

Mental health policy and the welfare state

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*A study on how Sweden, France
and England have addressed a
target group at the margins*

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Part I

Point of departure

Chapter 1

Introducing a study on welfare: theoretical challenges and a case of policy

Until a few decades ago, being treated for a mental disorder meant a life in isolation. Patients were literally disconnected from both family and the rest of society, and until quite recent days, such care was always compelled. Large hospitals were constructed for this purpose, sometimes housing thousands of patients, as well as staff. These entities became closed worlds of their own, often situated in the countryside where nature was supposed to have a curing effect, and at a safe distance from others. Most patients spent the rest of their lives in this setting, as few, if any, were ever considered cured and discharged. In the best scenario, the hospitals were asylums (this is actually what they were called) – places for rest. In the worst, they were total institutions where patients had to endure torture-like experiments in the search for remedies. Nonetheless, this was the main, and perhaps the sole, public support that was available to treat mental disorders.

Today, national policies of Western democracies do not propose isolation, but integration. From the 1960s on, it became increasingly clear that segregation was motivated from neither a humanitarian nor a treatment perspective. The mental hospitals are, therefore, history in many countries. New medications, developed welfare states and a less stigmatising view of mental disorder are often described as important prerequisites for this progress. The constructed marginalisation was to end, and

people were instead to be supported in the same way as any other vulnerable group of citizens, in the community. A psychiatric diagnosis was no longer considered necessarily resulting in a need for care, but alternatives were to be created for those in need of support in their daily lives. The eventuality of maintaining a 'normal' life, a life that resembled what it would have been without the diagnosis, seemed more realistic.

However, as time has passed, there have been increasing questions about the situation facing those with mental health problems. Were there really any alternatives developed to compensate for the health and social risks connected to mental disorder and disability? In 2004, the former British Prime Minister, Tony Blair, described the present situation in the following way:

[T]hose suffering from mental distress still find themselves excluded from many aspects of life that the rest of us take for granted – from jobs, family, support, proper health care and community life. This exclusion has a huge impact on the individuals concerned and on our wider society. It frequently leads to a downward spiral of unemployment, poverty, family breakdown and deteriorating health. The costs to individuals, their families and the country are huge, not just now but also in the future. Disadvantage, too, often passes from one generation to the next. (SEU 2004)

The citation highlights the vulnerable situation of a population that is often described as ignored by society at large, and not least at the political level, but whose marginalisation few would deny. This part of the population is often described as *one of the most neglected groups of citizens at all times*. According to Blair, marginalisation seems to be as prevalent as ever, even without the isolated residencies. Organisations and researchers have noticed this to be an international phenomenon (WHO 2001; EC 2005; Lancet 2007), but also individual countries, like Britain, have raised the question in recent years, launching national plans and reforms.

As much as the creation of the asylums was once an international trend (and still is in some parts of the world), so was the decision to leave them behind. However, little is known about the policies that were introduced

to replace them. In what ways are countries now supporting their citizens in times of mental ill health? This thesis aims to investigate the formal solutions that are in place in three European States: Sweden, France and England. As will be shown later on, people with mental disorders and disabilities are clearly viewed at a political level in these countries as a group that needs support, but scarce attention has been given to the features of this support. What does it entail? On what conditions is it delivered? Who provides it? And does it reach out to those who need it? One possible way of understanding the continual marginalisation described above is that the mental hospitals were never replaced by alternatives; another, that the alternatives somehow failed.

The coming chapters will outline the transfers and services that have been developed to meet the needs of people with mental disorders and disabilities with respect to five selected areas: treatment, housing, occupation, financial support and personal support (see Table 3). Consequently, interest is focused on health and social care. The policies will be analysed by looking at characteristics of entitlements, charges, reimbursement, attainability, accessibility, administration and provision, to identify variation in what is labelled *policy design* and *policy logics*, that is, variation in content and in the ideas that could be said to hold the policies together. The analysis will consider whether there is national consistency in the design and logic of these elements, and whether these patterns are in line with what could be theoretically expected. Are there separate or common political strategies when meeting the needs of this group? Where are the borders of divergence? At the end of this study, I will draw conclusions both about the differences in experience of mental health consumers in these countries and, on a more general level, about how to study contemporary welfare policy and what national variation to expect when studying welfare systems.

The theoretical setting

Mental health is seldom treated as a policy area, but rather as a medical issue (within the sciences or nursing) or as a matter of social control (in the tradition of sociologists such as Foucault, Goffman or Scheff). Con-

trary to the sociological tradition of questioning the existence of mental illness and diagnoses, I take my starting point in the political view, where those things are accepted. People with mental disorders and disabilities are today recognised as a vulnerable group of citizens in need of extensive support. I intend to discuss what support they receive, not whether they should be seen as a target group or whether psychiatry is right in its intentions to use these diagnoses. Although the interest in how policies are developed around different groups of citizens is highly relevant for the social sciences, the questions that are examined here have mostly been ignored in the academic literature. Thus, there is clearly an empirical gap to fill. I will also argue that the research questions evoke central theoretical issues that are of general interest.

How then should mental health policies be studied from a political science – or a public administration – point of view? In my opinion, the most reasonable choice is to treat this subject as a case of *welfare* policy, and the developed transfers and services as examples of what the welfare system offers its citizens. Consequently, the framing of this thesis concerns theories of the *welfare state*, which is the most essential literature that treats the question of how nations have designed their welfare policies, and which argues that different countries adhere to different designs and logics; in other words, that it generally makes a difference whether one is a welfare user in Sweden, France or England. As will be outlined, using mental health policy as a case of welfare will allow us to approach some critical questions within this theoretical field.

During the past decades, the debate on national models of welfare policies has been vivid within the social sciences. In 1990, Esping-Andersen launched the idea of ‘three worlds of welfare capitalism’. This research had its origins in earlier classics such as Marshall (1949) or Titmuss (1974) and has, to say the least, made an important impact on the academic world. Esping-Andersen argued that Western nations could be categorised into three ideological regimes, that is, three models with specific natures of design and logics.

Briefly summarised, he argued there were three ways of organising welfare support: first, a state-centred and generous social democratic model with general citizens as its users; second, a modest market-

oriented liberal model where public welfare was directed only to the poor; third, he pointed to a conservative, or corporatist, model where the family still seemed to be the welfare provider of first resort and where citizens relied more on professional schemes than on general national programme. In a quantitative analysis of 18 Western countries, Esping-Andersen argued that, even if national policies showed an internal mix of designs and logics, they did so to varying degrees. Scandinavia was depicted as the typical example of a social democratic welfare state, the Anglo-Saxon countries as carrying foremost liberal traits and continental Europe to be of the conservative kind.

He also analysed the social impact of different models; in what way do the policies have an influence as a stratifying system in themselves? The answer to this was to state that a social democratic model lays the ground for individual independence (from both the market and the family), whereas the liberal model is highly stratifying in terms of class, and the conservative, in terms of status.

In view of the attention that has been directed to the regime theory, one may conclude that there is something very appealing about the idea of categorising welfare in this way. Obviously, the regime theory catches differences that we recognise. At the same time, the general and normative conclusions laid the ground for a vivid academic argument over the years. Some researchers have questioned whether the selection of welfare areas actually was representative enough for generalisations about the design of national welfare policy. Esping-Andersen studied three areas: sick pay, unemployment benefits and old age pensions. This means – as feminists pointed out – that the selection was limited to the working population and to cash transfers. However, in spite of the fact that this is a quite narrow interpretation of welfare policies, both in terms of users and of policies, the results were used to interpret the features of the welfare state and social policy in general. Research that goes beyond the social security system has shown that countries cluster differently (e.g. Sainsbury 1999; Daly & Rake 2003; Jensen 2008), or not at all (e.g. Kasza 2002; Anttonen et al. 2003; Bambra 2005) when varying the study objects.

Some critics actually conclude that the regime theory is of little relevance to the study of current welfare systems, that it is *not* possible to identify general and national models of welfare. This is true not least when studying such central parts of the welfare system as health and social services. On the other hand, it is difficult to find alternative theoretical frameworks for comparative use, as few comparisons even make any attempts to generalise to other policy areas. Neither are such comparisons related to mainstream welfare theories. In that sense, one may, as Anttonen and Sipilä (2003:8) do, conclude that the field of comparative social policy is still in an early phase of progress.

Nevertheless, the interest in comparative welfare studies should be as strong as ever. The welfare mission of Western democracies constitutes an important budget share, and international comparisons are used to influence – or develop new – ideas and to position national strategies in a broader perspective. There are also continual discussions on harmonisation within the frames of multinational co-operations; the so-called convergence theory. These facts motivate an interest on behalf of users, policy-makers and researchers to answer the basic question of structural policy diversity, and its eventual effects.

This said, using mental health as a case of welfare, I broach several theoretical questions along the way. Choosing this study object will, as I argue in the coming section, provide the opportunity to illuminate some of the questions that are raised in the welfare literature.

Study design

The most common way of studying the welfare state has been to select specific areas, such as pension systems or childcare. Alternatively, some rare researchers have taken as their point of departure a specific target group. While the first option gives a picture of policies that a large number of citizens are supposed to use, the latter tells us something about how welfare is structured around those who are perhaps most dependent on welfare support.

Both perspectives are important in understanding how the welfare system is structured and functions. The focus of this study is of the latter

kind: how a number of nations have addressed the needs of a specific target group. Thereby, focus is set on a limited population, but the analysis is stretched to a wider translation of welfare than is usually made, where both transfers and services are included, as well as both health and social policy. As the academic debate has cast doubt on whether welfare state theories hold for welfare policies that goes beyond the social security system, and thereby transfers, this lays the ground for an interesting and more general, theoretical approach.

The arguments for using this policy area as *a case of* welfare policy are several and will be outlined here in brief terms, but further treated in chapter two. There are mainly four arguments that suggest mental health policy as an interesting welfare area that will allow a discussion on the complexity that hides behind the notion of the welfare state, and of aspects that generally have been scarcely discussed in the welfare literature so far.

A first argument for using this field is that the regime theory is concentrated on *transfers* and ignores the fact that welfare is also about *services*. Actually, the service side of the welfare state is crucial to the features of contemporary welfare policies. Several researchers have pointed to this fact, and it may be questioned whether it matters if welfare is interpreted as transfers or as services. This has been discussed by, for example, Anttonen and colleagues (1996, 2003), Daly and Rake (2003) and Rauch (2005), who all studied child and elderly care. Their results point to divergence between sectors within and/or between countries. Mental health policies include both types of support, as mental ill health has consequences for so many aspects of life: loss of income leading to a need for financial support, but also support in getting a job or maintaining the activities of daily life.

Generally, studies have shown that people who suffer from mental disorders diverge from the general population by having poorer health also in physical terms, lower income and lower educational levels. They are also more seldom married and have fewer social contacts. A majority seem to lack any kind of occupation. Hence, there is a need of both transfers and services for a welfare policy that aims at addressing the risks of suffering from mental disorder and disability.

Second, welfare state researchers almost solely focus on social support, whereas *health care* is a large part of national welfare budgets. As Moran (2000) puts it, health care has been ‘in the corner of their eye rather than in the centre of their vision’. The reason for this is intriguing and the same question could be asked again: is the design of health care and social care the same in a country? Jensen (2008) answered no to this question and argued that health care diverges from other fields by not having been translated into ideology. This result indicates that general conclusions about the welfare state are difficult to draw, as the policy designs will differ for health and social care. Contrary to this study, Jensen uses statistical cluster techniques and his answer is therefore not necessarily applicable. That health care is one of the welfare needs of this target group goes without saying. It will be investigated whether Jensen’s results holds also for a qualitative analysis.

Third, the welfare literature primarily treats *temporary* support, but does not consider that much of today’s policy is developed to meet *persistent* needs. Even if there are some exceptions, the welfare policies that are the focus of many studies are concerned with support that is part of a passing risk, foremost an inability to work because of unemployment, illness or children. This is true for the work of both Esping-Andersen and his opponents. It must also be said that more long-lasting support is taken into account, such as needs based on old age (pensions and elderly care). However, limited attention has been given to groups that have needs that may last throughout an adult lifetime, that is, *disabilities*. The policy features are not obviously the same for such a political commitment. Mental disorders and disabilities occur at different ages, but many of the most serious conditions – such as psychoses or bipolarity – appear in a life stage that is crucial for establishing important paths for the coming years, namely, building a family, continuing to higher education and starting a professional career. This means that, in many cases, people will stay dependent on welfare support for the major part of their life. What is more, the needs will considerably differ between individuals and over time.

Fourth and last, much of the welfare literature does not consider the fact that the ‘state’ hides *a complex system of public agents*, on both a

horizontal and vertical level. In other words, the fact that a nation consists of a number of local governments and administrations is mostly ignored. Instead, the state is treated as a holistic entity and the welfare mix in focus stays within a discussion on public versus private provision. Disregarding the mix of public actors seems problematic, as it is well known that a large number of the welfare responsibilities have become decentralised, and that for those that are centralised, there is a multitude of central and distributed agents. As an effect, the 'welfare state' is a patchwork of parallel agents, sometimes with incompatible interests. Not only does this affect the possibility of policy design, but as Rauch (2005) has shown, implementation. As this target group is a potential user of a large variety of services and transfers, it is also a potential target group for a myriad of agents that should bring this feature and its consequences to the light.

To summarise, using this target group as a case of welfare policy allows investigation of several central issues that are of interest for welfare policy studies in general. It will also shed light on two areas that are central welfare areas, but little studied as such: health and disability. Hence, I will look at the welfare state from another angle, which furthermore permits studying a group at risk of marginalisation. I will also argue that the welfare literature gives little guidance on how to study policy design. Therefore, this will also be the grounds for a wider argument on how to study and understand national welfare systems. It is, in this respect, an examination of the regime theory's usefulness in a contemporary welfare context.

Relation to earlier research

This study may be positioned in two ways: as a study on welfare and/or as a study on mental health policy. The intention is to interest readers belonging to either perspective by presenting a discussion on theoretical, as well as empirical, findings. As for the comparative approach, this study should be related to the welfare literature presented here, but centrally, that in chapter two. There are numerous examples of research that contain an attempt at 'welfare modelling', and this study aims to contribute

to that academic discourse. Earlier research has presented models that are supposed to help find distinct differences between national welfare policies. This study uses these theories as a framework for understanding policies around specific target groups. Comparable attempts have been made, by for example, Anttonen and colleagues (2003) when studying child and elderly care, Sainsbury (2006) in a study on immigrants and Lewis (1997) when focusing on lone mothers. The two latter studies share my attempt to view the welfare state from the perspective of a marginalised group. The resemblance of the study designs goes no further, as none of the authors provide a tool for analysis that I have found applicable.

A more common design is to compare one or several national policy areas as was done by Esping-Andersen. That study, then, often gives the illusion of comparing welfare states, instead of comparing examples of welfare policy. This is, for example, what is done in the recently published *The Handbook of European Welfare Systems* (Schubert et al. 2009). These comparisons often have very limited empirical ambitions. They are also most often occupied with quantitative data on expenditure levels. By contrast, my aim is to illustrate the kinds of welfare policies that have been directed towards a specific group of citizens by discussing the character – the quality – of these policies. I am not interested in which country spends the most, but rather in how the policy content differs and the consequences that may be expected for the users.

Even if it is reasonable to maintain that mental health has not been the focus of many studies within the social sciences, there are, of course, important examples of research that this thesis should be related to. When it comes to comparative studies, Simon Goodwin's *Comparative Mental Health Policy* (1997) must be mentioned. Goodwin describes and discusses how some countries have travelled from institutional to community care, that is, from mental hospitals to outpatient health and social services. Sweden, France and England are among the countries considered. An important part of his study is dedicated to the analysis of why the mental hospitals were left behind, which is not at all the focus of this thesis. However connected to the regime theory in some sections, the study does not try to categorise the type of existing support. Instead, the

author points to developmental traits that are shared by the countries once depicted as adhering to different regimes. The comparative findings are summarised in a table that is reproduced below.

Table 1. Example of comparative mental health policy

Model	Onset	Pace	Style
Liberal (e.g. England)	Early	Fast	Emphasis upon rehabilitation. Poor quality of long-term support services.
Conservative (e.g. France)	Late	Slow	Emphasis upon maintaining the status quo. Minimum state provision based on the principle of subsidiarity.
Social democratic (e.g. Sweden)	Late	Fast	Emphasis upon social rights. Good-quality services.

Source: Goodwin (1997:112)

Indeed, as the table shows, even though interesting findings on differences between Sweden, France and England are presented, scarce information is given about existing transfers and services. Furthermore, the latest time captured by the data is the early 1990s. Consequently, my study does not really overlap Goodwin’s book in aim, content or period of time. My ambition is to investigate the design of the contemporary welfare policies targeted at this group.

There are also examples of literature with a European comparative analysis, though without a theoretical welfare state perspective, such as Ramon (1996) or Knapp and colleagues (2007). Both are useful as descriptions of general trends and issues within psychiatry and mental health, but do not provide discussions on national variation. The content of the present study may also seem close to national studies on mental health reforms such as Urban Markström’s dissertation (2003), or the work by Lindqvist and colleagues (Lindqvist & Hetzler 2004; Lindqvist 2007; Lindqvist et al. 2010). Nevertheless, these studies are concerned

with mental health policy as a medical, historical or organisational matter, which leads the analysis in quite other directions than a welfare state context. This would also be true if relating this study to most research on comparable target groups, such as policies for other disability groups. One example would be the literature on mental retardation and the Swedish disability reform (e.g. Tideman 2000; Gynnerstedt 2004; Bengtsson 2005). Even for these examples, which are explicitly studied as cases of welfare policy, the analysis is concentrated on other types of empirical and theoretical questions.

Empirical limits

As should be evident by now, this study is limited to one area of welfare, mental health policy, and a number of countries where this policy is present. The selection of countries will be further discussed in the following chapter, but is based on theoretical representation. Further limitations have been necessary and will be treated here.

First, there is a limitation in *time* as the primary focus is on present policies. At the start of this project, there was an aim to study the reform of mental health policies. The intention was then, not only to analyse the contemporary support, but also to investigate at what pace it had developed, through what forces, etc. However, this was not possible to realise, as it would have been too time consuming to treat three countries and five decades, and because it would have been too difficult to reconstruct the policies of these periods – it proved to be challenging enough to grasp the contemporary situation.

Second, there is a limitation in political *level*, as primarily *national* documents have been investigated. Even if local and regional governments are concerned with mental health policy – and their importance will be highlighted – it is also a national question, as the national level is responsible for legislation, planning and evaluation, and for drawing the lines of its future. What more is, England has been chosen as the level of interest and not the United Kingdom. This is because even though the UK is not a federation; it contains four countries within the state: England, Wales, Scotland and Northern Ireland. Mental health policy will differ in

these countries, but there are also some common policies. While Wales, Scotland and Northern Ireland have local governments (though the local government of Belfast has been suspended at several times because of internal conflict), England does not have a special government – instead, the British government in London governs also over England. Hence, by choosing only England as the level of research, the Scottish, Welsh and Irish cases were excluded. It is the policies of the British (and also English) parliament that are referred to. As 80 percent of the British population lives in England, the mental health policy in place for the majority of the British people will nevertheless be covered.

Third, there is a limitation in which *parts* of the policy area are studied. Psychiatry is divided into child and adolescent psychiatry, general psychiatry and forensic psychiatry. This study is limited to policies directed to the general, adult population aged 18–65. Consequently, children and the elderly are left out, as they evoke somewhat different questions of welfare. The same is true for forensic care, that is, psychiatric care within the prisons. Also, intellectual disability (mental retardation¹) has been left out, as it is quite different from other mental disorders, though it is included in the international diagnostic manual (DSM-IV) and shares a history of mental hospitals. However, those with mental retardation are no longer a patient group primarily receiving psychiatric care (unless diagnosed with other psychiatric conditions). A final exclusion concerns drug addiction, which also is generally separated from psychiatry at large. In Sweden people addicted to drugs are not even primarily treated as a patient group, and definitely not as a disability group.

The use of central concepts

The ways of describing phenomena vary over time. This is true also for this field, revealing the surrounding normative thinking. I will here try to give a background to the many concepts fluctuating in the literature and political documents, as well as my use of them. On the one hand, this

¹ In Swedish, *utvecklingsstörning*; in French, *handicap mental*, *déficience mentale*, *retard mental*.

concerns concepts connected to mental health, on the other, concepts of the welfare literature or social science in general.

What was earlier called ‘madness’, ‘lunacy’ or ‘insanity’ later became known as mental ‘illness’ or ‘disease’ or mental or behavioural ‘disorder’. These latter medical terms are still used in public documents, but also the following: ‘mental health’, ‘mental ill health’, ‘mental disability’ and ‘mental problems’.² It is not easy to distinguish between these concepts, and they seem sometimes to catch the same phenomenon, sometimes not. A reinforcing ‘severe’ is also occasionally added. Often, there is no explicit definition of the concept used, or consistency, which further underlines the confusion. Both medical and social concepts connected to health can be traced to an international attempt at classification made by the World Health Organisation (WHO), which has been implemented in many parts of the world.³ In these documents, *disease* is described as a strictly medical/biological concept, while *illness* is described to be a culturally and subjectively bound definition; that is, even if diseases could be observed in different societies according to a diagnostic instrument, they would not always be perceived as illnesses. In the same way, *health* is often understood as a relative concept. Thus, health is not the absence of illness, but the ‘state of complete physical, mental and social well-being’ according to the old WHO definition; a definition that is sometimes criticised for being so utopian that few people in reality could be considered to experience health.

It is also delicate to distinguish between impairment, handicap and disability (see, for example, Grönvik 2007 for a recent study on the defi-

² In Swedish, *vansinne, sinnesjukdom, (allvarlig) psykisk sjukdom, (allvarlig) psykisk störning, psykiskt tillstånd, psykisk hälsa, psykisk ohälsa, psykiskt funktionshinder, psykiska problem*. In French, *maladie mentale, santé mentale, troubles mentaux ou psychiques, handicap psychique*.

³ This includes i) the International Statistical Classification of Diseases and Related Health Problems (ICD), a WHO classification since 1948, latest version from 1990; ii) the International Classification of Impairment, Disability and Handicap (ICIDH), from 1980; and iii) the International Classification of Functioning, Disability and Health (ICF), from 2001 that replaced the ICIDH. They are published in English, French and a number of other languages, though not Swedish. However, there are Swedish translations published by the National Board of Health and Welfare (in 1997 for ICD and 2003 for ICF).

nitions). The WHO classification system ICIDH/ICF is intended to describe consequences of injuries and chronic diseases. These consequences are called impairments and can result in handicaps. The impairment is thus connected to the individual's functional limits, while the handicap is connected to the environment, or the situation. The impairment does not necessarily produce a handicap: an eye disease may cause a visual impairment, which will become a handicap if the impairment stops the person from functioning, but not if the handicap can be avoided by using glasses. It may also be avoided if the society is adapted to all kinds of (non)capacities, or, of course, if one is not in need of better vision than the eyes are capable of. Hence, the problem is not the impairment as such – or the individual – but the socially constructed barriers that produce the handicap by adapting the society to able-bodied citizens (Oliver 1990). This puts the focus on the support that can prevent impairments from becoming handicaps, as well as on the fact that some impairments will be recognised by the welfare state and made part of handicap policies, while others will not. A third term is disability, which, confusingly enough, has been used as a synonym for both impairment and handicap. However, in recent years, handicap is not frequently used and disability seems to have replaced it.

While the medical concepts of disease, disorder and illness are generally understood as conditions that can be treated and cured, impairments have been understood as lifelong. If a medical condition is not curable, it is called 'chronic'. Some of the mental diagnoses have earlier been understood as chronic, but have more optimistic prognoses today. Schizophrenia is one such example. Today, schizophrenia is understood to be chronic for some individuals, while others recover. Whether a diagnosis is supposed to be persistent or not is, of course, a crucial difference to those concerned. For this reason, there has been a resistance to changing concepts – changing vocabulary from medical terms to a disability vocabulary could be understood as an acceptance of viewing them as chronic. But others have argued that disability could be viewed as dynamic as well as static; how the functions will develop depends on a number of factors. As much as schizophrenia is a disorder that may reach an end, so are its consequences (even if the disorder persists). It is also

argued that mental disorders as such show a greater variety compared to disabilities of somatic origin: two persons with the same diagnosis will not necessarily have the same kind of impairment, which is more often the case for disorders that result in physical disabilities (for example, paralysis). This makes mental impairments trickier issues for administrative decision makers and constitutes a quite new way of recognising a disability.

There is also a confusion produced by the legal use of the terms. The Swedish *psykisk störning* – which would be severe mental illness in English (Sandlund 2005:16) – is, for example, the term used for compulsory care or for judging when a person is not legally responsible for her/his criminal acts. However, this term was long used for covering the target group at large.

In many English-speaking documents the term ‘mental health problems’ is used. As this term lacks a definition, it will not be used here. First, it is too general, and second, it is not necessarily connected to psychiatric phenomena. In the following text I will use the terms *disorder* and *disability*. The latter is then understood as a consequence of the first. As a result, a person suffering from a disorder does not necessarily suffer from a disability, but all persons suffering from a disability also suffer from a disorder. For either of the terms, it is generally understood as important to underline that an individual should not be restricted to identify her/himself by the disorder or disability. Hence, an individual should not be described as ‘a psychotic person’ or a ‘mentally disabled person’, but a person with/suffering from psychosis, etc. This choice of description is used in this thesis.⁴ Another common concept that will be found in this text is ‘user’, which is supposed to be a neutral way of defining the individuals using the services. This is a notion that does not differ between service areas, which is the case with terminology belonging to

⁴ However, Oliver (1990:xiii) represents a divergent opinion, arguing that the disability is not an ‘appendage’ but ‘an essential part of the self. In this view it is nonsensical to talk about the person and the disability separately, and consequently, disabled people are demanding acceptance as they are, as disabled people.’ This also seems to be the view of the English disability movement (Ibid.), while the Swedish disability movements and administrations use the ‘appendage’ form.

the professions, such as ‘patients’ or ‘clients’. Furthermore, user is the official vocabulary of the target group itself (the ‘user organisations’).⁵

In 2001, the world health report by WHO was dedicated to mental health, which it defined as follows:

Mental health has been defined variously by scholars from different cultures. Concepts of mental health include subjective well-being, perceived self-efficacy, autonomy, competence, intergenerational dependence, and self-actualization of one’s intellectual and emotional potential, among others. From a cross-cultural perspective, it is nearly impossible to define mental health comprehensively. It is, however, generally agreed that mental health is broader than a lack of mental disorders. (WHO 2001)

Consequently, *mental health policy* have several meanings, but in this study it defines the welfare policies that could be said to have replaced the asylums, that is, transfers and services that are formally directed towards people with mental disorders and disabilities. The policies span from health services to housing, personal support, income compensation and occupation. By contrast, policies are *not* included if they only intend to improve mental health in a more general sense, closer to well-being than to psychiatry, for example, encouraging a friendly climate at work, creating green areas in cities, etc.

The very use of *policy* may, as well, cause confusion, not least when read in different national contexts. In French, there is no comparable term. In Swedish, policy is not always defined, but generally used for a specific programme, for example, the non-discrimination policy of a university. In this study, policy is used as a synonym for transfers and services, that is, for summarising the formal actions taken at the political level to address an identified problem. The term is found both in singular and plural forms, when searching for the policies (specific transfers and services) that could be said to constitute what is summarised as mental

⁵ Yet, one may notice that some groups prefer more radical vocabulary. That is the case in England where ‘survivors’ is sometimes employed, developed around the 1950s when people had ‘survived’ what they experienced as not only oppressive psychiatric treatment but also the prison-like asylums.

health policy (the sum of transfers and services). This should not be a controversial use of the term.

Furthermore, the combinations *policy design* and *policy logic* are used to analyse how these programmes are constructed. These concepts are central and will be further treated in chapter two. The policy design of each country is supposed to catch a number of specific and essential elements, for example, entitlement. The concept of policy logic presumes that there is some kind of comprehensive logic behind each design; what is sometimes referred to as an ideology. In my view, policy logic is a more appropriate term than ideology. The policy logic may be interpreted in ideological terms, but also labelled in other ways. The logic reveals the aim and the reasoning behind the design, reflecting values and norms concerning the target group. It reveals the needs that are understood to be legitimate. Even if the feminist researchers Daly and Rake (2003:2, 35) do not use the term policy logic, their argument for a gendered analysis of welfare is comparable; the policy design will reflect and effect national gender relations, but there is not necessarily one consistent and particular ideology to be found in a country. There is more than one kind of logic, and the various logics cannot necessarily be labelled in ideological terms (for example, patriarchal, as well as capitalist, logics, which were their examples). These concepts are used in the literature, but not in a distinct way. One example is Ingram and Schneider (1993), who use numerous combinations – policy design and policy logic, but also policy formulation, policy agenda, policy tools and policy rationales – without really defining their individual meanings or relationships to each other. My use of policy design is identical to the definition made by Schneider and Sidney (2009:104), where they refer to it as ‘the content of policy’ or ‘an architecture – a text and set of practices that can be observed’.

The same confusion as was noticed for policy may occur for *welfare*. This concept is sometimes given a very limited meaning, not least in an American or Anglo-Saxon context, including only means-tested assistance or means-tested social security benefits paid to poor households or lone mothers and their children. In other cases, welfare is used as a synonym for the welfare state or for social services (Deacon 2002:5). In Sweden, welfare and the welfare state are widely used concepts both in

academic and general contexts. The meaning is, then, contrary to the Anglo-Saxon use, very open, applied to all areas that include some kind of care or that are connected to education or the labour market. In France, there is not a specific term for welfare and the concept used for the welfare state is not part of common language.⁶

The blurriness of the welfare concept is also what has caused problems in the discussion on the academic concept the welfare *state* – is the discussion on a welfare study specific for a welfare area or true for welfare policies in general? This is often left untreated, but has consequences for the theorisation of welfare and welfare states. In this thesis, I argue that mental health policy should be treated as an example of welfare in the broader – and perhaps more Swedish – meaning of the word. Consequently, I have added such support, which is often defined as (personal) *social services*, *social care*. These concepts are equally problematic and cause the same kind of confusion (see, for example, Anttonen & Sipilä 1996). Consequently, there is an attempt to avoid any general use of these concepts. Instead, the kind of support is more specified than these concepts allow. This will be further outlined in the next chapter.

Realisation of the study

Certainly, there are both advantages and challenges involved in the comparative design. The means of meeting these are discussed here, but also in the final chapter.

The pros and cons of comparison

The Handbook of European Welfare Systems introduces readers to the notion of comparison with the following words:

Looking from the outside, comparing world regions, the most significant characteristic of the European Union (EU) is the high level of welfare and social benefits. Viewed from within,

⁶ *Välfärd*, *välfärdspolitik*, *välfärdsstat* in Swedish. *État-providence* in French. The French translation of welfare would be *bien-être*, which is closer to well-being and not in a comparable manner used in combination with *politique*.

the central characteristic is of course the plurality, the high level of differentiation and variance between the member states. This distinctive feature – plurality and variance – particularly applies also to the welfare systems in the states of the EU. (Schubert et al. 2009:3)

As the authors point out, comparison is about making sense of plurality and variance. Generally, comparisons are supposed to add perspectives that would not be noticed if the case were not mirrored against alternatives – the comparison opens the observer’s eyes to new aspects, or ‘allows one to depart from parochial policy analysis’, as Behrendt (2002:6) puts it. The design of this thesis may be categorised as a *focused comparison*, that is, a qualitative study of few cases and a specific area of interest (Hague & Harrop 2004:80). The comparative approach can be seen ‘as a means of separating out the general from the specific: what applies to all countries and what to only one’ (Doling 1999:64). This is important for understanding the policy area as such, not least in an internationalised era where convergence, or what is sometimes called policy transfer, could be expected (see, for example, Dolowicz & Marsh 1996). Thus,

[t]he advantages of a successful comparative approach are obvious. We can hope to understand much more about the development of the national welfare state if we see how welfare states have developed in other, broadly similar, countries and if we can identify common trends or divergences across countries. A comparative approach can help us to question aspects of our own national welfare states which we may have taken for granted. Similarly, a comparative approach may help to explain particular developments which may otherwise appear anomalous. (Cousins 2005:9)

Out of this optimism and interest, different academic genres have evolved, such as comparative politics, comparative social/health policy, etc. In some countries, these paths have developed into university departments. There are also a great number of scientific journals with a specific comparative focus. In other words, comparison is a treasured and prospering research design, or if one prefers, field of study. These re-

searchers sometimes describe the comparative study as the 'principal method' of political science, since it is as close to an experiment as a social scientist often gets; the experiment being the ultimate method of realising a theoretical test or development (Peters 1998:1). Yet, it certainly presents numerous challenges. Such is the experience of this study. Even if I argue that the result would have been put in a different light had I not contrasted the Swedish case to other nations, the comparison certainly has added difficulties to the analysis that would have been avoided by a (single) case study.

The aim of a comparative study is to cover the same phenomena in all cases, but the reliability problems of a comparative study are well known. If countries measure the same variables at all, they are still likely to define the variables differently. Here, international databases are of some use, such as the WHO European Health for All Database for statistics on quantitative data such as the number of inpatient beds. Even if the WHO also struggles with this kind of problem, its statistics are generally accepted as 'good enough' for comparisons and the differences are scrutinised and documented.

Researchers have to live with these kinds of imperfections, and consequently, should remain alert to their existence and humble in our conclusions. This is true not least when the cases represent different nations and different languages, but will be evident also when treating one context over time. How is it, for example, possible to know that the concepts cover the same phenomenon and to avoid what Sartori (1970) called the 'travelling' problem (cf. Adcock and Collier 2001)? One evident solution is to concretise as much as possible the concepts used. In this thesis project, I have tried not to rely on the given concepts used in the documents, but to create my own. What I have been looking for is not only what the nations themselves call a 'mental health policy', but also what I define as such. As it is not always clear what is meant by different kinds of notions in the documents, it has been a sometimes confusing assignment. It should also be said that international databases and comparisons were of insignificant use, as my interest came to be directed more to social than to health care-related issues. During the research process it became in-

creasingly evident that statistics concerning social services (social care) are still mostly undeveloped, at both international and national levels.

Much literature that is supposed to be comparative is, in fact, juxtaposed descriptions that are never compared – they may be highly interesting as separate cases, but comparison is omitted and not even possible for the reader to accomplish on her own, as the same aspects are not treated for the different cases. This is especially true for anthologies, but also for single authors (Doling 1999:61f). That is hopefully not the case in this work. Even if the cases cannot be depicted in a manner that allows for comparison of every single aspect, they should be presented according to the same structure and with a continual comparative analysis. For this reason, the empirical chapters do not treat separate States, but areas of support.

Generally, much of the comparative work is accomplished by research groups, where each participant is responsible for their own country. This provides the research with important knowledge on context and access; it has obvious advantages and is probably the most ‘cost-efficient’ working method. Nevertheless, it opens up the same kinds of risks when it comes to reliability and validity. The advantage of conducting a study by oneself is that one keeps control over the material, and perhaps, that it becomes easier to keep the structure strict for each studied case. Mangan (2004:310f) refers to this as the ‘safari method’ and lists a number of risks. There are dangers that the technique descends into the ‘touristic’, reliant on stereotypes, engaging only with respondents who reflect official discourse and naïve to the different values of professional cultures that affect policy implementation styles.

During this work, I have experienced the difficulties both of overcoming gaps of knowledge connected to foreign contexts, and of being treated as a naïve tourist. The mission of outlining the mental health policies of each country, especially those outside my native country, was more difficult than I could have imagined, which will be further discussed in the concluding chapter. As will be outlined there, this has to do with many things, but not least the fact that few policies are explicitly targeted at this group and that the rights of this group are seldom described and often not well known, even by the authorities involved. With the aim of giving

as correct a picture as possible, I have consulted a multitude of documents – everything available – and discussed my results with as many researchers and involved actors as possible (see references and appendix).

Sources of information

The mental health policies have been addressed through a study of different kinds of sources. The aim was both to understand how national governments and national agencies have approached the field, and to describe and analyse the policies that have been adopted.

Fieldwork of about five months was conducted in each of the three countries. In France (2004), the most important sources of information were the libraries⁷ and official data banks⁸ of the ministries of health and social issues, *Ministère de la santé, de la famille et des personnes handicapées* and *Ministère des affaires sociales, du travail et de la solidarité*, as well as the data bank of *La documentation française*,⁹ also belonging to the French administration. The ministries' publication *Études et résultats* from the *Direction de la recherche, des études, de l'évaluation et des statistiques* was useful (referred to in the thesis as Drees). In England (2006), the library of the London School of Economics, which is one of the largest social science libraries in the world, was of great use, and also that of the Institute of Psychiatry at King's College. These libraries gave access both to parliamentary and academic literature. In Sweden, most literature was available at the university and at public administrations. In Sweden, (2007), laws, commission reports (SOU) and reports from the National board of Health and Welfare (*Socialstyrelsen*) constituted main sources of information.

Public websites were used in all countries throughout the entire study period, collecting information and statistics from the social insurance agencies, ministries, administrations and other relevant institutions. All three countries use the Internet to disseminate information directed

⁷ *Centre de Ressources Documentaires Multimedia*, CRDM.

⁸ <http://www.sante.gouv.fr>.

⁹ <http://www.ladocfrancaise.gouv.fr>.

towards their citizens. These websites are very useful for finding updated figures, and also for instructions on how the policies actually work. Examples of websites of public information on these issues are *direct.gov.uk* and *service-public.fr*; there is no comparable comprehensive Swedish site.¹⁰

The published material under study can be divided into i) public documents such as government proposals, reports and evaluations by the national administrations or other political authorities; ii) research articles and books on mental health policy; and iii) publications from other actors within the field such as user, family or voluntary organisations. Through these sources I have tried to visualise the broad policy development and the present welfare policies in each nation. By contrast, I have not conducted any investigations of my own to collect new data, such as questionnaires aimed at the administrations, to create statistics that are not available. Instead, the study is limited to what can be said through the existent available sources. However, I was in contact with several administrations, researchers and interest organisations to verify that the most relevant information had been found and that it was treated correctly (see appendix).

Chapter plan

The theoretical framework that was used for this study is developed in chapter two. This includes a discussion on the classical welfare state regime theory and its critics. I will also widen the theoretical perspective to aspects that the regime theory leaves out, namely the fact that welfare is provided not only by a public-private mix of agents, but also by a variation of public agents. These welfare aspects together lay the groundwork for an analytical framework (Table 3), which has guided the study.

¹⁰ If no other source is given in the text, facts on entitlement, benefit levels etc. come from these public websites as this is where the most updated information is published. For Sweden, benefit levels are generally available at *forsakringskassan.se* (the Swedish social insurance agency), national governments home pages or *skl.se* (Swedish Association of Local Authorities and Regions).

Chapter three presents a background both to the empirical field and to the public administration of the three countries. This chapter is intended to guide the reader into the following analysis.

Five areas have been chosen as representing mental health policy: treatment, housing, occupation, financial support and personal support. These are the themes of the following, empirical part. Treatment and financial support are dedicated separate chapters, while housing, occupation and personal support are treated under the title of 'social support'. The empirical chapters are outlined country by country with a final concluding and comparative discussion.

Finally, chapter seven sums up the results of the analyses and draws conclusions as to whether 'three models of mental health policy' were found. To what extent did the theoretical framework help to make sense of these policies? The results will be used for a more general discussion on the explanations that seems applicable to an understanding of how national welfare policies are designed and the analytical tools that are needed for this search.

Chapter 2

Comparing welfare policies and nations

This chapter aims at outlining the theoretical framing of the study. In brief terms, I will discuss the statements of earlier welfare research and thereby motivate the selection of countries as well as the analytical tool that was developed to maintain the empirical exploration.

Categorisation of welfare policies

Categorisation of welfare policies into models, systems or regimes have been widely used in the social sciences. Researchers have noticed differences not only when it comes to expenditure levels – comparing national budgets – but also concerning the aim and content of the policies designed to improve national welfare. For the most part, this research has been concerned with policies designed to cover for the risks of not being able to participate in the labour market; risks in terms of age, illness and injuries that lead to programmes regulating pensions, sick-leaves and unemployment benefits.

As shown by Abrahamson (1999), the ‘welfare modelling business’ can be traced back to the early ideas of Wilensky and Lebaux (1958) as well as to Titmuss (e.g. 1968, 1974). Wilensky and Lebaux differentiated between *residual* and *universal* models of welfare, representing two opposing poles where the state was the welfare provider of last or of first resort. The analysis included a view that the universal welfare state was the modern version towards which residual states would transfer through

industrialisation. Titmuss, on the other hand, make a distinction between *marginal* (cf. residual), *institutional-redistributive* (cf. universal) and *achievement-performance* models. While Lebaux and Wilensky had noticed that states were more or less committed to social policies, Titmuss also showed that social policies were sometimes connected to professional status, that is, based on 'merit' and not only on citizenship, needs and means. While the residual group was connected to the Anglo-Saxon countries (and their poor laws) and the achievement-by-performance category to continental Europe, the example of the generous welfare state was taken from outside the western world referring to a cooperation in Tanzania. Wilensky and Lebaux referred to what they noticed within the US.

Another traditional distinction is sometimes made between systems inspired by the German chancellor Bismarck, and those with roots in the ideas of the English politician and economist Lord Beveridge (e.g. Bonoli 1997). Bismarck introduced the first obligatory social insurance system in Germany in the late 1800s, aiming at protecting the poorest workers, and financed by charges paid by the employers and employees (cf. the achieving by performance logic). Beveridge, on the other hand, set out never wholly realised ideas of a general welfare system in the 1940s in Great Britain while heading the national investigation on the social insurance system (cf. the universal model). In parallel to uniform and general social benefits and contributions, there would be a full employment policy and a national health system free of charge for the patients. This dualism is used not least when comparing health care (Blomqvist 2002; Burau & Blank 2006), but also in comparisons of social policies such as pensions (Bonoli & Palier 1998) or the social insurance system at large (Palier 2000).

Three worlds of welfare...

The most debated contemporary attempt to a comparatively categorise states on the basis of their welfare policies is Esping-Andersen's work from 1990. In what has become a 'classic', the author claims to find 'three worlds of welfare capitalism', symbolising different policy logics originat-

ing from different politico-historical backgrounds. The study was built on Titmuss' ideas and the aim was to compare countries on other grounds than summarising social expenditure. Contrary to for example Wilensky, he argued that the welfare feature is not just a natural consequence of economic growth, but dependent on ideological governance. In other words: social policies differed between different industrial countries as an effect of political context. Three interactive 'historical forces' were used as explanation for the development of different welfare models (the power resources theory):

[F]irst, the pattern of working-class political formation and, second, political coalition-building in the transition from a rural economy to a middle-class society. The question of political coalition-formation is decisive. Third, past reforms have contributed decisively to the institutionalization of class preferences and political behaviour. (Esping-Andersen 1990:32)

Esping-Andersen also argues against the common use within comparative social policy of measuring welfare as social expenditure. Consequently, he turned focus towards an understanding of the characteristics of welfare policies, that is, labour market policies. *Old-age pensions*, *sickness benefits*, and *unemployment insurance* were selected as the welfare areas to compare on the grounds of their *accessibility*, *equalising effects*, and *attainability*: the conditions for being included (contributions, means testing, working experience), how and when they are distributed (waiting days, duration), the kind of compensation (how much do they differ from normal earnings), the real spread (the percentage of the relevant population covered). This was quantified clustering the 18 studied countries in Western Europe, North America and the Antipodes in what he called *liberal*, *conservative* and *social democratic* directions; what Titmuss had once labelled the institutional-redistributive, the residual and the performance-achievement models. These regime types represent different ways of organising welfare policy around the state, market and the family and different choices when it comes to who should benefit from welfare, and how much.

In one cluster we find the 'liberal' welfare state, in which means-tested assistance, modest universal transfers, or modest social-insurance plans predominate. Benefits cater mainly to a clientele of low-income, usually working-class, state dependents. In this model, the progress of social reform has been severely circumscribed by traditional, liberal work-ethic norms: it is one where the limits of welfare equal the marginal propensity to opt for welfare instead of work. Entitlement rules are therefore strict and often associated with stigma; benefits are typically modest. In turn, the state encourages the market, either passively – by guaranteeing only a minimum – or actively – by subsidizing private welfare schemes. (p. 26f)

This means that the policy design is concentrated to selectivity and low benefit structures, as a consequence of a logic where welfare is equal to poverty alleviation and work is always preferable to benefits. Welfare policies are then only dedicated to the most needy groups, not to the general population. The state offers a safety net of last resort that should be used by as few as possible. Empirical examples of the liberal model were to be found in the Anglo-Saxon world: the US, Canada and Australia were pointed out as 'archetypes'. However, there is an uncertainty whether the ideal types are built on the empirical cases or not.

The second, conservative, model was described as follows:

Here, the historical corporatist-statist legacy was upgraded to cater to the new 'post-industrial' class structure. In these conservative and strongly 'corporatist' welfare states, the liberal obsession with market efficiency and commodification was never preeminent and, as such, the granting of social rights was hardly ever a seriously contested issue. What predominated was the preservation of status differentials; rights, therefore, were attached to class and status. This corporatism was subsumed under a state edifice perfectly ready to displace the market as a provider of welfare; hence, private insurance and occupational fringe benefits play a truly marginal role. On the other hand, the state's emphasis on upholding status differences means that its redistributive impact is negligible. (p.27)

The main characteristics of design and logic in this model thus emanate from work. The welfare support is an outcome of your employment situation, your status. This regime type was also shaped by the Church and the family. The state interferes only when these actors have failed. Austria, France, Germany and Italy were understood to belong to this cluster.

The third, and clearly smallest, regime-cluster is composed of those countries in which the principles of universalism and de-commodification of social rights were extended also to the new middle classes. We may call it the 'social democratic' regime type since, in these nations, social democracy was clearly the dominant force behind social reform. Rather than tolerate a dualism between state and market, between working class and middle class, the social democrats pursued a welfare state that would promote an equality of the highest standards, not an equality of minimal needs as was pursued elsewhere. This implied, first, that services and benefits be upgraded to levels commensurate with even the most discriminating tastes of the new middle classes; and second, that equality be furnished by guaranteeing workers full participation in the quality of rights enjoyed by the better-off./.../All benefit; all are dependent; and all will presumably feel obliged to pay. (p. 27f)

Accordingly, the policy design is universality and generosity according to logics of a wide-spread political commitment and welfare as a general social right rather than poverty alleviation, or the outcome of an employment contract. The closest empirical example of this kind of welfare was found in the Scandinavian countries, but also in the Netherlands. Yet, for all models, Esping-Andersen made clear that there were no 'pure cases'. Instead, most countries showed traits of all three models, but to a higher or lower degree (which has not prevented a tendency to view countries as more or less pure).

The three regime types were analysed in terms of what was called *de-commodification* and *stratification*, that is, the policy consequences for individual freedom read as independency from one's market value, and from social status. According to Esping-Andersen, the very idea of a welfare state should be about guaranteeing social rights to its citizens through the state, the market and the family. Social scientists should

study how well different countries, or welfare regimes, succeeded in this aim.

The outstanding criterion for social rights must be the degree to which they permit people to make their living standards independent of pure market forces. It is in this sense that social rights diminish citizens' status as 'commodities'. Social stratification is part and parcel of the welfare states. Social policy is supposed to address problems of stratification, but it also produces it./.../The really neglected issue is the welfare state as a stratification system in its own right. (p. 3f)

Stratification was measured both in terms of income levels and in terms of the 'structuring of social citizenship' (p. 57). The thesis was that a model with social policies only as a 'safety net of last resort' will be associated with shame and the individuals would consequently not be de-commodified, as with the old politics of poor relief. Hence, the system itself can be highly stratifying in creating or intensifying differences between parts of the population. The best de-commodifying conditions and the least stratifying effects were connected to the social democratic model, while the liberal model represented the least favourable situation. The conservative model was mainly viewed as problematic in terms of stratification, as it is built on several profession-based systems that preserve differences between classes.

... or more, or different?

In the aftermath of Esping-Andersen's 1990 study, other scholars have discussed, criticised and continued the modelling. This discussion raises different kinds of questions. First, did Esping-Andersen treat his material correctly; do the clusters really exist when studying the policy areas in these countries? Second, do other countries (that were left out in the Esping-Andersen analysis) fit the models? Third, are the results possible to generalise to other welfare policy areas; what happens if focus is turned to the non-working population or policies concerned with other risks than not being able to work? Perhaps all countries bear traits of all models; it is only a question of what policy area we are studying.

The answer to the first two questions has mainly been in favour of Esping-Andersen. Even if other researchers have suggested sub-groups within the liberal and conservative clusters or entirely new models (see for example Leibfried 1992; Deacon 1993; Ferrera 1996; Korpi & Palme 1998), he seems to have captured something essential. The most debated issue for the European countries concerns the relevance of grouping the countries of continental Europe with those of Southern Europe in a conservative cluster. Although it has been questioned whether the systems of, say, Germany and France are similar enough to speak of a common model, the systems of Italy, Greece, Spain and Portugal seem to be even more divergent. Consequently, a fourth model has been suggested for those countries where the welfare state is less visible both as a policy and as an implemented system. Leibfried named it the 'latin rim' type of welfare state; Ferrera simply the 'southern model'.

In parallel, Castles and Mitchell (1993) have separated countries within the liberal cluster, pointing to more and less 'radical' groupings. They find that Esping-Andersen has ignored the fact that even if the Anglo-Saxon countries all have low levels of transfer expenditure, they differ in their average benefit equality levels. As a consequence, with highly equalising levels of their transfers (though reaching a more limited number of recipients), Australia, New Zealand and the UK are more radical than their North American partners. It should also be said that Esping-Andersen – along with other researchers – made it hard to distinguish between empirical findings and theoretical conclusions. Thus, it is difficult to separate findings about Swedish (or other State-specific) policies and the ideal types they are supposed to represent (Schubert et al. 2009: 6).

Another question concerns the possibility of using the model on other continents, for example Asian countries (Gould 1993; Kwon 1997; Croissant 2004) or former communist states (Deacon 1993). Here, it has been argued that both the historical context and the empirical solutions are too different from the European experience. Yet, in the European studies, even if playing with alternative models of clusters, we end up quite close to the 'three worlds'. And even if the clusters internally show important

differences, they seem to be similar enough to stand out in relation to the other clusters.

Yet, the third question treating the external validity is perhaps the most interesting and the most difficult. Here, feminist researchers have made a considerable contribution (see for example Lewis 1992; Orloff 1993; Anttonen & Sipilä 1996; Ditch et al. 1998; Gornick 1999; Kilkey & Bradshaw 1999; Meyers et al. 1999; Sainsbury 1999; Daly & Rake 2003). Several important points have been made. One is that Esping-Andersen, by not gendering the analysis, ignored that access to work is also a stratifying component of the welfare state. The Esping-Andersen analysis says nothing about those who are not positioned in the labour market; neither does it include a discussion on the encouraging and discouraging features for equal labour market participation that are embedded in the welfare states. Thus, discussing de-commodification is not relevant for a group that has not yet been commodified, the feminists argued. In fact, other policies than income security seemed to be important when understanding the relationship between the welfare state and its citizens. Feminist authors found it

problematic that comparative research on the welfare state is based on a narrow understanding of social rights and citizenship. Thus, Esping-Andersen's theory does not really provide the tools that we need for the analysis of other types of relations of subordination and dependence. As far as women are concerned, crucial social rights include those that make them less dependent on the family and marriage/.../. (Anttonen & Sipilä 1996: 89)

Furthermore, they argued, by not deconstructing the 'family' concept, it was not made clear that family actually means women. Whether we talk of care for children, the elderly or the disabled, of formal or informal care, women stay providers. Hence, much attention has in these studies been paid to policies that relate to care and that enable women to enter the labour market, that is, to become 'breadwinners'.

Esping-Andersen later (1999: 51) answered to this critique by adapting a third concept: de-familialisation. He agreed that the welfare states in

this respect differed in their capacity of de-commodification and stratification, but also of their ability to ‘unburden the household and diminish individuals’ welfare dependency on kinship’. This has brought about a specific debate on whether welfare studies should be concerned with cash transfers – traditionally in focus – or services, which seem central in this respect. Feminists, among others, have suggested an increased interest in the latter (Daly & Lewis 2000).

In conclusion: have the countries stayed clustered in the way Esping-Andersen suggested when others have studied them from this point of view? The answer is both yes and no. The Scandinavian countries, and Sweden in particular, still stand out from the rest even if there is also a literature on the divergences within this group (Ellingseater 1998; Sainsbury 1999; Rauch 2005). The conservative and liberal clusters seem to show a greater complexity in these studies. This is true for example when studying child care and elderly care where countries seem to follow separate logics (e.g. Anttonen & Sipilä 1996; Daly & Rake 2003). On the other hand, if studying health care, most countries seem to follow the same, social democratic, line (e.g. Jensen 2008).

... or no models at all?

Some researchers have answered a definitive ‘no’ to the question on consistency when changing policy area. They see the models as nothing but an ‘illusion’ (Kasza 2002) or an inappropriate simplification (Anttonen et al. 2003). An important point seems to be that when focusing on social services, the regimes fall apart by other reasons than earlier discussed – these policies are more local/regional than national and the whole idea of speaking of national regimes then seems irrelevant (Johansson 2008: 173). The work of Anttonen and colleagues (2003) points in that direction. Their analysis of child and elderly care in Finland, Germany, Japan, the UK and the US found no support for the regime theory. Instead of models, they end up with particularistic and importantly varying logics and programmes in each country that only make sense when taking each specific historical context into account. Actually, their conclusion is not at all encouraging for researchers of comparative social care. Although more

positive in promoting comparative work, Daly and Rake (2003: 161, 167) finish by stating that

[t]here is no ready or easily identifiable grouping of countries that emerges from our work. Patterns emerge on some measures, but disappear from view almost as soon as one switches indicators. [...] Put simply, typologization is ill-suited to deal with the context-rich and complex information necessary for a gender-focused analysis.

A similar conclusion is made by Bazant and Schubert (Schubert et al. 2009: 515) when summing up the welfare systems of 27 EU countries. Analysing the spending, financing, actors and theme of the studied policy areas

shows first that it is possible to identify groups, but that second these groups have not much in common with any well-established welfare cluster, and third vary according to the specific characteristic.

In summarising the results, they conclude that (Ibid.: 533)

The bottom line is that we can definitely not speak of clusters or regimes.

This is a rather unexpected conclusion in a comparative handbook, intensifying the impression that welfare policies are particularistic and nationally varying to such a degree that the search for models is useless, or at least highly naïve.

Also Klitgaard (2007: 465), studying choice reforms in Swedish, American and German schools, found that the studied policies had little to do with regime theory. The hypotheses on social democratic, liberal and conservative ways of using voucher systems showed to have limited empirical evidence.

Reform developments in public schools and beyond in our three countries indicate that welfare regimes are of little relevance to the strategic possibilities and reform capacity of deci-

sion makers in relation to welfare services.[...] And they point to the conclusion that the currently most dominating perspective in comparative welfare state research, the theory of welfare state regimes, apparently has little to say about a crucial aspect of contemporary welfare capitalism, welfare services and public sector reforms.

As a result, Klitgaard suggests other theoretical frameworks to be used when studying welfare policy, namely institutional theories of decision making which would eventually better explain why the seemingly illogical ideological choices were made possible. However, Klitgaard leaves the reader without an analysis where such theories are tested.

The selection of countries

This chapter has argued that when studying comparative welfare policy, it is unavoidable to take Esping-Andersen's regime theory into account. It also intended to show that as much as this theory has formed this comparative field, it has also been contested. To solely expect nations to follow the ideal type characteristics would be ignorant – too many researchers have contested Esping-Andersen's results. Not to expect national variation would be as foolish – few researchers have argued that there are no national differences.

The interesting question, that still demands more case studies, is *how* welfare policy differs, whether these differences follow *national borders*, and whether countries show similar *traits* in a sense that makes it reasonable to talk of models. The design of the present study does not allow a final answer to these questions, but it intends to contribute to the discussion. The three countries were selected on the grounds of being similar enough for allowing a comparison as they are all European unitary countries that have closed down the asylums, but different enough to theoretically expect variation (cf. 'most different systems design').

The first case is Sweden. Even if the social democratic model lacks a pure case, Sweden is often understood as being as close as one gets to the realisation of such designs and logics. Contrary to the other Scandinavian countries, Esping-Andersen (1990: 74) attached few – if any – liberal or

conservative attributes to Sweden. His analysis was based on data from 1980 and much has happened since, but the social democratic feature is nevertheless understood to have consisted in spite of liberalisation and retrenchment waves (Lindbom 2001; Lindbom & Rothstein 2004). Hence, it may still be viewed as a 'critical case' when studying welfare; if social democratic traits are to be found, it should be here.

The second case is France, which is supposed to represent a conservative model. However, as is clear both in Esping-Andersen's version (Ibid.), and in other studies, the French case seems to be mixed. Even if it is closest to the conservative model, it also shows a 'medium' degree of liberalism. Daly and Rake (2003: 159ff), on the other hand suggest that France is rather close to the social democratic model – at least when comparing child-care services (cf. Anttonen & Sipilä 1996). Still, France is generally understood to bear traits of the conservative model and to cluster with countries of continental Europe. In line with this, France is supposed to be heavy on transfers, but lean on services as the family is viewed as the most prominent care provider (cf. Morel 2007). Another, perhaps more 'typical', conservative case would have been Germany. However, Germany is a federal country which would have complicated the analysis already from start.

The third case is England, which will represent the liberal model. Even if the United Kingdom is seldom portrayed as an archetypical liberal case, as is for example the United States, or the total opposite of the Swedish case, it seems to be the 'most likely' liberal case of Europe and it is generally clustered close to the rest of the Anglo-Saxon world. Abrahamson (1999: 404) notices that 'most British scholars seem to have accepted the label of residual or liberal as a characteristic of their welfare regime'. Yet, as with France, and in contrast to Sweden, the British welfare state is described very differently depending on policy area. Health and child care seem to have social democratic traits, whereas social security and elderly care remind of the liberal model (Anttonen & Sipilä 1996; Daly & Rake 2003). In view of the results of Esping-Andersen, an alternative choice of a 'liberal' case would have been Switzerland, but also that is a federal state.

Even when other model labels have been used (or none at all), differences are more commonly found than similarities when comparing these three countries. A number of studies where the three nations are included are summarised in table 2.

Table 2. Some categorisations in the studied literature

Author	Policy focus	Sweden	France	England
Esping-Andersen (1990)	Sick pay, unemployment benefit, pension	Social democratic model	Conservative /corporatist model	Liberal model
Leibfried (1992)	See above	Modern	Institutional	Residual
Lewis (1992)	Parental leave, child care, labour market participation	Weak male bread-winner model	Modified male bread-winner model	Strong male breadwinner model
Castles & Mitchell (1993)	Expenditure, redistribution etc.	Nordic family	Continental family	English-speaking family
Anttonen & Sipilä (1996)	Home help to the elderly, child day care and pre-schools	Abundant services for both children and the elderly	Abundant services for children, but not for the elderly	Abundant services for the elderly, but not for children
Korpi & Palme (1998)	Sick pay, pension	Encompassing model	Corporatist model	Basic security model
Ditch et al (1998)	Child allowances	Middling provision	Generous provision	Middling provision
Kautto (2002)	Expenditure	Service approach model	Service approach model	Service approach model
Blomqvist (2002)	Health care	Beveridge	Bismarck	Beveridge
Daly & Rake (2003)	Female labour market participation, provision of child and elderly care etc.	Distinct and coherent in minimising gender inequalities	Less coherent than Sweden in its gender equality policy, but favourable from a gender perspective	Not an opposing case to Sweden, but less equalising effects
Bambra (2005)	Sick pay, unemployment benefit, pension and health care	Social democratic model	Conservative (perhaps a subgroup as high-scoring on health care)	Liberal (perhaps a subgroup as high-scoring on health care)

As shown in the table, empirical conclusions have demonstrated that it is reasonable to expect variation in policy outcome when comparing these three nations, but it is less evident to develop hypotheses on where the differences will lie. Sometimes Sweden and England are understood to resemble each other; sometimes Sweden and France. Still, they are mostly regarded as being different, and placing them in the same 'box' is rare, Kautto (2002) representing the exception. With a theoretically 'stereotype' result, we should find that

i) *Sweden* will have a more extensive mental health policy: there will be a larger number of services and transfers. The entitlement to this support will be based on citizenship, it will be universal (as opposed to means tested or contribution/employment related) and flat rate (as opposed to earnings related) to its character. Most support will be publicly financed and produced – little will be left to the market, family and voluntary organisations. The Swedish welfare state will produce good prerequisites for inclusion/a social citizenship for this group.

ii) *England* will have the least policies: there will be a meagre provision of services and transfers, focused on poverty reduction. The entitlement to this support will be based on financial need: it will be selective to its character (means tested). The state will be involved to a very limited degree being a safety net of last resort, and the market, family or voluntary organisations will play a major role. The English welfare state will not produce good prerequisites for inclusion/a social citizenship for this group.

iii) *France* will place itself in the 'middle': a more extensive number of policies than England, but inferior to the Swedish case. The policies will be more about cash transfers than services and focused on income maintenance. The entitlement to this support will be based on contributions and dependent on employment status (employment and earnings related). Most support will be publicly funded, but the provision will equally involve public and private actors with an emphasis on the family. The French welfare state will produce limited prerequisites for inclusion/a social citizenship for this group.

The notion 'social citizenship' is frequently used in the welfare literature, and also in the disability literature without a common distinction.

Marshall (1949) distinguished between social rights as opposed to political and civil rights, and I would claim that Esping-Andersen distinguished a social citizenship from one restricted by means and status. By using it here, my point is to distinguish between policies that really open up for a 'normal life' and those that do not. Hypothetically, the support may – or may not – be designed in a way that cover up for the risks so that the life situation is not too marked by the diagnosis, as it was during the asylum era.

Nevertheless, as the literature showed, there is reason to leave open for other results than the stereotypes sketched out above. Both England and France have revealed social democratic traits when it comes to services areas. It is also possible that Sweden is not the country that has the most developed policies for a minor group like people with mental disorder/disability, as what is mostly studied concerns the major, general population. Instead, it is possible that England, in line with the liberal model, has identified this target group as one of the most needy and hence included it in the safety net while Sweden has no focus on such a group. However, Daly and Lewis (2000: 294) argue that

In terms of service provision, social care has tended in most states to be a more residual service (compared to education and health) and has rarely amounted to citizenship-based entitlements. Where 'marketization' is taking place, services have become more systematically targeted to those in most need, which has meant in practice a larger role for professional discretion in determining who receives services. Those with lower levels of dependency and risk or those with available family carers are less likely to qualify for provision.

Accordingly, a general trend of liberal traits might be as expected. Furthermore, it is also true that there is an ongoing debate on convergence, not least as an effect of the last decades' supposed retrenchments.

Following on the 1990 study, there are both studies that work with a larger number of countries to create clusters and studies that use a limited number of countries on new policy areas. This study resembles this latter variant, which was promoted by Abrahamson in spite of what is lost in terms of generalisation possibilities (Ibid.: 410):

This case-centred approach seems to be the most promising development of the application of welfare typologies. There seems to be developing the beginning of a consensus about abandoning the cluster analysis approach and a move to various case studies exemplifying the workings of the regimes.

Elaborating a model for analysis

In spite of a rich literature on welfare policies and welfare states, there is a lack of common analytical tools. As a result, there is no evident way of studying welfare policy design. This is perhaps partly due to the fact that many studies are quantitative (measuring expenditure and/or users), but there is no joint strategy present for qualitative studies either. The methodological question of how to measure, or study, welfare is mostly ignored. This is true for articles as well as for an ambitious volume such as 'The handbook of European welfare systems' (Schubert et al. 2009). An exception is Palier (2001: 119) who differs between 'three repertoires of social policy', or 'different logics' and 'instruments' that these repertoires consist of. I would claim that he treats the same kind of questions as is done here, but through more labels. One such example is that instead of entitlements as I use (see table 3), he categorises 'functioning principle' (e.g. selectivity), 'technique' (e.g. targeting) and 'mode of access' (e.g. need, poverty). In my view, all these features may be summarised as part of the formal entitlement. Furthermore, there is an interest in financing mechanisms (taxation or not), which have been left out here, but only a partial focus on what I have chosen to call provision and administration, that is, measures of institutional fragmentation. Palier instead suggests a focus on 'management, control, decision', which are supposed to be maintained through social partners (conservative model), central state (liberal) or local and state governments (social democratic).

For this study, an analytical tool was developed. It is supposed to serve the purpose of depicting the policy design of each support, as well as discussing its logic. This tool should be possible to transfer to any welfare area. I have used the same basic questions as former studies to portray the characteristics of each national policy: What kinds of welfare arrangements are available? On what conditions are they accessible? How

are they organised? What consequences do they have on the financial situation of the user? These are visible in the left column in table 3. The characteristics are hence developed from the theoretical literature, not from the empirical material.

The selected areas of support are supposed to illustrate the wide variety of major transfers and services that may be present in a welfare state of today. By including not only basic needs such as treatment, housing and income supply, the intention is to study to what degree the national policy includes more ambitious instruments of creating a social citizenship; ways of supporting, and creating, social contacts and activities. This is categorised under personal support.

Selection of transfers and services

Only policies explicitly directed towards people suffering from mental disorder and disability are included in the study. People from this target group may be touching also other kinds of support, but then grounded on other, general, entitlement criteria (e.g. poverty, unemployment). Also informal care is excluded from the study, as this would need another method for collecting data. What is outlined is the formalised care, which might include the family members as providers, but not the informal care that is made by family members with no formalised connection to the public administration (through benefits or programmes). Neither would it be useful to outline every existing transfer and service that could be used, as this would lead us to an endless detailed list. Instead, the major and most important transfers and services that I argue constitute the mental health policy designed for this target group will be mapped.¹¹

In this way the policies developed for this group will be outlined, categorised and analysed. It will be discussed to what extent they can be traced to the different models and to what degree they follow the lines of the model that the nations are generally connected to.

Basically, the selected policies are those that the mental hospital once offered: treatment, housing, occupation and social activities, but also income maintenance. All these policies are understood as central ele-

¹¹ Transport subsidy is an example of a measure that has been excluded.

ments for a modern mental health policy and are interrelated – treatment is not enough and it is not possible without a somewhat stable social situation etc. This is scheduled in the table below. Overall, it should contribute to scheduling the implemented policies and their design. The focus is on characteristics that make a difference for the user, but facts such as financing system has been left out (general taxes vs. independent insurance funds etc.). The intention is not to find out the most about how the systems differ in technical terms, but what difference it makes to be a user in Sweden, France and England. The analytical framework is summarised in the following table.

Table 3. Analysing the policy design of five support areas

	Treatment	Housing	Occupation	Financial support	Personal support
<i>Content</i>	In- and outpatient care: services with focus on (mental) health care.	Help with housing: independent, sheltered, residency etc.	Activities that serve the purpose of encouraging work or 'having something to do': help to salaried employment, sheltered employment, daily activities.	Financial support replacing an income or covering expenses connected to the disability. (Tax reductions are excluded.)	Help to manage the daily life through personal services in or outside the home: getting up, cooking, going out, administrative contacts etc.
<i>Entitlement</i>	What are the formal requirements for being accepted as a user: universality or selectivity? What kind of selectivity?				
<i>Charge or benefit structure</i>	Are the services charged? Are charges flat-rate or proportional? What kind of proportionality is used: relation to means, earnings, and contributions? Are charges systematically reimbursed? Are existing transfer systems flat-rate or proportional? What kind of proportionality is used: relation to means, earnings, and contributions?				
<i>Accessibility & attainability</i>	Is the support easy to access or are there any visible obstacles to access? Is the support limited in time, i.e. is the support based on short- or long-term use? Is the support widespread within the target group: How many users are expected and how many are actual users?				
<i>Provision & administration</i>	What agents are responsible for managing the transfer or service? What agents are responsible for provision? Is there a welfare mix between public and private agents? Is there a fragmentation within the public sector?				

Entitlement

The first design element in the table concerns entitlement, that is, what formal restrictions that are set up for being accepted as a user. As Esping-Andersen stated (Ibid.: 48): '[s]ocial rights are hardly ever unconditional'. The claiming principle serves to determine who the beneficiaries are. Is the support open for all citizens that show a (medical or social) need? Or is it restricted to those with an insurance contract? Perhaps, it is only to serve those who have no other ways of solving their situation, because of low incomes or because they have no social network to rely on? The entitlement criteria reveal the objective of the programme; the design tells us about the logic behind the programme.

As was discussed earlier in this chapter, the literature differentiates between three ways of designing entitlement. In the case of the social democratic model the entitlement is supposed to be based on citizenship (universalism) aiming at equalisation effects and income for all; in the conservative model entitlement is connected to contribution and the aim is not equalisation, but status quo, that is, to guarantee income maintenance for workers; in the liberal model the entitlement is poverty/means testing and the aim poverty alleviation for the most needy groups (Esping-Andersen 1990: 53f; Bonoli & Palier 1998; Palier 2001). This criterion should be able to derive from legislations or other less formalised policy documents.

However, the concept of universalism is problematic (see for example Anttonen 2002; Bergh 2004). Few, if any, welfare policies are truly universal, in the strict meaning of being available to all human beings and hence entirely without restrictions that limit the number of users. It is probably impossible to find any empirical example of such a support. Generally, entitlement involves an assessment of whether the user belongs to the requested *target group*. Belonging to the category 'citizen' may be one ground for entitlement, but it is more likely that a more specific category is addressed: certain age groups, immigrants, unemployed, sick, disabled etc. This often involves an understanding of a specific *need*, be it in medical or social terms. As pure universality is rare (or non existent), 'universal' is often implicitly used for policies restricted by group selectivity.

Another form of selectivity is when group adherence is not sufficient for entitlement, that is, when also your personal situation is considered. This may be about restricting the support to those within the group who have low incomes, limited means or who participate in some kind of insurance scheme through a history of contributions. Hence, according to the first design, a person is for example entitled to study/disability allowances if (s)he is a student/disabled, while entitlement according to the second design also, for example, demands that one's financial situation leaves the person below the poverty line.

In this study, a transfer or service open to all adult citizens or to a specific target group (group selective) is defined as universal. Support with *further restrictions* than being categorised as belonging to a target group, such as means testing and contributions (income selective) or a consideration of the family situation, is defined as selective. This is not a unique way of using the concepts, but as the definitions are not always declared, it is not always clear what an author means by universality. A reason for limiting the definition of selectivity is also that it is income selectivity that lays the ground for a discussion on both de-commodification and stratification, not group selection.

Charge or benefit structure

The second characteristic is about the generosity of the system. What consequence does the support have for the users' financial situation, that is, how costly are services and how extensive are transfers? The charge or reimbursement levels are tightly connected to the concept of de-commodification as it reveals whether it is a substitute to salary. Some benefits are extensive enough to cover 'normal living expenses', some will have to be combined with each other to construct a net of resources. As the level principle is connected to entitlement, universal policies could be expected to be flat rate, and the selective to be proportional to earlier contributions or to earnings in the conservative model or means tested in the liberal model (Palier 2001: 119). The benefits are expected to be more generous according to the social democratic logic with its equalising aims (middle-class standards), and to be modest in the liberal model where

high benefits are supposed to discourage work ambitions. Last, the redistributive feature of the conservative model is negligible, as it has no intentions of equalising status differences (Esping-Andersen 1990: 26f).

I have chosen to include not only benefits, but also charging principles as I find this element relevant from a user's perspective. The out-of-pocket payments may differ considerably between systems. Interestingly, the literature does not give any indications on charge levels, which is probably explained by the fact that services are less studied than transfers. However, when services are in focus, charges are left untreated (which is the case in for example Daly & Rake 2003). On the one hand, one may hypothesise that they follow the same logic as for benefits, that is, that universal services are connected to flat-rate charges and selective services to personal finances or to be covered by profession based contracts. On the other hand, one may also expect a generous (social democratic) welfare state to leave services uncharged. My personal experience is that non-Scandinavian welfare researchers often expect welfare services to be free of charge in Sweden, while the reality is highly subsidised but rarely gratuitous fees. Some light will then be shed also on this aspect of policy design.

Accessibility and attainability

A third ambition is to study both how generous the support is in terms of duration and to what degree it reaches the targeted population. For how many days is a person covered? Esping-Andersen studied duration, though without actually giving any answers on how the models, nor the nations, differed. Many studies also focus on how large parts of the population that are covered (by pensions, child care etc.). The main hypothesis then seems to be that only a universal entitlement creates a wide-spread support. However, I would claim that this is not necessarily true as a consequence of the rarity of proper universality; also selective designs may be connected to more or less long-lasting support. For a study of persistent needs, this is of course a central question.

Accessibility and attainability are also included to go beyond the formal picture, that is, to catch something of the realisation of the policies – do

they reach the target group? Some policies may, however, be connected with so many obstacles that they are difficult to access. This may be manifested by discretions in how the support is constructed, or by the fact that it is unknown by the users. Such obstacles may be visible, or described by the user organisations or in national reports. Attainability describes the number of users. Such statistics should be documented by national administrations.

The design of this study does not allow a thorough investigation of attainability and accessibility questions. Still, given the marginalisation that is generally described to surround this group, it is reasonable to at least have an ambition to catch whether the policies reach the target group. However, the literature gives us few indications on differences according to country or model, other than that the presence of institutional fragmentation may produce veto situations that hinder implementation to take place (Rauch 2005).

Esping-Andersen included attainability in his study, but only as a matter of policy design, not of implementation. However, later research has pointed not only to the question of how large parts of the population that are entitled to a policy (for example how many of the workers who are entitled to pensions), but to how widespread the policy really turns out to be. I find this perspective important, not least when studying a marginalised population.

The literature on institutional fragmentation is much less developed than the general literature on welfare states. Yet, it has been used by for example Rauch (2005) in a recent series of articles. The starting point – the ‘puzzle’ – of Rauch’s research is the variation within the Scandinavian family, that is, the cluster of social democratic model representatives. The variation concerns elderly and child care. According to his data, Denmark is the only country where national policies are implemented in both fields while Sweden fails when it comes to elderly care and Norway when it comes to child care. Why is it that seemingly similar contexts (the policy designs do look the same for all areas in all countries) end up with divergent results? Rauch seeks the answer in the presence of institutional fragmentation. If this fragmentation results in a veto position for implementing institutions, such as local governments and in some cases NGOs,

implementation risks being blocked. However, the results show that obstruction is not necessarily the consequence in such a scenario. There are also examples of when the local governments (of Sweden) do follow the intentions of the national level. Hence, Rauch concludes that national governments have the ability to steer even in a decentralised welfare context if they choose to use 'tight regulations'. Rauch argues that such relations are to be viewed as 'key factors to account for previously unexplained puzzles of welfare state variation' (2005: 31). Nonetheless, Rauch's studies leave no hypotheses on how the result may be generalised to or connected to other welfare contexts. Is this typical for Scandinavia? Or for the social democratic model? Or for decentralised countries? The selection of cases will be used for a discussion in the coming chapters.

Provision and administration

Jenson (1997) once suggested care to be analysed through the questions 'Who cares? Who pays? How is care provided?' in order to catch how the support varies when it comes to provision and administration. This is what is analysed through questions of provision and administration. When it comes to illustrating the actors involved, the easiest assignment should be to describe the role of public actors as it is formalised and should be covered in public documents. I will differentiate between national and local, deconcentrated and decentralised agents to make institutional variation within the public sector visible. When it comes to private providers I will differ between for-profit and non-profit actors as the first represent what the literature defines as the market whereas the latter are defined as part of the 'civil society' or the voluntary sector.

It also would have been desirable to catch the role of other parts of the civil society, such as the family. However, this is very difficult as informal care work is scarcely documented. Instead, conclusions on the role of the family are mostly drawn from an absence of alternatives. If there is no child or elderly care, the family (women) is the probable provider of care. However, the absence of publicly provided support does not necessarily

indicate that other agents provide support. People may as well be left without support.

While Esping-Andersen (1990) suggested differences between the role of public and private providers, he did not give institutional fragmentation further attention. By contrast, Palier (2001), suggests that the ‘management, control and decisions’ follow three different logics for social policies: reserving central roles to social partners in the conservative model, to the state in the liberal model and to state and local government in the social democratic model. Rauch (2005) suggested that decentralisation creates institutional fragmentation with consequences for the attainability. However, his study only included countries that were supposed to represent the social democratic model.

Conclusions

What has been said so far is that even if vividly discussed, the theory of ‘three (or four) worlds of welfare’ today represents a classic within social science. The regime theory is widely recognised and accepted, almost ‘referred to as common knowledge’ when discussing national variation (Abrahamson 1999: 408). It is then a natural starting point for comparative studies on welfare policy. Still, it is contested whether the theory holds for a generalisation on all welfare areas (education, health, social care) and kinds of support (cash transfers as well as services). In the present thesis, the case of mental health policy will be used to contribute to this discussion, as *both* health and social care are included, as well as *both* transfers and services. Instead of focusing on one specific policy area, a *welfare population* or *target group* is in focus; in this case one of the most vulnerable groups that has been pointed out as being at the margins no matter historical or geographical context.

The study aims at contributing to the understanding of how welfare policies may vary within or between countries; how they are designed, how they function and what outcomes that may be recognised. What similarities and differences become visible and to what extent could they be said to follow theoretical hypotheses? What difference does it make to be a user of mental health-related welfare policies in Sweden, France and

England? General conclusions on whether the regime theory is applicable for all welfare areas cannot be drawn, but a discussion on its weaknesses and advantages as a theoretical frame is nevertheless possible. I have also launched an analytical tool, built on theoretical expectations of variation, which will be tested.

Chapter 3

Setting the scene: mental health and public administration

Before entering the empirical analysis, a brief introduction of the welfare area as well as of the institutional settings in the three nations will be given. In a first section, this chapter serves at presenting a background to the mental health policy area in order to embed the coming ‘snapshots’ of contemporary policies in some historical context. The background aims at deepening the understanding of what mental health policies have been, and are, about. I will claim, particularly in the final chapter, that it is not without importance to consider what target groups that we are dealing with in a study of the policies surrounding them.

Secondly, the chapter serves at presenting the public administration of each country. This presentation will illustrate the welfare state agents in a way that I mostly find missing in welfare analyses. The aim is hence both to give a background to those readers not acquainted with the multilevel governance of these countries, and to motivate the interest in institutional fragmentation that I argued for in the previous chapter.

The empirical setting: mental health

In spite of the fact that mental disorders affect most of us – as patients or relatives – at some point in life, mental health is not part of common knowledge and a short introduction is motivated. The care responsibility has travelled between formal and informal agents, voluntary, private and

public sectors. In the coming chapters it will be investigated where it lays today, but first some attention to history.

The asylum

While some target groups of the welfare state are recent constructions, people with mental health problems have been considered a State responsibility since hundreds of years. During the preceding century, the care of a number of vulnerable groups was thoroughly reformed in the Western world, and the closing down of the asylums is part of this transition. Populations such as orphans, the poor, the elderly and the mentally ill and disabled that had earlier been cared for at special institutions were to be transferred to more 'normal' settings in closer relation to the surrounding community (e.g. Qvarsell 1991). The treatment of these groups is often a story of stigma and shame, even if the intentions were also somehow good; to offer an alternative to the present distress. This is true not least when it comes to people suffering from mental disorders. Even if society early intruded in the life of the 'mad', it was long a family issue, and as Porter shows, cruelty was not unique for the institutions, but reflecting a general disregard.

[J]ust as with children; lunatics and 'village idiots' typically remained in domestic care – often enough, neglect or cruelty – hidden away in a cellar or caged in a pigpen, sometimes under a servant's control. Or they were sent away, to wander the pathways and beg their crusts. Insanity was deeply shameful to a family, on account of its overtones of diabolical possession or of bad stock. (Porter 2002: 90)

What today is regarded as mental disorder has historically been understood in various ways: a punishment from God, obsession of evil spirits, imbalance of body fluids to mention some (e.g. Porter 2002). Already in the 14th century, religious institutions for those then called 'lunatics' opened in many west-European countries. This was the start for formally isolating this group both from the family and from society at large. At the same time, it was a place where the one could be cared for, and rest: an *asylum* as it was called in many countries. One of the oldest European

institutions of this kind is Bedlam in London, inaugurated in 1247, as a monastery. The asylum was a place both to store and treat citizens that showed 'abnormal' behaviour; a tool for social control (the power of this control is the theme of the famous work of Foucault, 1961).

The asylum is often described as a world of its own; 'a self-sufficient colony' as Porter (2002: 116) puts it, and the asylum area was sometimes larger than the surrounding villages. The Swedish hospital Säter is one such example (Beckman 1984). The asylums housed hundreds or even thousands of patients. This in an era where the hospitals in general were yet to develop and had few beds (Qvarsell 1991: 99). From the 19th century on, the asylums were commonly constructed at the countryside as the nature itself was thought to have a positive impact. At the same time it was convenient to separate the patients from the rest of the population for safety reasons. Both patients and employees were accommodated in the area and the treatment often included work, for example some kind of contribution to the common 'household' including laundry, agriculture etc. The area was closed and the patients never left it.

From the 19th century on, a medicalisation took place and the speciality of psychiatry developed. The medicalisation had the positive effect of structuralising and documenting the care, but it also had dark sides, such as phrenology, lobotomy and sterilisations. In Sweden, as in other European countries, a law admitting compulsory sterilisation on mental patients was introduced in the 1930s and used during the following years (Beckman 1984: 159; Qvarsell 1991: 107).¹²

Still, it was the asylums and not general hospitals that were primarily used for treatment. Consequently, psychiatry was disconnected from the rest of the health care system.¹³ During the 1960s, a questioning of psychiatry in general, and the asylums in particular, was intensified, not least through what is often called the 'anti-psychiatric wave'. This movement contained various forms of criticism ranging from a totally ques-

¹² However, according to Qvarsell (1991:108) sterilisations were foremost used for patients suffering from mental retardation.

¹³ This division is still present in today's general health care where one differs between somatic and psychiatric care. All other medical specialities but psychiatry is included in the first category.

tioning of the existence of mental illness – Szasz (1961) calling it a myth – to more moderate reform attempts (Crossley 2006). At that point in time, optimism had hit psychiatry. So far, the hospitals had only received an ever-increasing number of patients without having much cure to offer. A number of different treatment trends – the latest being about rest and hour-long baths – had passed by without giving any effects on patients' health. Now, new types of drugs were introduced on the market: neuroleptics and antidepressants. They are often described as representing a therapeutic revolution. For the first time, a therapy really seemed to have a positive effect on the patient's life. As time came to show, several of the drugs also had serious side effects, sometimes mortal. The impact was nevertheless thorough, not least for the population suffering from schizophrenia which is one of the most severely disabling psychiatric conditions. For the first time in the asylum history, the discharge of long-term patients seemed realistic. Earlier, discharges seemed to be an effect of having housed a person that was never ill in the first place, rather than an effect of recovery (Qvarsell 1991: 100ff).

During this period, the supply of both labour and housing were fortunate in many European countries, which supposedly facilitated the change into an 'ex-mural' life.

Leaving the asylum behind

Nevertheless, even if the critique and newborn optimism led to political intentions of closing down the asylums, this mostly showed to be a slow process. The number of beds at the mental hospitals generally rose between 1950 and 1970, but started to decrease during the 1970s (Mangen 1985). Only Italy chose a radical path as all asylums were closed down over one night in 1980. A more common solution was to phase out the asylums while constructing alternative care forms. In many cases, old patients that had spent such a long time at the mental hospital that they were not understood to be able to adapt to a new setting stayed, but fewer and fewer new patients were accepted. Generally, the abolishment of the asylums seems to have been much easier than the creation of alternatives in the outside world, which later led to a reversed criticism – if patients

earlier were overprotected, they were now left behind with no one to watch over their health and well-being.

Statistics from the WHO database (HFA-DB) show that the studied countries have experienced the same trend when it comes to inpatient capacity at the mental hospitals. The most radical shift is seen in Sweden, starting out with the highest bed density, and finishing with the lowest whereas the reverse is true for France. Some comments will be made on the national processes of closing down the asylums and developing alternative care forms. In a general sense, the processes bear common traits: the process has been slow, the steering weak, and there is a new-born interest for the mental health field in the 2000s.

... in Sweden

Looking back at the 1960s, when psychiatric care started to be widely questioned in the general debate, Sweden reported more inpatient beds in relation to its population than any other country (Leijonhielm & Rydén 2007: 104). It is also a fact that new asylums were still inaugurated at this time. At political level, the intentions to leave the asylums behind became visible in public documents in the 1970-80s (Socialstyrelsen 1970; 1973; 1978; 1980; 1982), but the implementation of these ideas really took off in the 1990s. Yet, alternative care forms were developed already during the 1970s, resulting in a local variation apparently dependent on the commitment of individuals (foremost psychoanalytically inspired psychiatrists). At the same time, new groups of patients reached psychiatry: those with acute crises, women, younger patients and people from lower socio-economic levels (Spri 1981; Stefansson 1985). These groups had been less represented at the asylums. However, the new care forms were also criticised for turning its back on the most difficult patients, as treatments were most useful for less severe mental disorders and disabilities (Eliasson & Nygren 1981; 1982). Hence, the modernised care was questioned for not being an alternative for the asylum population.

Even if the National board of Health and Welfare clearly had declared that psychiatry would no longer include the asylums, a radical shift never took place. The slow process of turning from asylums to new forms of in-

and outpatient care has been criticised in national documents at several times, not least by the mental health committee that was initiated in 1989 in order to propose an improved mental health care. The final committee report concluded a number of failures and suggested a continual break with the asylums and further increases of social services (SOU 1992:73). However, the reform (Prop. 1993/94:218, often referred to as the mental health reform) that followed in the paths of this committee were more about social services than about the psychiatric care, other than incitements to coordinate the different services between administrations.

In 2003, a second greater national political investigation of psychiatry took its start, triggered by a number of violent crimes committed by persons who had earlier been treated for mental disorders. At several close occasions during September that year, people were publicly attacked, and some of them killed, by men with a history of recognised mental disorder. The last of these happenings, all occurring in Stockholm, concerned the Minister of Foreign Affairs, Anna Lindh. As these violations were associated with insufficient treatment, they resulted in a debate on mental illness and psychiatric care. The government elected a 'coordinator' who would, with the help of a professional team surrounding him, oversee the field during a few years (Dir. 2003:133). The coordinator Anders Milton, a well known physician (but not psychiatrist which was a conscious choice), finished his and his staff's work by a report in late 2006 (SOU 2006:100).

A consequence of the 'coordination project' was seven reports, a number of workshops, propositions and a new wave of local projects initiated to once again encourage coordination and the development of alternative services. Among the many and detailed suggestions, four overall aims were set for the year 2015 (SOU 2006:100, p. 28): by that year, every municipality is to report that all individuals with severe mental illness or mental disability i) have a proper housing situation, or that an active process has started to achieve this goal; ii) have a meaningful occupation, be it work, sheltered occupation or training; iii) are offered the adequate care and support they need; and iv), that the yearly health survey show that most people experience that they receive sufficient support to be integrated in society and that their social network is as large as they wish

it to be. The means to reach these goals were an increase in social support concerning housing, case management¹⁴, personal assistance and occupation, but also enlarged benefits, better rehabilitation, cooperation, research, evaluations and new state subsidies.

... in France

The feature of psychiatric treatment in France has developed in a manner that shows both resemblance and difference in comparison to Sweden. Contrary to the Swedish case, however, the French government introduced a 'revolutionary' reform attempt already in 1960, suggesting a closing down of the asylums (*Ministère de la santé publique et de la population* 1960). Several facts are described as motives for a new view on psychiatry at this time, not least the alternative care and support that had already developed outside the asylums during the 1950s as a parallel sector. It was activities inspired by psychoanalysis and the belief in the positive treatment effects of such an environment, e.g. the so called social clubs. Another fact that seems to have been influential is connected to the Second World War. By the time of peace, it was discovered that almost half of the population at the asylums had died, most of them from starving, which created associations to the concentration camps (Bernard 2002: 41). The *circulaire* of 1960 can be understood as an answer to such facts.

At the same time, while Sweden had the most beds, France housed some of the largest asylums in Europe, residing more than 4,000 patients. The public hospitals were overcrowded and accommodated the patient groups with the most extensive needs. In addition, there were some psychiatric units outside the asylums but equivalent only to some percent of the totality of beds. There were also non-public alternatives for those who paid privately for their treatment (Mangen 1985: 120f). The reform was concentrated on de-institutionalisation and modernisation of the asylums: the psychiatric hospitals now conceived as obsolete were turned into specialised hospitals focusing on treatment and not on 'stor-

¹⁴ Case management is a term with different meanings in the literature. When used in the Swedish case, I refer to the service called *personligt ombud*.

ing' dangerous individuals. The patient was no longer to be isolated from the society, but integrated with the help of medico-social teams following the patient through care in the community. These teams were to work within so called sectors, that is, geographical territories within the *département* that were supposed to use a holistic and coordinated approach towards the population under their responsibility. In this way, they could form a chain of care and support even if spread on several actors. The French sectors are usually considered the inspiration for many other countries when reorganising the care, including the Swedish projects of the 1970s.

Even if the document of 1960 was visionary, it was also somewhat cautious about its limits, at least when it came to difficulties of implementation. It is also a fact that the instrument used was very weak: the *circulaire* is only guiding to its character. Hence, in line with the Swedish choice of steering, no change was forced on the field. Mangen (1985: 122) describes the reception of the new policy as generally 'unenthusiastic' among the psychiatrists. 1960-64 is described as a period of extreme creativity, but nevertheless, things were not moving quickly and after some reorganisations at *département* level, stagnation became the state of affairs: '*la politique entre en sommeil*'¹⁵ (Fourquet et al. 1980: 184ff). In spite of the national policy, psychiatric hospitals were constructed until 1975, and many of them are still in use (Reynaud et al. 2000: 3).¹⁶

The slow implementation and the total lack of activity – the old structures and extensive number of beds persisted while the alternatives were not developed – in some parts of the country were regretted and further engagement encouraged by the government in *circulaires* and *arrêtés* during 1960-90.¹⁷ Furthermore, two national reports on the future of psychiatry were demanded by the Minister of Health during the 1980s (Demay & Demay 1982, Zambrowski 1986) and a third during the early 1990s (Massé 1992). All four authors were psychiatrists.

¹⁵ The policy falls asleep.

¹⁶ I have not seen a precise number, but according to the psychiatrist and commissioner of the 1990s, Dr Massé, the number should be 120 (interview 2004).

¹⁷ *Circulaire du 16 janvier 1969, du 18 janvier 1971, arrêté et circulaire du 14 mars 1972, circulaire du 9 mai 1974, du 21 décembre 1987, du 14 mars 1990.*

Demay and Demay suggested a 'French way' of development, which seems to be much about moving slowly towards a future without asylums and without a concentration on hospitals. The radical shift that had taken place in other countries was used as a warning; a dangerous way of change. Instead, the asylums were to languish. Moreover, concrete suggestions on how the mental health policy should develop are hard to find. The report rather manifested an intellectual discussion on what psychiatry should represent, not least in ethical terms. Both medical and disability notions are more or less rejected as they were viewed as too narrow. Likewise, they asked for participation from public as well as private actors, medical as well as social, as important if a life outside of the asylum should be possible. The difficulties of getting income supply and accommodation for this group were understood as real obstacles to deinstitutionalisation.

The second report also concentrated on the problem of the continual concentration on the hospitals and gave a number of proposals on how alternatives could develop. Furthermore, Zambrowski focused on how the private sector had increased, but was disconnected from the public one. The care divergence was the theme also of the third report as Massé argued for the importance of having a system where the different producers complement each other instead of competing or constituting parallel systems. Massé, as Zambrowski, was not suggesting a closure of the psychiatric hospitals, but an intensified implementation of psychiatric units at the general hospitals to reach the goals of the 1960s reform attempts.

During the early 2000s, further reports of this kind were published (Piel & Roelandt 2001, Roelandt 2002) as well as national plans of implementation (*Plans* 2001, 2003, 2005), which continued the ambitions of a new organisation of care. As in the Swedish case, the development was understood to have a too slow pace and the increasing heterogeneity was described as a problem. The focus in national mental health reports have been centred on medical care, and not least the organisation of this care, whereas social questions are mostly left out. The exception is a parliamentary report from the early 2000s (Charzat et al. 2002), a report with no visible influence.

... and in England

Also England had an earlier start than Sweden considering national policies of de-institutionalisation. In a famous speech in 1961, the Minister of health, Enoch Powell announced a rupture with the asylum era:

There they stand, isolated, majestic, imperious, brooded over by the gigantic water tower and chimney combined, rising unmistakable and daunting out of the countryside – the asylums which our forefathers built with such immense solidity to express the notions of their day. Do not for one moment underestimate their power of resistance to our assault. /.../For the great majority of these establishments there is no appropriate future use /.../.¹⁸

The minister announced a 50 percent reduction of the psychiatric beds within the coming 15 years. This was in line with the new Mental health act that had been introduced in 1959. Yet, as in France there was a concern about the time that this would take; one could not expect the staff ‘to take the initiative in planning their own abolition, to be the first to set the torch to the funeral pyre’ after years of improving the asylums. The announced policy shift surprised the audience (Rivett 1998: 160). Jones (1993: 160) describes the news as quite shocking

His audience, composed in the main of senior psychiatrists and administrators, had not expected this policy change, which was introduced without consultation. Their main task in the preceding few years had been to try to get money and technical support from a reluctant Ministry to improve the hospitals. Now they found themselves described as the ‘defences we have to storm’ by a Minister who had not only avoided their assault, but was attacking them from the rear.

The policy was later followed up in circulars, White papers and hospital plans, but the process became slower than expected which might be explained by the citation above; it was an unexpected and abrupt shift of focus that was not established among those who were to act for its reali-

¹⁸ The speech is available at www.nhshistory.net/watertower.html

sation. From now on, *community care*¹⁹, was to replace the old hospitals, both in psychiatry and for other patient groups. The policy documents of the 1970s presented ‘more of the same’, that is, a continuing emphasis on action and regret over the slow pace of change, if any (e.g. DHSS 1971, DHSS 1975, DHSS 1976). An ambitious White paper²⁰ was published in 1975 (DHSS 1975) with the title *Better services for the mentally ill*. It started by stating that mental illness might be *the* health problem of our time, hence leaving no doubt that this should be a prioritised area. The documents of the early 1960s had imagined a thorough shift from hospital care towards community-based settings. Reality proved to be quite different.

Indeed, there has for years been general recognition of the significance of the social and environmental aspects of mental illness. Yet, although it is sixteen years since the act of 1959 gave legislative recognition to the importance of community care, supportive facilities in a non-medical, non-hospital setting are still a comparative rarity. /.../ Specialist care is still mainly based in large geographically isolated mental hospitals (DHSS 1975: ii).

The paper set up new goals in line with the ones set in 1962, but this time with an even longer time frame – the process was supposed to take another 25 years.

During the 1990s, mental health seems to gain a more important position as a health issue at national level. One might claim that a landmark of this upgraded status was when mental health was placed as one of five priority areas in the *Health of nation* White paper in 1993, and the fact that it has remained there since (e.g. Boardman 2005: 33). However, it is

¹⁹ This is a widely used, but seldom defined concept. In a general meaning, it indicates care that is offered within the community, that is, close to the citizens and not as isolated hospitals. It also generally seems to indicate that the care is not only about medical treatment, but a wider understanding of health and social support both in the offer and in the professional composition.

²⁰ A White paper is a policy document of guiding character, presenting the intentions of government. It can be compared to Green papers that are more frequent, and less precise in their content.

in the late 1990s that the number of documents and initiatives really seems to augment. With the new Labour government, taking seat in 1997, the appointed Secretary of state for Health, Frank Dobson, declared that community care had ‘failed’ and that there must be an end to earlier years of neglect (Department of health 1998). The proposals for improvement were both specific to the mental health field – more acute beds and crisis teams, supported accommodation and training opportunities and an updated mental health act were among the suggestions – and general for the service development. He asked for effective drugs and therapies through the new institute of clinical excellence, NICE, and ‘top quality local services’ through the new institution of National Service Frameworks. In 1999 the National Service Framework for mental health was presented following on the ideas of the previous paper (Department of Health 1999). In the foreword Dobson declared that

The Government is committed to do whatever is necessary to deliver a modern and dependable health service, fit for the new century. Mental health services and the professionals who provide them will get the attention and resources they deserve. This National Service Framework will set the standards and these standards will be met.

The framework was set out as a 10-year project with explicit goals and ‘mile-stones’, good examples to follow and plans for implementation. In 2000, a National director of mental health in England – also called the mental health tsar – was appointed to supervise the work²¹, and in 2002 the National institute of mental health in England, NIMHE, was created to support ‘the implementation of positive change in mental health and mental health services’. NIMHE is formally headed by the national director. In 2004, the framework’s progress was summarised in a report by the national director, who pointed to special key areas for further action (Department of Health 2004x). Special attention was given to inpatient wards, dual diagnoses, employment and the connection to discrimination, ethnic minorities, primary care involvement in long-term care, and

²¹ Louis Appleby, professor of psychiatry at the University of Manchester. The post seems to be a part-time position.

the availability of 'talking therapies'. During the 2000s, an extensive number of implementation guides published by the Department, and guiding and informative documents produced by NIMHE, which was transformed in a new organisation by 2009.²² The most recent attention on the social situation connected to mental ill-health is seen in the Social Exclusion Unit Report published by the Office of the Deputy Prime Minister in 2004 (SEU 2004). This report had a special focus on work, but also on social inclusion in a wider perspective.

The users

More than 25 percent of all people are expected to experience a mental disorder at some point in life. At any point in time, however, mental disorders are present in 10 percent of the adult population (WHO 2001). According to the WHO, adult psychiatric disorders account for about 12 percent of the global burden of diseases and neuropsychiatric disabilities account for about 43 percent of the total burden of disability (Ibid.). The major adult psychiatric diagnoses are affective disorders (including bipolar disorder and depression) anxiety disorders (including panic disorder and obsessive-compulsive disorder) and schizophrenia. These disorders have a wide spread of symptoms and effects; while depression is the most common diagnosis, schizophrenia has the most severe disabling consequences. Depression is estimated to touch up to 35 percent of the population (Mattisson et al. 2005), schizophrenia up to one percent (Bogren et al. 2007).

A mental disorder affects your way of thinking, acting and functioning, and a psychiatric diagnosis is constructed as a list of symptoms, where a number of them must be present in the patient. Many of us will easily recognise some of the symptoms, such as change of mood for depression, since they are symptoms that are generally experienced during a life course. However, to be diagnosed, one needs to experience several of the listed symptoms during a certain period of time, with a certain degree of

²² NIHME became National mental health development unit, NMHDU in April 2009. The latter organisation is smaller, but stayed an agency with the mission of supporting implementation. See www.nmhdu.org.uk/nmhdu/

severity. Following the earlier example, it is only when the depressed mood becomes so dominating that your functions – eating, sleeping, working, maintaining relations – are negatively and severely influenced that a diagnosis and treatment are applicable.²³ However, according to research, most people that experience symptoms serious enough for diagnose will not seek care. This is called the ‘treatment gap’ and is understood to be much wider for psychiatric disorders than for any other condition (e.g. Lancet 2007). This is often recognised as a consequence of the stigmatising attitudes that are still associated with these conditions. The ultimate consequence of ignored psychiatric symptoms is regarded as fatal as it is connected to suicide, which is one of the most frequent causes of death.²⁴

The institutional setting: public administration

The second ‘scene’ is equivalent to the welfare systems of each country. In order to prepare for the coming chapters, the public administration connected to welfare issues in general will be presented for each country.

The fragmented welfare state

The welfare literature has mostly treated the welfare state as a holistic entity, ignoring the fact that the ‘state’ includes several public actors: different state agents as well as local governments and administrations. Instead, the ‘welfare mix’ discussion stays focused on whether the state

²³ In some situations treatment can also be forced on a person through compulsory care legislations. Briefly, compulsory care is ordered if a person with a diagnosed mental disorder is considered to endanger her/his own or anyone else’s life or health and if the person, in addition, does not accept voluntary treatment. Decisions on compulsory care are delicate and controversial, but today they constitute a minority of the treatments within psychiatry. On the contrary, at the asylums there was no such thing as voluntary care. Compulsory care is regulated in national mental health acts.

²⁴ In Sweden, suicide is the most common cause of death for men aged 15-44, and the second most common cause for women of that age group. For older age groups it is one of the most common causes of death (Socialstyrelsen). According to WHO statistics, 1 million people throughout the world commit suicide every year and 10-20 times as many attempt to do so (WHO 2001:x).

has left welfare in the hands of non-public agents. However, leaving it untreated whether the private agents are publicly funded or not, that is, how market oriented the welfare policies really are. As was argued in chapter 2, the involvement of different parts of the public administration may have effects on attainability (Rauch 2005). I have chosen not only to illustrate the fragmentation between different governmental levels, but also within the public administration interpreted in a wider sense where all agents are included. The possible mix of public agents may be illustrated as in the following table, differing between vertical and horizontal variation.

Table 4. Institutional fragmentation of public actors

National government Centralised national agencies		
National agencies at regional level (deconcentration)	Regional government Regional agencies (decentralisation)	
National agencies at local level (deconcentration)	Regional agencies at local level (decentralisation)	Local government Local agencies (decentralisation)

The provision of welfare services and transfers may theoretically be handled by any, or several of these levels. Some levels are more probable to be responsible for planning and control, while other levels are involved in the procedure of delivery, or of organising the delivery. The importance and presence of these levels should vary between countries and over time.

I claim that this multitude must be taken into consideration in a welfare study of the late 2000s, as this complexity is important for the understanding of the welfare system. If the analysis is widened to anything beyond the social security system of a country, this fragmentation becomes obvious and it seems important to analyse what consequences it has both for the policy design – maybe this explains variation within or between countries – and on the outcome, such as attainability. If most

policies are to be found at local level we will end up with greater diversity, which may cause difficulties not only to theorise about national welfare states, but for the very study of welfare policies.

The countries of this study are all unitary states; they are not federations where the importance of non-national levels can be taken for granted. Yet, as will be outlined, the role of local levels is important in all three of our cases. Generally, France and Sweden represent 'typical' examples of two poles: a highly centralised versus a highly decentralised country. However, reforms over the last decades have changed the picture not least for France. England, or the United Kingdom, on the other hand represents a country where local governments are particularly large but weak and questioned. In other words: even in this aspect, the three cases may be said to represent different models (e.g. Lidström 2003). A brief description of these variations as well as how they have developed over the last decades will follow.

Sweden

Few countries are considered to have as strong local governments as the decentralised Sweden, both politically and legally. The self governance of the local governments is grounded in the constitution, which states a strong autonomy and a general sphere of authority. As the welfare state has grown in size, so have the duties of local governments.

Since 1862, there are two levels of local governments, today represented by 20 county councils²⁵ and 290 municipalities. These two levels are free to organise their activities within the existing legal frames, with the general – visionary – mission of effectuating the same care in all parts of the country. National laws and guidelines regulate both levels, but while the social services are individual legal rights in the sense that they are possible to appeal against, health and medical care is an admin-

²⁵ Today there are 21 geographical areas administrating the duties of a county council. 18 of these are called *landsting*, two are called *regioner*. In addition, one municipality (the island of Gotland) handles the duties also of a county council (but there is only one local government). The number of inhabitants differs between 128,000-1,900 000 (Swedish association of local authorities and regions, webpage 2008).

istrative obligation (that can not be claimed or become the issue of an administrative court, see for example Karlsson 2003).

The local governments have become more and more autonomous over the last decades. Several reforms have contributed to such a development, for example the Health care act of 1982. The national regulation mostly concerns general laws and guidelines as well as supervision. In addition, guidelines will be outlined at local level. As a consequence, national variation has increased over time between different parts of Sweden. In some respects too, the overview of variation is difficult to consider since statistics are not always coordinated at national level. Hence, data will not always be collected, or not comparable. Variation seems to be dependent both on size and on what political parties that are governing. This is evident both when looking at for example the services and at the role of private providers (Trydegård 2001). Another striking feature of the development is the expanding areas of responsibilities for the municipalities, not least when it comes to social care for children, the elderly and disability groups (Montin 2007).

National level

Although mainly decentralised, some welfare areas have stayed national and are delivered through regional offices (deconcentration instead of decentralisation). This concerns parts of the social insurance system as well as labour market policies and higher education. A national insurance agency is responsible for a number of transfers: sick pay, old age pensions, disability pensions, parental and child allowances and disability allowances. National agencies, such as the National board of Health and Welfare or the National agency for education, are responsible for informing and supervising the decentralised welfare institutions. In that sense, they are involved in the implementation of national welfare policy goals. There are also county administrative boards, headed by nationally appointed governors, with similar responsibilities.

County councils

Some of the duties of a county council are obligatory, some are elective. The first category of duties includes medical health care, dental care and

public transport. The second category includes culture, tourism, education and regional growth and expansion. The main target of the county council is medical health care.

The county is steered by a directly-elected council (*landstingsfullmäktige*) and was initially financed through State grants, but progressively more through county taxes which increased considerably during the 1960s and forth. Today county taxes constitute the major part of the financing (about 70 percent), and State grants are less central. Patient charges constitute a minor part of the funding (3 percent). The county councils are free to organise their duties, set charges and taxes within the frames of national legislation and regulation.

In 2003, a commission started to investigate the future organisation of county councils. A report was delivered and vividly discussed in early 2007 (SOU 2007:10). In line with the commissioner suggestions, a few counties are expected to expand their areas of responsibility – including regional development – and some are willing to merge into larger entities. Hence, a reform process has started that is supposed to strengthen this level of local government.

Municipalities

The municipality is generally more present in the daily life of a Swedish citizen than the county council. Its main task is to be ‘the extended arm of the welfare state’, which was realised through a merge reform in the mid 1970s. At this time, the number of municipalities decreased from about 2,500 to less than 300 (Montin 2007: 36). A nationally regulated system of equalisation compensates smaller municipalities (and county councils) through taxes paid by the local government. This system is supposed to reduce the effects of local variation that influence the capacity of welfare delivery.

The list of obligatory duties includes child care and education, social care (these areas constitute about 80 percent of the budgets), planning and building issues and emergency services. In addition, voluntary duties include for example leisure, culture, housing and energy. The welfare responsibilities of the municipalities have grown considerably over time as the areas that dominate the present budgets were decentralised or

importantly extended, especially during the 1990s.²⁶ This has intensified the tension between national and local level. The municipalities have criticised the government for transferring heavy welfare responsibilities without adding financial compensation; this at a time of general financial problems (Petersson 2007).²⁷

The municipality is steered by a directly-elected council (*kommunfullmäktige*) and primarily financed through local taxes, but also on State grants and charges. As with the county councils, the duties of the municipalities are set at national level, but the implementation is left in the hands of the municipalities. Hence, they may for example purchase the care from private providers, which has been increasingly common during the last decade (Montin 2007).

France

In contrast to Sweden, France is often used as the main example of a centralised state where most policies are set in Paris and implemented with a strict control of the regional and local areas. This feature is usually understood as an old political heritage with Napoleonic or even older, Jacobin, roots. It is then interpreted as a reaction to the decentralisation that followed on the French revolution and a means of steering a large country (Hesse & Sharpe 1991; Page 1991; Bennett 1993). There is also a historical conflict between the state and the church that provoked central steering (Archambault 1997). The Catholic Church early took seat as a welfare producer for the poor, sick and old, but also for education, being a leader in charity. Contrary to the case in neighbouring countries, charity became the business of private actors. However, the state transferred much of the welfare activities to become government responsibilities already in these early years. The charities were left to organise areas ignored by the state (Ibid.). However, it is also a fact that private actors have been, and are, present as welfare providers both when it comes to larger enterprises and non-profit organisations.

²⁶ Reforms concerning education, elderly care, child care, mental health and disability.

²⁷ Also see the Swedish Association of Local authorities and Regions for the most recent statistics or for statements on these issues (web site www.skl.se).

The local governments have traditionally been weak and almost regarded as part of the state administration; an extension used to realise national policies at local levels. However, a decentralisation reform in the early 1980s changed the picture, enforcing the power and responsibilities of local governments. Elected assemblies were implemented at all levels, as well as the right to apply local taxes. This first decentralisation initiative has been complemented by legislation during the 1990s and 2000s that further emphasised the decentralised feature of France. However, even if there is specific legislation for every level of government, the division of responsibilities is not all clear – several levels may claim that they are in charge of the same duties (Lidström 2003: 85). According to Maze (1993: 61), the French decentralisation reforms have been

minimal and incremental in nature, each initiative adjusting slightly the existing arrangement. /.../ Nevertheless, the cumulative impact of these piecemeal changes has been a significant increase in the importance of the meso level. Here, two parallel trends can be clearly identified: the progressive councils; and the piecemeal establishment of the elected regional governments.

Even if the state still keeps influence through the ‘power of the purse’ (Goldsmith 2002: 98), the picture is today much more multifaceted than before the reforms.

A more complex picture of local government has emerged, a more mosaic-like pattern resembling the situation found in many other countries throughout Europe and very different from the previous well-organized system controlled by civil servants and enshrined within financial and legal constraints set by the state. /.../ All in all, a complicated picture has emerged, and one finds a confusing pattern of intergovernmental policy networks and complex financial arrangements. (Borraz & Le Galès 2005: 15)

Four levels of government are present today, all of which are more or less involved in the financing, implementation or planning of welfare services and transfers.

National level

Although a number of welfare areas have been transferred to local government, the state is still an important welfare actor. The main area is the national social insurance system, which includes a number of branches: sick pay, pensions, family allowances and disability support. Unlike in Sweden, where one agency manages these questions (the national insurance agency), the French social security system is fragmented both at national and local level. There are for example different schemes according to professional adherence (*regimes*²⁸), including a number of agencies (*caisses*²⁹) according to scheme and type of insurance branch. Furthermore, there are a number of other national agencies – about 30 for the area of health and social affairs – as well as numerous deconcentrated agencies at regional and local levels.³⁰

The French *Sécurité sociale* has its roots in late 19th century social assistance laws, but originates in its contemporary forms from 1945. In contrast to countries such as Sweden and England, France never had any poor laws to build from. Instead the social assistance and security legislations were concentrated on workers rather than citizens. Employed workers were included and the system financed through charges paid by both parts: the employee and the employer. These two actors, and not the State, were also responsible for managing the system through special funds (*caisses*) to which the insured are connected. These are private organisations, but with a public service function (Thévenet 2005: 29). Self-employed workers and some other professional categories formed their own social security schemes as they wanted to maintain privileges from the earlier system (for example concerning the age of retirement).

²⁸ For health related insurances there are mainly three schemes: one general (covering 80 percent of the insured), a second gathering agricultural professionals, a third for other self-employed professionals. There are also special schemes for professionals of different kinds: sailors, public transports, parliamentarians etc.

²⁹ For the general scheme: CNAMTS for health related insurances, CNAV for old age insurances, CNAF for family allowances, ACOSS for cash flows. A fifth branch is in development since 2004, not yet having the same status as the other four: CNSA for handicap issues.

³⁰ For examples of other national agencies, see Hardy & Lhuillier (2008:111f). Examples of regional and local agencies in this area: ARH, DRASS, DDASS, MDPH.

In addition, complementary private insurances are common; often as part of the employment contract.³¹

Other centralised welfare duties are unemployment insurance and insurances for war victims and combatants. The unemployment insurance is compulsory since the 1960s and involves the labour market actors. It is based on contributions through work. In the mid 1980s a complementary State insurance was set up to cover the unemployed who did not fulfil entitlement criteria; a 'safety net of last resort' (Thévenet 2005: 48ff).

Régions

There are today 22 *régions* in France. They were implemented during 1964-1973, at that time being a state agency steered by a *préfet* (equivalent to the local leader in the largest *département*) responsible for realising the governmental policy and with some representation from local organisations and authorities. The main original task of the regions was financial planning and the territorial borders were drawn on former geographical planning divisions (Mazey 1993: 63f). In 1972, the regions were formally legalised and given a more general mission of contributing to the social and economic development. Their budgets were based both on national means and regional taxes.

The political power of the region grew during the coming years, and according to Mazey (Ibid.), at the beginning of the 1980s, a regional identity and a politically important role had developed. As part of the decentralisation reform, the executive role was transferred from the *préfet* to an elected body and leader. Still, a nationally appointed *préfet* maintained a position within the region, though in a coordinating and economic role. The first elections took place in 1986. In general, the political role of the regions has not been very important which is probably due both to a limited budget and national restrictions on their autonomy (Lidström 2003: 85). The responsibilities are still focused on economic development and planning but also on the labour market, some higher

³¹ *Mutuelles, entreprises d'assurance, institution de prévoyance.*

education and culture. The welfare mission of the region is hence very limited.

Départements

The next level of local government is older and more institutionalised: the 96 *départements* originating from the regime of Napoleon I (Mazey 1993: 61). This has become the most important local government level in the French system, perhaps as a consequence of the shortcomings of the municipalities, which are too small in size to be efficient welfare providers (Ibid.). Since the decentralisation acts of the 1980s, the duties include health and social care (those not part of the social insurance scheme), education, planning and infrastructure (Goldsmith 2002: 107f). Minimum levels of provision are set at national level, but the local governments are free to exceed them (Hardy & Lhuillier 2008: 57). Hence, the service and transfers may differ between localities.

The *département* is, as all local levels, financed through local taxes, state grants, service charges and loans. It is steered by an elected assembly (*conseil général*), yet, also at this level, a nationally appointed *préfet* is present to supervise the politics. Earlier, this was realised through approvals in advance, but today the role is more restricted and the national level has limited power to intervene other than if a local decision is understood as in conflict with national law.

Municipalities

Also the fourth level of government, the municipalities, represents an old structure. There are more than 36,000 municipalities in France; a number that has persisted for hundreds of years and that seems difficult to reform even though such attempts were made in the 1970s. Only a marginal difference was achieved. As a consequence, the French municipalities are minor than any other commune system in Western Europe (Borraz & Le Galès 2005: 15). Some are even without inhabitants (Lidström 2003: 82). Hence, the municipalities need to cooperate to be able to provide their services, something that is also encouraged through law (Goldsmith 2002: 98).

This has resulted in ‘an inter-municipal revolution’ in later years, and a complex structure of overlapping and heterogeneous collaborations (Ibid.: 21). Contrary to Sweden there is no national association gathering all local governments of different levels. The state has tried to formalise the inter-municipal collaborations into three models (more or less ‘federal-like’ collaborations) in the aim of some kind of structuring.

A publicly elected body is in place, which appoints the executive leader; the mayor. The compulsory areas of responsibilities cover education, infrastructure, police, fire prevention and physical planning; the voluntary duties include tourism, culture and communication. The budget, primarily based on taxes and state grants, is relatively modest, but the municipalities possess an important autonomy in how to spend it. Consequently, its autonomy is comparable to that of the Swedish communes (Borraz & le Galès 2005: 16). However, and in contrast to the Swedish entities, some kinds of decisions must be approved at national level. There is also an extreme variation in autonomy as an effect of size and level of indebtedness.

England

Contrary to the previous countries, England (the United Kingdom) has no written constitution. Consequently, the local government levels have a much weaker power position. Formally, any local level could be abolished at any time, and their discretion is limited to what is explicitly expressed in national law and doctrines (the so called ‘ultra vires’). Another divergent feature is the more visible tension between national and local governments, expressed not least during the Thatcher era. During that time, the local governments were accused for being inefficient and wasteful. Therefore, they were deprived from some of their duties (Lidström 2003: 53).

*National level*³²

In the aftermath of the Second World War, a number of important social reforms took place in Britain. One of them was the national health system, NHS, implemented in 1946. During the same decade, national insurance and assistance were introduced. While the first covered unemployment, sickness and pensions through contributions, the second was a means-tested safety net of last resort. As in France, a number of different deconcentrated agents are today involved in the delivery of the support; Jobcentres, Social security agencies, the Pension, Disability and Carers Services etc. (e.g. Rowlingson 2004).

Sub-national level(s)

The English local government system is less distinct than the previous cases as the same sub-national levels are not present in all parts of the country. In contrast to Sweden, the local government structure has changed at numerous occasions, both historically and in recent years. Since a number of reforms during the last decades, different parts of England (and Britain) are organised in different ways: a one-tier or a two-tier system. The two-tier system was invented in 1974, introducing *counties* and *non-metropolitan districts*. Today, there are 27 counties divided into 201 districts in England. A number of duties are connected to each level. When it comes to welfare issues, the counties became responsible for education and social services, whereas the most local level became responsible for housing. The non-metropolitan districts are sometimes named *borough* or *city*.

In 1990, a local government reform transferred a number of areas into one-tier systems called *unitary authorities*, that is, local administrations that embraced all areas of responsibilities. These were foremost invented in middle-sized urban regions. Today, there are 56 unitary authorities

³² As has been explained in Chapter 1, England is treated as national level even though it has no parliament of its own other than the British. Differences in the organisation of welfare will appear in Wales, Scotland and Northern Ireland (which have for example their own version of NHS). These areas have a local government of their own since the late 1990s, but different levels of autonomy. As for the other local levels, the power of these localities may be restricted or abolished at any time.

present in England (National statistics³³). Also London uses two levels, although this has varied over time.³⁴ Furthermore, in some parts of England, the old structures of county councils, formally abolished in 1986, are still in use. An additional confusing factor is that non-metropolitan districts as well as unitary authorities may also be named *borough* or *city*.

All administrations are steered by publicly elected councils and financed through state grants, county taxes, business rates and charges. The responsibilities for local governments include a long range of responsibilities: education, transport, strategic planning, fire services, refuse disposal, social services (generally at county level of two-tier system), housing, infrastructure, building, environmental health (generally at a more local level if two-tier system), recreation and culture (shared even if two-tier system). The decentralisation of social services, so called community care, took place through a reform in 1990 (The NHS and community care act). This includes services for older and disabled adults that need personal support.

The most debated local reforms were realised by the Conservative government in seat 1979-90 as Thatcher initiated thorough public sector reforms. Consequently, local government lost influence over a number of areas such as education and housing. This was realised through centralisation, privatisation or reorganisations where duties were transferred to non-elected quasi-public bodies, so called quangos. Furthermore, the central government intervened in the local budgets and tax levels. This situation contrasted earlier decades when the central-local relationship had been characterised by local discretion and increased national financial assistance (Goldsmith 2002: 95). It also contrasted the development of other countries where local governments became more and more important and independent.

By the early 1990s, the situation in Britain was such that observers no longer described sub-national governmental arrangements in terms of local government, but used the term

³³ http://www.statistics.gov.uk/geography/counties_nonmet_ua.asp

³⁴ Today represented by a Greater London Authority and 32 London boroughs (Ibid.).

local governance instead, as local governments increasingly became one of many agencies involved in dealing with local problems. In this situation, local government in Britain has moved from being largely a direct service provider to an enabler, imitator, and sometimes co-ordinator of, as well as partner in, an ever increasing number of centrally sponsored local initiatives in which a wide range of public agencies, together with the private and voluntary sector, are involved. (Goldsmith 2002: 96)

Indeed, also the Labour governments, taking seat in 1997, have criticised local governments for not being efficient, transparent or modern. The introduction of mayors and attempts of mainstreaming the organisational structure are central initiatives that have intended to improve this (Ibid.).

Conclusions

Although far from complete, this overview is intended as guidance into the following chapters. The reader should by now also be somewhat more acquainted with the target group, which is, as I will argue in the final chapter, relevant. The chapter should also have served as an illustration of institutional fragmentation as generally being a central characteristic of modern welfare policies and welfare states. This is true both when considering vertical and horizontal levels of public administration. The following chapters will illustrate how this fragmentation occurs in the example of mental health policies. Focus will now be turned to the presence of mental health-related policies in the three nations

Part II:

Mental health policy in
Sweden, France and England

Chapter 4

Mental health and medical treatment

While mental health policy once was equal to what was performed by psychiatric care providers, psychiatry is today only one part of mental health policy. Yet, it is an important component that is sometimes even a prerequisite for other support, both when it comes to entitlement (when one needs a doctor's certificate) and to the personal ability of maintaining them (which demands a certain health). Psychiatry is one of many medical specialities, but has historically been separated from the rest of the health care system. This was manifested by constructing special hospitals and by differing between somatic and psychiatric care, the first including every other medical specialty.

Some words could be said about treatment and care trends, which are similar in all three countries (see for example Knapp et al. 2007 or *Acta Psychiatrica Scandinavica 2001:104*). The content of modern psychiatric care is different forms of treatments, including care visits, medication, psychotherapies and hospitalisation. Today, the latter is rarely used and the majority of inpatient beds have disappeared. Furthermore, the number of days in inpatient care has been reduced even if a minority of patients still stays for years. The reduction of beds and length of stay is not unique for psychiatry, but a trend within the health care sector and could be understood both as a result of economic restrictions and of health care 'ideology', that is, that hospitalisation is not only costly, but also inferior to a patient's personal environment in so many aspects that it should foremost be avoided. Improved medical treatments are also of obvious

importance. Yet, as the number of days in inpatient care has decreased, the number of treatment occasions has increased; patients have shorter treatment periods, but they come back more often.

The specific treatments will differ with professionals, clinics, areas and diagnoses. Outpatient care is the most central provider, whereas inpatient care is very limited. Some patients will primarily meet general practitioners (GPs), a nurse or a psychiatrist; others will also have additional specialities included in their care programme, such as psychologists, physiotherapists or occupational therapists. Specialised teams have been developed for some groups, and in some parts of the countries. Patients will hence be offered a variety of treatments and there is lacking national documentation on what care is offered what groups and on what conditions. It is a matter for national administrations to supervise this local diversity.

Sweden

Entitlement

Although much has happened in Sweden when it comes to psychiatric treatment, the formal access to care has not changed. Entitlement follows a universal design, that is, all citizens are entitled to subsidised medical health care as far as they are considered in need of it. Hence, there are no means tests or contribution systems that inhibit the patient from access to care (Hälso- och sjukvårdslagen, SFS 1982:763).

Charges

Charges are set at county level (Ibid.: 26§), which causes an important national variation, though in a limited span and with a flat-rate design. The mental health coordinator team recently showed that this variation is considerable: the difference between some areas was estimated to exceed 100 percent (Nationell psykiatrisamordning 2006c, also see SKL 2010).³⁵

³⁵ Outpatient care varies from 120-300 SEK for seeing a psychiatrist, 0-150 SEK for seeing a psychiatric nurse, 60-150 SEK for psychologists. 40-80 SEK/day for inpatient

All publicly funded care is potentially charged, but there is an annual national maximum cost level (ceiling) for all publicly financed outpatient care. Consequently, out-of-pocket payments stay at around 100 Euros at the most.³⁶ When reaching this level, charges are fully covered by the social security system to which all citizens adhere.

However, inpatient care is not covered by this ceiling and shows even a greater variation and with a proportional design: depending on county it varies with income, age and length of stay. People on low incomes or disability pension only pay 50 percent of the normal fee in many counties, but often with restrictions on age and length of stay (SKL 2010). Even if there is no national ceiling for the total costs, the inpatient charges may not, according to national law (HSL 1982:763), exceed a certain sum per day (around 9 Euros). Some counties have also introduced their own monthly ceiling.³⁷ The important mix of design and local variation makes it hard to classify the charges in welfare terms: charges are *primarily* flat rate, but not necessarily, they are highly subsidised and *primarily* regulated by maximum levels (as outpatient care is more common than inpatient care), but one may at least conclude that they are principally charged.

On the contrary, pharmaceutical costs only follow national legislation and hence show less variation. Also drugs are charged and highly subsidised. As for outpatient care charges, the costs are regulated by an annual ceiling of about 200 Euros and functions in the same way as the ceiling for care expenses.³⁸

For the private care that is totally disconnected from the public sector (providers with no contract with the public sector), there are no charge regulations. Hence, charges may be set at any level and they are not cov-

care, this higher level being legally regulated as a national maximum charge level (Nationell psykiatrisamordning 2006c).

³⁶ The maximum personal cost (*högkostnadsskydd*) for medical care is equivalent to 900 SEK/year in 2010.

³⁷ Some examples are Västra Götaland and Västerbotten, using a monthly ceiling of 1,200 SEK, equivalent to a daily fee of 40 SEK (county websites 2010).

³⁸ The maximum personal cost (*högkostnadsskydd*) for medical care is equivalent to 1,800 SEK/year in 2010. Not all, but most, subscribed drugs are included in this scheme.

ered by the ceiling. This is accordingly to be viewed as a totally disconnected and parallel care supply that is only regulated in the sense that providers must deliver a qualitative care.

In addition to the general public ceiling, there are a number of other policies in place to reduce the personal burden of care expenses. All kinds of charges may be covered by private insurance, but even if the number of users is increasing, only a few (2.5) percent of the population is estimated to subscribe to such a scheme (Anell 2008). Employment-related contracts may also cover expenses for medical care. This is for example true for civil servants, whose costs are partly covered, including visits at a psychologist or a physiotherapist, care and drugs.³⁹ However, these reimbursement schemes are not documented and their importance is hence not possible to state. Nevertheless, this means that in reality, the individual burden of costs is even more differentiated than the official system tells, and that stratifying effects are hidden.

For reimbursements of charges, there is hence one universal, national system, but there are also complementary systems that are dependent on professional contracts, a contributory design which contrasts the all-inclusive one. Parallel systems with different design and logics coexist. Ultimately, if a person is not able to pay, (s)he may apply for means-tested social assistance to cover the fees. Hence, your 'market value' does not influence your entitlement to care and care expenses should not burden any citizen too importantly – the system contains clear de-commodifying effects, which does not exclude that it also contains stratifying elements.

Accessibility and attainability

What obstacles may be noticed for access to care for Swedish citizens? There are no formal obstacles in terms of referrals – a Swedish patient may contact either a GP or a psychiatrist within their county for a first visit. The decentralised Swedish health system generally allows county councils to set their own rules, but the autonomy is sometimes limited.

³⁹ *Alfa-avtalet* reimburses medical or psychologist visits by up to 95 SEK, inpatient care by up to 70 SEK and all costs for subscribed drugs.

While referrals are optional to regulate for most other specialities, psychiatry is part of an exception. Yet, this is true only for general psychiatry; which means that for teams and units specialised on specific diagnoses or groups, a referral is requested.

The inpatient capacity has been continually reduced over the years, resulting in a situation opposite to the asylum era. Sweden has become a country where inpatient beds are particularly rare in comparison to other West European countries. According to the WHO data base, only Italy, which is a country well known for its abrupt abandonment of the asylums in 1980, shows lower numbers (HFA-DB). In 2003, a debate on whether the number of inpatient beds had become too meagre took place (see chapter 3). The picture given was that the scarce resources of psychiatric care had led to a situation where people who asked for care, or whose needs were well known, were left behind. In the aftermath of this debate, the government appointed a national coordinator who would investigate the field for the coming years (Dir. 2003:133). The final report (SOU 2006:100) confirmed that both users and staff experienced that the number of beds was not in proportion to the patients that would need them (p. 114). However, they also concluded that the attainability and accessibility is very difficult to examine as there is a lack of data. The commission's impression was after all that (p. 118, my translation)

[w]hen it comes to content and quality of psychiatric care [we] judge that there are serious shortcomings in access to competence, staff, methods and ways of working, but also within the care organisation.

Statistics from later years show that there are today about 4,500 inpatient beds in Sweden. However, only 3,000 of these are available for general psychiatric care as the data also include forensic care, which should be related to a population of 9 million (Sjukvårdsdata i fokus 2010). The international data of chapter 2 showed that this is equivalent to a relatively low bed density.

The Achilles' heel of the Swedish health and medical care system in the 2000s is generally described as an inability to offer the requested care in every county, leading to waiting lists (Palier 2004). As a consequence, a

‘care guarantee’ was realised in 2005 guaranteeing a contact with a physician in seven days, a specialist in another 90 days, and the approved treatment within additional 90 days. This guarantee was turned into law in 2010 (SFS 1982:763, 3§). If care is not realised within these time limits, the patient is allowed to seek care in another county. The fact that referrals are not demanded eventually makes the number of waiting days fewer than for other areas.

The care availability is documented by the National association of local governments. Generally, the number of waiting days is understood to have decreased during the last years. However, statistics show that there is an important national variation and that some patients have to wait more than 13 weeks for a visit at a psychiatric unit.⁴⁰

Formally, the Swedish health care system allows the patient to choose between care providers within the borders of the county (and outside if the ‘guarantee’ is not fulfilled). Some counties have further underlined this freedom of choice by introducing a specific policy (*vårdval*), but this is rather a policy concerning care providers who are thereby differently reimbursed (per visit instead of a global budget), than users. It is also a fact that the patient choice is dependent on a multitude of care providers, which is not evident in this field, especially not in rural areas. Sweden reports, since long, a shortage of psychiatrists and recruitments are of course more difficult in some geographical areas (Socialstyrelsen 2010).

Provision and administration

Split of public agents

Swedish health care is characterised by a public centred, but decentralised system. Health care is the responsibility of 22 county councils. While the counties have to follow national laws and regulations, they may implement care according to their own policies. In theory, this could increase the risk of a heterogeneous supply. Still, comparable statistics have not been developed to measure such effects, at least not in the psychiatric field. Planning and supervision is maintained by the Department

⁴⁰ www.vantetider.se 2009-04-20

of Health and the National agency of health and welfare. The county councils are responsible for funding and planning within their region, as well as provision.

Public-private mix

As an effect of local self governance, the public-private mix will vary geographically. Some counties have chosen to purchase more private care than others. Nevertheless, health care is public centred in Sweden. In general, the county councils purchase about 10 percent of its medical care from private providers. Most private providers are found in primary care, representing about a fourth of the care services. In 2006, the private sector represented 6 percent of the publicly financed care, varying from about 1-10 percent in different counties (SKL 2007, table E31). In addition, psychiatrists may also offer care that is entirely disconnected from the public sector. However, this care is not covered in national statistics and of minor importance. As mentioned earlier, the presence of private insurances is also negligible in Sweden.

France

Entitlement

Entitlement to medical care is similar to the Swedish case: it is a universal right for all citizens and patients are free to contact any doctor or psychiatrist (*Code de la sécurité sociale*).

Charges

In line with the Swedish case, there are a number of different designs when it comes to how this care is charged. Charges for publicly funded outpatient care are either regulated⁴¹ or not⁴², but they are flat rate in the

⁴¹ *Secteur 1*, charges set at 22€ for a GP, 25€ for a specialist, 37€ for a psychiatrist in 2009. This charge will be reimbursed by social insurance (*assurance maladie*) and is called *ticket modérateur*. On top of this, a doctor may charge extra, but that cost can only be covered by complementary insurance schemes (*mutuelles CMU-C*).

sense that they are independent from means or contributions. Two types of contracts exist for providers to choose between if they are connected to the publicly funded care. Private doctors may also choose to be all disconnected from the public sector, but they are quite rare. Such care is unregulated and can only be reimbursed by private means.⁴³

Similar to Sweden, a different design is used for inpatient charges. Psychiatric inpatient care is less charged than general inpatient care, but contrary to outpatient care, this charge is not reimbursed by the social insurance scheme. However, people on low incomes (receiving disability benefits or CMU, see below) are exempted from charges.⁴⁴ Consequently, this cost is means and income related.

The system of reimbursements further complicates the picture. When the health insurance system (*l'assurance maladie*) was once constructed, it was based on the idea of full employment, that is, that profession-based funds would cover all citizens. A number of funds are in place both for the employed and the self-employed. The largest of these funds covers 85 percent of the working population. These funds are governed by a State agency. Privileges will differ between funds; this system has clear stratifying effects both between professions and between the working and non-working population. As it became evident that some residents were not covered by these schemes, for example because of unemployment, a complementary State scheme was introduced in 2000: the *Couverture maladie universelle, CMU*. This is also a contributory system to which a person applies for adherence. For those on a low income, adherence is free.⁴⁵ There are also means tested benefits to cover for the 'top-up' kind of schemes (*CMU-C*). Less than one percent of the population is estimated to be concerned by the CMU (Durand-Zaleski 2008). Conse-

⁴² *Secteur 2*: charges are set by each doctor. Social insurance will only reimburse parts of the expenses (about 70 percent of sector 1 charges), the rest may be covered by complementary schemes, except for 1€.

⁴³ *Secteur 3*: charges are set by each doctor. Social insurance will reimburse the costs by about 1€.

⁴⁴ *Forfait hospitalier*: Psychiatric inpatient care is charged 12€ (general inpatient care 16€). This charge is not covered by social insurance, but may be covered by complementary schemes.

⁴⁵ Taxable annual income of maximum 7,447€ for a one-person household in 2009.

quently, the system could today be described as building the basis for de-commodification, even if it is also true that these patients are less 'profitable' and hence at risk of not being accepted.

Over 92 percent of the French population subscribe to a private insurance, mostly as a result of employment contracts (Durand-Zaleski 2008). However, some payments are non-reimbursable, independent on insurance adherence. This is the case for the patients who ignore the house doctor policy. However, the out-of-pocket cost stays at 1 Euro per visit (Ibid.).

France hence contains different logics not for entitlement to care, but for how charges are set and how the care costs are covered for the users. There is a division where the public system takes responsibility for the more 'difficult' citizens, in the sense that they diverge from the thoughts behind the system (which did not count on long-time labour market absence). Non-public actors cover the working population while the state covers up for those that 'fall between'; those with a low(er) capacity of commodification. This safety net of last resort plays a minor role as most citizens are covered by the employment related and private schemes.

Accessibility and attainability

Patients are free to contact any doctor or psychiatrist. This last feature is a core characteristic of the French health system where the autonomy of the physician is highly treasured. For budgetary reasons, a new policy was introduced in 2004 encouraging patients to appoint a house doctor (a specialist or a GP) that should always be contacted in the first place. However, this has not out ruled the freedom of choice.

In 2006, there were 55,701 full-time inpatient beds in France, which should be related to a population of 65 million people. According to the WHO database, France has, in a European perspective, a large bed density. Consequently, it is perhaps not surprising that access to care is not described as a problem. Contrary to Sweden, no national report has suggested an increased number of beds. What is described as a problem is that the care is unequally spread over the country (see chapter 3). This should show that a centralised system is not necessarily more efficient

than a decentralised system in creating a homogenous supply – decentralisation is one of several grounds for veto positions. Another ground is, as seems to be the case in France, the presence of a private sector, where professionals may establish their clinics independent on population needs. Consequently, there is an overrepresentation of psychiatrists in popular areas, and an under-representation in less popular – and rural – areas (Cases & Salines 2004).

Generally, in accordance with the policy goals expressed by the government, the number of beds for full time hospitalisation has diminished over the years, while it has increased for *hospitalisation partielle*. All in all, the number of beds – the possibility of hospitalisation – has been reduced. In the material studied, the reduction is approved as a problem only in the official presentation of the 2005 plan where it is said that further reductions shall be temporarily stopped, until it is ensured that alternatives are really put in place. Nevertheless, in the final plan this interruption was no longer to be found among the suggestions.⁴⁶

Provision and administration

Split of public agents

The administration of the psychiatric field, as the medical sector in general, is split on numerous public agents on national and local levels (de-concentration), with some involvement of regional agents. Their missions are not easily separated from each other and the administrative organisation of care is particularly difficult to grasp as it contains so many parallel patterns (Cases & Salines 2004).

According to the *circulaire* of 1990, the sector teams are to be in contact with any other care actor in the field, and the generalists and private care actors are supposed to be informed of the sector function. Nevertheless, the coordination rests a problem, not least since the roles of the different actors – in private and public organisations and in social and

⁴⁶ According to Deboux and Bonnafous (interviews 29/04/2004) the first proposal should be understood in relation to the dramatic events in Pau in December 2004 when a patient killed two nurses. This event provoked a debate on the reductions in psychiatric care and an attempt from the minister to calm the professionals.

medical fields – are not really defined (Reynaud et al. 2000: 23). Hence, coordination and national steering seems as problematic in a context of de-concentration as one of decentralisation.

Public-private mix

The French health system is characterised by a public-private mix of providers, but there are differences to be noticed between in- and outpatient care sectors. A majority of the full-time inpatient beds, 68 percent, is provided by public actors, while about a fifth is found in the for-profit private sector and the rest in the non-profit part (DREES 2007:618). Also for providers offering part-time care, public providers dominate (89 percent according to Cases & Salines 2008:183). By contrast, about 50 percent of the psychiatrists work in the private sector (DREES 2003). As most inpatient care is public centred, this should mean that they are to be found in outpatient care.

As was discussed earlier, the charging system involves non-public actors, both non-profit (*mutuelles*) and for-profit actors (private insurances). This means that there is an important mix of private and public actors in both the funding and provision of care.

England

Entitlement

The ground for entitlement is exactly the same in England as in Sweden and France: entitlement to subsidised medical health care is universal: all citizens are included independently of means and contributions.

Charges

When it comes to charges there is an important difference. Contrary to the other countries, publicly funded health care in England is free of charge at the point of delivery. Privately funded care is not regulated and may only be reimbursed by private insurance. According to Boyle (2008), 12 percent of the British population is covered by private insurances,

which may be compared to almost all citizens in France, and almost none in Sweden.

However, patients pay for being prescribed drugs. Generally, a flat-rate prescription fee per item is used. There are a number of grounds for being exempted from this charge, and also ways of limiting the costs. A first reason for charge-free medication is low means and incomes. The NHS Low Income Scheme regulates these levels, which are equivalent to for example the income-related disability pension or income support.⁴⁷ A second reason is age: people over the age of 60 do not pay prescription charges. This means that charges are means, income and age related.

A person may also be exempted from charges based on of her/his disorder or disability, through what is called a 'medical exemption certificate'. Only some diagnoses are formally accepted by the Department of Health, for example diabetes and cancer. These groups have been recognised as users whose treatment costs should not be an individual burden, without regards to the personal financial situation. However, no psychiatric conditions or mental disabilities are included in this exemption at present. Another medical ground for being exempted is if a person receives inpatient care. In this case, no difference is made between diagnose groups. There are also ways of limiting the costs, comparable to the Swedish ceiling. This is called 'prepayment schemes', which means that one pays a fixed sum instead of per item. The annual prescription cost is then limited. This is available for all users.⁴⁸

Accessibility and attainability

Another difference from Sweden and France is that access to specialised care, including psychiatry, is restricted by referrals. Since 2009 patients have a legal right to choose between providers as long as they meet set standards and costs. However, some specialities are exempted from this

⁴⁷ The prescription charge was equivalent to £7.20 /item in 2009. When household means (capital and savings) exceed £16,000 (or £23,2500 if permanently living at care home) you are not eligible for the Low Income Scheme. A low income is equivalent to levels of income supplies, for example the income-related disability pension. Source: NHS website 2010.

⁴⁸ The costs are then limited to £140.

right, mental health being one of these cases. Hence, it is the opposite situation compared to Sweden where referrals where possible, but not for the area of psychiatry. The national policy is that the period between a GP referral and treatment should not exceed 18 weeks. This policy turned into a legal right in 2010. Statistics do not tell whether there are waiting days for mental health as this area was generally not included in the 'guarantee' and therefore not monitored (Healthcare commission 2007), and since the law is very recent.

Overall, the public documents (for example the NSF) is not concentrated on questions of attainability or access, but on 'high quality care', that is, questions of evidence based treatment, user and carer perspectives etc.

Provision and administration

The NHS of 1948 constituted a publicly funded, owned and provided health care. However, reforms have opened up for private providers to compete for the public funding; resulting in a 'new NHS' (Talbot-Smith & Pollock 2006). These reforms were initiated during the Thatcher government and have developed ever since. What started with an outsourcing of non-medical duties has developed into a market also for clinical providers in the 2000s. Talbot-Smith and Pollock (Ibid.: 7) describe the new role of the NHS as

A sort of holding company, 'franchising' health services out to various providers, public and private. The NHS is to be the government-funded payer, but less and less the direct provider, of health services.

As for the other countries in this thesis, psychiatric care is foremost publicly funded, but provided by both public and private agents under the organisation of the NHS. When it comes to inpatient care, private establishments⁴⁹ are in majority and have increased considerably during the

⁴⁹ Private providers are labelled 'independent' in national statistics, which formally includes both for-profit and non-profit agents. The Healthcare commission is the national agency for assessing both public and private sectors in England since 2004.

last years, but as they are small in size most patients are therefore nonetheless treated by public providers. Still, the proportion of inpatients in privately provided care has been rising during the last years according to national statistics: from 9 percent in 2005 to almost 13 percent in 2008 (Healthcare Commission 2008). This resembles the figures for Sweden.

For outpatient care, statistics do not differ between providers (personal correspondence NHS Information centre).

Comparative discussion

In all three countries, different kinds of psychiatric in- and outpatient care is present in such a variety that their content is impossible to describe in general terms. At the same time, all countries apply the policy that primary care should bear the greatest responsibility for treatment; that patients are primarily supposed to use general practitioners, GPs, and the general care system. As an effect, psychiatry tends to treat patients with the most difficult disorders while the majority of the patients are directed towards non-specialists.⁵⁰ In other words: it is not possible, neither plausible, to suggest that the care content differs in any structural way between the countries. The analysis of the five design elements is summarised in the table below.

⁵⁰ Contrary to in France and England, also GPs have a specialist training in Sweden. Still, they are of course not specialised on psychiatric disorders to the same degree as a psychiatrist.

Table 5. Predominant characteristics of medical treatment

	Entitlement	Charging structure	Accessibility & Attainability	Provision & administration
Sweden	Universal	<i>Charges?</i> Yes <i>Flat rate?</i> Partly <i>Proportional?</i> Sometimes to income, age, length of stay <i>Reimbursement?</i> Primarily through universal, national ceilings for care and drugs. Private insurance rare. Employment-related schedules exist.	<i>Referrals?</i> No <i>Duration?</i> Needs based <i>Availability?</i> Waiting lists, but guarantee should limit waiting days <i>Coverage?</i> Not known. <i>Reported problems?</i> Scarcity of inpatient care. Scarcity of psychological care. Geographical heterogeneity. Coordination.	<i>Administration?</i> Primarily local government, but also national government and State agents. <i>Public provision?</i> Main provider <i>Private provision?</i> Minor provider
France	Universal	<i>Charges?</i> Yes <i>Flat rate?</i> Partly <i>Proportional?</i> To contribution <i>Reimbursement?</i> Primarily through employment-related schedules combined with private insurance. Also income-related national scheme.	<i>Referrals?</i> No <i>Duration?</i> Needs based <i>Availability?</i> Easy <i>Coverage?</i> Not known <i>Reported problems?</i> Geographical heterogeneity. Coordination.	<i>Administration?</i> Primarily national government and State agents, but also regional agents <i>Public provision?</i> Main provider of inpatient care <i>Private provision?</i> Equal split of public and private outpatient care
England	Universal	<i>Charges?</i> Not for care, but for drugs <i>Flat rate?</i> Partly <i>Proportional?</i> Sometimes to means, income, age, disorder. <i>Reimbursement?</i> Universal, national ceiling for drugs. Generally full cover. Private insurance rare.	<i>Referrals?</i> Yes <i>Duration?</i> Needs based <i>Availability?</i> Not known. <i>Coverage?</i> Not known. <i>Reported problems?</i> Scarcity of psychological care. Geographical heterogeneity. Coordination.	<i>Administration?</i> National government and State agents <i>Public provision?</i> Main provider <i>Private provision?</i> Minor provider

Entitlement

When it comes to entitlement, all countries use the same design, universality, and logic, all citizens in need of care should be able to access care without any other request than that they have a need for it. This is not in line with the regime theory, but neither a surprise as it reflects the results of earlier studies (Bambra 2005; Jensen 2008). As was shown in the previous chapters, health care was then identified as a non-ideological welfare area.

Charges

The second element, charges, was more complicated to categorise. It also revealed differences. The idea of categorisation is based on an expectation that a country will represent *one* type of design, at least per policy field, and per element. However, both France and Sweden use several designs for charges: flat rate for outpatient care and drugs, but proportional (to income, means, age, length of stay) for inpatient care. Furthermore, all countries use reimbursement schemes in order to limit the expenses for frequent users. Interestingly, this did generally not include inpatient care. The schedules were designed as part of social security, which in Sweden and England means that all citizens are connected to the same system with the same limits, while it in France means that rules will differ between schemes. Private insurance was frequent only in France.

The policy logic, the idea behind the design, is in all cases that no citizen should be burdened by medical costs, neither for care, nor for drugs. Still, the logic is also different, as France uses a design where the result will differ between citizens leaving them with different choices when purchasing care if they are to be fully unburdened, while Sweden and England uses a design that should guarantee a more similar situation. Hence, the French design does not share the idea of equality with the other two versions. Still, as was noticed earlier, the English design of a truly charge-free solution for all citizens is even more likely than the Swedish one to guarantee an equal result, at least for purchasing publicly funded care, which constituted a majority of the provision. In Sweden,

the ceiling leaves open for employment-related and private parallel systems that leaves some citizens better off than others, based on private means and employment contracts. However, this is of theoretical importance, but of little practical relevance. From a user perspective, it does not make a big difference as the outcome is the same – charges are subsidised and limited.

Accessibility and attainability

Formal obstacles to access – referrals – are used only in England. On the other hand, both England and Sweden use referrals for some specialities, but not for others which reveals the fact that any general conclusions (for other target groups) are difficult to draw. On the other hand, it draws the attention to the fact that patients are not treated in the same way – which was true also for reimbursement schemes – which may be interpreted as a form of stratification.

For most, access and attainability was hard to describe. What can be said is that the inpatient care has been considerably reduced, but that this is only regarded as a problem in Sweden. Here, the bed density seems to have been most radically reduced, which is not easily explained from a welfare state context perspective. If anything should be expected for Sweden, it would be a generous service. Moreover, the supply of outpatient care was rarely measured. Both England and Sweden used care guarantees, intended to limit the waiting days but it was not evident to depict the existing waiting lists or the eventual effects of the guarantee.

Administration and provision

When it comes to provision, Sweden and France show the expected characteristics, but England has a greater emphasis on public provision than the liberal model would suggest (because of the NHS which was no empirical news). However, in all three countries, hospital care, especially inpatient care, that is, the most ‘heavy’ part of treatment is in the hands of public providers. This indicates that public and private providers are playing different roles no matter what kind of model (a public centred or mixed design). The difference is that they are present to a greater or

lesser degree in different national contexts. The private sector is most important in the country where private insurances are widespread.

All three countries have a non-regulated private sector, funded through patient charges and private/occupational insurances, but it stays minor in relation to the publicly funded and provided care.

The health care systems in general, but also the psychiatric field, are characterised by institutional fragmentation in all countries. The fact that a health system is national or not does not seem to make an important difference. In both cases, there are so many actors involved in the administration and provision of treatment that the outcome cannot be described in other terms than fragmentation. In both kinds of systems this seems to result in problems of providing a heterogeneous supply within the nation. This seems to be as problematic in the decentralised Sweden as in the centralised English and French systems. In the French system, one might argue that this is due to the steering problems of a system with such an influence of private providers that do not have to take population needs into account. Nevertheless, variations are present also within the NHS, leaving us with a conclusion that geographical variations occur and are difficult to address in all contexts.

De-commodification and stratification

This means that access to care is not restricted by means or contributions – no one should be denied medical treatment on formal grounds as long as they show a need for it. Such features are instead considered when setting the treatment costs. The three countries represent separate and diverging design for care charges, which contradicts the idea of a connection between the logic of entitlement and of charge levels. As was shown, universal entitlement does not necessarily mean that there are no charges, or that charges are flat rate. While all three systems must be considered to have de-commodifying effects, both Sweden and France have stratifying effects, but in different ways. While the French system creates differences between professional groups and between workers and non-workers, the Swedish system creates differences between geographical areas; a non class-based kind of stratification. The English

system must be considered as having few stratifying effects, but it does differ between patient groups when it comes to prescription charges as only some chronic diseases are exempted. This may as well be described in terms of stratification.

Conclusion

Did each country deliver consistent design and logics? Can they be summed up as similar or different? The answer must be that they show different designs but similar logics, in the sense that the public mission of offering medical treatment was important in all three countries, that the care was not costly and did not request anything beyond a medical need. At the same time there were differences: private providers are less important in Sweden. However, as a consequence of national politics (the centre-right wing government of 2006-2010 encouraging privatisation), this might be in change. The national diversity of designs was also striking, foremost in France but also in Sweden, which makes these countries difficult to summarise in any holistic way. In ideological terms, Sweden and England show the most social democratic traits, while France is an interesting mix of conservative (charges and reimbursement), liberal (the importance of the private sector) and social democratic (the universal entitlement and reimbursement scheme) traits.

Chapter 5

Mental health and financial support

Chapter five outlines the most important cash transfers that are directed to people with mental disorder and disability. The question of income security is especially important for this group as poverty seems to be connected to mental problems both as being a result of living with mental disorder, and as being a risk factor for developing mental disorder. Hence, the target group may be expected to have financial needs already at the start and these will deepen if the disabilities are persistent. The aim of these transfers may be what I have defined as either *income replacement* or *financial compensation*.

The first kind of transfers are used when a person is not able to earn a regular income temporary or continually. The most common examples are sick pay and disability pensions, and the different designs of these two schemes will be outlined here.⁵¹ The second kind of transfers covers the extra expenses that the disorder/disability causes. This often means to cover the expenses of certain services, but it may also be a compensation for low incomes if the income replacement stays at low levels. As will be shown, the design and logics of these different kinds of programmes are not necessarily the same.

⁵¹ I will use these two concepts for outlining what cash transfers that are in use to cover up for shorter (sick pay) or longer (disability pensions) absences due to mental disorders and its disabling effects. Alternative concepts would have been for example sickness benefit for the first or invalidity/early retirement pension for the latter.

Sweden

People with mental disabilities have been found to have lower incomes than the general population in Sweden. Even if there are other disability groups that score even lower, no other group shows as many with extremely low incomes, or as many who find it hard to live on their income (SOU 2006:100, p. 96). There are probably many reasons explaining this situation and the mental health commission of the 2000s discussed the following: they are compensated to a lesser degree for their expenses, they are not enough supported in keeping a budget, they are more often vulnerable to alcohol/drug dependence, and they are to a greater extent not active in the labour market (SOU 2006:100, p. 96f). Still, there are a number of public programmes that are supposed to cover up for the risk of not being able to earn a regular income.

Income replacement

In Sweden, both sick pay and disability pension are part of the social security system and hence administered by the national insurance agency, which decides on whether the medical condition is accepted as a reason for absence from the labour market. For eligibility to sick pay, the disorder must be considered to decrease your working ability by at least 25 percent. Moreover, entitlement to sick pay is employment related, that is, based on compulsory contributions through your salary or, if a person is self-employed, by optional contributions. The adherence to this insurance is realised after one month of employment, or after having worked for at least 14 days in a row. This means that without *any* work experience, a person is not entitled to sick pay, but on the other hand, the employment period may be relatively short.

During the first 14 days of sick leave, the employer provides the benefit, thereafter it becomes a responsibility for the insurance agency.⁵² A doctor's certificate is needed after 7 days of absence. During the 1990s, one waiting day was introduced (and another has been debated), but there is an annual maximum of ten waiting days to lighten the effects. The sick

⁵² The first 14 days of benefit is called *sjuklön*, the following days are called *sjukpenning*.

pay is also income related, that is, the compensation is equivalent to about 80 percent of your income up to a certain limit.⁵³ According to recent reforms, a person is accorded sick pay in two steps: after a first assessment for 364 days during a period of 450 days and later eventually for another 550 days. For the first 90 days your ability is only considered in relation to your present work assignments, after another 90 days it is considered in relation to other assignments that your employer could offer. At that point, if the social insurance agency considers that a person is not probable to recover enough for working at the old employer within a year your ability will instead be considered in relation to the labour market at large. Hence, instead of being assessed further days, a person may be denied sick pay and asked to apply for new jobs and for unemployment allowance. If not, and after a year, the sick-pay period may be extended for another 550 days. During the extended period, the compensation is reduced to 75 percent. This is if your condition is not considered as life threatening; in that case it may be prolonged for an unlimited amount of time and stays at 80 percent.⁵⁴ Private insurances may top up compensations, but there are no statistics on how many Swedes that subscribes to such schemes privately or through employment-related contracts. Also, those who are unemployed are eligible for sick pay if they are registered at a job centre. However, their compensation will stay at lower levels.⁵⁵ An individual with no experience of work, and hence no earlier income, will not be eligible for sick pay.

The *disability pension* is used when a person is not considered to have a work capacity even in the long run. It is possible to apply for the disability pension after the sick-pay days have expired, or at an earlier stage. Two schemes are used depending on age: one for those aged 19-29 and one for those aged 30-64.⁵⁶ The prerequisite for touching these pro-

⁵³ The ceiling was equivalent to an annual income of 321,000 SEK in 2009 (about 3,000€ /month).

⁵⁴ The first example is called *förlängd sjukpenning*, the second *fortsatt sjukpenning*.

⁵⁵ The income compensation will then be adapted to your unemployment benefit level, which has a lower ceiling. Income replacements for unemployment are selective demanding both a history of membership and of labour market participation.

⁵⁶ The first is called *aktivitetsersättning*, the second *sjukersättning*. Earlier labels have been *sjukbidrag*, *förtidspension* and *invalidpension*.

grammes is an evaluated invalidity of at least 25 percent (i.e. to be partially or fully absent from work) that is supposed to last for at least one year for the younger group and permanently for the older group. Compensations are lower than for sick pay: 64 percent of the earlier salary. If a person has low or no earlier incomes, there is a guarantee level.⁵⁷ Since reforms in 2008, the pensions are to be understood as time limited; even if your incapacity to work is considered to be permanent (still a prerequisite for entitlement), the insurance agency will continually check that your ability has not changed for the better. Since that year, it is also possible to start working or studying, in the aim of testing your ability without losing your pension entitlement (during some month one may touch both salary and pension, but register that one is working).

Hence, the basic income support programmes are earnings related and selective, but with a universal safety net for those without a history of work. Without the 'welfare base' of an earlier income and employment a person will not be without income, but stay at relatively low levels (cf. Nationell psykiatrisamordning 2006c). This has major impacts on the incomes of those who fall ill early in life, as is often the case for mental disorders. The system is stratifying between those with and without 'commodification capacity', but also between income groups.

Mental disorders dominate in recent sick-pay statistics, constituting the reason for sick leave for about one third of all beneficiaries (*Pågående sjukfall, Försäkringskassans statistik 2005-2009*). Mental disorders are also the most or the second most common causes for long periods of sick leave (two years or more, *Avslutade sjukfall, Försäkringskassans statistik 2005-2009*).

The number of disability pensions based on mental disorder has risen from 8,000 in 1979 (Socialstyrelsen 1980, p. 34) to 85,000 in 1997 (Socialstyrelsen 1998, p. 114), and 170,000 individuals today (Försäkringskassan, personal correspondence). Actually, in 2006 mental disorders had become the most common ground for new admissions of disability pensions and represented 40 percent of all cases (Försäkringskassan 2007a, p. 6). This should mean that access to disability pension is not

⁵⁷ The lowest level is set to 8,560 SEK/month (before taxes) in 2009. The ceiling is the same as for sick pay.

problematic. On the other hand, one might argue that the welfare state has become stratifying in itself as it has directed this population away from occupational activities towards a permanent exclusion from the labour market already at young age, trapped with low incomes (Försäkringskassan 2007b).

The health insurance system has been in use since 1955, but reformed at several times, not least during recent years. The changes have included restrictions aimed at lowering the national expenses, such as waiting days (which have varied between 0-3 days) or reduced compensation levels (which were as high as 90 percent during the 1970s-90s), but also entitlements. During the last years, the duration of the schemes have been debated as 'lock-in' effects have been noticed; people with work capacity stay on sick leave only because they are not properly rehabilitated or because their working options are not fully considered (Ståhlberg 2008). Still, it has been debated whether a reformed system would push people back in the labour market too roughly. It is quite possible that the agency, the treating doctor and the user do not agree on the individual's capacity, but the decision is still only in the hands of the agency. At the same time, a disability pension may constitute a final 'exit' from the labour market.

Financial compensation

As a complement to sick pay and disability pensions there are some minor sources of incomes. Two will be mentioned here. First, *LASS*⁵⁸ that is explicitly used to cover expenses for those entitled to personal assistance (explained in chapter 6). This benefit is flat rate and paid by the municipality or the national insurance agency. The first is responsible for less extensive assistance (up to 20 hours a week), the latter for more extensive assistance. Provision of the service is realised by the user.⁵⁹

The second transfer to be mentioned is the *disability allowance*, which is supposed to cover important extra expenses caused by the disorder/disability, for example treatment, special housing, drugs, personal

⁵⁸ *Lagen om assistansersättning* (SFS 1993:389)

⁵⁹ In 2010, the LASS is equivalent to 252 SEK/hour, or if motivated, to a maximum of 282 SEK/hour.

support etc.⁶⁰ The expenses must exceed a certain sum annually (otherwise they are not considered ‘important’) for mental disabilities.⁶¹ Some other disability groups are exempted from this demand, that is, they automatically receive the lowest level of allowance (or more if they can show further costs). This is true for individuals who are blind or deaf (the allowance was originally constructed for the blind, SOU 2006:100, p. 335). As was discussed in the previous chapter, this kind of design may be described in terms of stratification – the system treats patient and disability groups differently which should reflect their various statuses.

Furthermore, the disability allowance is part of the social insurance agency responsibility and the amount will vary with your need and expenses up to a certain ceiling. It may also be restricted if accorded other allowances. The need must be considered to last for at least a year. Hence, both compensations are flat rate, but only the second is related to actual costs.

According to national investigations, both benefits are rare when it comes to this disability group (SOU 2006:100). Instead, personal assistance and disability allowance are foremost used by persons with physical disabilities. This problem of access and attainability contributes to create stratification between disability groups, as well as in relation to the general population as it may be assumed that this contributes to the financial gap that exists. The commission of 2006 suggested that this problem of access and attainability may be explained by an unawareness both from behalf of the target group (resulting in that they do not claim the benefit or do not argue well enough in their applications) and the administrators at the national insurance bureaus (who deny applications). Therefore, the commission suggested that the disability allowance should be truly universal, that is, that mental disability should be added to the target groups that receive the allowance without an individual examination (SOU 2006:100, p. 337).

⁶⁰ In 2010 the disability allowance is equivalent to 15,2264-29,256 SEK/year dependent on degree of impairment and expenses.

⁶¹ In 2010 your costs must exceed 12,084 SEK/year.

France

Income replacement

The French system of *sick pay* involves more variation than the Swedish version. The general sick-pay scheme is a cash transfer based on medical verification through a doctor and contributions to professional funds through your salary or, as an alternative, on labour-market participation.⁶² The applicant needs a certain income level, or at least 6 weeks of full time work experience during the latest 3 months to be eligible for 6 months of sick pay. This means that sick pay is selective and that entitlement criteria are more demanding than in Sweden. Furthermore, there are three waiting days and it is limited to 360 days at the most (running over 3 years). The administration of sick pay involves a number of funds and the local social security administration.⁶³

Compared to the Swedish version, the compensation is relatively low: around 50 percent of the income. Furthermore it is restricted by a comparatively lower ceiling.⁶⁴ Unlike in Sweden, the family situation is considered when setting the limits, allowing higher levels for families with children. Furthermore, family members are included in the insurance. If a person is unemployed, but with a recent labour market experience (during the last year) and entitled to unemployment benefits, (s)he is entitled to sick pay, but adapted to the unemployment benefit level.

As a consequence of the low compensation, about 85 percent of the French citizens also subscribe to private insurances that further compensate the income loss.⁶⁵ There are numerous insurances to choose between and the compensation varies significantly.

The room for particularities is hence important and connected to your status and active choices. No figures on attainability are available, probably as a consequence of the fragmentation.

Entitlement to a *disability pension* is due to a recognised incapacity to work (that must be at least two thirds), to a history of contributions to the

⁶² *Indemnités journalières*.

⁶³ *Caisse primaire d'assurance maladie*, CPAM.

⁶⁴ Generally 46,21€/day at the most, but more if you have three children.

⁶⁵ *Indemnités supplémentaires*.

social security system and to a history of labour market participation.⁶⁶ The benefit will be equivalent to 30-50 percent of the former income depending on the disability level. Users are categorised in relation to their disability: some capacity to work, no capacity to work, or no capacity to work as well as an extensive dependence on personal support. For lower levels of disability, the allocation is supposed to be complemented by a salary. The pension cannot exceed a certain amount; neither may it fall below a minimum.⁶⁷ The disability pension is not permanent, as it leaves open for an increased capacity over time. Unlike in Sweden, the application may be realised by others than the individual; the treating doctor or the insurance agency itself (the *caisse d'assurance maladie*). People with mental disabilities constitute the most important group of recipients, constituting about 28 percent, or 20,850 individuals, in 2006 (CNAMTS 2008). This reveals that people with mental disabilities are an institutionalised target group for this support, but it does not reveal to what degree it reaches those who would need it. What can be said is that the users have augmented considerably during the last years; an increase with about 35 percent since 1998 (Ibid.).

In addition to these basic schemes, France has introduced a third type of income compensation which is *not* based on contributions or labour market participation: the disability allowance, *Allocation aux adultes handicapés*, AAH. This benefit was introduced in 1975 as an effect of the disability legislation. In 2007, it was the income of about 750 000 individuals, 28 percent of them registered as having mental disabilities, which corresponds to the largest group of beneficiaries (Drees 2008:640). The recipient must be considered to a certain level of permanent incapacity. If this is below 80 percent, the applicant must answer to two further prerequisites: having recognised difficulties of obtaining an employment as a consequence of the disability and not being employed for the last year. The AAH is means tested and means related, that is, selective but on another basis than sick pay and disability pensions. Personal resources will adjust the benefit level, leaving the maximum level to

⁶⁶ *Pension d'invalidité*. One year of contributions is required.

⁶⁷ The minimum level was equivalent to 3,097€/year in January 2008, the maximum level to 9,982.80-16,638€ depending on incapacity.

those with low private means.⁶⁸ As the transfer is not extensive, it may be combined with other sources of incomes, for example a disability pension. However, in that case the levels will be adjusted so that they do not reach a certain ceiling. The AAH is administrated and provided by different agencies adhering to the social security system and the local handicap administration.⁶⁹

Financial compensation

In France, there is an important number of complementary benefits that are supposed to 'top up' the basic schemes. Two schemes are connected to the disability allowance (the AAH), which means that entitlement is due to being an AAH user. Therefore, indirectly, they are all means tested. Furthermore, entitlement is based on a high level of disability (incapacity of at least 80 percent) and on having an independent housing situation, which means living by your own or with a family. The first allocation is directed towards those with a housing allocation and some work capacity (5 percent at the most): the *Garantie de ressources des personnes handicapées*.⁷⁰ The second instead turns towards those who are considered not to have any work capacity at all, and who receives some kind of housing support (service or transfer): *Majoration pour la vie autonome*.⁷¹ These reimbursements are administered in the same way as the AAH.

There are also ways of topping up the disability pension. First, if it is inferior to the AAH, it will be adjusted to the AAH level (AAH is then

⁶⁸ Your annual incomes may not exceed 8,179,56€ (higher if you have children). The maximum level of AAH was 681.63€/month in 2010.

⁶⁹ The CAF, *Caisse d'allocation familiale*, or *Mutualité sociale agricole* for provision, CDAPH, *Commissions des droits de l'autonomie des personnes handicapées* at the MDPH for examination.

⁷⁰ Equivalent to 179,31€ in 2010.

⁷¹ Equivalent to 104,77€ in 2010. A similar allocation was used until 2005: *le complément de l'allocation pour adult handicapé*.

used as a financial compensation). There is also a means-tested complement for those with scarce resources in spite of the disability pension.⁷²

Since 2006, there is also an allowance that may be comparable to the Swedish LASS, but with greater variation when it comes to the size of the support that may be purchased, the *Prestation de compensation du handicap*, PCH. This allowance is managed by a special fund,⁷³ as well as by the local handicap administrations.⁷⁴ It compensates for the costs of personal support in the daily life for those who have serious and definitive needs of support in at least one essential area for at least one year. This may for example be home help or social activities. The compensation is equivalent to standard amounts for each service and means related. Full compensation is only attributed to those with limited incomes, but all citizens will be compensated to at least 80 percent.⁷⁵

Consequently, all but one of these compensations are selective, and often in several senses: in terms of means, contributions, capacity and incapacity levels, housing situation. Furthermore, one of the income guarantees connected to AAH⁷⁶ is limited in time; ten years at the most, but generally accorded during 1-5 years.

There are no figures that illustrate how commonly these compensations are used by people with mental disability.

England

The social security system in the UK is known to be complicated both because of its fragmented feature and because of its complexities. There is not one main benefit that will constitute your basic income and cover

⁷² *Allocation supplémentaire du Fonds Spécial d'Invalidité*. Your annual incomes (e.g. allocations, pensions) must not exceed 7,859.08€. The allocation was equivalent to 4,520.24€/year in 2010 and exempted from taxes.

⁷³ CNSA: *Caisse nationale de solidarité pour l'autonomie des personnes âgées et des personnes handicapées*.

⁷⁴ CDAPH, *Commissions des droits de l'autonomie des personnes handicapées* at the MDPH for examination.

⁷⁵ *La Prestation de compensation à domicile/établissement*. The allowance covers expenses fully for those with annual incomes p to 24,259.88€/year and to 80 percent for those with incomes above that.

⁷⁶ *Complément de ressources*.

all, or most, costs, but a range of different benefits and grants that are supposed to cover up for specific costs. The result is a patchwork of income sources. It is not only difficult to understand what benefits that are relevant for the specific case, but also how to apply for them in a successful way. As a consequence, several voluntary sector organisations have specialised in giving advice and information through ‘citizens advice bureaux’ (staffed with volunteers), and the local authorities also provide guidance through ‘welfare rights offices’. Another example is the Disability Alliance who publishes an extensive handbook each year explaining all relevant benefits and the system at large.⁷⁷ The Department for Work and Pensions, DWP, has its own confidential phone line – the Benefit Enquiry Line – where citizens can make anonymous calls and the county councils might offer the DIAL – the Disabilities Information and Advice Line. An example of internet based services is the Benefits and Work website⁷⁸ initiated by a welfare rights worker where the claimants and organisations pay for getting in reach of ‘confidential’ information and general tips to ‘make the best possible claims and appeals, get the UK’s top guides and the DWP’s top secrets’. The challenge of navigation was confirmed in the national report of 2004, by the Social Exclusion Unit, where many from the target group reported that they lacked advice about claiming benefits and that they found the system confusing..

The Labour government introduced a Welfare reform act in 1999 aiming at ‘joining up’ among the many benefits and their different eligibility grounds, but Burchardt (2004) has difficulties in seeing any consistent programme or extensive improvements for the working age disability population, at least not in light of what was promised. Becker (2004) claims that the focus on ‘work for those who can’ has overshadowed ‘security for those who cannot’ (as was the Labour slogan) leaving the latter group without any real secure situation. As Becker points out, there are no minimum income standards in England.

⁷⁷ <http://www.disabilityalliance.org/>

⁷⁸ <http://www.benefitsandwork.co.uk/>

Income replacement

The English *sick pay* rules varies between employments and schemes and is in that sense a less politicised issue than in Sweden or France. Hence, your rights will be employment related in a wider sense in that your entitlement depends on employment history and the contributions that this indicates. Sick pay is thus highly dependent on contracts, agreements or practice developed at the present job. Usually,

[a] typical sick pay scheme /.../ starts after a minimum period of service (for example, a three month probationary period). You would then receive your normal pay during any period that you are off work due to illness, up to a specified number of weeks. After this, you are likely to receive half-pay for a further period before any sick leave you take becomes unpaid. (Government website⁷⁹)

As an effect of the private feature of these kinds of schemes, there are no common rules on entitlement, duration, waiting days and so on. However, for those who are not covered by a company scheme, there is a State-regulated version that employers must pay to those employees that fulfil the entitlement.⁸⁰ Entitlement to this scheme is employment and income related; the applicant has to be employed and started working and there is a lowest level of income to fulfil.⁸¹ As in France, there are three waiting days. Another prerequisite is not having touched unemployment or incapacity benefits during the preceding months, and not being hospitalised. These regulations are more demanding than in both Sweden and France. The publicly regulated sick pay covers 28 weeks and is flat rate at a relatively low level.⁸² Unlike in France and Sweden, it is paid by the employer, that is, not part of a social security system. Due to this diverged feature, there are no available statistics on the attainability.

As in Sweden, the cash transfers directed at people that experience longer, and supposedly more permanent absences than is covered by sick

⁷⁹ http://www.direct.gov.uk/en/Employment/Employees/Pay/DG_10027238

⁸⁰ Statutory sick pay.

⁸¹ You have to earn at least £90/week on average (2009).

⁸² Equivalent to £75.40/ week in 2009.

pay have been reformed recently. What is here classified as a disability pension is equivalent to the *incapacity benefit* and *income support* until late 2008, and the *employment and support allowance* since then. As in the Swedish case, changes are officially motivated by a belief in a regained work capacity and a focus on abilities rather than inabilities. Consequently, the allowance is associated with support that is supposed to encourage a comeback in the labour market, not least through the help of a personal adviser. If possible, the pension should be combined with work and hence adjusted to a salary, but if the user is not understood to have a work capacity, it will be higher and work preparation only voluntary. A person is entitled to claim disability pension if (s)he is self-employed, unemployed, has used the 28 weeks of sick pay, or is not eligible for sick pay. Furthermore, the disorder/disability must decrease your ability to work during a certain number of days a week. If a person qualifies for these criteria, the capacity will be assessed for a period of 13 weeks during which one touches an allowance which is income and age related with a low maximum ceiling.⁸³ However, this assessment period may be avoided for some conditions for which disability is implied, including some mental disorders. Thereafter, the 'real' period starts if your application is successful.

The pension is then either contribution based or income related. The first applies if one has contributed enough through national insurance contributions (and labour market participation), the latter if one has not or is on low incomes. For the means-tested entitlement, also the working capacity of your partner is taken into consideration.⁸⁴ On the other hand, when receiving the income-related allowance, it may be topped up by further financial support. There are three waiting days, but this applies only to those who have not used sick pay. The rates are set at low-level ceilings, only slightly higher for those with no work capacity at all.⁸⁵ A person with an assessed work capacity who does not follow the work-supporting programme will risk losing the entitlement. According to

⁸³ The ceiling was set to £60.50/week for those over 25 in 2009.

⁸⁴ Your savings must not exceed £16,000 in 2009. Furthermore, your partner must not work for more than 24h/week.

⁸⁵ Ceilings are set to £84.50 or £89.50/week in 2009.

national statistics, 42 percent of the claimants of disability pensions do so for mental health reasons, which also include intellectual disabilities (The Cross-Government Health, Work and Well-Being Programme 2009: 41, personal correspondence).

Financial compensation

Sick pay and disability pensions can be complemented by other kinds of support of which the most common will be outlined below. The disability living allowance, DLA, is based on the logic that disability results in extra living costs that should be compensated for, such as personal care. Mental disability is an explicit target group and about 14 percent of the users are accorded on mental health grounds (SEU report 2004: 89). Entitlement is based on an assessed need both for the past and the future: a person should be able to claim need since at least three months and for at least the coming six months. This should be confirmed by medical examination. The DLA is universal and flat rate, that is, not dependent on contributions, incomes or means. In addition, DLA is not related to work capacity. There are two so called components meeting two different kinds of needs: care and mobility. For each component there are 2-3 dependence levels meaning that a person with extensive needs will have higher compensations than those with limited needs. Mental disorder/disability may be assessed the highest rates in both cases.⁸⁶

Furthermore, special funds and grants to support life outside of institutions are available, such as the independent living funds.⁸⁷ A person receiving DLA to the highest rate, who obtain social services to the value of a certain sum, and have limited resources, is eligible for this fund if (s)he is expected to be living in her/his home for at least the coming six

⁸⁶ Care component £18.95-71.40/week, mobility component £18.95-49.85/week in 2010.

⁸⁷ The first fund, the Independent Living (Extension) Fund, was closed for new applications by the end of March 1993, but is still administrating the old ones. The second fund, the Independent Living Fund (1993) concerns applications from April 1993 onwards. The new fund was formed to cover for the needs that the local authority does not account for. The funds have common administration, but contrary to the old fund, the new fund work in partnership with local authority.

months.⁸⁸ The money can be used to cover the costs for support carried out by an employed carer or personal assistant. The support must not be delivered by the social services or a relative living in the household. The amount will not cover all the costs as the user is supposed to contribute with her/his own resources, for example at least half of the DLA. Also other posts, such as *direct payments*, are encouraging the individual involvement in service provision, in line with a wider ‘choice agenda’ of contemporary (Labour) politics. In this case, a person receives an amount to purchase the services instead of passively receiving them from the local authorities. Anyone having assessed needs may demand direct payments from the local council.

Comparative discussion

The financial support is summarised in the table below. First, it may be concluded that the same kind of transfers were found in all three countries. Second, it may be concluded that these transfers followed different patterns *within* the countries. Hence, the result does not hold for stating that every country follows a specific design with a particular logic, neither is there a clear common pattern. Still, when mirrored against each other, some expected differences become visible.

⁸⁸ Support of at least £320/week from social services. Household capital (savings, investments etc., but not the property you live in) must not exceed £22,250. Incomes from work are not considered.

Table 6. Predominant characteristics of financial support

	Entitlement	Benefit structure	Accessibility & attainability	Provision & administration
Sweden	Primarily universal, but also selective	Earnings related or flat rate	<i>Obstacles?</i> Labour market participation sometimes required, indistinctness <i>Duration?</i> Not limited, except for sick pay <i>Waiting days?</i> No, except for sick pay <i>Attainability?</i> Rising numbers for income replacements, but rare use of financial compensation	<i>Administration?</i> Primarily one State agency, but also local government <i>Public provision?</i> Yes, primarily deconcentrated agency, but also decentralised agents <i>Private provision?</i> No
France	Primarily selective, but also universal	Earnings related, flat rate, or means related	<i>Obstacles?</i> Labour market participation sometimes required <i>Duration?</i> Not limited, except for sick pay <i>Waiting days?</i> No, except for sick pay <i>Attainability?</i> Rising numbers of income replacements, but not known for financial compensation	<i>Administration?</i> Numerous State agencies and funds, decentralised agency <i>Public provision?</i> Yes, through deconcentration <i>Private provision?</i> Yes, funds and private insurances
England	Primarily universal, but also selective	Earning related flat rate or means tested	<i>Obstacles?</i> Labour market participation sometimes required <i>Duration?</i> Not limited, except for sick pay <i>Waiting days?</i> No, except for sick pay <i>Attainability?</i> Rising numbers of disability pensions, but not known for financial compensation	<i>Administration?</i> Primarily national agencies <i>Public provision?</i> Yes, through deconcentration <i>Private provision?</i> Yes, funds and insurances

Entitlement

Entitlement is foremost universal in Sweden, as expected, but also in England. The exception is sick pay that is employment related in all three countries. Apart from disability pensions, sickness is understood as absence from a *place of work*, not absence from the labour market in general. As a consequence, those who fall ill before having a more or less stable employment situation will have to depend on other forms of income maintenance programmes. If the disorder is considered as severe enough, a person may instead be eligible for disability pension, otherwise (s)he has to turn to other means-tested schemes such as social assistance. This selectivity is important as it underlines how labour – and not citizenship – is the ground for essential welfare programmes, something that is not always recognised. Supporting people to work is then important not only for its supposedly positive social consequences, but also for opening the door to general welfare transfers. As was shown, it may also be important for allowing higher levels of support. Even if there are sometimes universal ‘backup’ schemes, these stay at considerably lower levels. This is true for disability pensions.

Selectivity is primarily used in France, where only the financial compensation of personal support is universal. For all other transfers, entitlement is based on contributions for income replacements and on means tests for financial compensations. There is also a means-tested income replacement. Put together, French transfers are primarily constructed as poverty reductions.

In one case, the English disability pension, also the household’s working capacity was considered. This design is rare, but based on the logic that income maintenance is a family responsibility. Other supports in the English package adhered to other logics; sometimes one policy had different tracks.

Benefit structure

It was not evident to compare financial support in economic terms. The real costs of living differ between the countries. Furthermore, there are

three different currencies whose value varies over time. The intention for this study was not to measure amounts of money, but to what degree a reimbursement covers up for income losses. A reimbursement level of 80 percent of the earlier income is then different from a level of 50 percent in that the first design aims at reassembling a 'normal income', while the latter is not. It is clear that the Swedish income replacement schemes had a more generous design than France, but the English version is difficult to compare as it has no set levels (private sick pay scheme), or has a level that is not in proportion to income (statutory sick pay).

Nevertheless, a number of compensations were found and they were based on standard amounts, not percentages of lost incomes. Earlier research gives little guidance on how to compare such support. In this study, the solution has been to compare them as such, and in terms of more or less, but not exact sums.⁸⁹ It may then be noted, for example, that the lowest level of disability pension is similar in France (AAH and its top ups) and Sweden (the guarantee level). The English disability pension only reaches half that level. The English user is then especially dependent on being able to construct a 'benefit puzzle'.

Income replacements were most often earnings related in all three countries, and financial compensations flat rate. However, in France and England the latter were sometimes means related, while they were never so in Sweden.

Also the financial compensations show differences worth noting. All three countries compensate for personal support services, but the Swedish LASS is more generous than the others as it does not demand personal funding as a general complement. It also gives more extensive freedom of choice than the English version in that it is not limited to some forms of housing (but one will have to claim special reasons if in residential housing) or to whom to hire as provider (family members are possible to hire in Sweden).

⁸⁹ In order to make comparisons I have used the following currencies: 1€=9,7 SEK, 1£=12,5 SEK, which are equivalent to average currencies over the last five years (*Riksbanken*).

Overall, it was difficult to find any national patterns of structure for the sum of benefits. Instead, each country showed proof of particularistic and diverse solutions.

Access and attainability

Most policies have no time restrictions, but sick pay was found to be an exception to this rule. All countries use a time limited design, but there are noticeable differences in their generosity. The shortest periods were observed in England and the, by far, longest, in Sweden. France demands the longest labour experience for entitlement, while England demands the shortest. Sweden also uses the shortest number of waiting days, but the difference is only about a couple of days and should hence not be paid much attention.

The attainability of these transfers was difficult to depict, except for disability pensions which are widely used in all countries and most so in England according to the statistics, at least when measured as how large the target group is in relation to other target groups. As has been noticed previously, being directed to a disability pension may be considered a trap as it may enforce exclusion. Nevertheless, this seems to have been a common solution in all three countries and has resulted in creating stratification between those who work and those who do not. In a recent OECD report on disability and income security, it is stated that mental illness is a growing disability ground in most countries, not least when looking at younger ages. Today, people with mental disorders constitute one quarter to one third of all disability benefit recipients (OECD 2003: 85f). This point to a welfare dilemma: for all other transfers, attainability is considered a positive thing, but disability pensions seem to have become a stratifying instrument leading to exclusion rather than inclusion. At the same time, when entitlement is revised in order to encourage people to work, there is a fear both among users and professionals that people are to be forced into work even when this is not appropriate (because there is no work opportunities or because people are not well enough).

Another access problem is connected to entitlement. An important part of the financial compensation schemes demands independent living. This

means that if a person becomes hospitalised, there will be a rupture in the benefits although a person may have the same expenses during hospitalisation. A problem of access that has been discussed in Sweden, where financial compensations seem to be a matter mostly for other disability groups, concerns the administrative interpretation of 'needs'. For much, it seems as if the needs of this group still have not been enough formulated. This is a necessary prerequisite for access.

Provision and administration

When it comes to sick pay, the private sector plays a more important role in France and England as contractual sick pay is more common than in Sweden. In England this is manifested through contractual arrangements that lay the ground for sick pay, whereas in France it is manifested through contractual or personal arrangements that top up the sick pay. This latter solution has become more important in Sweden over the last years, but is still of minor importance. As there is only one, general sick pay scheme in Sweden (part of the social security system), it reaches the least stratifying effects of the three countries compared in this thesis. In England, the national sick pay scheme is only a way of setting the rules for those employees and employers that have not chosen their own solutions; a lowest level of rights for the employer to follow. Contrary to France and Sweden, it is disconnected from the social security system. Any general conclusions of what kind of sick pay that a general user will touch is then also impossible to draw. Except for sick pay, the private sector does not play a role that became visible in this study.

The institutional fragmentation is least present in Sweden where the national insurance agency is responsible both for administration and provision of all the transfers, with one exception. Again, France is highly fragmented as both administration and provision are split on different public and private agents. Yet, the variation in logics within each nation cannot be interpreted as a consequence of decentralisation (as was the conclusion in Rauch's 2005 study). Rather, it seems to be a consequence of the general feature of the welfare system, being a patchwork of parallel and/or complementary schedules.

Conclusion

To sum up, the area of financial support was not evident to categorise, and hence to discuss in terms of design, logics and de-commodifying and stratifying effects. Policies in Sweden were, for example, primarily universal, but both flat rate and proportional (to earlier income), they were primarily for long-term use, but not uniquely, and except for income replacements, it was difficult to conclude whether they were more generous than other countries' as there were so many combinations and particular rules in the comparing countries. France is also very difficult to categorise along any design or logic as there was a mix of support building both on a private and public responsibility for welfare. England is perhaps the most unitary example with a common design of selectivity and low levels based on a policy logic that income maintenance is not a great concern of the public sector and that citizens should stay concerned with upholding a work.

Chapter 6

Mental health and social support

The previous two chapters treated the identified medical and financial support offered on the basis of a mental disorder or disability. This final empirical chapter outlines the social support. Three areas that are supposed to be central for mental health policy have been studied: housing, occupation and personal support. During the asylum era, housing was not an issue as the asylum became the home – or at least a roof over your head. Yet, it became one of the first problems to solve when closing down the hospitals. In the same way, it is still a central question every time a patient is discharged. With no or insufficient housing support for this group, the hospital tends to be the only alternative to homelessness. As the de-institutionalisation has been implemented, most people with mental disorder and disability are now living in the community, but how may their housing situation be described? As Anderson and colleagues (2007: 284) write

[p]eople with mental illness face the same set of housing issues as other groups in the community – availability, adequacy, appropriateness and affordability. However, their situation may be especially insecure or precarious, and access to adequate, affordable housing may be especially critical to recovery from illness and to maintaining good mental health.

It is therefore relevant to investigate what their rights of support to get a proper accommodation are, and what kinds of housing that are proposed.

The same is true for occupation. The importance of having a structured day has become a major focus in mental health policy. Apart from a consensus on the importance of activation for all citizens, this seems to be connected to the fact that mental disorders have become a 'leading cause of early retirement and disability pensions' (EC Green paper 2005: 5, treated in chapter five). Thus, mental disorder has become an increasing financial post in many national budgets. One of the questions treated in this chapter is hence what measures that have been taken to support people into some kind of occupation, be it an employment on the regular market or a so called sheltered work (available only for those with disabilities), or some other form of structured activities that are supposed to be substitutes to employment. Generally, this group is supposed to have problems both of entering the labour market – because of a decreased capacity or because of discrimination – and of maintaining an employment. While the first is especially true for conditions such as schizophrenia or bipolar disorder, the latter tends to become as true for depression and stress-related disorders, which are increasingly reported as a ground for long-term absence (Ibid.).

The third kind of support investigated in this chapter, personal support, is a more recent invention connected to the increased focus on social exclusion, and the intentions of engendering integration. Mental disorder is sadly related to loneliness: it increases the risk of being divorced, of feeling isolated and of having few social contacts. The personal support aims at covering up for this loss. The previous policies may be described as forming a welfare 'base': treatment against ill-health, a roof over the head, an income to cover necessary expenses and some structured and continual occupation. This last category, personal support, goes beyond these. It aims at maintaining and creating an autonomous life once the 'basic' grounds are set. This means that these policies recognise a more delicate need. This need may be manifested by an inability to 'organise' life in the own flat, or by an inability to leave it, that is, both to maintain an everyday life and to encourage social activities. A study of such support will show what needs that are politically addressed in each country, but also, to some extent, what the public administration expects from other welfare agents.

Sweden

Housing

The attention paid to housing has increased with the deinstitutionalisation process, but less so than issues concerning psychiatric treatment or occupation. The need of housing options was first noticed in the national report of 1982 (Socialstyrelsen 1982: 123f), which stated the end of the asylum era. However, as the report focus was rather on psychiatric care than on mental health policy, housing was treated in rather brief terms and as a future challenge rather than a present one. The report authors concluded that the responsibility would lie in the hands of the municipalities and underlined the importance of offering a broad range of housing options and of a functional cooperation between welfare agents for the transfer from institutional to community care to work out.

A more extensive focus on housing was presented by the commission of the early 1990s (SOU 1991:92; SOU 1992:73). The commission reports then shed light on several problems: a shortage in services, lack of competence within the social services, lack of coordination between the health and social care administrations, and a blurriness concerning the administrative responsibilities (at least the awareness of them) were some central themes. About 20 percent of the inpatients in 1990 seemed to stay in hospital foremost as a consequence of no adequate accommodation alternatives. However, that same year, to avoid such situations, the municipalities were given a legal financial responsibility for discharged inpatients (SFS 1990:1404), that is, if the patients stayed at the hospital as a consequence of homelessness, the costs became a burden for the municipality and not for the care sector.⁹⁰ It was also estimated that at least half of the inpatients had no settled housing situation. Thus, housing was not only an unsolved question – ‘a non-issue’ – but also an obstacle to de-institutionalisation and rehabilitation. Furthermore, the challenges of not creating a ‘trans-institutionalisation’ where the discharge only led to a new kind of institutionalisation and of preventing

⁹⁰ The financial responsibility starts 30 days after the discharge notice. These patients were first called ‘fully medically treated’ (*medicinskt färdigbehandlade*), but since 2003 the formal notion used is ‘ready for discharge’ (*utskrivningsklara*).

that independent living⁹¹ became isolation were also highlighted. In the final report, the authors calculated that most people would solve their own housing situation, but that about 20,000 individuals would be in need of some kind of housing service, though not indicating what kind of support that might be (SOU 1992:73, p. 15; 336ff). They also referred to an investigation showing that ‘remarkably many’ from the target group had not left their parents’ home at the age of 40 (Ibid.: 340). During the early 1990s, State grants encouraged the construction of so called group homes in general, but they were not earmarked for certain target groups (prop. 1990/91:150; SFS 1991:1280). In the mental health bill, such an earmark was realised for long-term residents (prop. 1993/94:218, p. 94). However, the majority was being used for older persons (with dementia) and residents with intellectual disability.

The mental health commission of 2003-06 also put focus on housing services as one of the central municipal responsibilities. This time, housing was not perceived as ignored – a varied service supply existed – but still underdeveloped in relation to the known demands. The situation varied much between localities (Socialstyrelsen & Länsstyrelserna 2005; SOU 2006:100).

The Swedish municipalities are responsible for supporting people in their housing situation according both to the Social services act since 1982 (SFS 2001:453) and the Disability act (LSS in Swedish) since 1994.⁹² In the first act, this responsibility applies both for the general population and for specified target groups, including those with difficulties stemming from ‘mental causes’. The second legislation only applies

⁹¹ Independent living is used as a concept to define when your housing does not include staff that resides in your shared flat or in your house, contrary to sheltered housing which necessarily includes some kind of staff presence and therefore is not applicable for non-disabled groups. I do not use ‘supported housing’ (which is sometimes used as a synonym) as this may be confused with services such as ‘support in the home’; even in a case of independent living, you may be supported in your home.

⁹² LSS (SFS 1993: 387) is translated by the Ministry of Health and Social Affairs in the following way: ‘The act concerning support and service for persons with certain functional impairments’. However, for readability reasons, it will instead be named the ‘Disability act’ in this thesis. This act is the most central act solely treating disability, though not the only act that treats this question.

to specific disability groups that needs sheltered housing, in this case: if a person is considered suffering from autism spectrum disorders, or if (s)he is considered to suffer from other mental impairments that are not a result of ageing, and if the impairment is enduring, important and producing considerable difficulties in the daily life and hence results in a need for extensive services that are not satisfied in the present situation. In all cases, one must claim the service personally. Entitlements are not means tested. Neither do they request any kind of contribution. Nevertheless, the entitlement criteria are quite demanding in the Disability act. A person is not only to prove that her/his needs are extensive, but also that they are not taken care of in the present housing option. Hence, this legislation is applicable only where no other solutions are found.

Several housing options are possible for those who fulfil the entitlement criteria above, are registered in the municipality and have not succeeded in solving the housing situation on their own. First, a person may be offered independent living through the Social services act, that is, help with getting a flat of her/his own. This could be done by offering an 'ordinary' flat from the private or public sectors (being of equal sizes according to Turner 2007: 148) or special flats targeted needy groups. It could also be done through a 'social contract' by which the social services operate as a guarantor towards the private landlord. If there is a need for support in the home, the person may apply for different kinds of home help, which will be treated further on. Secondly, if an independent living is not applicable, several kinds of sheltered housing are available where staff will be present all hours or just at certain times. This decision may be the product of either the Social services act or the Disability act.

One example is group homes where the user disposes an own room or apartment and where there are common areas where the residents may eat and spend time together if they wish to. Another alternative is a separated apartment in a house with other users where staff comes by. A third type includes medical care services at the residency and is hence reserved for those with the most important disabilities, but this housing is, contrary to the former examples, not supposed to be permanent. This is sometimes called residential care or care homes, and is the option that

reminds the most of the old institutional care. It is also possible to be accommodated in a family, but this is rare.

National legislation gives the municipalities the right to charge the housing service (rent, meals, care) if the user has an income. The charge levels (rents) are set at municipal level, but are measured against income, guaranteeing that a certain sum is left for other personal expenses.

As there is a lack of national statistics, it is difficult to picture how the housing situation has developed for this target group over time. However, the documents still make some statements on the issue. First, it is estimated that most people have an independent living of some kind (Socialstyrelsen 1998: 81). Secondly, it seems clear that the supply of sheltered accommodation has increased since the 1990s, which should be due both to state grants encouraging such a development and to an augmented demand as the mental hospitals closed down during that decade. The most comprehensive and recent attempt to map the existing accommodation services for this group was made by the National board of Health and Welfare in 2003 (Socialstyrelsen 2003).

This report found 8,000 accommodations spread on 850 entities. About two thirds were categorised as 'home like', but one third as 'institution like': shared rooms, restrictions, large entities, personal furniture etc. were used as indicators. For 86 percent of the residents, the housing was permanent (no discharge plan existed), that is, the support was not part of a rehabilitation programme leading towards independent living. Furthermore, a shortage in the local housing supply led to that a certain number of people (20 percent) were directed to other municipalities, which is contradictory to the policy intentions. For Stockholm, this was the case for as many as 43 percent of the individuals. While the report estimated an abundance of beds (empty beds) in the country as a whole, all three of the largest municipalities were estimated to have a deficit in their supply although it is well known that they have an overrepresentation of mental disorder and disability among their population.

The public sector held a majority of the units in 2001/2002, but the number of beds was equally shared between private for-profit and public providers. An increase was reported to have taken place during the past

five years. This 20 percent increase was entirely found in the private sector (Socialstyrelsen 2003: 23f).⁹³

For independent as well as sheltered living, the user will be reliant on availability. If there are no existing flats or beds, the accorded need will stay unmet unless the administration does not decide to purchase the service from another municipality, and the user accepts this. What more is, the available flat must be considered appropriate for this target group.

Occupation

Employment and occupation are today regarded as prerequisites for both health and integration in the public discourse. Still, Swedish commissions have declared that people with mental disabilities have lower occupational rates than any other group in society, including all other disability groups (SOU 2006:100, p. 97). This means that few people from the target group report that they have any kind of structured activity, be it regular or sheltered work. Hence, a mental disability seems to have more serious impacts on the occupational capacity and activity than what is noticed for other disabilities (Nationell psykiatrisamordning 2006a: 41). In general, about 60 percent of those with some kind of disability report that they have a decreased work capacity and about 65 percent that they have some kind of occupation. For mental disability, almost 90 percent report a decreased work capacity, and only 35 percent report some form of occupation. They were also more frequently absent from work, if they had one, and they were overrepresented when it came to unemployment (Ibid.: 42f).

A number of government commissions and other analyses from the 1990s and forth have stated that public support aiming to rehabilitate people with mental disabilities into work does not meet the needs. In spite of this, no thorough changes have been made to solve the problems. (Nationell psykiatrisamordning 2006a: 72, my translation)

⁹³ The statistics do not differ between non- and for-profit providers, but the non-profit sector is more or less non-existent according to one of the authors (personal correspondence with Claes-Göran Stefansson 2008-11-24).

The committees of 1992 and 2006 argued that the general Swedish labour market policy applied to other groups, that is, that work should be prioritised to benefits if possible (*arbetslinjen*), is not applied to this group. Instead, they found that people were too easily directed towards early retirement schedules, even if they were young and rehabilitation would be a more proper solution. The committee of 1992 argued that the problem was more about the labour market than about the users – most people were capable and willing to work at least to some degree, but the labour market was not adapted to their need of adjusting the work to their capacity (SOU 1992:73, p. 29). Neither were the involved authorities. The commission of the 1990s suggested that the rehabilitation responsibility should lay solely on the social insurance agency, and thereby become more focused. The commission of the 2000s pointed to the shortcomings in rehabilitation; with this link broken, people are not really given the chance to participate in the labour market. It also stated that the measures taken were rather adjusted to administrative interests than to individuals (Nationell psykiatrisamordning 2006a: 9). The government seemed to agree on this as they initiated educative programmes for involved bureaucrats in 2009 aiming at increasing the knowledge of the target group and of suitable solutions. An inventory of present work-related programmes was also initiated (Prop. 2008/09:193).

The responsibility for getting people into salaried work or other forms of occupation is split on several authorities in Sweden. First, the public jobcentres have a general responsibility of matching jobseekers with available positions. They are also responsible for capacity assessments for those with a recognised mental disability if they are unemployed and registered as job seekers. The jobcentres are national agencies with local representation. The jobcentres are also responsible for increasing the work capacity and hence employability through work-related rehabilitation organised by a unit at the jobcentre and/or by the social insurance agency, which purchases services from the private sector, or through vocational training programmes.⁹⁴ Any kind of employer – public or private – may provide the training, which is funded through a job

⁹⁴ So called *arbetspraktik*.

allowance from the social insurance agency. This benefit is dependent on earlier incomes, but with a lowest level.

In general, the training covers full-time work during six months (Nationell psykiatrisamordning 2006a). If a salaried and regular employment is not perceived as a realistic option, the jobcentre may offer a sheltered employment, foremost within the public sector.⁹⁵ A prerequisite for these policies is that the individual is conceived as having a (potential) work capacity and is motivated, though in need of temporary support. The different kinds of support include solutions where the salary is temporarily covered through state grants up to a certain sum and for a certain amount of time, but the salary should be adapted to general labour market conditions. However, a person with this kind of employment is not completely covered by labour legislation.⁹⁶

The employer is free to pay higher levels and to transfer the employment into a regular one (which is what the policy aims at even if it is not necessarily conducted). A person with mental disability may also be offered an employment at the State-owned company *Samhall* if they have no work experience before, or if they have been absent from the labour market for a longer period of time. Here, regulated salaries are paid and the work may constitute for example manufacturing or cleaning, but also in this case, the employment is supposed to be exchanged for a regular post as soon as this is appropriate, or when another employment is offered. The support is mainstreamed for disability and realised to a very low degree for mental disability representing about 10-20 percent of the positions. It may be due to the fact that this support is mostly directed to those who have at some earlier point been working. Even if work experience is not a prerequisite for entitlement, it seems to have become so in reality. Another reason may be that when the public administration

⁹⁵ For example *offentligt skyddad anställning, lönebidrag, arbetsmarknadsåtgärd, SIUS-konsulent, trygghetsanställning* (Nationell psykiatrisamordning 2006a;b).

⁹⁶ The ceiling was generally 16,700 SEK/month in 2009. The sheltered employments are covered by collective agreements, which regulate salaries and rights connected to Swedish employments, but not by the Employment protection act (SFS 1982:80), which regulates employment security. This means that the employer has no obligations to prolong the employment once the sheltered program is finished.

strives for visible results, those with the best capacity are prioritised (Nationell psykiatrisamordning 2006a: 43, 65).

Secondly, for those with an employment, the work related rehabilitation responsibility is shared between the social insurance agency and employers who are supposed to collaborate for a programme that facilitates coming back to work after a sick leave. This may for example result in changes in work assignments or rehabilitation services.

Third, if a person is not approved as employable, other forms of activities may be offered. According to the Social services act, municipalities are responsibility for assuring a 'meaningful occupation'. However, the legislation does not specify certain entitlement criteria other than a duty to support those who need so for 'physical, mental or other reasons'. The municipal organisation is often split on at least two divisions working on occupation, sheltered employment and work-related rehabilitation for this group (SOU 2006:100, p. 268). Often, it is not clear where the borders of the target group should go even when there are specialised social-psychiatric units (Nationell psykiatrisamordning 2006a: 64).

The occupational support can include anything from a more social character to structured occupational activities such as gardening or professional cooking. It is not evident to differ between their social and rehabilitation aims and administrations may define the activities differently. The occupational activities could be seen as a way of vocational training, but they seldom seem to lead in that direction (Nationell psykiatrisamordning 2006a: 51f). In the early 2000s, the municipal engagement in this group was investigated by the supervising authorities. They found that about two thirds of the municipalities could offer at least three occupational services, but that only half of those from the target group that should be in touch with such services were using them. Thus, according to the report authors, the supply was not so much a problem as the fact that it did not reach the target group (Socialstyrelsen & Länsstyrelserna 2005). One reason could be that in some local administrations, no formalised decisions were taken for occupational services; users were to find and join them on their own. It also seems as if the service is primarily applicable for older persons, and for those with severe disabilities,

but not to younger persons or to those with less severe disabilities (Nationell psykiatrisamordning 2006a: 50).

Also the Disability act includes occupational services, but mental disability is *not* included except for autism and autism-like conditions.⁹⁷ This exclusion (that concerns no other of the services) has been criticised, not least by the mental health coordinator (SOU 2006:100, p. 311ff). In 2007, the government demanded an investigation on the subject (Dir. 2007:84). The commission suggested an amendment to be implemented in 2010, realising an inclusion of the target group (SOU 2008:77), but no such decision has yet been taken. The commission estimated that the target group in question would include about 10,000 individuals. In 2009, the government aimed at increasing the number of services by encouraging municipalities to purchase occupational services for this group through state grants (Prop. 2008/09:193). This money was earmarked for private providers, with an emphasis on voluntary organisations, which are today involved, but still playing a marginal role.

The local governments have been encouraged to cooperate more with other public administrations as well as with the private sector in realising services for this group ever since the 1990s, but it still seems quite rare (Nationell psykiatrisamordning 2006a: 45).⁹⁸ The voluntary sector is also present in the role of volunteering, which may as well constitute a structured occupation, though without payment. However, this may be in conflict with the eligibility to rehabilitation and vocational programmes or benefits, as it is understood to indicate that a person has a more important work capacity than once evaluated (Ibid.: 57).

⁹⁷ The formal notions used in the laws are *syssestättning* (Social services act) and *daglig verksamhet* (Disability act).

⁹⁸ This interest in the voluntary sector as a welfare agent is also expressed in general documents such as *Civilsamhället som utvecklingskraft* published by the National association of local authorities and regions (2009).

Personal support

Formalised support

Two services are used for support in the home: home help and what is usually called *boendestöd*.⁹⁹ They can contain the same support (and sometimes municipalities do not differ between them), but while home help is limited to activities in the home, *boendestöd* is not necessarily so and seems to include more varying services, and also activities that are not performed in the home. Hence, *boendestöd* seems to be of a more activity-based character, that is, aiming at activating the user and not just at being in charge of the things that the user is incapable of doing herself (SOU 2006:100, p. 244). The support may contain help and training with daily life activities (dressing, cooking, personal care), social activities (cinema, trips), occupational activities, help with medication or administrative contacts. The two first categories are the most common according to a national investigation (Socialstyrelsen & Länsstyrelserna 2005). Some users receive both home help and *boendestöd*. Home help is specifically regulated in the Social services act, whereas *boendestöd* is not. Instead, it seems to be accorded based on either the intentions of the Social services act or the Disability act and it seems to exist in most municipalities; it has become an established kind of support (Ibid.; Baig et al. 2007).¹⁰⁰ They are both universal.

Municipalities decide on charges, which will vary between municipalities, but also with income and the number of hours used. In many cases, these services are not charged, but there is a considerable variation

⁹⁹ It is not evident how to translate *boendestöd*; support in the home or housing support are two suggestions. David Brunt, one of the most experienced researchers of *boendestöd*, describes it as something that has developed out of home help; that it could have the same content, but that it often is about more than traditional home help. He has also clearly shown that the understanding and content of the service will vary between localities. Publications within the research project on housing, led by Brunt, see <http://194.47.65.210/ivosaforskn/boendeprojekt>.

¹⁰⁰ Government commissions have suggested different solutions for formalising this support: The mental health commission suggested it to be specified in the Social services act (SOU 2006:100, p.244), while it has also been suggested to be added as one of the specified services of the Disability act (SOU 2008:77, p.44).

of local applications.¹⁰¹ The mental health coordinator stated that it is difficult for this target group to get information on the costs. The regulations are difficult to understand both for administrations and users. Neither is there any information adjusted to this target group on which services that are applicable and what their costs may be (Nationell psykiatrisamordning 2006c). According to a minor survey from the early 2000s, home help and *boendestöd* constitute the most common personal support accorded by the municipalities for this group (Socialstyrelsen & Länsstyrelserna 2005: 158). The municipalities may also offer a 'contact person', which is a layman who is supposed to help organise personal affairs such as contacts with care and social administrations (SFS 2001:453). This service is free of charge. As for the previous services, no satisfying statistics on attainability were found.¹⁰²

Furthermore, the Disability act specifies four services that should be categorised as personal support. First, counselling and other personal support that demand qualified experts on major and continual impairments, for example social workers, psychologists, physiotherapists. Second, personal assistance, which implies help with basic needs. Third, companion service encouraging activities outside the home, and forth, a contact person¹⁰³ which is supposed to break with social isolation. It is not evident to differ between these services or how to relate them to the earlier mentioned services. The interpretation of their meaning may also

¹⁰¹ The minima charges for home-help and *boendestöd* varied between 0-1,576 SEK in 2005 (Nationell psykiatrisamordning 2006c). Charges exceeding 940 SEK/month can be covered by *Handikappersättning* (administered by the Swedish social insurance agency). Meals on wheels 16-58 SEK/meal depending on municipality and income. Users with low incomes are guaranteed to keep a minima level of means. In 2002 this level was equivalent to 4,087 SEK for a single household.

¹⁰² In the public report of 2005 (Socialstyrelsen & Länsstyrelserna, p. 158), a survey from 2002 including 32 municipalities is presented. Here, the municipalities are asked what kind of support they offer people with mental disability. According this survey, 44 percent are receiving home help/*boendestöd* and 10 percent have been accorded a contact person. However, these data do not tell how many from the 'actual' target group that receives support (only how the support is spread on those who are receiving any support).

¹⁰³ The same term is used in both acts, but contrary to the earlier mentioned contact person this person has a wider mission which is not restricted to practical arrangements.

differ between administrations. However, the guiding documents describe counselling as being about more practical advice (as opposed to care) whereas the two latter are about activation. Personal assistance is viewed as the most radical invention as it is described as a support that should really make a difference in the life of a person with severe disabilities. For some individuals this means that assistants are present day and night. These assistants are employed by the user her/himself and covered by public funding from the municipality or the social insurance agency. Except for counselling which is formally part of the county council responsibility, the services are administered by the municipality. None of these services are means tested or provokes any costs for the individual user. Entitlement is due to an approved need, that is, that the impairment is major and permanent and causes considerable needs of extensive support.

Personal assistance has mostly been accorded people with physical needs, which is in line with the attentions when preparing the law (Prop. 1992/1993:159). The difficulty for a person with mental health problems is not that (s)he, for example, is not physically able to get dressed. Instead, the need may be about encouragement to get up in the morning and make sure there are clean clothes to wear. This is not included in the intentions of the law.¹⁰⁴ For the years prior to 1998 and from 2004 on there are no official statistics on the number of individuals from the target group (mental disability in general) that were accorded these services. In 1998, there were about 2,000 reported cases; in 2003 the number had increased to about 2,600 (Socialstyrelsen, statistics 1998 and forth). This foremost includes special housing, contact person and counselling. As has been shown earlier, autism and autism-like conditions have been separated from mental disability and disorder in general. Individuals with autism are instead placed in a target group with fewer restrictions, also being the target group that has been accorded 85 percent of the services. Yet, as it is not possible to separate individuals in this target

¹⁰⁴ In the legal documents this motivation or activation of the individual is called '*påputtning*', which could be translated as 'help to get started'. See Bengtsson & Gynnerstedt (2003:105ff) for examples of how support to this target group has been denied and how this is motivated in different legal processes.

group (including autism and intellectual disability), it is not possible to sort out how many individuals to add to the number above.

During the 2000s, it has been debated why so few from the target group have been accorded services based on the Disability act, but there are not really any answers to be found in the public reports. One explanation could be that implementers have had difficulties in understanding what mental disability is about; a failure in mainstreaming mental disability in the practical work (Bengtsson 2005). Hence, claims have been rejected. Another explanation may be found in the fact that few individuals have claimed these services. Studies have shown that when the individual is formally supported (through the support described below) in the application process, the services are more often accorded this group (Björkman 2000). The obstacle would then not (only) be found at administrative level, but in the construction of the claiming procedure.

Personligt ombud

The commission of the early 1990s suggested a new and unique form of personal support to make part of the Disability legislation: *personligt ombud*, in English often called ‘case management’¹⁰⁵ (SOU 1992:73, p. 227, 237ff). The idea was a specialised and complementary support to help coordinate the care; a professional person that can represent the interests of the user and be a link towards the public administration. This was motivated by the fact that one of the impairments of mental illness is communicative, which means that a person risks having a decreased ability to formulate personal needs and interests. Furthermore, the local administrations were understood to have a lacking understanding and

¹⁰⁵ However, case management is internationally used as a label for many different activities that may differ importantly from the Swedish version (see for example Björkman 2000 or Socialstyrelsen 2009). These services are sometimes called care management, which is a more proper notion, the assignment of these managers being focused on coordinating health care providers. Such a manager does not necessarily meet the user and may manage about 50 cases. By contrast, *personligt ombud* has a wider mission of encouraging independence, what is often called ‘empowerment’, but also of making demands on the public administration in order to realise proper support on all areas (not just psychiatric care). Furthermore, the Swedish manager is not in a decision-making position.

knowledge of the needs and rights of this target group. Hence, the case manager would be someone that could bridge these facts. The case manager is supposed to be independent from public administrations (although they might be employed by them) and with a user perspective; to focus on what is best from behalf of the user, not taking administrative considerations into account. In the ideal situation, the user steers the work and is treated as the 'expert'.

In 1995 what came to be called *personligt ombud* was introduced as a national 'experiment'. The government intended to try different solutions and started projects in ten municipalities during three years, including 250 users and 32 case managers (SOU 2006:100, p. 340). Evaluations showed that the case manager had positive effects on the life of the user:¹⁰⁶ a reduction of in- and outpatient care, improvements in quality of life, a more active social life and, as mentioned, an increase of demanded and accorded personal support. It has also been shown that users are highly satisfied with the support given by the case manager (e.g. Björkman 2000; Socialstyrelsen 2005). Still today, this support is not regulated by law,¹⁰⁷ but encouraged through additional national budgets.¹⁰⁸ Hence, case management will be offered in some parts of Sweden, but only where there is an interest from behalf of the authorities. The content, financing and management of the support will also differ considerably although national and regional authorities have trained and financed case managers (Printz 2004: 36; Socialstyrelsen 2005).

The municipality is the managing administration. Most often, the service is included in the municipal social services (handicap care or social psychiatric care). In a quarter of the cases, another organisation distributes the service, most often the voluntary sector (Socialstyrelsen 2005: 19). Yet, it seems to be free of charge in all parts of Sweden. Another

¹⁰⁶ Users were mostly persons diagnosed with psychosis, without occupation and a limited social network.

¹⁰⁷ The National board of Health and Welfare, responsible for evaluation, suggested legislation in 1999 (connected to the Disability act) and 2005 (as a separate legislation) (Socialstyrelsen 2005).

¹⁰⁸ This has been a fact since 2000. From 2002, this annual national budget is equivalent to 90 million SEK and is *primarily* directed to support case management activities (SOU 2006:100, p. 340).

effect of the non-existing legislation is that there are no set entitlement criteria or application procedures. The National board of Health and Welfare has highlighted the unsatisfying situation that follows on this. The lack of legal frames is problematic not least because the users are very dependent on the case managers (as on other administrators). As for now, they have nowhere to turn when denied the service or for complaints as users (Ibid.).

Another complexity concerns the situation of the case manager who has no legal frames to guide the contents of the service, or necessarily colleagues. The case managers have 10-15 clients in general and have for the most part professional experiences from care work and the target group. With no instructions and an unconventional mission, the work is not documented. Hence, contrary to other administrative posts, there is no transparency. Consequently, evaluation and supervision is difficult. The National board of Health and Welfare assumes that the service will disappear once the national additional budget is not prolonged (Ibid.).

Meeting places etc.

The voluntary sector is another non-formalised arena for social support. The user movement, Christian organisations or 'social clubs' are some of the actors that offer meeting places with more or less structured activities.¹⁰⁹ These could cover everything from offering coffee or a shower to realising courses (on for example empowerment) and excursions or being a bridge to other forms of support (Nationell psykiatrisamordning 2006b). These activities are supported through public funding, but also private donations. If the services are charged, the costs will stay at low levels such as a few Euros for course material.

France

Housing

The housing question for people with mental disability is rarely discussed in the studied French mental health policy documents over time, where

¹⁰⁹ RSMH, Stadsmisionen, the Salvation Army, Fontain house, the Red cross etc.

focus is mostly medical. However, attention is increasingly directed to social questions in the 2000s, not least after the 2005 disability legislation (*Loi 2005-102*), which is described as an important turning point for the life conditions of this group (*Plan psychiatrie et santé mentale 2005-2008*, p. 25). However, the law makes no stipulations concerning housing. Nevertheless, the plans from this time express an objective to enable access to housing solutions and state that when it comes to social policies, many people still stand without other solutions than their families or the hospital (*Ibid.*, p. 29). Another example is the parliamentary report from 2002 (edited by Charzat), which is the first example of a national report with a disability, or social, perspective on mental health. Also here, the importance of a proper housing solution is underlined, though in brief terms.

The general right to a proper housing situation is stated in several laws, as well as in the French constitution (*Haut Committé pour le logement des personnes défavorisées 2009*). Local governments are also obliged to plan for the housing of vulnerable groups (*Plans départementaux pour le logement des personnes défavorisées* according to *Loi 2009-323*). At the same time, it is a well known fact that these intentions are not realised for all citizens: 3 million people are estimated to be without a place to live and an important part of these are estimated to have a mental disease (*Haut Committé pour le logement des personnes défavorisées 2009*). The fact that the housing problems seem consistent, or even increasing, among vulnerable groups resulted in a new law in 2007 according to which the State guarantees to help those who are not able to solve their situation by themselves (*Loi 2007-290*, also called DALO). This means that citizens may claim their right legally if the local public administration does not realise their obligation to offer a proper apartment.

As in Sweden, housing is generally a municipal question, but also *départements* may be involved. Generally, a person may be accorded an apartment (independent living) for mental disability reasons as these may be recognised as a ground for priority, but social housing is never-

theless means tested.¹¹⁰ However, most citizens are potentially eligible, at least for parts of the services (for the housing options offering the highest formal standards) as ceilings are set at high income levels. Hence, few applicants should in reality be denied an apartment because of their earnings. Unlike in Sweden, it is not the public administration, but the landlord that decides on whether a user is eligible for the housing solution in question. Charges are flat rate and regulated at national level, though varying for different regions (Scanlon & Whitehead 2007: 19). The apartment could be part of the general, public social housing programme, or some kind of accommodation involving the voluntary sector (e.g. *appartement associatif*). This latter category of apartments is owned by an association, which sublets them to people with mental disorder/disability, but with a stable medical condition. There are no formalised entitlement criteria, but as the housing is based on health conditions, health authorities are often involved in the application procedure. An increase in such apartments has been promoted by the government in later years (*Plan santé mentale 2005-2008*, p. 30).

When it comes to sheltered housing, the variation is important when it comes to provision, entitlement and charges. It is not evident how to categorise and differ between the structures, but one rare attempt was recently made by the association *Mission nationale d'appui de santé mentale* in (Pluriels 2007). They differed between 20 types of arrangements, which are not easily separated from each other and whose labelling will vary over time. Still, it is an important picture of the existing patchwork and the obvious difficulties of navigation.

There are a number of temporary or permanent solutions offered either by the health care sector (the State),¹¹¹ the social services (the municipalities),¹¹² a mix between these two (called *secteur médico-social*),¹¹³ or the

¹¹⁰ Social housing is regulated by the *article R441-1 du Code de la Construction et de l'Habitat*. The public housing offer targeted vulnerable groups is called *habitation à loyer modéré, HLM*, i.e. housing with a moderated rent.

¹¹¹ Including *Accueil familiale thérapeutique, appartements thérapeutiques, foyer de postcure, appartements associatifs du secteur psychiatrique*.

¹¹² Including *Maisons relais, résidence d'accueil, hébergement de stabilisation, Centre d'hébergement d'urgence et nuitées d'hôtel, Centre d'hébergement et de réinsertion sociale*.

voluntary sector¹¹⁴. Entitlement is primarily due to the medical condition for those alternatives that belong to the health sector and to the work capacity for those that belong to the medico-social sector. Some housing is even connected to employment. Entitlement to the municipal service is due to ‘vulnerability’, including those with scarce economic resources and important social difficulties (e.g. homeless or isolated people). Nevertheless, they are not means-tested in the meaning of *demanding* low levels of financial needs.

The kind of sheltered housing called *appartement thérapeutique* was studied by Velpry (2009). Such apartments are connected to care and are often initiated by the psychiatric care team. It aims at facilitating a ‘normal life’ in a way that the hospital is unable to, perhaps at the discharge of inpatient care. This is a temporary solution, but there is no specific time limit. Some users stay for some months, others for several years (Ibid.: 174f). It may be an individual or, which seems to be common, a shared housing solution with present care professionals, though physically disconnected from the hospital. The rent is covered by the health sector or the individual. Entitlement is due to the medical condition – to be healthy enough but still in need of important or at least continual care – and an approved need of housing. Velpry (2009: 175) describes a situation where the user is highly dependent on the engagement of the treating doctor and where the social situation and the care history are taken into consideration when choosing between applicants. It is also important that the user expresses her/his desire to enter this specific accommodation.

Thus, to be admitted to an *appartement thérapeutique* you need the right profile, but also a psychiatrist that considers this option and maintains regular and cordial contacts with the apartment team in order to show that you are willing to accept an adaptation to the proposed environment. (Velpry 2009: 175, my translation)

¹¹³ Including *Lits halte soins santé, appartements de coordination thérapeutique, foyer de vie, foyer d'accueil spécialisé, foyer d'hébergement pour travailleurs handicapés*.

¹¹⁴ Including *Résidences sociales, appartements associatifs*.

This citation illustrates the difficulties of analysing the entitlement design. It is not difficult to single out when other needs than the social and medical needs are requested, but this very need is central and a matter of interpretation. It is not always easy to enter the needles eye of entitlement even though it may seem open to all in formal terms. As the medical sector generally seems central for entitlement, it may be assumed that this is relevant also for other admission procedures.

There are also a number of different kinds of sheltered housing specialised on target groups. However, in contrast to Sweden they are connected to the capacity and are seldom (in only 3-7 percent of the reported cases) designated uniquely for this group, but mixed with other disability groups such as intellectual disability. Consequently, some care homes accommodate people with a high level of independence, while other homes welcome those with extensive needs. Many of them also offer a range of social activities and social and/or medical support. In some cases, they are permanent solutions, in some just temporary. As is shown in the table below, entitlement is sometimes not only due to impairment, but to employment situation.

Table 7. Examples of sheltered housing in France

Categories of sheltered accomodation	Entitlement
Foyers occupationnels ou foyers de vie	Incapacity to work, but a certain level of physical or intellectual autonomy
Foyer d'hébergement	An employment either on the sheltered or open labour market
Foyer d'accueil polyvalent	A need of both accommodation, occupation and medical care – all services being included in the housing solution
Foyer d'accueil médicalisé	Extensive care needs and incapacity to work
Maison d'accueil spécialisé	Need of medical supervision and constant care

Source: Drees (2008:641)

As an effect of public policies, the number of sheltered accommodations has increased during the 2000s both when it comes to disability in general and for mental disability in particular (Drees 2008:641). Yet, there is an important discrepancy between parts of the country. 23 percent of the

residents are accommodated in other *départements* than their own (Drees 2005:419), which indicates that local areas have difficulties in meeting the needs.¹¹⁵

Lévy-Vroelant (2007: 80f) points to the private sector as an important provider of housing for vulnerable groups. Private landlords offer what she calls, ‘affordable housing’, ‘quasi-social housing’ or ‘de-facto social housing’, the latter defined as ‘poor living conditions and lower prices’. This means that the housing is of obvious low standards, for example without toilet, bath or heating, and is estimated to be equivalent to about one fifth of the rented sector. Parts of this supply has been renovated by public means and thereafter submitted to regulated rents, but the major part is still unregulated and hence expensive. Shelter-like housing provided by the private sector has also been used as temporary options by the public administration. Furthermore, several programmes have been introduced to encourage poor households to become owners (Ibid.). However, to my knowledge, no studies have been realised to investigate to what degree people with mental disabilities rely on the market as a provider of housing.

Overall, it is impossible to picture how people with mental disability live. The only conclusion that may be drawn is that most people are supposed to solve their housing situation without public support. Furthermore, it is also difficult to illustrate the present welfare policy – there are not enough documents and the local variations are supposed to be important. The examination of existing sources gives the impression of programmes with diverse logics, and which are sparsely used. This conclusion was also made by the *Mission nationale d’appui en santé mentale* (Pluriels 2007:65). The organisation concludes that the plurality of providers and administrators aggravates the problems of poor visibility.

¹¹⁵ Statistics covering 1987, 1997 and 2001 in Drees 2005:419 and 2006 in 2008:641.

Occupation¹¹⁶

In both Sweden and England, the low occupational rates for people with mental disability have increasingly been understood as a problem at political level. This is less true for France. National reports and plans give little attention to occupation, as well as to its effects on public finances (the high levels of disability pensions). Hence, there is less attention on commodification in France.

People with a recognised mental disability are eligible for sheltered employment or support to a regular employment according to the Disability law of 2005 (and earlier through the Disability law of 1975). In the latter case, employers are encouraged to hire a person with disabilities to a reduced cost, that is, part of the salary is covered by state grants. This service is called *CAP emploi*, which is effectuated by a deconcentrated agency which is supposed to cooperate with the job centres and with disability administrations. Actually, people with recognised disabilities, but a working capacity, are supposed to constitute six percent of the working force of private and public enterprises with more than 20 employees (*Loi 87-517*). Employers that do not reach this level are punished by a charge paid to the national agency for disability and employment.¹¹⁷ About 50 percent of the private employers and 90 percent of the public employers are reported to reach this level (Agefiph 2010). There is no documentation on whether the law has contributed to increase the chances of people with *mental* disabilities to reach the regular labour market.

If a person has a recognised working capacity of at least one third compared to a person in general, (s)he may be directed to a so called *entreprise adaptée*.¹¹⁸ This means that a person is offered an employment that is adapted to the estimated capacity, but at a working place that is not restricted to persons with disabilities (20 percent of the workforce may

¹¹⁶ The French terminology concerning occupational services varies, but some common terms are *insertion et formation socioprofessionnelle*, *accompagnement professionnel*, *emploi en milieu protégé*, *emploi en entreprise adaptée*.

¹¹⁷ The name of the agency is *Association de Gestion du Fonds pour l'Insertion des Personnes Handicapées*, Agefiph.

¹¹⁸ Called *Centres d'aide par le travail* previous to the disability act of 2005.

have full working capacity). The employment is permanent or temporary, and reimbursed with a salary. If it is considered possible, the user should be supported to continue to an employment on the regular market. The Disability act also describes a type of sheltered employment for those whose work capacity is estimated to be less than a third compared to a person in general. These are called *établissements et services d'aide par le travail*, ESAT¹¹⁹ and offer employment and medico-social support. Both are financed by the State, and administered through deconcentrated state agencies.

The second service, directed to those with the least working capacities, is the most common disability support (Agefiph 2010).¹²⁰ On average, 14 percent of the individuals holding a sheltered employment of this kind are admitted principally as a consequence of mental disability. In the latest mental health plan, the government declared an intention to increase the number of ESAT positions with 8,000 places for all disability groups, but with a certain concern for mental disabilities. An increase also seems to have taken place. However, most places are dedicated to people with intellectual disabilities (Drees 2008:641).

Entitlement is based on being recognised by public administration at local level (the CDAPH at the MDPHs). Reimbursement differs between programmes, employers and contracts¹²¹, but State grants guarantee that they reach a certain level. There are different rules for regular and sheltered employment, but also for different *kinds* of regular or sheltered employments. The guarantee spreads from 50 to 130 percent of a minimum salary (*le SMIC*). For the lower level, the employee is supposed to

¹¹⁹ Since 2005, the French administration no longer categorise this employment as sheltered, but I have chosen to continue to do so as it is equivalent to what I categorise as a sheltered employment: the employee is not directed to the regular market, but to an employment position and/or a working site that is solely open for people with disabilities.

¹²⁰ In 2009, there were 1,329 ESAT employing 116,211 individuals and 637 EA employing 29,702 individuals (Agefiph 2010).

¹²¹ Some examples of contracts: *Contrat d'accompagnement dans l'emploi*, CAE, for employment at public or non-profit organizations. *Contrat d'avenir*, CAV, and *Contrat insertion – revenu minimum d'activité*, CI-RMA, for a return to the labour market for those on AAH (or some other benefits). *Contrat initiative emploi*, CIE, for employment in the private sector. (Agefiph 2010).

use disability allowances to reach a higher level of income. Some contracts also serve to enable a person who has not been working for a long time to get a work experience and, in the long run, replace benefits with a salary. Employment services are never charged.

Voléry (2009: 282) describes the field of occupational services as a 'particularly fragmented sector' and extremely specialised. A number of public administrations (Agefiph, ANPE, MDPH, ML¹²²) are involved, both national and local levels, and the voluntary sector seems to be one of the major providers which in itself intensifies the diversity as they offer particular programmes. Voléry, studying a French region, concludes that the voluntary sector has increased its role during the last decades, constituting a bridge between public administrations and the target group. Public administrations are the funding part, while the voluntary sector has the ideas of what to offer.

Personal support

These kinds of services are generally treated as *accompagnement* in France, which is a notion with a vague definition. In later years there is a specific service with this label, but it could as well be used for any kind of social support. Since the revised disability act of 2005, special agencies, MHDPs are in place with the aim of counselling and informing disability groups on their social rights.¹²³ This is a new type of agency, but it rests unclear to what degree the MHDPs are oriented towards mental disability.

Home help

It is, since 2006, possible to purchase home help for the allocation *PCH* presented in chapter five. This support – *aide humaine* – includes essential acts of the everyday life such as dressing, eating or participation in social life. Entitlement is evaluated by the handicap administrations¹²⁴

¹²² *Missions locales, ML*, are specialised in getting young people into work.

¹²³ These are called *Maison départementale des personnes handicapées*, MDPH.

¹²⁴ *Commissions des droits et de l'autonomie* at the MDPH.

and the cash provided by local government and State agencies.¹²⁵ Any actor chosen by the user provides the service. A person with mental disability is entitled to the *PCH* if the impairment is considered permanent or to last for at least a year, if it provokes an absolute difficulty of realising at least one essential activity or an important difficulty of realising at least two essential activities. Another prerequisite is a stable housing situation, but this is not necessarily an obstacle (if the user follows special formal adjustments).

The *PCH* is a recent and growing kind of support for people with disabilities. Between 2008 and 2009, the number of users increased by 67 percent (Drees 2009:710). However, it is not possible to distinguish the number of users from this target group. It may only be concluded that they are formally entitled to this transfer, which will allow a personal support service. Neither are there any statistics describing the number of mental health users that touch home help (but not necessarily the *PCH*).

Accompagnement

For a long time, personal support was a non-formalised mission of voluntary organisations. However, the 2005 disability act seems to have encouraged a new national interest in this kind of support, resulting both in formal regulation¹²⁶ and enlargement of the service extent. In the national mental health plan of 2005, the government introduced an investment in a service that had earlier been initiated by for example the mental health interest organisation Unafam (gathering families).

These services are of two kinds: *les services d'accompagnement à la vie sociale*, Savs, and *les service d'accompagnement médico-sociaux pour adultes handicapés*, Samsah. The Savs is a personal support outlined in accordance with the needs of the individual concerning all essential acts necessary in the daily life, for example administrative contacts, household activities, spare time activities, studies etc. The service aims at supporting the individual in her/his 'life project', not least when it comes

¹²⁵ *Caisse nationale de solidarité pour l'autonomie* covers 98 percent of the expenses, the *département* the remaining sum.

¹²⁶ Décret 2005-223.

to family and other social and professional relations and commitments. It is charge free and financed by the local government (*département*).

The Samsah has an element of care in addition to the mission of the former service. It is not charged and it is financed by the *département* (as it is a social support) and the national social insurance (as it is also about medical care). Entitlement is universal in the sense that it is not connected to means tests or contributions. Instead, a user is accepted when (s)he is in need of assistance or attendance for realising all or parts of essential acts in life, or in need of social attendance outside of the institutions, learning to become autonomous. This need is evaluated by local handicap administrations.¹²⁷ Applications may be realised by the user or someone else, for example the doctor or a family member. The service may be permanent or temporary and delivered by any kind of organisation – private or public – or profession. Hence, the content and provision of these services will differ considerably, but they will all formally have the same aim: supporting individuals to maintain a life outside of the hospital.

There is a lack of statistics, but both services seem to have increased in number during 2001-2006 (Drees 2008:641). The 2005 plan set out to create 1,900 Samsah in the following years. The increase of Sams is a responsibility for local government. In sum, this is a marginal service for the target group of mental disability, which is supposed to include at least 600,000 individuals.

The PCH may also be used to cover for expenses that concern social activities.¹²⁸

Meeting places etc.

The voluntary sector also plays an important role for this kind of support, inter alia through so called advocacy organisations. These have a wide mission of ‘standing behind’ people with mental disabilities, but also to offer a meeting point. However, their services are not part of a national

¹²⁷ *Commission des droits et de l'autonomie des personnes handicapées* (CDAPH) at the MDPH.

¹²⁸ *Aide humaine* or *dépenses exceptionnelles*. The CNSA mentions vacations adapted to the impairment as one possible interpretation of exceptional expenses.

programme or publicly financed service. Consequently, they are not covered in statistics and they are not formalised. Local organisations may use their own entitlements and charges, or they may not use any at all. The voluntary sector was further encouraged to form social groups through the Disability act and the mental health plan of 2005. These documents initiated self-help groups – *groupes d'entraide mutuelle* – financed by the national disability administration and local governments. In 2009, 333 such groups had developed in all *départements* but one (Barrès 2009: 207f). Entitlement is not formalised; everyone should be welcomed. The groups will vary in structure, but may collaborate with present social and health care agents as well as with interest organisations (Ibid.).

England

In 2004, the social situation of people with mental disability was expressed in terms of social exclusion in a national government report that put this theme back on the political agenda (SEU report 2004). The report was primarily focused on occupational questions, that is, how to 'enable adults with mental health problems to enter and retain work', but it also discussed social inclusion in a wider perspective; 'how can adults with mental health problems secure the same opportunities for social participation and access to services as the general population'? Since then, several programmes have been initiated aiming at improving the social inclusion of this group. A special Inclusion institute was given the responsibility for implementation.¹²⁹

Housing

The Social Exclusion Unit report estimated that 'four out of five people with severe and enduring mental health problems live in mainstream housing, with the rest living in supported housing or other specialist accommodation' (Ibid., p. 86). Housing is the general responsibility of

¹²⁹ The Inclusion Institute at the University of Central Lancashire: www.socialinclusion.org.uk

regional and local governments. This responsibility includes supporting vulnerable groups independently of their financial situation. Local governments are responsible for providing 'residential accommodation for persons aged eighteen or over who by reason of age, illness, disability or any other circumstances are in need of care and attention which is not otherwise available to them' (National assistance act, section 21 a).

The council will assess the needs and the level of priority. There is no formal means test, but the priority will be considered as higher if the means are low. If a person is considered entitled to (social) housing (s)he will be directed towards the public or private sectors. So called Registered Social Landlords, RSLs, offer flats to rent as well as schemes that allow individuals to buy or part buy their home at low costs. The RSLs are independent from local government, but regulated by a national agency (The tenant services authority). It is also possible to apply directly to the housing association, which may accept residents even when the local council has not nominated them. Sometimes they have coordinated waiting lists (The tenant services authority 2010).

The rent in RSLs are regulated by government restrictions assuring that it is in proportion with average incomes in the neighbourhood and with the value of the home (Ibid.). Often, this type of housing is connected to further forms of support and/or activities. As in Sweden, the realisation of the policy is dependent on availability, but meanwhile awaiting a temporary accommodation, the local authorities are obliged to offer a temporary solution. However, this gap between decision and implementation has been described as a problem as the accommodation is seldom suited for the target group. The use of bed and breakfast accommodations has been especially criticised (SEU report 2004: 87).

There are also a number of sheltered housing options. These could be categorised as the Swedish case: group homes, connected flats, residential care, and to be hosted and cared for in a family (adult placement scheme). There are also specialised hostels, run by public administrations or by the private sector, offering short-term care and housing. Another form of temporary accommodation is called therapeutic communities, which combine housing with rehabilitation.

The community mental health team is supposed to help out with housing questions, directing the user towards the relevant administration. Planning for accommodation is supposed to be a matter of the care programme approach. There are also voluntary sector organisations that advise exclusively on this issue, 'Shelter' being the largest in England.¹³⁰ In 2003, a national programme was initiated called 'Supporting people' which had as one of its aims to support this target group to get in reach of proper housing, and to keep it. Several actors were involved to form networks: local government bodies, housing associations, health care and voluntary organisations (Anderson et al. 2007: 285). There is no documentation on whether this programme has made any difference for mental health users, but about ten percent of users are registered as having 'mental health problems' (Centre for housing research 2010; personal correspondence).

There has been, and still is, a shortage of suitable accommodation for this group, having as one effect that people are not being discharged from hospital as they have nowhere to go (NIMHE 2003). Generally, since almost two decades and due to political reforms intended to diminish the public housing stock, the public sector is a minor actor in housing than both the private and voluntary sectors (Kendall and Knapp 1996; Kendall 2003), but there are no statistics on proportions when it comes to mental health. However, it is clear that the voluntary sector is highly present. Perhaps as a consequence of the scarce public supply, it may be hard to be informed on available housing possibilities, as there is no overview of available options. Furthermore, the public 'social housing' is connected to poor-quality and stigmatised areas (Wade & Henderson 2006: 195).¹³¹

Charges are regulated in national law (Section 22 of the National Assistance Act). The costs for being accommodated in sheltered housing are income related and hence adapted to the fact that many users rely on benefits. Furthermore, charges are means related, counting property, savings and investments.¹³²

¹³⁰ www.shelter.org.uk. They offer 24h helpline, online advice and face-to-face meetings.

¹³¹ Social housing is used as notion for needs-based housing support.

¹³² If savings and investments are equivalent to at least £23,000, full charges are paid, if they are less than £14,000 no charges are paid.

According to national statistics, the number of care home residents with mental health problems increased by 15 percent during 2000-2004. While the public sector decreased its services by 50 percent during this time period, the private (for- and non-profit) sector increased its placements by 20 percent at residential homes and by 49 percent at nursing homes (Community Care Statistics on supported residents in England 2004: 5f;14). In sum, about 12,600 individuals were accommodated at a care home temporarily or permanently in 2004. The main population of working age was people with learning disabilities, including three times as many residents.

Occupation

The importance of occupation was one of the leading themes in the Social exclusion unit report (2004: 51), which concluded that

People with long-term mental health problems have the lowest employment rate of any of the main groups of disabled people – according to the Labour Force Survey definition, only 24 percent are currently in work in England.

According to the same survey, more than 60 percent of those with physical disabilities were employed. Several hypothetical reasons for the low numbers were presented. In sum, the authors were clear in stating that the low occupational statistics were not an effect of individual incapacities to work, but of shortcomings in the welfare state's capacity of giving the right support as well as the general discriminating attitude towards the group and other structural barriers that the system itself provokes:

Many people feel that leaving benefits represents a real threat to their financial security. They have concerns either that they would be worse off in work, or that the job would not work out and they would need to reclaim their whole benefits package, which might have been difficult to secure in the first place. People claiming through their health insurance fear having higher premiums or being unable to get health insurance in future if they return to work. (SEU report 2004: 60)

Employment support may be provided by health or social services, which may in their turn, purchase them from public or private sector agents within day services, specialised facilities or community settings. The GPs are viewed as an important actor as they are supposed to refer the person to a vocational advisor. The care plan, that every patient should have, also includes a mission to consider occupational alternatives (Department of health 1999).

Jobcentres Plus have a national responsibility and are to work in partnership with other actors. Hence, many agents are involved (Ibid.: 55). At the same time, it seems as if the existing services are not always known and used by the target group (Ibid.: 60). The British government of the last decade has had a work focus in general, but also for people with disabilities. The government launched several pilot programmes to move people from benefits towards work. Some examples being a *New deal for disabled people* in 1997, *Pathway to work* in 2003 and the *Welfare reforms* of 1999 (act) and 2006 (bill) as well as reforming the department and its agencies: introducing the Department for Work and Pensions taking over the tasks of the Department of Social Security, and replacing the Employment service and Benefit agency by the work- and benefit-oriented Jobcentre plus (in 2002). *Pathway to work* is a programme of the Jobcentres plus addressing those who claim a disability pension and aims at finding a work solution instead. This is done through personal coaching, financial incentives and cooperation with medical actors.

The Jobcentres Plus also administer a number of other programmes aiming at finding special solutions overcoming the barriers of disability, such as *Access to work*, *Workstep* and *Job introduction schemes*. However, several of these programmes require that participants are quite healthy which excludes those with more severe problems (SEU report 2004: 67). During the same period, the government also introduced a national minimum wage (1999) and work- and disability-related tax credits, which should benefit people with disabilities as they are overrepresented when it comes to low-paid work (Burchardt 2000). The New deal is still running and uses a network of 'job brokers' from private, public and voluntary sectors who are to give advice, support and information to the users and be in close contact with employers.

There are several interventions aimed at supporting a route (back) to work, but none specific to the mental health field. Among those directed to people with mental disability can be distinguished: *sheltered employment*, *supported employment* (“Workstep”) and *training and education*. Rosen and Barfoot (2001: 297) notice a shift from group activities in a sheltered environment to jobs in the ‘real world’ or consumer-led and/or owned ‘social firms’ with real pay and individual and independent contracts.

Even though it is not clear whether the work policy have had any effects, it is clear that the employment rates of people with disabilities have risen since 1997 which is a positive break with earlier stagnated numbers (Burchardt 2000; 2004). For the specific handicap group of interest here, there are no available statistics on engagement in programmes, work opportunities etc. However, the issue was highlighted by the government in 2009, presenting a plan for action in this field, *Working our way to better mental health: a framework for action*. It intended to

deliver significantly better employment results for people with mental health conditions, supporting them into work, helping them to stay in work and assisting them to return to work more quickly after sickness absences. (Department of work and pensions 2009: 8)

A number of actions were suggested, for example introduction of ‘a new mental health coordinator role in every Jobcentre Plus district in Great Britain’ (Ibid.: 9) in order to adapt the mainstreamed services to this target group, but also to better coordinate the services in general:

We are determined to step up our efforts to support people with mental health conditions at work and to help those out of work to return quickly to fulfilling and rewarding employment. The government’s response to improving the opportunities for work for individuals with mental health conditions has not in the past been well co-ordinated. But Government cannot act alone: we require united action between health care professionals, employers, service providers and individuals themselves. (Ibid.: 16)

As in Sweden, there are also so called day services which offer a wide spread of activities, differing between one service to another; sometimes they have a character of structured occupation, sometimes being more of a social meeting place. Generally, they offer support during the day, and access to further services and advice. One outcome of attending the service may be support into paid employment (SEU report 2004: 42). Hence, the content is not formalised and the same is true for entitlement. Anyone actor may provide the service, for example a voluntary organisation in cooperation with the local government. However, according to the Social Exclusion Unit Report, day services have become more structured, moving from just being a 'place to be', isolated from the rest of the community, towards a service that actually serves to encourage social inclusion in terms of occupation or other forms of participation in the 'outside world' (Ibid.).

There is a large variation of sheltered employment alternatives in England and the SEU report mentions some of the models that may be identified (2004: 56): sheltered workshops where people operate unskilled activities, often to low wages; vocational training programmes and job search services aiming at paid employment; social firms where people are employed in a sheltered environment but where the business may be realised in the open market etc. These all resemble the programmes offered in Sweden and similar to the Swedish case, it seems as if it is difficult to describe access and attainability, and local variation seems important:

The extent to which different schemes operate in the UK is not well understood, in part because different projects open and close all the time. One study in the North West of England found high variation in provision and poor relationship between the schemes identified and the needs of the areas in which they operated. In that research, the highest level of provision of places was in the area with the lowest deprivation and unemployment levels. (SEU report 2004: 57)

As in Sweden, incentives have also been taken to encourage people on benefits back to work. According to these 'permitted work rules' a person

on disability pension may start working up to a certain number of hours or earning a certain sum per week while remaining on pensions during some time. Other kinds of policies that aim at limiting the risks of trying the workability is that if a person fails and needs to reclaim the pension, (s)he may be eligible for the same benefit level for some years (SEU report 2004: 61).

English disability policy is generally described as highly focused on rehabilitation and occupation (e.g. Drake 1999: 54ff). As a country involved in both the first and second world wars, the need of such support was immense. The government answered to this by introducing rehabilitation and vocational programmes and by encouraging the labour market to use also this part of the labour force when recruiting staff, comparable to the French case.

[A] register of disabled people was created. The intention was that companies with more than 20 staff had to employ a quota of those on the register. In theory, 3 percent of the workforce of each qualifying employer was to be made up of registered disabled persons. In the event, however, the quota scheme was widely ignored. About 80 percent of firms failed to meet their obligations, and exemption permits were granted in huge numbers. (Drake 1999: 55)

The quota policy was used until 1995. Another way of creating occupation for this group was a possibility to reserve certain posts for a person with a disability. However, according to Drake these posts often proved to be low-paid and low-skilled work. Since the late 1950s, legislation also encourages sheltered workshops and private companies that provide employment or employment services to people with disabilities (Ibid.).

Personal support

Formalised support

In England, there are no specific, formal services directed only at this target group. However, as a disability group, people with an assessed need may be accepted as users of general services such as home help or meals on wheels which are part of the local council's social services.

Meals on wheels mean that food is delivered to someone who has difficulties with cooking in their own independent living. Home help (or home care) may include for example cleaning, dressing, preparation of food or shopping. Such services are charged, but the costs will vary between localities and are both income and means related though not means tested.¹³³ Once the support is assessed, the user may choose to purchase it from other providers than the local council through the so called direct payment system that was introduced in 1996. Through these means it also becomes possible to purchase a service which is not offered by the local government. The user is free to employ any person, but generally not someone from the own household.¹³⁴ The use of direct payments is not only an option, but is, according to present law, supposed to be discussed as a *first* option by local councils and there is an official aim of increasing the number of users that choose a private provider. Even if the numbers have increased during the 2000s, it still only constitutes a few percentages of all social service spending, and it is almost inexistent for the target group of interest: representing 0.3 percent of all expenditure compared to 9.4 percent for physical disability in 2004/05 (Healthcare commission 2007: 24).

A second scheme of this kind, where the individual purchases the care, is also tried in England: individual budgets. This scheme puts even more responsibility in the hands of the individual and is part of a wider reformation of social services introduced in the mid-2000s. The leading key words of both schemes are choice, control and independence. By organising care in this way, power is supposed to be transferred from the social administration 'gatekeepers' towards the individual once the need is assessed. Hence, it is part of both a choice and an empowerment agenda where individuals are supposed to become more involved, have an improved influence and take a greater responsibility for the realisation of

¹³³ Example from London City council: An hourly fee of about £9 up to 14 hours of home care per week, and about half that sum for exceeding hours. Users with means over £19,000 are not eligible for cost reductions.

¹³⁴ This person may be called a personal assistant (PA), but one should note that unlike in Sweden where this is a concept with legal status indicating a specific social service, it is a general concept in England. Hence, a English PA may as well be someone working in an office, as someone realising support for a person with disabilities.

care and support. It has been debated whether such a position is really possible to mainstream, or if it is rather designed for the most 'able' (the least disabled) parts of the target population and how this should be handled.

Since the Community care act of 1990, social workers are responsible for so called care management services. This may be compared to the Swedish *personligt ombud* in its strivings for supporting the individual into an independent life. At the same time, there are also important differences, such as not being independent from the public administration, or not having brokerage and advocacy as central features. It is therefore perhaps to be understood rather as a work 'approach' (a more needs led one) rather than a service where the user meets a specific kind of support (Lewis et al. 1997). Hervey (2006: 189) describes the mission of care management in the following way:

[T]hey can identify and arrange a number of suitable services. These may involve a community support worker, day care, employment schemes, educational courses, residential or nursing care, specialist groups such as 'Hearing Voices', a travel pass or paying for a telephone connection. The range of services available differs from area to area.

Other assignments of the care manager may be to coordinate the outpatient care or to offer counselling (Ibid.).

Meeting places etc.

When it comes to advice and information, the voluntary sector is of great importance. One example is the *Citizens advice bureaus*, which are primarily funded by central and local government grants, but also by charities, companies and individuals. These bureaus are in place since the 1930s and provide 'free, independent, confidential and impartial advice to everyone on their rights and responsibilities'. There are about 400 offices in England, and the support is primarily provided by volunteers. The most common issues that people seek help with are of financial character, such as debts and benefits, but also questions on housing and em-

ployment.¹³⁵ According to the SEU report (2004: 89f), about 20 percent of those who seek help at a bureau suffer from mental health problems. They also report that in some areas specialist advice has been offered at mental health institutions to meet this need. However, it seems to be of short term character and is not part of a formalised support as in the Swedish counselling service. Other ways of getting advice support is to use the so called *advocacy* services, which are also part of the voluntary sector services that may be publicly funded. As with the bureaus, the aim is to help people access information and to get in reach of the existing support. One advocacy service describes its mission in the following way, which reminds of the Swedish *personligt ombud*:

The advocate is there to ensure that clients have an opportunity to speak up for themselves and get their voice heard. Working at the client's direction, the advocate can support the client to deal with issues including housing, financial services, welfare benefits, and legal issues, as well as practical help with forms and letters. (SEU report 2004: 90)

General advice and information is also available via telephone help lines or internet by organisations such as Mind or Rethink, that is, mental health charities that work for improving policies and supporting users and/or their families.¹³⁶

The day services that were treated as occupational service also may have a social support character as being a kind of meeting point.

Comparative discussion

A variety of social support directed to people with mental disorders or disabilities was found in all three countries. However, in contrast to the medical and financial supports, it seems less likely to find main programmes when it comes to housing, occupation and personal support. This is true whether the responsibility is national – as for employment – or local – as for housing, personal support and occupation. The conse-

¹³⁵ www.citizensadvice.org.uk

¹³⁶ www.mind.org.uk, www.rethink.org

quence is an important variation within each country. This variation was intensified by the fact that private providers were involved in all areas, and that some services were non-compulsory duties.

Table 8. Predominant characteristics of social support

	Entitlement	Charging structure	Accessibility & attainability	Provision & Administration
Sweden	Universal or not formalised	Income related, flat rate or not charged	<i>Obstacles?</i> Indistinctness in the interpretation of need <i>Duration?</i> Sometimes limited <i>Waiting days?</i> Not formally <i>Attainability?</i> Difficult to depict, scarcity is reported	<i>Administration?</i> Decentralisation, Deconcentration <i>Provision?</i> Local government, deconcentrated State agencies, non-profit sector, for-profit sector
France	Universal, means tested or not formalised	No charges or charges covered by financial compensations	<i>Obstacles?</i> Administrative delays, variety of schemes, limited availability <i>Duration?</i> Sometimes limited <i>Waiting days?</i> Not formally <i>Attainability?</i> Difficult to depict, scarcity is reported	<i>Administration?</i> Decentralisation, Deconcentration <i>Provision?</i> Local government, deconcentrated State agencies, non-profit sector, for-profit sector
England	Universal or not formalised	Income related, means related or not charged	<i>Obstacles?</i> Varying schemes, clash of benefits <i>Duration?</i> Sometimes limited <i>Waiting days?</i> Not formally <i>Attainability?</i> Difficult to depict, scarcity is reported	<i>Administration?</i> Decentralisation, Deconcentration <i>Provision?</i> Local government, deconcentrated State agencies, non-profit sector, for-profit sector

Entitlement

Interestingly, entitlement was generally universal in all countries and for all services. The exception is the right to ordinary housing, which is connected to means tests in both France (formally) and England (informally). In these countries, the public commitment in this question is limited to financial vulnerability. This means that the support is potentially more restricted and that so called social housing is more stigmatised – a case of stratification.

For some services, there is no formal entitlement. Instead, users are dependent on availability and administrations, but there are no possibilities of claiming the service – it is far from being a ‘social right’. This especially concerns personal services with a wider mission of encouraging independence and improving administrative contacts.

It is also evident that although it is reasonable to categorise entitlements as universal, universality is not equal to accessibility. While the literature identifies two obstacles to entitlement, means tests and contributions, there are far more restrictions that determines whether a person is accepted as a user. These restrictions may be as important, selective and stratifying. On the one hand, the evaluation associated with entitlement concerns the level of disability and illness. Legislations leave open for discretion in the bureaucratic process of assessment where the needs may be considered inappropriate because a person is too healthy, too ill, too functioning, too impaired or just because the demand is not sufficiently legitimate. The borders of the target group are open. Moreover, the needs must not be covered in the present situation, which means that the public support is not a first, but a last, option. The public intervenes where other actors have failed. This is true also in a country such as Sweden. Moreover, the disability or illness is to be understood in relation to available support – even if there is an assessed need, there is not necessarily policies developed to meet it.

Charge and reimbursement logics

While employment and occupational support is not charged, reimbursements vary with programmes in the three countries. Charges, when exist-

ing for housing and personal support, are flat rate or means related and sometimes income related. There are no common patterns per nation or per service area. In Sweden, the same kind of service may be charged or not depending on what legislation that was used as ground for the approval. National reports have argued that this unpredictability is problematic. The confusion should be intensified by the fact that the support is sometimes realised without a formal decision even when such legislation is available. Yet, the problems of foreseeing the charges and reimbursements seemed as present in all three countries.

Access and attainability

Even though the number of users was difficult to determine, it may be concluded that social services seem to reach a limited group of people in relation to the estimated size of the target group. The reasons for this poor attainability may be due to many facts. One hypothesis is that the services are not well known among the users and/or the administration, that is, that mental disability is not yet an established disability group within the social services when it comes to implementation. During the work of this study, it has been clear that mental disability is not an evident target group, and their needs and (dis)abilities are not fully known.

Compared to other target groups, mental disability has no obvious borders. The situation is different when, for example, gender or age based groups such as women, children or the retired are studied. I would also claim that it is more intricate compared to other disability or patient groups (the blind, deaf, paralysed or even intellectual impairments), although Bolderson and Mabbett (1991) have argued that disability is a particularly unsuccessful category as such. For mental disabilities, there are no methods for deciding when a person is disabled or not – the diagnosis is not enough and there are no specific tests. Likewise, the impairments seem to differ from other and established groups. At the same time, the solution has most commonly implied a mainstreaming of existing support. The social support may then be described as scarcely adapted to this target group.

Another hypothesis would be that this is an effect of fragmentation. It has been apparent that the existent services are difficult to depict as they are not assembled. No agency has an overall responsibility for the welfare of this group, which might have led to a situation where no actor prioritises mental disability as there are so many other target groups in need of resources.

The most striking problem, which lays the ground for both low incomes and social isolation, is the low occupational rate, that is, the lack of commodification. This is a common problem for all countries in this study. As was discussed in the previous chapter, disability pensions have become a final exit from the labour market. At the same time as users express an anxiety of becoming forced to work, there is an expressed interest in getting the chance to do so. Presumably, the high level of disability pensions is at least to some parts possible to interpret as consequences of an unsuccessful occupational support.

Provision and administration

The ambition of differing between private and public providers turned out to be difficult in all three countries as there were not enough documentation. What can be concluded is that private providers are important when it comes to sheltered housing in all three countries. In Sweden, providers adhere to the for-profit sector, while the English and French actors seem to adhere to the non-profit sector. The private sector is also present in the field of personal support and occupation in all three countries. While for-profit agents act in an area such as home help, the voluntary sector – not least user organisations – are important when it comes to occupation, though foremost in terms of social activities. This role seems to be growing considering how governments, even in the Swedish case, have emphasised the importance of their involvement in recent policy documents. Hence, one must conclude that there is a public-private mix in all countries, but that its proportions are hard to establish.

The involvement of the private sector is an interesting result as it opposes the theoretical expectations on Sweden. This said, one must consider that social services are foremost publicly centred in Sweden. How-

ever, the involvement of the public sector is important even in the other countries. This means that users are not solely left to the market (and their market value) or voluntary organisations (and their willingness) in any of the nations. Instead, users will meet a mix of public and private actors and the services will most often be financed through public means.

Generally, the services were more extensive and developed in Sweden and England than in France. This might be understood as a consequence of a more far-reaching general social service production for disability groups in these countries. This was most visible in the case of personal support and occupation where the French services are very much in progress. The handicap perspective met more important resistance in France, and was implemented in legislation a decade later than in for example Sweden. It also seems as if France still uses a more institution-like and medical centred social care. Decisions around housing, occupation and personal support emanate from the doctor and are connected to health care.

Sweden and England differs in that England has a more explicit choice agenda. In Sweden, users are generally approved the right to a service, while in England, they are approved the right to purchase it with the help of public means. However, it is interesting to notice that the private sector is strong when it comes to housing in Sweden. The same is also true for personal assistance (although this is mostly a service that has been accorded other disability groups).

Conclusion

The diversity of policies thus leads to difficulties of identifying national models. Instead, the result seems to go in all directions. No users are solely, or centrally, dependent on States or markets, nor families or other parts of the civil society in order to achieve social support. Public services are present in all countries and they are generally universal to their character; the general rule is that a person is not denied a service because of personal means or a lack of contributions.

In that sense, de-commodification can be said to reign in all three countries. At the same time, it is evident that this is a group that has been

commodified to a very low degree even when individuals are able to work. A more general conclusion should then be that for some groups in society, commodification is a more ardent question than de-commodification. As for the area of transfers, an employment history is sometimes a prerequisite for other areas of support. This was true for some occupational services, but also, in France, for some types of housing. Hence, the importance of labour activity and/or experience should not be underestimated as an entry to welfare support.

It is also true that for- and non-profit sectors are important in all countries, not least when it comes to sheltered housing and social activities, but also in the delivery of other forms of support. All three countries use cash benefits which allow the user to purchase care from any sector, or use private providers for publicly funded care. To some extent it seems possible to claim that public and private providers play different roles, but also that the welfare mix is a reality in all contexts.

At the same time, it may be concluded that France shows a more conservative side in the meaning of preserving a 'status quo'. The services are less developed and the dependence upon psychiatric actors is more important whereas Sweden and England are using more mainstreamed services and social agents. As several researchers have shown (Daly & Rake 2003; Morel 2007), France is a latecomer in the field of elderly care and the same seems to be true for disability in general, and particularly for mental disability (cf. Delbecq & Weber 2009: 7). The results also fit with the idea that France is heavier in transfers than in services. Nevertheless, indications of an increasing mission was shown, at least when it comes to funding such services. There is also an ongoing debate in France, which might lead to an inclusion of disability as one of the major risks handled by the social security system (see for example Moreau 2008).¹³⁷

¹³⁷ Dependence would then be the fifth area (*le cinquième risque*), added to the previous four protection schemes concerning sickness, family, occupational injury and pensions. The government points out people with mental disabilities as a group that would be concerned by such a reform.

Part III:

Conclusion and discussion

Chapter 7

Mental health policy and the welfare state: a story of fragmentation and stratification

Part one of this thesis introduced the study, the research area and the public administration of each state. Part two of this thesis presented the empirical findings. It outlined the support that has been developed to meet the needs of people with mental disorders and disabilities when it comes to five selected areas: treatment, financial support, housing, occupation and personal support. The policies were analysed by looking at characteristics of entitlements, charges and/or reimbursement, attainability and access, and finally, administration and provision, to identify variations of what I have chosen to label *policy design* and *policy logics*, that is, of their content and of the ideas that could be said to hold them together. The aim was to illustrate what has been done to break with the marginalisation as originally constructed; to portray contemporary mental health policies through the lens of welfare theory. In what ways is contemporary welfare support creating the ground for a 'normal' life and a social citizenship? I wanted to know whether there was national consistency in the design of these elements, and if there was a common logic to be found, an idea of how this group should be supported and by what actors. I also intended to find out if these patterns were in line with what welfare researchers, not least proponents of the regime theory, would lead us to expect. Are there separate or common political strategies for

meeting the needs of this group? Where do we find the borders of divergence? From a theoretical point of view, and as was stated in the introductory chapters, there were reasons to believe that these nations have chosen different ways of designing their policies. Nevertheless, it remains contested where the borders of this divergence are. Consequently, this study aimed at further investigating such questions.

It is now time to draw conclusions, both about what difference it makes to be a user in these countries and, on a more general level, how contemporary welfare policies are to be studied and what national variation to expect. The final part of the chapter is hence dedicated to a discussion about the usefulness and shortcomings of welfare state theories as tools for understanding welfare policy design and their logics. It will be argued that more attention needs to be directed to the construction of 'welfare states', as well as to the multitude and heterogeneity of target groups. The idea of a holistic system and a general user stands in the way of a more proper understanding of how welfare policies are designed and how they mirror and influence the society at large.

Tracking down three models of mental health policy?

To start with, a multitude of transfers and services were found in all countries, but very few examples of specific support were found, that is, support solely used for this group. Instead, this target group has been mainstreamed into general disability policies. Mental health policy thus becomes dependent on the disability policies of a country. In terms of realisation, it is also dependent on its ability to recognise this group as a disability group in a stage of implementation. I will come back to this latter fact later on in this chapter and start with a discussion on the identified support: what differences and similarities were found in the design and to what degree do they constitute different models of welfare?

Entitlements

The first analysis category was entitlement, aiming to define which citizens are covered and on what conditions. Theoretically, there was reason

to assume that Sweden used universal entitlements, while France asked for contributions and England had means tests as a prerequisite.

For the most part, entitlements are formalised and based on recognition of disorder and/or disability. The exception concerns personal support, where a number of services are available without any formalised entitlement, ranging from counselling via telephone helplines to versions of case management. This support is often part of the voluntary sector. The presence of an entitlement procedure means that even if the transfer or service is not means tested and not connected to any contributory system – which is the present definition of universality – one still may not be considered as entitled to the support. It is evident also that this gate keeping function is important to understanding stratification and marginalisation. The concept of universality is deceptive in the meaning that universal support appears to be available and accessible to all citizens.

In reality, this is seldom the case, as it is necessary to prove membership in the target group – to deserve to be taken care of. This recognition is not always evident, which is illustrated in this material. Whether one is assessed a service or transfer seems to be dependent on administrative discretion; where regulations are indistinct or borders of target group adherence are vague, the influence of individual officers on decision outcomes may be expected to be important. It is probably also dependent on social norms and a general recognition of the appropriateness of welfare support and target group needs. Therefore, this barrier (administration as a gatekeeper) may be more present for some groups than for others. Hypothetically, one might expect that groups that are already institutionalised (in the sense of having a manifest position) within the welfare system are less questioned in the claiming procedure, than more recent, less known or less accepted groups.

With regard to treatment and occupation, and generally, personal support, all countries applied *universal* rules. This was also true for housing in all cases but France, where support for independent housing is connected to a means test. Hence, *services* generally seem to be of universal character. Yet, universality was also the most common ground for some kinds of transfers, that is, those allowances that are constructed to com-

pensate for the extra costs that a disability may cause, here called financial compensation. These types of benefits are generally not very extensive and supposed to 'top up' the income, but not to constitute a basic income. By contrast, *selectivity* was used for financial support in terms of *income replacement* such as sick pay and disability pensions. These are benefits connected to a history of contributions or labour market participation, that is, an earlier income. However, in Sweden, a person may be eligible for disability pensions even without such a history, but the user will then stay dependent at a guaranteed level that is relatively low. A similar design was found in England (though at constantly low levels).

Hence, universality is the most common ground for entitlement for most support in all countries. This is a surprising result. The exception is income replacement, one of the studied transfers. In some sense, transfers and services seem to follow different logics. This difference appears when transfers connected to labour market participation are studied, that is, transfers connected to the social security system. What is more surprising is that the three countries primarily follow the *same* kind of logic – what Esping-Andersen called the social democratic model. Principally, a person with an approved mental disability is eligible for services and transfers, irrespective of personal means. However, labour participation matters for financial support. In this sense, no country follows a so called social democratic logic entirely.

It is also interesting to note that a formalised entitlement is not always present even for publicly funded, and sometimes publicly provided, support. From a user perspective (and probably also from an administrative view), this contributes to confusion. Even if this support may be classified as belonging to the welfare system, it can hardly be classified as a 'social right', which the literature seems to presuppose. Rather, it is to be viewed as some kind of 'social bonus' – one is lucky to get within reach of the support, but cannot count on it.

Charges and reimbursements

The second criterion concerned whether the service was related to charges and, in that case, whether these charges were flat rate, earnings

related or means related. Moreover, the levels of these charges were investigated. The same questions were asked for reimbursements. Welfare theories gave scarce guidance on what to expect, but it was assumed that Sweden would use flat rate and generous ('middle class standard') benefits, and that France and England would use less generous and means-tested or earnings-related benefits. This as a consequence of the fact that only the social democratic model is supposed to have equalising effects and aims. By contrast, the conservative model intends to keep a status quo and the liberal model is understood to use welfare policies only as a tool of poverty reduction. What is more, the liberal logic is about keeping benefits at levels low enough to make them unattractive forms of incomes. The same kind of logics could be expected for charges, although these are more or less ignored in the current welfare literature. It was also claimed that there seems to be an expectation of uncharged services when connected to universality.

In general, and in line with entitlements, there is a mix of designs when it comes to charges and benefits. This is true for all areas and for all three countries. For treatment, Sweden shows the most important variation, as charges are a decentralised issue, but variation exists in all countries, partly due to a cleavage between publicly and privately funded care. The latter type of care uses unregulated charges in all three countries. From a user perspective, patient fees for care visits at publicly funded care providers are most expensive in Sweden and least so in England, which is surprising enough from a regime theory perspective. In both France and Sweden, charges are regulated in such a way that they become unpredictable for the user. Hence, charges differ not only dependent on care provider, but on geography, age and income. However, the final out-of-pocket cost depends on private insurance to a greater extent in France and England than in Sweden. The number of people who subscribe to a private insurance plan in Sweden is still low. However, and as in the two other countries, Swedish employees may be covered by employment schedules that compensate for treatment and drug costs. It may then be argued that even if Sweden mostly follows social democratic model logics, employment is connected to further privileges here also. This point

is important when considering the stratifying effects of a system, especially when focusing on a group that is mostly unemployed.

To sum up, Sweden exemplifies a social democratic logic, though one should note that health care is not free of charge; England follows a social democratic logic for treatment and drugs; and France must be considered conservative, but with a social democratic parallel system that catches those not covered through employment.

Charges for housing and reimbursements for occupational services were difficult to depict, as there is a plurality of programmes, and as the charges/reimbursements are not always explicitly formalised. However, it seems clear that reimbursements are often set at low levels, leaving them quite far from comparable earnings among the non-disabled population and in line with a liberal logic of not allowing salaries and benefits to meet. For personal and financial support, there is an important mixture of logics. Personal support is sometimes not charged at all. This is true for some of the services delivered by the voluntary sector, such as counselling, but also for the French *accompagnement* and the Swedish *personligt ombud*. All in all, the variation is too wide to draw any conclusions about model adherence or to depict a common design. Users should expect any kind of logic in all three countries, though seldom that the service is free of charge or that reimbursement is set at 'middle class standards'.

Services such as home help apply charges that are earnings related. In Sweden the charge system is especially complex, as there are different programmes applying different designs and logics, but containing similar services. For financial support, income replacements are generally earnings related, while compensations are flat rate. The levels vary significantly between countries, leaving Swedish users better off compared to both England and France, if looking at, for example, sick pay. But apart from this difference, it is hard to find any national patterns.

Consequently, the mixture was too great, both for developing hypotheses about relationships between charges and entitlements, and for pointing to any models. What causes this situation is that, except for health care, there are no central programmes to rely on. Instead, the mental

health policies consist of numerous central, regional and/or local interventions that vary with time and space in an unpredictable way.

Accessibility and attainability

The third investigated characteristic concerned accessibility and attainability. The aim was to observe obstacles to access and to ask whether the supports seemed to reach the target group. Such a question is relevant, as it is well known that people with mental disorders and disabilities still are considered to be a marginalised and vulnerable group in terms of income, health and education. Thus, it is interesting to know whether this may be connected to a lack of policies or, rather, a problem of getting within reach of existing support. However, there were no precise theoretical expectations concerning the outcome in the three countries or how access and availability could be connected to the type of welfare state. Hence, this question was a very open and explorative one, not generated through theoretical hypotheses, but presumably possible to use for a discussion on similar and different outcomes in the three contexts.

As the target group is not clearly defined in public statistics, it was difficult to make any statements on the attainability of different services and transfers. Another problem was that, even with available data, the extensiveness of the target group was not known – administrations are unaware of how many people are in need of different kinds of support. There is often an estimation of the size of the group, but not of who needs what, which is a central question when dealing with a target group with varying needs. This contrasts to other target groups, such as age groups – for example, children or pensioners – where state and local agents calculate the need for preschools, transfers, etc., and where the exact number of individuals is known. In that sense, this study object turned to be especially problematic. What could be concluded is that, in general, people with mental disorders and disabilities were understood to use the available services to a low degree. In Sweden, this was also debated for psychiatric care, which may be understood as a consequence of a particularly reduced health care capacity, both for psychiatric inpatient care and for

outpatient care in general. Moreover, important local discrepancies were noticed as a problem by both Swedish and French governments.

Another problem of access may be due to indistinctness in legislation. If target groups are not specified, or if entitlement is not formalised, it may be difficult for potential users to get within reach of services. This seems to be the case for much of the welfare policies studied here. For financial support, there were also clear restrictions of time limits and waiting days. The rules concerning income replacement were most generous in Sweden and least so in England.

If accessibility and attainability are difficult to measure, the very existence of some services confirms the presence of problems. One such example is the Swedish case management, *personligt ombud*. This support is a service still in progress, but it was originally developed to overcome the problems of access and attainability. Studies also have shown that, with the help of a *personligt ombud*, a person becomes a more frequent welfare user, at least with respect to parts of the services and transfers (Björkman 2000). In England, market actors provide users with information that is supposed to increase the success rate when applying for welfare services. As much as it is interesting to find that the state and the market play comparative roles that (partly) fit within expected welfare contexts, both examples indicate that the welfare state is a complex system to navigate, not least for this group.

It seems to be a general feature of welfare systems that the transfers and services have to be claimed by the user her- or himself. The only exceptions seem to concern services and transfers directed to children – such as compulsory school or child allowance – as they could not be expected to claim their own rights. Hence, the welfare system implies an active citizen – and today increasingly an active *consumer* of welfare services. As logical as this may seem in an era of ‘choice agendas’, one may question whether this is the most efficient way of addressing all target groups, especially those whose impairment is manifested through an inability of communicational art. It is possible to imagine a system where one assessment is the gateway to several services, a package that could be reviewed over time. That would at least limit the claims procedure. The present system – no matter which model – also leaves an im-

portant responsibility in the hands of local officials as advocates of democratic and social rights. In both England and France, doctors or other members of mental health teams seem to play key roles for access to further services.

In sum, it seems that, if the number of users from this target group is to increase, the welfare system itself must become aware of both the population size and the needs of potential users. Instituting a case/care manager is one way of both overcoming lack of knowledge within the administration and of increasing the awareness of potential needs and the general life situation of different groups. Several obstacles may stand in the way of getting within reach of welfare support. As the implementation process was not the focus of this study, the discussion here must be limited. However, as access and attainability seems to be central issues for mental health policy, something should be said.

Apart from shortcomings at the administrative level in terms of formal vagueness or understanding, it is also possible that members of the target group show a lower awareness than those of other target groups about their rights, and therefore are not claiming them. It is also possible that they have greater difficulties in claiming them, in spite of awareness, as their disability is of a communicative character – the claims procedure is perhaps an obstacle in itself. In that case, the solution of access problems and a low level of attainability is then not only to be found in improvements on behalf of the administration, but through services such as case management, where the ‘negotiation’ between the citizen and the welfare system is conducted by a third party.

Administration and provision

The fourth category of analysis concerned the organisation of the welfare system in terms of public and private actors. Most often, focus has been directed towards the division of state, market and family/civil society involvement in the provision of welfare. In a social democratic model, the citizens are supposed to be covered by public providers and programmes, while citizens in the liberal model purchase their insurance and services foremost from the private market. The conservative model represents

solutions connected to occupational schemes, and families and charities will be more frequently seen as providers of care. In addition to revealing this kind of welfare mix, there was an intention to illustrate the institutional fragmentation within the public administration, as this division has been used to explain why some policy areas are more left behind than others (Rauch 2005).

Institutional fragmentation was visible in all countries, and in most areas. This concerns fragmentation on both horizontal and vertical levels and between public and private actors as well as within the public administration.

Public-private mix

The three countries share several similar traits. There is a mix of public and private providers in all three countries, covering for-profit as well as non-profit sectors. This is especially true for social care. In two areas, public provision is more important than private alternatives. The first is inpatient care, and the second, long-term income compensations. Hence, the 'heavy' care delivery is a public issue, even in France, where the private sector is generally prominent. This is probably due to the fact that hospitals offer more complicated treatments and have a more far-reaching responsibility for the population served than do other areas of health and social services. Hypothetically, public services are generally most likely to be found in highly professionalised and technically demanding parts of the welfare system. By contrast, the chances of finding private providers increase in services that are less professionalised, such as social services. This is true also in Sweden and especially for housing. This is a picture of Sweden that is seldom recognised in international comparisons, especially as it concerns the for-profit sector. It may also be concluded that all three countries use public programmes for financial support of a more durable character, for example, disability allowances and different types of compensation. It seems that, generally, only temporary benefits are trusted to the private sector, for example, sick pay. Thus, it is only in this exceptional case that the countries adhere to the theoretically determined hypotheses on differences.

Generally, the proportions of the sectors were difficult to depict, as statistics are rarely available. Conclusions must therefore be drawn with caution. Based on what was found, it still seems as if the private sector, though present in Sweden, is more important in France and England. At the same time, it also seems as if the public sector is more present in France and England than I had expected. The private sector, and perhaps most so the voluntary sector, in Sweden have been paid scarce research attention, possibly because they are supposed to play a limited role (e.g. Lundström & Wijkström 1997). However, non-public providers have become more important in Swedish mental health policy when it comes to both occupation and social services. This development has been encouraged at the national level, particularly during the 2000s, underlined in terms of both rhetoric and financial incentives. For this area, Sweden shows more liberal traits than its counterparts. There is a need for further research on the role of non-public agents in Sweden. The presence and growing importance of which this material gives evidence should be possible to find also for other areas of social care, not least when it comes to care and treatment of vulnerable groups, for example, in the areas of alcohol and drug treatment (Stenius 1999) or homes for young individuals with some kind of identified problem. Interestingly enough, it seems as if private providers are historically established in Sweden with respect to this kind of smaller target group, rather than to larger populations in areas such as education, elderly care or health care (Ibid.). This may perhaps serve as a reason why they have not been as visible in earlier studies.

Split of public agents

The fragmentation of public actors characterises most areas and all three countries. This means that the policy is seldom a national responsibility, and when it is, it is most often deconcentrated to several parallel administrations. The exceptions concern health care in England, where users meet a more unified organisation, and financial support in Sweden, which is solely handled by a deconcentrated insurance agency. The welfare system of France seems to be the most complicated among the systems here studied. The number of agencies is large and seems to be in an

almost constant state of expansion. The result is a network of complementary and parallel agents that is hardly possible to map. As was discussed earlier, this fragmentation is likely to cause complications for both accessibility and attainability. The split of public agents especially characterises the service area in each country.

Implications for de-commodification and stratification

According to Esping-Andersen (1990), the point of differentiating between models of welfare is to show that these models have implications for the citizens in terms of de-commodification and stratification. In a social democratic model, citizens would be less dependent on their abilities and on having access to work, and the system would create fewer cleavages between different groups of citizens. The opposite would be true for the other systems. What conclusions should be drawn from a study of the mental health field? What about the abilities of de-commodification, and what about system effects in terms of stratification?

As de-commodification presupposes commodification, the question is somewhat inappropriate. At the same time, it might be claimed that people with mental disabilities are guaranteed an income if they are considered incapable of work. This is true for more permanent reimbursements such as disability pensions, but not for temporary schemes such as sick pay, which demand a history of labour market participation (and hence contributions). Nevertheless, without earlier incomes, a disability pension will not reach levels that resemble a salary, that is, meet middle class standards. This means that labour market participation is central, even if there is available support to manage absence from work. There will be stratifying effects between those who work and those who do not – those who have had the possibility to commodify themselves will be better off.

It seems that in all three countries, this part of the population represented by the target group is commodified to a very low degree. This has been observed at the national level in all three countries during later years, but most so in Sweden and England. Neither governments nor

users seem pleased with this situation, as more people are both capable and willing to work. At the same time, it is a complex matter, as work promotion may also be understood as an enforced commodification. Perhaps some groups are not suited for the labour market? Perhaps the labour market is not suitable for some groups? Is it then reasonable to expect and encourage participation? At present, inactivity is certainly viewed as a more serious problem than commodification. I would claim that this is due both to growing financial costs and to a concern for people's welfare. It is also obvious that more can be done to support people in finding occupations or activities.

Generally, this group is also described as having greater financial problems than the general population, and also than comparable target groups. One central reason may be found in this lack of *commodification*. Another may be that occupational services, even though universal and free of charge, also use reimbursements that are low and temporary. Consequently, they are unsuccessful in terms of de-commodification. The feminist critique against the regime theory was that the analysis was not gendered. While Esping-Andersen analysed the social rights of workers, he drew conclusions about the social rights of citizens. Many researchers have addressed the need to distinguish between groups of citizens. One example is Langan and Ostner (1991: 130), who stated that Esping-Andersen

uses the categories of commodification, de-commodification and social rights either as simple concepts or perhaps at too high a level of abstraction (see Offe, 1984, pp. 15–18). Hence they seem to imply 'sameness', that the individuals who are commodified or de-commodified are all essentially similar. But different social groups and, crucially, different gender categories, have different relationships with the process of commodification and de-commodification.

This problem is as evident in the present material. One question is how the welfare state functions for those who are established in the labour market – though perhaps temporarily absent from it – and quite another issue is how it functions for those who never get the chance to become

commodified. By not considering how the so called welfare state works for different groups, the analysis risks resulting in a false picture of who the users are.

The system seems stratified between those who are established in the labour market and those who are not. Furthermore, it is stratified between disability groups. This is true for all countries, but particularly visible in the Swedish disability legislation, where mental disability has been excluded from occupational services, but where entitlement is also more restricted than for other disability groups. Unlike other groups, those with mental disabilities need to show special reasons and more expressed needs. The system also stratifies between different diagnostic groups within the target group, as people suffering from autism are more included than other groups. This difference is found in all three countries and may be due to the fact that autism is connected to another disability group. About 80 percent of those with autism also experience a mental retardation. This is a target group whose needs have been recognised to a greater extent and for a longer period of time. Autism is also one of few diagnoses that occur in childhood, which contributes to an early 'introduction' to welfare support.

However, it may also be concluded that all the selected countries actually *have* developed a national policy with a range of support to address the needs of people with mental disorders and disabilities and to break with marginalisation. Increasingly, the shortcomings of this policy have also been recognised, mostly in Sweden and England, but also in France. In all three nations the same problem is present: mental health policy only reaches the target group to a limited degree. Hence, something is obstructing implementation. Some hypothetical answers to why this is so will terminate this chapter.

Ignored aspects of welfare policy studies: fragmentation and target group positions

The central question of this thesis was to investigate whether the mental health policies of three nations followed different welfare designs and

logics. The answer to this question must be that evidence that holds for an argument of three models of mental health policy design and logic (or three worlds, as Goodwin (1997) put it) was not found. Essentially, the result does not point to any models at all. Instead of important variation *between* countries, important variation *within* each country was found – this to such a degree that it is difficult to categorise the three cases into any ideological box. Several designs are present at the same time, creating a complex patchwork of transfers and services that are sometimes difficult to separate from each other. Put together, they do not constitute coherent patterns. This result is in line with the findings of some other authors studying social care. These were cited in chapter two and concluded that social policy is simply too divergent to make sense of through categorisations.

The importance of *what* – attention on institutional fragmentation

The analytical tool was useful for categorising the support, but it did not identify different patterns. What are the reasons for this failure? One explanation would be that the instrument was not valid enough to find existent patterns. Relying on the fact that the tool intended to identify transfers and services in a way that is not too divergent from earlier research, this should not be the case. Another explanation would be that the choice of welfare field was too divergent from other welfare areas, and therefore could not be expected to show the same patterns as other areas. The theoretical framework was perhaps inapplicable to the study object. The absence of a model pattern may then be explained by the fact that both transfers and services were under study, that health care was included, as well as decentralised welfare areas and/or that a target group with eventual persistent needs was in focus. However, transfers did not follow ideological patterns more than services did. Neither should the health care inclusion have disturbed our case – instead, other areas showed the same lack of differences as did health care. Neither were there different results for non-decentralised and decentralised support. Last, is this a result that is due to the fact that persistent and not tempo-

rary needs were studied? Not even this argument seems reasonable, as the needs were not always interpreted as persistent.

Consequently, I would argue that it should be possible to generalise the results of this study to other areas: contemporary welfare policies are complex and mixed in developed welfare states. If the comparison is based on several aspects and more than one area, it is reasonable to believe that the result would also be the same for other policies. As was discussed in part one, the experience of ‘modelling failure’ is shared by other researchers, such as Anttonen and colleagues (2003: 171), who investigated child and elderly care in five industrial countries representing different regime types. They conclude that

[t]o suggest that nations are even preponderantly of one mode of provision or another [...] is to underestimate diversity in each country, the degree to which systems are changing and the amount of choice that people exercise in opting into or out of what is available. There are also limits to which it is useful, or even possible, to document this complexity; the result is a very detailed institutional description of little analytical usefulness.

Hence, they experience that a cross-sectional analysis of social policies risks being deadlocked. The patterns that become visible are not of a national character, but an evolutionary one. Instead of focusing on the support as such, the authors turn their focus to how support has developed within each nation over time. The variety of support formed no national or ideological pattern, but the way it developed in terms of social rights did show common patterns. Three dimensions of change are highlighted: First, how the care provision travelled from the family towards the public sphere; second, how entitlement to publicly funded care turned from family based to being based on individual citizenship (at further distance from the family); third, how entitlement moved towards being universal in availability and take-up (however, a process with scarce empirical evidence).

All these processes are said to take place in each country and for each area, but to varying degrees and at different paces. The result is a varied

and unsynchronised development within each country, though similar in that this pattern is common to all the selected countries. As true as this may be, I would claim that this is of little help for understanding welfare policies, in general, and social policies, in particular. Neither do the authors argue that their finding is surprising. I could easily suggest that the mental health policies have developed the same features as these, and at different national paces, but it would not reveal much of what the welfare policies actually contains. Instead of categorisations, the authors argue that national policies may only be understood in relation to nation-specific historical contexts that explain the developmental pace of particular service areas within the country. Some general suggestions are nevertheless made. One proposition is that services that do not reach 'the arena of democratic politics' stay selective, as their regulation remains a matter for bureaucrats and professionals. These services have their roots in old 'poor law' assistance. On the contrary, services that are the product of vivid political discussions and party political interest tend to be adapted to the middle class. A brief attempt to explain variation is also made (Anttonen et al. 2003: 193f). The authors argue that social care has a greater degree of 'plasticity' than other welfare areas; a mixture of solutions is particularly likely. Contrary to medical care or education, agents other than the public sector are as probable (and capable) providers of the support. If the (local) government does not offer home care, a relative or perhaps a voluntary organisation will help out. Alternatively, the individual in need may purchase a cleaning service.

Because there is high substitutability between sectors in the case of care there is also more room for difference between nations as well as more opportunities for politicians to tinker with its forms of production and consumption. One reason why social care policies in industrial societies sometimes shift with surprising abruptness may be that politicians know, or at least can implicitly assume, that if the state role changes, the market and household sector will adapt. [...] If spending on acute treatments in a health system is insufficient the results will be visible in a way that does not apply in the case of social care. Rather the evolution of a public role in social care can be local, partial, piecemeal, disorganized and even accidental.

The consequence of such an argument is that there is a need to take into consideration what kinds of welfare policies that are studied. I think this is an important point, but that it does not necessarily lead to an abandonment of the categorisation idea. Even if modern welfare programmes are inevitably complex, there are ways of structuring the picture that are seldom done. I suggest we start by situating the support in the national welfare system. Table 9 is an attempt to structure a general division of welfare responsibilities within a country. Is it possible that the diversity of national welfare policies may be traced to the fact that they belong to different welfare systems of a country?

This is a question that I cannot fully answer through this study, but I argue that the ‘welfare state’ becomes more comprehensible when performing this dissection. The concept ‘welfare state’ is established, but deeply problematic, as it is open to multiple interpretations and has largely been left undefined. Both ‘welfare’ and ‘state’ need to be discussed, so as to draw the borders of the welfare state. What is welfare policy and what is not? Is the discussion about states as nations, that is, one that aims to describe what is offered to citizens of different countries, or only about the state as a centralised level of politics? When the welfare state concept is questioned, it concerns a debate on whether nations are still a relevant basis of analysis in a globalised era (e.g. Schubert et al. 2009: 9). However, welfare policies are still national matters, rather than international, and we need to discuss the actors that operate within the national borders. Rather than going global, welfare has become increasingly local. Using a concept such as the welfare state, then, seems quite misleading.

The general impression is that a wide range of support is to be found in the welfare literature, including both transfers and services and spreading over health and social care, education and (un)employment policies. These all belong to different organisational systems within a country. To make sense of this complex picture, I would suggest to differentiate between different *kinds* of welfare policies. With the exception of Hardy and Lhuillier (2008: 36), this division is to my knowledge left untreated when discussing the structure of welfare policies.

Table 9. The policy design of publicly funded health and social care

Category	Administration	Provision	Content	Entitlement	Charges/benefits	Status
Social insurance/ security ¹³⁸	National government and its agencies	Deconcentrated offices for transfers, public or private actors for services	Sick pay, medical care, parental and child allocations, unemployment benefits, pensions	Foremost employment related, but occasionally universal	Income related, if based on contribution Flat rate, if universal	Legislation (compulsory)
Social care ¹³⁹	Local government	Local government bodies or private actors	Housing services, occupational services, financial and personal support for vulnerable groups	Means tested or universal	Any	Legislation (compulsory)
Other kinds of social support ¹⁴⁰	Local government	Local government bodies or private actors	Any (kind of services directed towards a vulnerable group)	Any (or none)	Any	None, indistinct or legislated as a non-compulsory support

¹³⁸ *Socialförsäkring* in Swedish, *Sécurité sociale* in French

¹³⁹ *Socialtjänst* in Swedish, *Aide sociale* in French

¹⁴⁰ *Action sociale* in French.

This is a general model that could encompass most societies, at least in the Western world. Instead of a seemingly holistic welfare system, we should be able to identify twin or triple foundations with separate histories (cf. Evers & Sachsse 2003). The social security system dates further back and mostly treats labour market-related questions. Social care can generally be traced back to old poor laws. Still, there is a constant process of change where borders are widened and narrowed, shutting out or welcoming groups of citizens.

The fact that researchers treat different kinds of welfare support may explain the lack of coherence and the multitude of solutions found within every nation. The table shows that when leaving the area of social insurance schemes, the design of welfare policies becomes less predictable. It is also apparent that the more policies that belong to the third category, the more difficult it becomes to describe a national welfare system. Consequently, it is not surprising that results in the literature have differed among welfare areas. The design of the social security system simply is not necessarily applicable to welfare in general. Nor is the design of social care.

My point is that every analysis of welfare policy design would benefit from using such a map as a starting point to set the feature of the policies under study. Thereafter, we may discuss whether there are structural differences between nations that allow us to speak of models when it comes to certain types of support, or overall. However, the results of this study do not indicate such patterns. Rather, they indicate that variation very much depends on the type of welfare support and that when we leave the area of social security, the probability of a mixed up logic increases. One possible variation would be that nations use the third and weaker type of policies to varying degrees. This could indicate that the involvement of non-public actors is more important in countries where less welfare is part of the compulsory public welfare supply. Another might be that the policies are more or less generous (in levels) or rich (in content).

A first conclusion that has been drawn is that the support developed to meet the needs of this target group *does not follow different national patterns* – the regime theory was not a framework that made sense of

these national examples of mental health policy. Instead, I argued that the policies followed a design that becomes comprehensible only if considering the *institutional fragmentation* of the welfare system. In this sense, the impression was rather characterised by *similarity* than by difference, in the sense that the same types of support were generally found and they followed a *mixture* of designs.

It is possible that nations cluster around ideological cleavages if specific programmes are selected, but the result of this study points to increasing problems with such theories, when selecting target groups as the starting point. As the welfare policies of a country spread over more areas, new target groups are developed; a more complex system is then required, to meet increasingly complex needs. Important parts of the welfare production are local, and not central, systems of care. Perhaps, the very idea of national comparisons of welfare policies is outdated for anything that goes beyond the social security system? There is an ongoing debate on whether national comparisons are obsolete as a consequence of globalisation and national convergence, but the conclusion discussed here is quite opposite: the reason would be that welfare issues are increasingly a local question leading to a divergence within each country.

This certainly makes welfare policies a more complicated study object. Premfors (1998) is one of many researchers that used the concept *välfärdskommuner* (welfare municipalities instead of welfare states) to underline the (increasing) importance of Swedish municipalities as welfare producers. The point made here is that the 'welfare state' as a concept is problematic, as it presents an illusory image of holistic national welfare policies. It is plausible that the social security system still constitutes the main welfare production of some countries, but it certainly is not true in the countries of this study. Instead, there are different welfare systems working in parallel. To some degree, welfare studies would profit from differentiating between these, as researchers find structural differences between national and local welfare systems. What is more, studying not only welfare transfers, but also services, opens up a view of greater diversity within each nation. This diversity is not only difficult to grasp, as there is often a lack of sufficient information, but it risks un-

dermining all attempts at general categorisations. This is a true challenge for social scientists, and there is a true need for further studies to contribute to both the empirical and theoretical understanding.

This fragmentation highlights the critical role of professional welfare actors, who are non-present in the welfare theory. As the results indicated, it is not evident who is to be included as a member of the target group. The process of turning people into clients was analysed by Lipsky (1980), in what is today a public administration classic. He concluded that

[i]n allocating benefits and sanctions street-level bureaucrats obviously affect the relative well-being of clients. They contribute to change and development, to the resources clients control, and to the status clients suffer or enjoy. While eligibility for public service benefits often may seem cut-and-dried, a considerable part of eligibility is in fact problematic. Rules and regulations provide only a measure of guidance in determining eligibility. It may be because classifying the behaviour or background of the client is a matter of discretion [...]. Or it may be because the categories into which clients fit are actually problematic and not fixed [...]. (Lipsky 1980: 60)

Mental health users seem to be one of these difficult target groups. A multitude of actors are involved in both the administration and provision of services and transfers. Except for those in psychiatry, they do not have a history of meeting this group. Neither are they necessarily – nor even likely – trained to do so. While this group often has multiple needs and thereby is dependent on a wide range of welfare support, there is no such thing as a holistic welfare state that takes this into consideration (at least not without a case or care manager with such a mission). Instead, executive officials are used to considering one need and perhaps only other target groups. This may result in a situation where entitlement is ignored or where welfare support becomes traps. One agency might consider an individual too healthy to be on benefits, while another considers her too ill to work. And once she has succeeded in receiving a benefit, she might be too afraid of not succeeding an eventual next time. Trying to enter the labour market again is turned into too great a risk. In that sense, the

welfare system of a country represents parallel worlds, at the expense of the user. It is also true that, as the welfare mission has increased over time in a way that the budget has not, different target groups are increasingly prioritised in competition with each other. Some will be 'winners', others, 'losers'. Thus, attention must be given not only to what kind of policies we are studying, but also to what kind of target group we are dealing with.

The importance of *who* – attention on target group positions

The main strategy of all countries has been mainstreaming, that is, including this target group in general disability policies, instead of using specific transfers and services. This is sometimes done implicitly, sometimes explicitly. However, it seems reasonable to argue that mental disability, as a concept, is less institutionalised in the public administration than physical disability is. This means that existent support is adapted to other forms of impairments (inability to walk, hear, see, etc.) and that the definition of mental impairments and how they should be supported is less well formulated. This leaves room for uncertainty as to who should be entitled to what, on behalf of administrators, providers and users alike.

Welfare policy is to a high degree about categorisation – about which groups are to be considered deserving or not of public support. The failure to recognise this group as deserving may then be explained by an un(der)developed understanding of the target group and by the presence of institutional fragmentation, which has made this failure possible. Thus, one possible answer is to be found in the *construction of the welfare system*, as such. Another seems to be found in the *construction of the target group* – mental disability has for long been stayed a blurry concept. This is true for all three national contexts.

While Lipsky pays attention to the social construction of clients, Schneider & Ingram (1993, 1997, 2005, Ingram et al. 2007) discuss the construction of social groups in a way that may be applicable to understanding how different groups hold different positions within the welfare

state. They argue that the welfare system reflects both power positions and normative connotations about parts of the population and that this is vital for the political outcome. Without considering whom the policies are about, the basic question of ‘who gets what’ cannot be answered. So far, I have argued for the problems of a holistic welfare state concept. I will continue by arguing that it is as illusory to imagine a general welfare user.

Ingram and Schneider discuss how different social groups (used as a very wide notion of any identified set of individuals) are constructed – or not – as target groups for political action, that is, as those groups that are ‘actually chosen to receive benefits and burdens through the various elements of policy design’ (Ingram, Schneider & De Leon 2007: 95). By analysing how target groups are politically constructed, they open the possibility to explanations of how policy fails to solve some identified problems and why an ‘unequal citizenship’ is sometimes produced. In other words, they show *how stratification is shaped* (Ibid.: 93). The framework has been applied to several areas, but primarily in an American context analysing, for example, how policies are designed around immigrant, pension or patient groups (see Schneider & Ingram 2005). The authors differentiate between four types of target populations that are formed as an effect of the respective groups’ influence (vertical axis) and how they are apprehended (horizontal axis).

Table 10. The social construction of target groups

		Constructions	
		Positive	Negative
Strong	Power	<p>Advantaged Deserving, important, respected groups receiving benefits rather than burdens.</p>	<p>Contenders Undeserving, relatively selfish, untrustworthy, morally suspect groups receiving hidden benefits and empty burdens.</p>
Weak		<p>Dependents Deserving groups, at least of sympathy and pity. Receiving benefits that are heavy in rhetoric, but low on financing.</p>	<p>Deviants Undeserving groups blamed for the ills of society and receiving a disproportionate share of burdens and sanctions.</p>

Source: Schneider & Ingram (1993: 336)

The examples of target groups vary by year of publication, but initially, groups such as elderly people, scientists and veterans were placed in the upper left corner, and big unions, cultural elites and minorities in the upper right. Mothers, children and disabled people were seen as examples of ‘weak’ and ‘positive’ constructions, and criminals, drug addicts and gangs as ‘weak’ but ‘negative’ (Ingram & Schneider 1993). In the later version the groups are somewhat different and the sharp borders are erased. Examples of disadvantaged target groups are, for example, mothers, children, poor people, the mentally handicapped, homeless (dependent), and feminists, gay/lesbians, welfare mothers, criminals, illegal immigrants and terrorists (deviant). As the authors write (Ingram et al. 2007: 103f) target groups may be more or less ‘in transfer’ between the poles or boxes as they travel through time or as they are divided into subgroups. A second assumption made by the researchers is that

[p]olicy design elements, including tools, rules, rationales, and delivery structures, differ according to the social construction and power of target groups. [...] The way clients are treated by government during implementation differs significantly depending upon the power and social construction of target groups. The deserving target groups typically are clients of federal programmes with professionalized services and specific rules of allocation, whereas the less or undeserving are subject to state or local administrators with greater discretion in the hands of caseworkers. (Ingram et al. 2007: 104)

As a consequence, programmes for deserving groups seem to be universalistic and have clear rules, while dependent groups are left with particularistic, discretionary and underfinanced programmes. Path dependency is suggested to characterise the two ‘extremes’ – the advantaged will stay privileged and the deviants, punished.

Even if the results of this study do not fully follow these suggestions – universality was the most common entitlement and not all responsibilities were decentralised – the framework of Ingram and Schneider highlights something that is ignored by the regime theory, namely, that the welfare system itself reflects the norms and attitudes of a society. Welfare policies must be studied in this context if we are to understand how problems are addressed, but also how the welfare system functions. Studies of target groups should make such structures visible, for both vulnerable and powerful groups.

The regime theory departs from a socioeconomic class analysis and later also from a recognition of gender structures, but the welfare system also structures and is structured by other forms of ‘identities’. The different social policies have been understood as consequences of the labour movement’s (the social democratic parties’ and the unions’) power positions; this is a similar interpretation, though focused on society at large.

The conclusions from this study suggest that there is still uncertainty about the deservingness of this target group in all three countries, as national policies have not succeeded in breaking with the negative construction that has historically surrounded mental illness. It is also a group that, contrary to many other disability groups, has stayed weak in the sense of being little organised. Indeed, there are organisations of

users and families, but the members only represent some small percentages of the total mental health population, and they can hardly be described as influential, even though they are today represented at some administrative political levels. Neither do they have any 'advocates' who fight for their rights to any greater extent. This is especially true for advocates from the social care sector.

The importance of these facts becomes clear when comparing to the situation for people with intellectual disabilities in Sweden. This is a disability group that shares the history of hospitalisation. However, the policy shift affecting them took place at an earlier stage, and today they constitute an established disability group that is well known by the responsible authorities.¹⁴¹ Even if the welfare policy surrounding this group surely has its shortcomings, their rights are more explicit and services seem to have reached the target group at large. Contrary to people with mental disabilities, they represent an evident disability group and users of welfare support. Considering the theoretical ideas of Ingram and Schneider, this is not a surprising result. The construction of intellectual disability is positive: they are definitely understood as in proper need of welfare services. This might also be connected to the fact that, contrary to mental illness, intellectual disability is normally diagnosed in childhood. Consequently, this group of individuals become welfare users early on. I would also argue that this early recognition contributes to the positive construction, as children have an obvious vulnerability that is not questioned.

Another effect is that advocates have been present: the parents. They were organised as early as the 1950s (supported by a well known physician who shared and encouraged their commitment). Today they comprise about 28,000 members, who can be related to 38,000 individuals with some kind of intellectual disability in Sweden. Actually, no other diagnosis group is described to have such a strong network. To situate this group in the upper left corner of the table is then quite logical. The

¹⁴¹ Special legislation was implemented in 1968 and amended in 1986 stating rights to treatment, housing, occupation and personal support. Interestingly enough, the closure of mental hospitals and care homes for people with mental retardation was also stated in law in 1985, contrary to the closure of other mental hospitals.

same favourable position is held by individuals concerned with autism. This diagnosis was added to the disability legislation about ten years before the disability reform and shares important features with intellectual disability: this is also a diagnosis that occurs in childhood. Furthermore, as was mentioned earlier, 80 percent of those with autism also have a mental retardation.

A brief comparison with another close target group may also be made: people suffering from drug and/or alcohol abuse. Although addiction is technically understood as a psychiatric disease (it is included in the DSM-IV), these individuals are not even necessarily entitled to medical care in Sweden. Instead, they are directed to social care at the municipal level, which is fully disconnected from the understanding of a disease. Furthermore, all services are connected to restrictions (clients will, for example, not be allowed to be drunk at their accommodation service; symptoms are punished). Thus, the deservingness is highly questioned. Far from being understood as having a disease for which no one is to blame, abusers of drugs and alcohol are made responsible for their situation. Neither can this group be understood as having any advocates. Rather, addiction often causes great harm to families, and instead of constituting a support, familial relationships are broken. Contrary to mental retardation, addiction is often more likely to be a problem of many generations within the same family. Hence, I would situate addiction in the bottom right corner.

This discussion was not based on the studied material, but a comparison of these target groups – or, for instance, different disability groups – in several countries certainly would be interesting. The analysis of policy design and logics would then be connected not only to the welfare system, but also to the context surrounding the target groups in question.

A similar hypothesis on how the feature of the target group affects the policy outcome is present in the current welfare literature. It is then argued that benefits directed to middle-class users, as opposed to for example the poor, will be more difficult to impair. This is due to the fact that such support is under more prominent ‘protection’ by both users and interest organisations (for example when it comes to pensions). Consequently, policy-makers will choose to do cutbacks that are more probable

to go unnoticed because they touch other groups or because they are realised in an obfuscating manner; a blame avoidance behaviour (see for example Lindbom 2007 for a recent article testing such hypotheses on Sweden). This literature is, in my reading, occupied with explaining change (retrenchment) and not with policy design as such. However, it shares the thought of bringing in an analysis on what kind of policies and target groups that are focused.

Implications for policy-making and further research

I have attempted to show the need for new tools to understand the complexity of modern welfare policies, but also that this complexity needs to be acknowledged. This has consequences both for policy-making and for research.

A main implication for future policy formulation concerns the role of professional actors. Users are dependent, not only on their ability to attain support, but also on their ability and willingness to fit all the pieces of the 'welfare puzzle' together. The welfare system follows its citizens 'from the cradle to the grave', that is, in variable ways over a lifetime. Yet, the system is perhaps less adapted to the fact that needs are not only multiple in a life cycle perspective, but here and now. Some groups of users have complex needs that call for coordinated solutions. My argument is here in line with what is discussed by Lindqvist and colleagues (2010: 90ff) in a recent work on Swedish mental health policies. It may also be related to what Hjern (2001) called 'humans with multiple needs' (*den multipla behovsmänniskan*). The welfare system is, according to this argument, organised around specific needs, not multiple or complex needs where more than one welfare component should be involved. In this sense, there is a lack of preparedness for meeting an existing reality and adapting a holistic view of the applicant. This is a challenge that the welfare institutions have disregarded.

Diedrich and Styhre (2008) identified a similar problem when it comes to refugees' access to welfare support. They concluded that the lack of a coherent programme for the target group forced the users to navigate

between a number of parallel administrations and adapt to numerous roles in order to fit as users. The system has an organisational logic that may suit the classification work of its administrators, but operates, eventually, at the expense of its users. It is a true challenge for a user to survey the situation. Lindqvist and colleagues (2010) point to this as a basic dilemma of the welfare state.

Another implication concerns a need for attention to the specificity of the target group. If welfare policy intentions are to be realised, the position of a target group must be taken into account both in the formulation and implementation of policies. Unless national, but also local, policy-makers argue forcefully for the deservingness of a vulnerable group of this kind, welfare policies will not be efficient in covering the identified risks. Historically, a general perceived lack of convenience among the general population has been used as a reason for *not* stressing social inclusion for this group of people. This is reflected in policy documents studied during my work with the thesis. During the 2000s, this attitude is no longer seen. Instead, I have noticed a concern for the connection between mental ill health and marginalisation, at least in rhetorical terms. Recent reports, initiated campaigns and revised policies are seen in all three countries, as well as at the EU level. Ultimately, it is a democratic problem if some target groups fail to formulate their needs and to use the welfare system; likewise, if they cannot use the welfare support because of a poorer individual capacity to claim their rights or because of a structural incapacity on the part of the system to acknowledge some needs and rights.

Welfare policies are central parts of Western democracies. Still, there is an evident call for further theoretical and empirical work if we are to find ways of understanding how these politics are structured and function. Since they are crucial for people's ability to overcome difficulties and manage important challenges during life, welfare should continue to be an urgent study object also in contemporary social sciences. We need more tools to achieve a broad picture of how it protects (or does not protect) citizens from different kinds of risks. It should be fruitful to continue to focus on different target groups, for example, by using a case-centred design to mirror stratifying effects. Examples of characteristics

that were important in this study are those that were not only means, but also employment, related. This is not unique to mental health policies, but can be found in, for example, transfers and services connected to parenthood. In this respect, the welfare policies are not so much designed to cover the risk of a decreased capacity to earn a labour market income, but the risk of interrupting an ongoing labour market activity. The difference is important and illuminates the fact that labour market participation or experience is central to most welfare benefits. De-commodification is perhaps more rare than is generally expected. In some cases, the design or logics were even more exclusive, taking diagnosis, special needs or age into account.

Perhaps, national modelling is an outdated operation. Nevertheless, we must search for ways to make sense of the present and pluralistic welfare support. This chapter suggests that welfare policies should be situated within the welfare system (a recognition of the institutional fragmentation), and that the argument of Ingram and colleagues could help us understand the outcome of these policies. This could hopefully lead to a deeper knowledge, not only of the content and logics of welfare support, but of why some groups stay marginalised, even in seemingly generous welfare contexts.

Appendix

Interviews

France

Bokobza, Hervé. Psychiatrist, former President of the FFP, President of *Etats généraux de la psychiatrie* in 2003 and head of the private psychiatric clinic *Centre psychothérapeutique St Martin de Vignogoul*. Montpellier 08/06/2005.

Boitard, Olivier. Psychiatrist, Médecin chef de service, *Centre Hospitalier Interdépartementale*, Clermont de l'Oise. President of *Comité d'Action Syndical de la Psychiatrie*, CASP. Clermont de l'Oise 19/04/2005.

Bonnafous, Evelyne. Adjointe au Chef du Bureau, *Direction de l'hospitalisation et de l'organisation des soins*, DHOS, *Ministère de l'emploi et de la solidarité*. Paris 29/04/2005.

Boulein, Patrick. Employed/volunteer at *Fédération nationale des associations d'(ex)-patients en psychiatrie*, Fnap-psy. Paris 09/06/2005.

Caillard, Françoise. Head of Iris-Paris, *Service d'accompagnement*. Paris 03/06/2005.

Debaux, Fabienne. Head of *Bureau de Santé Mentale*, *Direction générale de la santé*, DGS. Paris 29/04/2005.

Durand, Bernard. President of *Fédération d'aide à la Santé mentale*, *Croix-Marine*. Paris 07/06/2005.

Dutoit, Martine. President and founder of *Advocacy* Paris. Paris 01/06/2005.

Massé, Gérard. Report writer and psychiatrist at the psychiatry hospital St Anne, Paris. Paris 02/06/2005.

Monod, Christiane. President of the Paris section of *Union nationale des amis et familles de malades psychiques*, Unafam. Paris 02/05/2005.

Roelandt, Jean-Luc. Psychiatrist, head of the public psychiatry in Lille, WHO coordinator, report writer. Lille 10/06/05.

England

Bird, Anna, November 21 2006: Policy officer at Mind National, former coordinator of the Mental Health Alliance.

Goldberg, David, November 9 2006: Professor emeritus of King's College, Professor of psychiatry and Director of Research and Development at Maudsley Hospital 1993-2000s, Professor and head of department at Manchester University 1972-1993.

Rogers, Brian, November 29 2006: Professional officer at the Mental Health Nurses Association. A branch within the large trade union Amica.

Thornicroft, Graham, November 3 2006: Consultant psychiatrist and director of research and development at the South London and Maudsley NHS Trust, professor of community psychiatry and head of health services research development at King's college London/Institute of Psychiatry, expert in government, WHO, EU.

Zigmond, Anthony, December 8 2006: Consultant psychiatrist and vice president of the Royal College of Psychiatrists. Leeds.

Sweden

Lundgren, Rakel. President of one of the Swedish interest organisations within the mental health field Intresseförbundet för personer med schizofreni och liknande psykoser, Schizofreniförbundet. Stockholm, 2006-04-06.

RSMH, User organisation within the mental health field, Riksförbundet för mental hälsa. Jan-Olof Forsén (president), Jonas Dahl, Claes Rundqvist, Stefan Åhlin, Ami Rohnitz. Stockholm, 2006-04-06.

Printz, Anders, Stefansson, Cleas-Göran and Gerle, Mårten at the National board of Health and Welfare. Stockholm, 2008-10-27.

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Swedish summary

Mentalsjukhus var fram till för några decennier sedan den vanligaste åtgärden för den som behövde vård och omsorg som en konsekvens av psykisk sjukdom. Dessa innebar i sig ofta en isolering både från familj och från samhället i stort. Här tillbringades resten av livet och allt patienterna ansågs behöva fanns tillgängligt inom murarna. Mentalsjukhusen brukar beskrivas som egna världar som ibland växte sig större än närmsta samhälle (se t.ex. Beckman 1984; Qvarsell 1982, 1991 för berättelser om den svenska mentalvården, Mangen 1985 för Europa). Fram till 1950-talet utökades mentalsjukhusens kapacitet allt mer, för att sedan starkt ifrågasättas och slutligen avvecklas. Själva miljön ansågs inhuman och dessutom kontraproduktiv ur ett behandlingsperspektiv. De stora institutionerna blev också kostsamma poster i den statliga budgeten. Istället kom en ny politik att dominera där människor med psykiska sjukdomar skulle mötas av samma stöd som andra patient- och handikappgrupper: på allmänna sjukhus och med ett socialt stöd som möjliggjorde ett "vanligt" liv.

Internationell statistik visar hur avvecklingen av vårdplatser skett i olika takt, men att trenden varit densamma i västvärlden (WHO HFA-DB). Däremot saknas kunskap om vilken politik som ersatt mentalsjukhusen. Detta trots att det tydligt framkommit både i nationella och internationella rapporter att denna grupp i mångt och mycket fortfarande är marginaliserad på många sätt: hälsan är sämre, utbildningsnivån och inkomsterna lägre, arbets- och sysslolösheten större och de sociala kontakterna färre (WHO 2001; EC 2005). Att avveckla mentalsjukhusen räckte uppenbarligen inte för att överbygga den risk som psykisk sjukdom innebär för möjligheten att "leva som alla andra".

Denna studie syftar empiriskt till att undersöka vad som faktiskt görs för att stödja människor med psykisk sjukdom och/eller funktionshinder i Sverige, Frankrike och England. I fokus står den offentligt finansierade vård och omsorg som bedrivs inom fem områden: sjukvård (kapitel 4), ekonomiskt stöd (kapitel 5), samt boende, sysselsättning och socialt stöd (kapitel 6). Vilka insatser erbjuds idag till den som har svårt att klara livet på grund av en psykiatrisk diagnos? Vilka aktörer står för detta stöd? Och vad krävs för att få tillgång till det? Insatserna har undersökts i tre länder som teoretiskt förväntas representera olika typer av välfärdssystem. En grundläggande fråga är därför också om det finns någon variation mellan länderna och om den i så fall motsvarar det som kan förväntas utifrån välfärdsteori.

Teoretisk ansats

Utgångspunkten i den här studien är att insatserna för denna grupp bör kunna studeras som ett fall av välfärdspolitik. Vård och omsorg är kärnverksamheter för välfärdssektorn. Dessutom finns det en akademisk debatt om hur generaliserbar välfärdsteori är på olika områden. Studiens teoretiska syfte är att bidra till den diskussionen.

Esping-Andersen lanserade 1990 idén om olika slags välfärdsstater. Denna forskning har sina rötter i andra klassiska verk (såsom Marshall 1949 och Titmuss 1974) och är idag en oundviklig referens för den som studerar hur välfärdsåtgärder är utformade i olika länder. Enligt denna teori finns det framför allt tre sätt att organisera välfärdspolitik på. Dessa modeller anses ha växt fram som en konsekvens av nationella, politiska kontexter där olika aktörer haft olika stort inflytande. I den socialdemokratiska modellen är välfärd ett åtagande för den offentliga sektorn, åtgärderna är riktade till medborgare i allmänhet och reglerna är generösa. Att inte kunna stå till arbetsmarknadens förfogande är därför inte riskfyllt – staten stöttar den som är gammal, sjuk eller arbetslös. Esping-Andersen kallar detta för *de-commodification*, vilket skulle kunna översättas som att medborgaren inte blir (helt och hållet) beroende av sitt marknadsvärde. Han menade också att detta bidrog till ett jämlikt samhälle såtillvida att välfärdssystemet behandlar alla lika: du behöver var-

ken vara fattig eller privat försäkrad för att få stöd när du är i behov av hjälp. Alla medborgare bidrar till systemet och alla nyttjar det, åtminstone någon gång i livet.

Ett alternativt sätt att organisera välfärden är att framförallt överlåta detta till marknaden: den liberala modellen. I denna förväntas medborgaren istället själv försäkra sig mot risken att inte stå till arbetsmarknadens förfogande. Den välfärd som staten står för begränsar sig till att stödja dem som har det allra svårast, det vill säga den vänder sig inte till människor i allmänhet utan till att möta fattigdom. Därmed blir också välfärdsåtgärder förknippade med skam och nivåerna på bidrag låga. Effekten är den motsatta mot vad som konstaterades för den förra modellen – graden av *de-commodification* är låg och systemet bidrar till att skikta befolkningen (vad som kallas för *stratification*).

En tredje, och sista, väg som teorin pekar ut kallas konservativ. I denna har en tredje part en betydande roll som välfärdsproducent, nämligen civilsamhället i form av familj, kyrka eller till exempel frivilligorganisationer. I denna modell är statens uppdrag när det gäller välfärd begränsat, men däremot verkar marknaden spela en viss roll i form av välfärdslösningar som är knutna till anställning. Det innebär en skiktning av befolkningen eftersom olika anställningar är kopplade till olika förmåner. Till skillnad från den socialdemokratiska modellen syftar detta system inte till att skydda alla medborgare på samma villkor, istället bidrar den till att behålla de skillnader som finns – att bevara status quo.

Esping-Andersen konstaterade också att de flesta av de 18 länder som han studerat uppvisar en blandning av dessa tre former, men att de gör det i större eller mindre grad. Han menade att de skandinaviska länderna till största del passar in i den socialdemokratiska modellen, medan de anglosaxiska länderna kopplas till den liberala modellen och länder som Tyskland och Frankrike sägs bära konservativa drag.

Teorin har kritiserats av många anledningar. Några har vänt sig mot det normativa anslaget i studien, andra menar att det finns fler modeller än tre (kanske fyra eller fem), ytterligare andra menar att kategoriseringar inte alls är möjliga att göra. Men den mest intressanta kritiken handlar om huruvida studien verkligen håller för en generalisering av all välfärdspolitik, inte minst eftersom den har kommit att präglade bilden av

hur det ser ut rent faktiskt i dessa länder. Esping-Andersen jämförde tre typer av finansiella stödformer: sjukpenning, arbetslöshetsförsäkring och ålderspension. Det betyder att han drog ett likhetstecken mellan arbetstagare och medborgare.

Kritik från feministiskt håll handlade framförallt om detta: att många medborgare, inte minst kvinnor, inte arbetar och därmed inte kvalificerar sig för dessa åtgärder, åtminstone inte på egna meriter. Att tala om *de-commodification* blir missriktat när en grupp inte alls ”kommodifierats”. Den fortsatta debatten har inte minst kretsat kring denna fråga om extern validitet (generaliserbarhet utanför studien). Går modellerna att applicera även på andra områden, som servicesektorn eller för sjukvården? Och följer länder då samma linje som när det gällde ersättningar? Det är också rimligt att fråga sig om välfärdspolitiken är sig lik i de undersökta länderna idag, 30 år senare.

Med avstamp i ovanstående teoribildning, vilken presenteras i kapitel 2, syftar avhandlingen till att bidra till diskussionen kring hur välfärdspolitik kan studeras och förstås, och vilka modeller som är möjliga att spåra.

Studiens upplägg och genomförande

Avhandlingen skiljer sig från många andra studier genom att utgå från en målgrupp (människor med psykisk funktionsnedsättning) istället för en insats (t.ex. pension). Detta är inte unikt (se t.ex. Lewis 1997; Sainsbury 2006), men mindre vanligt. Den särskiljer sig också genom att i) inkludera både finansiellt stöd och service, ii) titta på stödformer som till skillnad från många andra insatser kan förväntas vara mer eller mindre livslånga, iii) inkludera både vård och omsorg och iv), ha ett kvalitativt upplägg, dvs. studera politikens innehåll istället för utgifternas storlek. Målet med analysen är att belysa hur välfärdssystemet fungerar ur ett ”brukarperspektiv”. Det finns också en ambition att diskutera den aspekt som Rauch (2005) pekat på, nämligen att ”staten” som välfärdproducent är ett trubbigt sätt att beskriva offentligt finansierad välfärd. Detta begrepp innehåller i sig en mängd aktörer, vilket också präglar hur systemet fungerar.

Material har insamlats på plats i varje land, men också på distans för att hålla studien uppdaterad. Det handlar om alla slags dokument som beskriver fältet och existerande insatser. Material har även samlats in för att beskriva hur politikområdet utvecklats. Intervjuer genomfördes också med personer på administrativ nivå, från professionen och intresseorganisationer.

Materialet täcker de insatser som finns dokumenterade, vilket betyder att egna efterforskningar av insatser inte gjorts, till exempel via enkäter till brukare, familjer och organisationer. Det är tveksamt vad en sådan efterforskning skulle ge. Snarare än att studera hur civilsamhället i praktiken utför välfärdsinsatser verkar slutsatsen om dess roll bygga på en föreställning om att civilsamhället tar vid där stat och marknad inte gör det. I realiteten kan dock även denna part vara frånvarande. Konsekvensen för studien är att de insatser som identifierats framförallt är sådana som finansieras av offentliga medel då andra insatser sällan är dokumenterade.

Resultat och slutsatser

Vilka insatser kunde då identifieras och på vilket sätt, om något, skilde de sig åt mellan länderna? Svaret är inte helt enkelt. För det första var det problematiskt att identifiera vilka insatser som faktiskt riktar sig till gruppen. Detta tolkas som att målgruppen fortfarande inte är en väletablerad brukare inom välfärdsadministrationen. Medan utvecklingen gått från vård- till omsorgssektorn och därmed till en inkludering i en generell handikappolitik har varken psykiska funktionshinder eller gruppens behov tydligt definierats.

För det andra visade länderna ibland lika drag (per område eller när det gäller vissa karaktäristika), ibland olika (i hur väletablerade insatserna var eller i sina karaktärsdrag). Variationen inom varje land var alltså så stor att det var svårt att tala om någon enhetlig design eller logik. Detta beror sannolikt delvis på att insatserna genomförs av så många aktörer och på så många nivåer inom välfärdssystemet. Detta gäller inte minst serviceområdet där mycket ligger på lokal nivå (kommuner eller motsvarande) och där det inte finns ett offentligt finansierat program

(som för t.ex. barnbidrag), utan många. Den fragmenterade välfärdsstaten blev därmed tydlig.

Ett tredje resultat som lyfts fram i avhandlingen, och som är gemensamt för länderna, handlar om att insatserna tycks komma gruppen till del i liten utsträckning. Detta var förvisso svårt att belägga eftersom tillgänglig statistik var knapphändig, men när den fanns pekade den på att i jämförelse med hur många som beräknats tillhöra målgruppen är det få som har fått hjälp med boende, arbete, sysselsättning, ekonomiska ersättningar eller vardagsstöd. I Sverige talar rapporter dessutom för att gruppen inte ens får tillgång till den vård de behöver. Den enda insats som framstår som välanvänd är så kallad förtidspension. Det verkar alltså som att denna grupp inte "kommodifierats" i någon högre utsträckning, vilket är problematiskt inte bara på grund av de sociala fördelar som finns med arbete och som förväntas gynna psykisk hälsa och funktionsförmåga, utan också därför att många ersättningar (t.ex. sjukpenning, förtidspension) bygger på tidigare inkomster.

Det var alltså svårt att dra några slutsatser om vilka modeller som nationell politik följer eftersom variationen inom varje land var så stor. Den avslutande diskussionen handlar därför om hur välfärdspolitik kan förstås. Är det alls rimligt att förvänta sig att ett lands välfärdspolitik generellt sett är utformad efter en viss design och utifrån en ideologiskt härledd logik? Och vilka logiker är det egentligen som tycks påverka vilka insatser som erbjuds en viss grupp?

Den första frågan diskuteras genom att föreslå att hänsyn tas till vilken typ av politik som studeras. Snarare än att förvänta att all välfärdspolitik följer samma mönster bör förväntningarna kanske begränsas beroende på om det är socialförsäkringssystemet eller socialpolitik som behandlas. Även en tredje typ av åtgärder presenteras, vilken skulle kunna kallas "frivilliga insatser", det vill säga sådana insatser som existerar men som ingen aktör är skyldig att utföra.

Poängen med att sortera insatserna på detta sätt är att tydliggöra att variationen av design åtminstone delvis tycks bero på vilken typ av välfärdspolitik som behandlas. Fortsatt forskning skulle kunna tydliggöra modellens giltighet samt var skillnaden mellan olika länder ligger. Att diskutera "välfärdsstaten" som något enhetligt tycks dock inte rimligt

eftersom det inte bara handlar om en mängd aktörer i termer av offentlig och privat sektor, utan också därför att många offentliga välfärdslösningar inte är statliga (centrala), utan lokala. Välfärdssystemen är därmed allt mer komplexa och åtgärderna allt mer varierande.

Detta hindrar dock inte att kategoriseringar både är möjliga och önskvärda. Däremot behövs mer kunskap om hur dagens välfärdssystem är uppbyggda och vilka effekter det får för användarna av systemet. Att insatserna i det studerade fallet inte verkar komma gruppen till del kan då delvis förstås som en effekt av det fragmentiserade och komplexa system som välfärdspolitiken är en del av. Att navigera inom detta system är inte lätt, särskilt inte för den som har ett psykiskt funktionshinder. Om detta vittnar också den insats som i Sverige kallas personligt ombud och som innebär just en hjälp att koordinera och matcha insatser, samt att utkräva dem.

Den andra frågan besvaras således delvis av diskussionen ovan: design och logik tycks delvis bygga på vilken typ av politik som åtgärden kan klassificeras som. En annan logik som lyfts fram är att det verkar spela roll vilken målgrupp vi talar om. Det verkar alltså inte rimligt att tala om en enhetlig välfärdsstat, men inte heller att förutsätta att det finns en enhetlig användare av välfärdspolitiken. Välfärdssystemet återspeglar samhället i stort: inflytande från olika grupper och rådande normer. Även detta måste vägas in i studien av välfärdspolitik. Ingram och Schneider (1993, 1997, 2007) lyfts här fram som exempel på forskare som teoretiserat kring liknande frågeställningar. Utifrån deras resonemang framstår det inte som förvånande att denna målgrupp inte gynnas eftersom de rimligtvis bör beskrivas både som en så kallat svag grupp (i förhållande till vilken makt och status de besitter) och som en grupp som i stor utsträckning förknippas med negativt laddade föreställningar (om vad psykisk sjukdom innebär). Sådana grupper kommer, enligt teorin, att marginaliseras därför att det råder en osäkerhet om hur "förtjänta" de egentligen är av hjälp.

En sista viktig aspekt som lyfts fram för att förstå gruppens marginalisering – trots ett relativt stort utbud av välfärdsåtgärder – är att välfärdslitteraturen talar om sociala rättigheter trots att många välfärdsinsatser i praktiken inte är några rättigheter som kan utkrävas. I vissa fall

borde de snarast beskrivas som någon slags "bonus" – har du tur bor du någonstans där de erbjuds. Men framförallt handlar det om att litteraturen inte tillräckligt diskuterar behovsprövningen som en spärr gentemot medborgaren. Vid sidan av inkomstprövningar och försäkringstillhörighet är detta ett väsentligt inslag i välfärdspolitiken. Få insatser är universella i den meningen att de erbjuds alla som tillhör målgruppen i vid bemärkelse (barnbidrag skulle kunna vara undantaget från regeln).

I stället sker en prövning i varje enskilt fall där det gäller att kunna påvisa ett adekvat behov. Detta är en förhandlingssituation som vissa individer och grupper klarar bättre än andra och där vissa utsätts för hårdare prövning än andra. Att bevisa att du behöver ett stöd är inte en självklar sak, särskilt inte för mer okända och kanske "osynliga" funktionshinder. Den offentliga förvaltningens aktörer har ofta stort handlingsutrymme, men begränsade resurser. Vissa grupper kommer att prioriteras, andra inte. För mindre etablerade och svaga grupper krävs det förmodligen både kunskap från förvaltningens sida och kanske även att det finns någon som strider för gruppens intresse för att utfallet ska bli till dennes fördel. När det gäller psykiska funktionshinder tycks båda faktorerna saknas.

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