well as specific features of the Lower Austrian system. It includes a portrayal of the actors involved and outlines the financial transfers and reimbursement mechanisms employed. The theoretical framework is applied to analyze the incentives in mental health care financing in Austria-on the basis of the situation in Lower Austria-and to study the impact on mental health care reform. The authors conclude their analysis by pointing out some crucial elements for resource re-allocation in mental health care reform.

## Incentives in Health Care Systems: a Theoretical Framework

Most of the existing health care economics literature about incentives and their implications for health care systems evaluates providers' responses to particular reimbursement systems.<sup>1-10</sup> As Lercher notes, however, these analyses usually do not take into sufficient account the complexity of the subject, most importantly the numerous actors involved, and are based on the assumption of linear causalities within financing systems.<sup>11</sup> Thus, health care financing is often seen as a technical fix where choosing a certain method leads to a desired outcome.

From a more constructivist perspective, however, an analysis of incentives and their implications has to consider the crucial role of the actors involved and how their complex interaction may result in several different outcomes. Here, the notion of mechanistic control within financing systems contrasts with the perception of non-linear dynamics due to actor interaction. From a holistic point of view, financing systems are therefore also social systems, which follow their own logic.<sup>11</sup> In other words, economic action cannot be explained without taking into account the power relations among the various actors and the social embedding of actions, including dependencies, organizational and personal discretionary power and various degrees of autonomy.

Boyer and Mechanic<sup>12</sup> provide a telling example to underpin this view with their examination of the failure to implement an innovative reimbursement system for psychiatric care in New York State. They conclude that "...no reimbursement reform can stand by itself. Coordinated strategies are required by multiple state agencies and the regional and local programs providing funds".

Giving due merit to these issues requires an appreciation of the fact that financing systems are embedded in a specific local and national context. Though this makes it difficult to compare different health care systems or even different regions within a country, it contributes to the underlying international discourse about the financing of health care.

Because of the specific characteristics of health and health care, the regulation of economic activity primarily via price and competition is either not possible or leads to undesirable macro-economic and micro-economic outcomes. This phenomenon, known as "market failure," results in specific

policy responses and has allowed the development of particular incentives for the actors involved.<sup>13,14</sup>

A major feature of market failure in health care is the existence of "asymmetric information" among financiers, providers and patients.<sup>13,15</sup> This means that in transaction processes, information is distributed unevenly between two or more interacting parties because information is not equally accessible. To analyze this asymmetry from a theoretical point of view, several researchers have used the institutional-economic principal-agent theory developed in the 1970s.<sup>16,17</sup> The theory describes the conflicts of interest that exist within organizations and institutions between an ordering party (principal) and an undertaking party (agent). Because of asymmetric information, the principal is not fully able to control the agent's behavior and has to develop incentive mechanisms in order to shape the agent's conduct. As Pratt and Zeckhauser,<sup>18</sup> state: "Whenever an individual depends on the action of another, an agency-relationship arises. The individual taking the action is called the agent. The effected party is the principal." The theory is thus concerned with dependency relationships characterized by asymmetric information. Balancing the information deficit leads to so-called agency costs, which can be monitoring costs for the principal, bonding costs for the agent or residual losses. The sum of those costs has to be borne by the "contractual parties."

Various studies based on this concept have addressed the implications of new hospital reimbursement forms for payers and providers<sup>19</sup> or single actor relationships within managed care.<sup>20,21</sup> Smith *et al.*<sup>22</sup> applied the theory to compare the transfer of funds in health care in an international context, while Schwartz<sup>23</sup> analyzed incentives in hospital care.

Various principal-agent relationships can occur within health care systems. Given the constellation of actors in the Austrian health care systems, the following key principal-agent relationships can be defined (**Figure 1**): between the payer as the principal and the patient as the agent (A); between the payer as the principal and the provider as the agent (B); and between the provider as the agent and the patient as the principal (C). In this paper the principal-agent approach will be used as an analytical framework to examine systematically the respective actor-relationships in the overall mental health care financing system, thus taking into account the numerous actors involved.

Although it is meaningful to analyze these relationships as they pertain to the individual actors, it is important not to neglect the complexity of the overall system. According to Schwartz,<sup>23</sup> the individual actors' level has to be supplemented by the organizational or collective level (e.g. trade unions), topped by the governmental level where legislative issues are determined. This approach implies that incentives are also created due to diverging aims within the system, which need to be taken into account in the analysis.

The aims of this paper are twofold: to obtain an overall understanding of the financing system and to evaluate the current forms of interactions and interdependencies at the individual level. The principal-agent theory is an appropriate analytical instrument to demonstrate how actors are part of

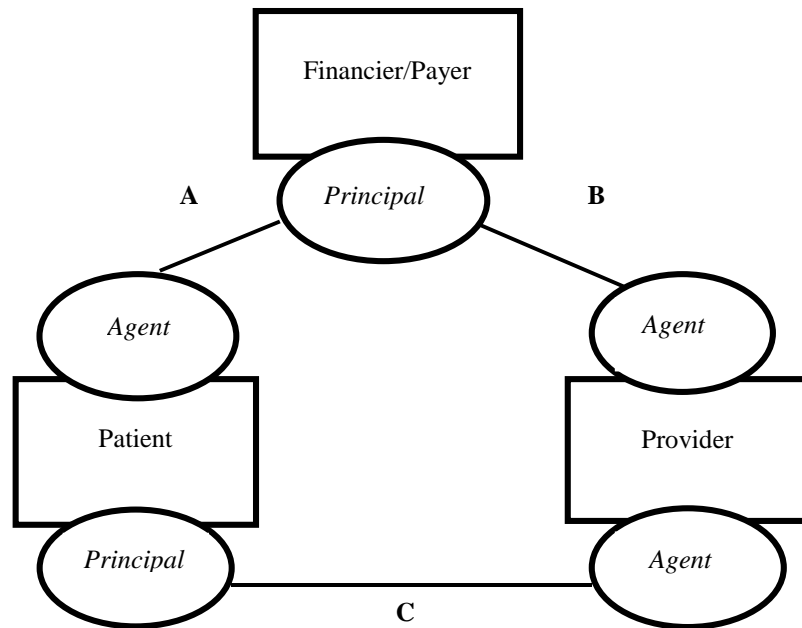


Figure 1. Key principal/agent relationships in health care

complex constellations and how incentives in the principal-agent relationships are shaped in mental health care financing. The theory is also used to show, at a simplified, abstract level, the inherent degrees of power and power relations and the incentives that result from these. The framework also sheds light on the role of single actors (e.g. patients) within the system.

There are four circumstances to bear in mind when analyzing incentives in mental health care actor-constellations. First of all, agents, as the parties who are fully informed, enjoy a superior position. This allows them to take advantage of their discretionary power and to act in their own interests. To name just a few, these can be monetary interests, particular corporate interests or special ambitions of individual actors, such as establishing psychiatric units at general hospitals. They may, however, conflict with other parties' interests.<sup>24</sup> On the other hand, principals (who are not fully informed) will, depending on their position in the overall system, offer incentives in order to make agents behave according to their own expectations, thus offsetting the information asymmetry. As Mayntz and Scharpf<sup>25</sup> make clear, these scopes of action need not only be used to the actors' benefit in a rational sense, because emotions and habits also play an important role in determining the actions.

Next, the constellation in the health care system results in a "double-agent" situation of providers which inevitably raises conflicts of interest. Medical professionals, for example, are the agents of patients as well as of payers.<sup>26</sup> Third, because of the hierarchical structure, both the analysis of existing individual relationships and the question of power relations are important. For example, it is meaningful to consider how and to what extent principals can select their agents (e.g. in the provider-payer relationship or in the patient-provider

relationship). Here, again, information and knowledge play an important role. As Foucault, cited by Turner<sup>27</sup> has pointed out, "There is no power-relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power-relations."

Finally, many of the actors described above primarily act within organizations that function by their own rules. The behavior of actors is shaped through "micro principal-agent relationships" resulting from existing professional and social differences. Hierarchies and phenomena such as tribalism result in diverging aims within organizations, as is the case for example in hospitals.<sup>23</sup>

## Financing Mental Health Care in Austria

Historical issues and traditions as well as the country's federalist structure have led to a complex pattern of public sector involvement in the Austrian health care system. The federal government, the provincial governments, communities and social insurance are involved as funding bodies. Meanwhile, the role of private contributions must not be ignored. Planning and regulation is organized via negotiation and coordination between federal and provincial governments; the federal level is responsible for the general structure.

In mental health care, the situation is even more complex. Due to the special position mental health care and psychiatry have within the welfare state, social care as well as health care plays an important role in the provision of services. As a result, financing responsibilities -more so than in somatic medicine- shift between those in charge of financing *health*

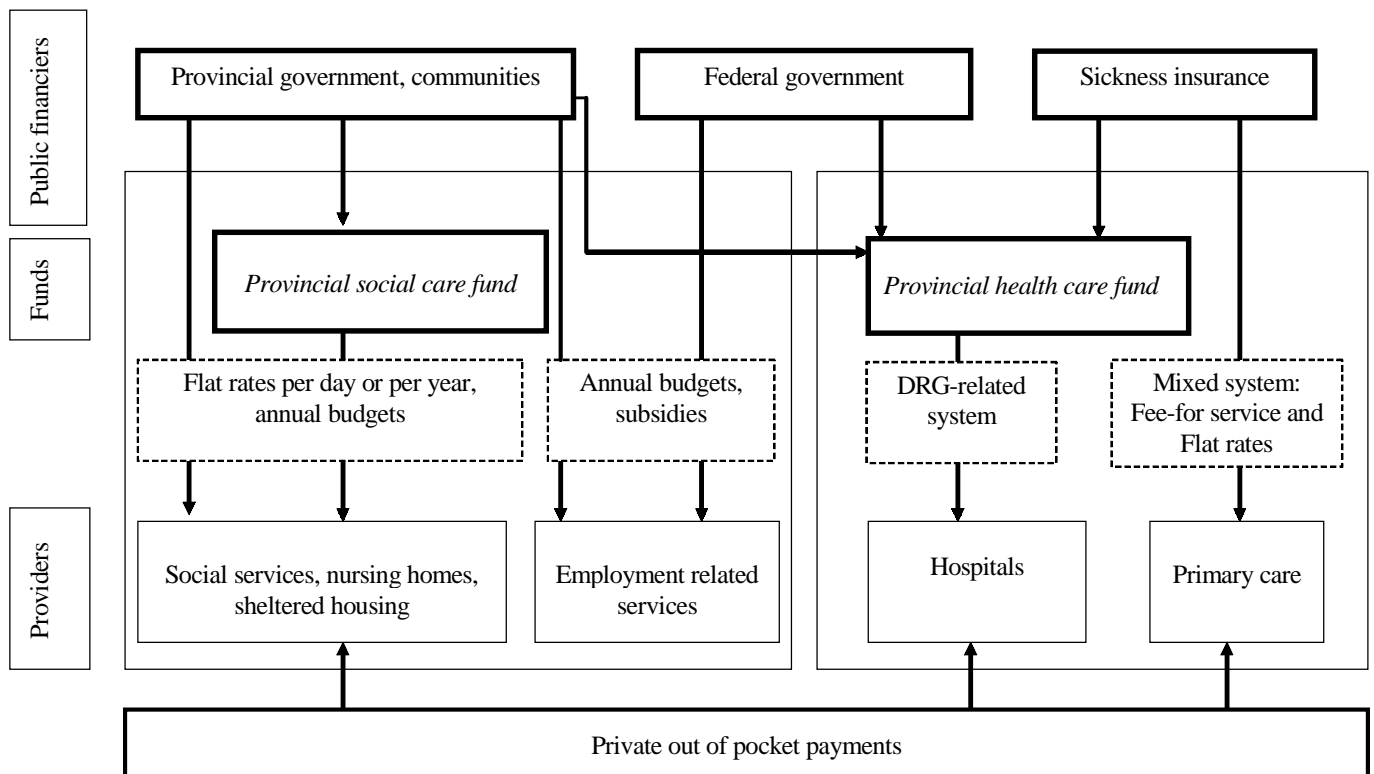


Figure 2. Pre-reform structure of financing mental health care in Lower Austria

care and those in charge of financing *social care*. For Lower Austria, the major actors and flows of funds in the pre-reform structure of mental health care financing are shown in **Figure 2**.

Care can be accessed at different levels of the system. In public health care, patients can visit either a GP or a specialist. For hospital services, a referral from the appropriate professional is required, except in case of emergency. In the social care system some services can be accessed directly (e.g. specific ambulatory and mobile social psychiatric services), whereas for others (e.g. sheltered homes) patients need to apply in advance to the payer.

### Sources of Funding

#### Funding Health Care

Austria belongs to the so-called “Bismarck group” of countries in which health care financing is based on sickness insurance, as opposed to the Beveridge group of countries which have *tax-funded* health care systems.<sup>28</sup> Employers and employees as well as the self-employed have to make mandatory payments into particular sickness funds. These funds finance about 50% of the health care system,<sup>29</sup> with most of the rest coming from tax funds invested by the federal and provincial governments (25%) and from out-of-pocket payments (24%)<sup>13</sup> in the form of co-payments (e.g. prescription fees, daily flat rates for hospital stays), private payments for certain services (e.g. private consultants), or

private insurance. In the year 2000 overall expenditure for health care in Austria came to 8.2% of GDP.<sup>30</sup>

The Austrian insurance system is based on the concepts of federalism and solidarity. The sickness insurance system is decentralized and self-governed by autonomous bodies. Unlike private insurance, the premium is adjusted to one’s income level and is independent of the payer’s health status. Moreover, access to health care and the type of services to which individuals are entitled bear no relation to the premium paid.<sup>31</sup> Eligibility, however, depends strongly on the definition of illness according to the General Social Security Act (*Allgemeines Sozialversicherungsgesetz, ASVG*), which takes a curative approach.<sup>32</sup> Thus, the potential for cure via medical intervention is the prerequisite for service payment by the sickness insurance fund.<sup>13</sup> This reflects a focus on orthodox medicine, which is associated with a negative definition of health (health as absence of illness or disease) as described by Baggott.<sup>33</sup> By implication, cases for which a cure is deemed impossible and for which long-term care would be required are excluded from the health insurance system.

#### Funding Social Care

In contrast to health care, the responsibility for social care-some services excepted-rests with provincial governments. The legal basis is constituted by provincial Social Assistance Acts (*Sozialhilfegesetze*) which stipulate that the financing of social services is based on the principle of subsidiarity. Thus, for the provision of social services,

pensions and long-term care allowances, according to the Federal and Provincial Long-Term Care Allowance Acts (*Bundespflegegeldgesetz, Landespflegegeldgesetze*), are the primary source of funding. The difference with respect to full coverage of costs is financed via taxes, and may in retrospect be recovered from the private savings of clients and close relatives. The laws allow a rather broad interpretation, which results in considerable variety as to the implications for individual patients even within the same province.<sup>34</sup>

Very few specific social services are entirely publicly funded. In these cases the financier is primarily the provincial government using tax money, or social insurance bodies (e.g. funding-qualified nursing care) and, to a marginal extent, the federal government. In 1998, one third of social care expenditure in Austria for social services and living arrangements was privately financed while public funds accounted for the remaining two thirds.<sup>35</sup>

### *Transfer of Funds*

#### **Reimbursement in the Hospital Care Sector**

The reimbursement of providers is also organized in rather variegated fashion. Hospitals are reimbursed via the diagnosis-related hospital reimbursement system (*Leistungsorientierte Krankenanstaltenfinanzierung*), which was introduced in 1997 in order to limit further increases in costs, by replacing the retrospective reimbursement system that was based on flat rates per day. As in the diagnosis-related-group-system (DRG), introduced earlier in other countries, hospitals earn "points" for every diagnosis and for some specific specialized services. The monetary value of each point is determined in retrospect and depends on the total points earned by all hospitals in a province. Running costs are exclusively financed via diagnosis-related hospital reimbursement whereas expenditure for capital investment is funded separately.

In the 1997 reform, central provincial institutions with a prospectively determined budget for financing all publicly funded hospitals were established in each of the nine provinces. All public financiers pay into these provincial funds (in Lower Austria the *Niederösterreichischer Gesundheits- und Sozialfonds/ Bereich Gesundheit*). Around 40% is covered by the sickness insurance funds in the form of a prospectively determined flat rate. In addition, predetermined payments are made by the federal government, the local governments and the communities via taxes. Any hospital deficit which arises due to expenditure that exceeds the allocated budget is borne by the providers. Thus, the hospital reform has transferred the financial risk from the payer to the provider.<sup>36</sup> Since provinces and communities are major providers of hospital services, they often have the final financial responsibility.

#### **Reimbursement in the Primary Care Sector**

Regulations for hospital financing are treated separately from primary health care regulations for General Practitioners (GPs) and consultants who usually work in solo practices.

Negotiations on a corporatist basis are the norm. The medical association and the sickness insurance funds agree on fees for those GPs and consultants who are in a contractual relationship with the sickness funds. Remuneration follows a mixed reimbursement system with a combination of flat rates and fee-for-service. Patients pay for services rendered by private, non-contract consultants on an out-of-pocket basis and are partially refunded by sickness funds or private insurance.<sup>36</sup>

#### **Reimbursement in the Social Care Sector**

In social care, within each province a rough patchwork of service provision has evolved that is still inadequate when it comes to social services for the mentally ill. The reimbursement systems vary considerably among the nine Austrian provinces. In Lower Austria, expenditure for nursing homes is paid via flat rates per day and is recovered from residents and close family members. Other types of living arrangements, such as staffed group homes or sheltered housing and day care centers, are financed via flat rates per patient and year. Specific ambulatory and mobile psychiatric social services (*Psychosoziale Dienste*) are financed via annual budgets. Services promoting employment and labor market integration are funded via a combination of annual budgets and subsidies from the federal and provincial governments and by the Labor Market Service (*Arbeitsmarktservice*).<sup>37</sup>

For financing social care services in Lower Austria, the provincial Social Care Fund (*Niederösterreichischer Gesundheits- und Sozialfonds/ Bereich Soziales*) acts as a counterpart to the provincial Health Care Fund. However, financial flows are much more complex in social care. For each type of social service provision, there are specific funding mechanisms that result in completely segregated monetary flows. The role of the provincial Social Care Fund as a central institution for resource distribution and allocation for social service providers has so far been rather marginal. Major regulatory responsibilities rest with the provincial government.

#### **Incentives in Hierarchies and Power-Relations: The Example of Mental Health Care in Lower Austria**

##### *Mental Health Care Reform Plans in Lower Austria*

Austria, like most western societies, has taken steps toward the deinstitutionalization of mental health care. A decrease in the number of psychiatric hospital beds from around 12,000 in the 1970s to 4,173 in 1999<sup>38</sup> is the most obvious indicator of this trend.

The Lower Austrian Psychiatric Plan<sup>39</sup> proposes decentralization and the establishment of integrated community-based mental health care. The aims are to reduce the under-supply (e.g. in the social care sector) and over-supply (e.g. in the hospital care sector) of services and to change the provision of services from a supply-determined to

a needs-determined system which should also enable continuity of care. The intention is to provide services close to where the patients live, according to their individual needs, thereby optimizing the quality of life of the mentally ill. These plans can be summarized as an overall attempt to provide needs-based and patient-oriented services, defined as the “provision of effective, professional and humanly adequate services” in the reform document.<sup>39</sup>

The objectives should mainly be achieved through structural and organizational improvements in service supply. In that context, within more recent discussions, suggestions have been made to change the focus of service provision from institutional-centered care to home treatment carried out by multidisciplinary teams. To accomplish that goal, a case-management model has been proposed that combines caring and coordination of services, similar to the so-called “assertive outreach model”.<sup>40,41</sup> Provision of care is supposed to be organized into seven psychiatric regions to be run autonomously by seven regional regulatory bodies. These bodies are responsible for continuous planning and service improvements which should be achieved via cyclical processes of monitoring, needs assessment and discussion processes among relevant actors. The plan also mentions that a substantial reform will require a change in the financing structures, but does not go into detail.

So far, the reform plan has been implemented only in part. Efforts have focused primarily on shifting inpatient care from mental hospitals to psychiatric wards in general hospitals. Thus, one important step towards implementation was the political decision in the fall of 2000 to close a mental hospital which has so far served a population of 800,000 people and to replace it with four psychiatric wards in general hospitals. Further implementation initiatives are currently under discussion. So far, however, structural financing issues have not been addressed at all. This is mainly due to political resistance and the complexity of responsibilities in mental health care financing.

In the following section, we will look at existing incentives and disincentives in the Austrian mental health care financing system in order to evaluate whether they are consistent with the overall reform aims described above. Further to the structure of Austrian health care, incentives will be identified through a systematic, in-depth analysis of the principal-agent relationships. This will also demonstrate the links between individual relationships and the overall system and the implications which arise therefrom.

### *The Hospital Care Sector*

In the field of hospital care, the prospectively determined flat rate contributed by the sickness insurance funds has, in combination with diagnosis-related reimbursement, caused an important power shift from providers to payers. As has occurred in other countries,<sup>42,19</sup> this, by implication, places financial risks increasingly on service providers and has led to the growing “economization” of hospital care. If providers do not want to produce losses they are forced to think more about

micro-economic issues and technical efficiency. In the case of Lower Austria, where the providers of hospital services are, without exception, public institutions at the provincial or community level, the financial risk has been transferred from the federal to the provincial and community level and from social insurance to taxation.

As mentioned earlier, providers always find themselves in a double-agent situation between the patients and the payers. In other words, given the information they possess in the transaction process, their position is more advantageous than either the payer's or the patient's. A crucial question is this: which principal can set the stronger incentives to offset the information deficit? Because of how the system is structured, the patient is a considerably less powerful principal than the payer. Hence, the relationship between patient and provider is less relevant than that between payer and provider, even more so in the new DRG system.<sup>21</sup> By implication, as has also been shown in other countries,<sup>42</sup> providers may take advantage of their superior agent role in the patient-agent relationship by using the situation of asymmetric information, and trying to transfer the financial risk on to patients. In practice, this can take the form of adverse selection (transferring or rejecting economically unattractive patients), cream skimming (selecting economically attractive patients), and boosting the supply by increasing admission rates. Hence, as Kühn<sup>42</sup> points out, if negative implications for patients are to be prevented it is paramount to establish a good system of quality control. Otherwise, providers will seek loopholes in the reimbursement system to maximize income and thus justify their existence. This last argument is especially relevant for Lower Austria, since providers are all public institutions and often face political pressure to prevent hospital closure.<sup>43</sup>

Hospitals, however, are not uniform actors but complex systems with multiple actors. As Schwartz<sup>23</sup> argues, “It is not the hospital as an institution that acts economically, but the actors and decision makers within.” Therefore, it is crucial to understand the hierarchy of the hospital occupational group, since this has considerable implications for the patient in the individual staff-patient relationships. Various authors have demonstrated the dominance of the medical profession in hospital employees.<sup>44-46</sup> As in other countries, the general power-shift to the payer in Austria has been described as a loss of medical autonomy,<sup>21</sup> since financial constraints have shifted decision-making with limited resources to the micro-level of individual doctors, thereby in a sense aligning doctors with payers. However, this power shift is only valid for the *doctor-payer* relationship, not the *doctor-patient* relationship. In the latter, doctors (the agents) still have the upper hand, and because of their alignment with the payers may be forced into discriminatory processes toward patients.

Finally, the payer-patient relationship is also of interest. In Austria 99% of the population is covered by a compulsory insurance scheme.<sup>47</sup> The structure of the insurance scheme and its position in the Austrian welfare system have considerable implications for the mentally ill. According to Goodwin,<sup>48</sup> mental health problems “compared to physical conditions are relatively difficult to diagnose accurately, the treatments available are highly variable in their effect, and the problem

often exists for a long period of time.” Thus, mental health problems often do not fit into the model of social insurance, and in particular, insurance funds do not take responsibility for the long-term mentally ill.

The definition of illness in the Austrian sickness insurance act mirrors, as mentioned earlier, the higher appreciation of a biomedical model as opposed to a psychosocial model. The inherent dualism separates curing from caring, biological from social, and body from mind, resulting in dichotomy and exclusion rather than integrated care. In consequence, mentally ill patients are shifted among different payers. As Bock<sup>49</sup> points out, exclusion from the insurance system and the shift into the secondary and subordinate system of social care and social assistance exemplify how the mentally ill are positioned in the health care structure. They also reflect the bifurcation of the welfare state into social insurance, which represents the “productive core” of society, and social assistance, which represents the detached, excluded group.<sup>50</sup> The division of competence and responsibility is not only to patients’ disadvantage in terms of financing, but also of successful treatment. Overall, within the patient-payer relationship the power-relations are largely in the payer’s favor.

### *The Primary Care Sector*

The situation in primary care is slightly different from the hospital system. Compared with secondary health care, the payer has less power in the provider-payer relationship. A crucial point might be the corporatist way of planning and controlling and the relatively strong influence of the medical association in the regulation of prices. According to Mayntz and Scharpf,<sup>25</sup> the high capacity for consensus that has characterized corporatism in Austria reflects balanced power relations among the actors involved. On the other hand, this encourages medical professionals in their role as agents for patients to increase the supply of services, resulting in supplier-induced demand. From the patients’ point of view, it can be argued that patients, although they play the role of the principal, have a certain influence since they can, to a certain degree, choose their preferred medical professional in primary care. They can select the provider and thus determine the type of principal-agent relationship.

However, the overall lack of insurance-funded ambulatory mental health services provided by free-practicing contract doctors<sup>38</sup> signifies that the problem of supplier-induced demand is of minor importance in mental health care. It also limits patient choice while supporting hospital-based care. Additionally, neither GPs nor consultants serve as gate-keepers, which fosters the tendency to raise the number of hospital referrals. Finally, the hospital reimbursement system, although it sets incentives to reduce the length of stay, still contributes to hospital-centered provision of services by simultaneously setting incentives to increase admission numbers. The more cases a single hospital administers, the more points it can earn, hence the more income it can generate. However, due to the prospectively fixed provincial hospital budget, a higher number of total points decreases the

value of a single point for each hospital. This can result in insufficient cost coverage. Caught in this dilemma, hospitals still tend to employ a point-maximizing strategy.<sup>11,51</sup> The sickness insurance system has no interest in discouraging this “top-heavy” 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 borne by the hospital providers themselves. Many of these are provincial or local public bodies who do not exercise strict budget limits.

Taken as a whole, these incentives result in hospital-focused mental health care even when other types of services would be more appropriate from the viewpoint of patient well-being or cost-effectiveness. In short, they hinder the expansion of primary mental health care in the community.

Finally, the fragmentation of financing mechanisms in hospital and primary care inhibits integrated health care. The provincial Health Care Fund, though established as a central financing institution with a global budget, is only responsible for hospital care which, administratively and financially, separates hospital from primary care.

### *The Social Care Sector*

The problem of “patient-shifting” not only arises between health and social care but also within social care itself. In contrast to hospital care, the existing financing structures in social care bestow considerable power on certain individual providers. This is partly caused by existing retrospective forms of cost reimbursement. Additionally, single providers often have a monopoly on specific regions and/or health care fields and strive to utilize capacity in order to justify their existence. Because of their hegemonic status, these providers have considerable power to choose their patients, hence they are in control of establishing the patient-provider relationships.

Patient shifting is hardly an issue between different financiers (the payer is primarily the provincial government); where it takes place is between different providers of various types of services. Diverse forms of reimbursement (even for similar services, e.g. living arrangements) and different monetary transfer modes make cooperation between services difficult. Moreover, no responsibility for coordination has yet been formulated. In addition to selecting economically attractive patients or rejecting economically unattractive ones, patient shifting mainly takes place due to the fragmented supply of services. In other words, supply is not tailored to individual patients’ needs; patients have to fit into the predetermined supply patterns of the single providers and are therefore shifted between different providers whenever there is a change of needs. Patients who suffer from complex problems are difficult to treat adequately in any of the single community-based settings, and must often be treated in hospitals because of inadequate alternatives.<sup>52,53</sup>

In some cases, on the other hand, limited statutory regulations result in considerable political power for the payer, i.e. the provincial government. Since patients face a rather dependent status within social assistance schemes, they are

also the subordinate party in the payer-patient relationship. One expression of this is the payer's possibility to recover costs from the private savings of clients or close relatives.

## Conclusions

We identified a number of characteristics of actor-relationships in the Lower Austrian mental health care system. First, within the hospital care sector, the payer-provider relationship dominates and the more powerful actor is the payer. We also found a general power dominance of hospital care with respect to primary care, and a supremacy of providers within social care actor-relationships. Due to incentives resulting from actor constellations and power relations in the current financing structures, the mentally ill are in the weakest position in the patient-payer-provider triangle. This situation is reinforced by the fact that, in contrast to somatic medicine, the mentally ill belong to a socially disadvantaged group and are hence particularly vulnerable.

The consequences are the considerable fragmentation of mental health care and a hospital-centered rather than community-based type of mental health care. Even when mental hospitals are closed, the existing incentives lead to a continuation of hospital-centered psychiatric care, albeit in psychiatric wards of general hospitals. Moreover, the incentives favor supply-oriented rather than needs-based and patient-oriented mental health care. Incentives may also lead to supplier-induced demand for additional services such as psychotherapy. Overall, the incentives identified in the existing financing scheme are inconsistent with the main reform targets of needs-orientation and the establishment of a community-based service. If the reforms are to be successful, financing mechanisms will have to be changed. Our analysis suggests that for any alternative approach to financing it is helpful to recognize existing actor constellations and power relations and to ask how these relations can be changed and what implications would result from newly emerging relations. This is similar to the findings of a mental health care evaluation study in the U.S., whose authors argue that neglecting power relations within financing structures may have been a significant reason for the failure of reform efforts there.<sup>54</sup>

In order to support patient-oriented care, the allocation of resources has to enable an integrative approach to mental health care. This can only be achieved by rethinking the current dualistic approach, which pervades psychiatric care at the medical level (division between body and mind, curing and caring) as well as the organizational level (division between health and social care, hospital and primary care), and replacing the dichotomy with a holistic model of financing.

Next, in order to strengthen the position of patients, some have suggested enforcing their status as consumers (see for example Le Grand *et al.*<sup>55</sup> for the UK). This, however, leaves the power relations between providers and patients untouched.<sup>49</sup> Rather than strengthening the patients' position directly, a way to do so indirectly would be to balance the power relations in the overall financing structures. The more balanced the power relations, the more difficult it will be for

any actor to exploit the system. Finally, a criticism raised in various countries is that a move to community care can easily be used as a measure for cost containment, thus shifting responsibilities to the informal care sector.<sup>48</sup> Therefore, to guarantee deinstitutionalized professional care, care must be taken to sufficiently re-allocate resources from secondary to primary and social care, all the more so as primary care and social care services are now in inadequate supply.

The way forward could be to transfer financial responsibility for all psychiatric services from different payers to (regional) budget fundholders. This kind of model exists, for example in Germany, in the U.K. and in the U.S.<sup>56,33,57</sup> The following elements are considered to be crucial: the fundholder must be an organizational structure into which existing funding streams are pooled. While responsibility for legislating general standards of supply would have to rest with the government, actual service provision could be organized entirely by the fundholder, embedded within a structure for coordination and management. Between payers and providers, performance-based contracts are needed to assure quality standards. The introduction of specific reimbursement methods can support the shift from hospital-centered to community-based care. Finally, to achieve "power-balanced" mental health care, the establishment of participatory processes where all actors' representatives are included in decisions as to resource allocation and service development is a key requirement within the organizational structure. Learning from international experience will help to build these cornerstones for needs-based care programs and integrated services in Austria. In doing so, a major challenge for research and policy practice will be to develop a model that also recognizes the context of the Austrian welfare state at the national and regional level.

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