

The definition of health, two perspectives: psychiatry or community based mental health care

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10.1 An impossible assignment

Can one, as an illustrative exercise, investigate the border between health and illness on the basis of the distinct difference in perspective between psychiatry and the world of the community-based Regional Institutes for Ambulatory Mental Health Care in the Netherlands (RIAGG)? Is it true that psychiatry, i.e. the psychiatric hospitals, are confronted with a 'well defined' caseload with difficult patients, while RIAGG's are confronted with large numbers of people who sometimes suffer from serious problems even if it is not always clear if these problems should be categorised as diseases?

The answer to both questions must be negative. The perspective from intramural psychiatry on the one hand and the more broadly defined mental health care on the other is not so distinctively different. Psychiatric patients do not by definition have a 'disease' where others are suffering mainly from a 'problem'; psychiatric problems are also not by definition well defined and psychiatric patients are not always difficult. In the field of mental health care, the Diagnostic and Statistical Manual of Mental Disorders (the concept of 'disorder' deliberately avoids the choice between disease and problem) of the American Psychiatric Association is now used fairly generally throughout most of the world (in 1980 it was introduced as DSM III, since replaced by the updated DSM IV). The diagnostic label does not in itself indicate whether an admission is required or whether ambulatory or some other form of care will suffice: this depends on the individual case and on the collective sense of the profession.

Mental health care as a whole is increasingly organised in regional circuits for (respectively) children and young people, adults/short-term treatment, adults/long-term, addicts and the elderly. In each circuit 'customised care' is in principle offered, with the duration, nature and intensity depending on the needs, possibilities and wishes of the patient. For most patients the input can remain limited and admission is not required.

Over the course of time mental health care has increasingly and, in part, quite consciously become health care and not (or no longer) welfare work, judicial care, educational care or poor relief. At the same time, however, there has been a growing awareness that the consequences of a mental disorder can manifest themselves in many areas of life and that this therefore needs to be taken into account in the organisation and delivery of care. The pharmacological and psychotherapeutic treatment of psychiatric disorders has become increasingly possible and effective, but guidance and care also remain highly important.

Mental disorders provide the basis of the work in mental health care and also provide its ultimate legitimisation. Mental disorders are not, however, isolated or self-contained phenomena but manifest themselves in the behaviour and words of people in relation to themselves, to other people and to the material

world. If, in the words of Freud, mental health is the capacity 'to love and to work', i.e. to deal with oneself and others and to be capable of meaningful action, the task of mental health care is to look after people who are not or no longer capable of doing so and to help them where possible. Organised mental health care funded out of the Exceptional Medical Expenses Act (AWBZ) is in the first place concerned with people among whom both these capacities have been affected. In addition there is an increasingly private world of psychotherapeutic help for people who wish to function more effectively or who themselves consider that they fall short in one of these two areas. Although there is considerable interest in such help in the public sphere, the amount spent on it is comparatively modest in relation to mental health care as a whole, and much of the expenditure is privately funded by the patient. One point of criticism might be that many of the best trained care providers in mental health care - especially psychiatrists - have a marked preference for precisely these activities.

The essence of my assignment is not in fact formed by the relationships within mental health care but by the question as to the 'definition of basic or elementary health care'. As part of my analysis I have sought to garner material in order to arrive at such a definition, which does not even amount to an agreement but will always be a political decision. First of all I examine the *significance* of health and health care in modern society in terms of an economic good or 'commodity', a 'value' (i.e. norm; goal) and 'truth' ('evidence-based'). I also seek to delineate the *separate nature* of the concepts of health and health care by contrasting ideal-type physical and mental health care against one another. At issue is not the sector of physical or mental health care but the social institution and the activities carried out in that framework. This is followed by three specialist chapters. First of all a brief description is provided of the development of the concept of mental health which will, I hope, help clarify the way in which mental health care has evolved in this century and how important the parting of the ways from welfare work has been. The special *role of the government* in mental health care makes it clear in the following chapter how the roots of mental health care are socially based and, finally, an overview is provided with key quantitative figures.

These observations do not solve the problem of the definition of basic health care, although I hope that the analyses of health, health care and illness will illuminate the discussion or at least render it more interesting. Fundamental questions are at any event addressed and in a number of respects they are also about the future of health care as an organisation in the service of the autonomy of the individual.

10.2 Health as commodity, value and truth

What things are really important in life? In 1996 35 percent of Dutch people replied 'good health'. A similar proportion of 35 percent assigned top priority to a good marriage, 15 percent opted for a strong faith and 8 percent for a nice family. Thirty years later the importance of health appears only to have grown. Now only just 5 percent of the population refer to a strong faith as the most important thing in life, a good marriage has fallen as first preference to 14 percent, the importance of a nice family has clearly increased (14%) but, towering above the rest, is good health: 60 percent of the population consider this to be the most important thing in life (SCP, 1992). Only among the youngest age-groups (i.e. adolescents), for whom good health is taken as a matter of course, is this not (yet) the case.

Although the importance of health as a value may have increased among the population in recent decades, the recognition of its importance is certainly not new. Hippocrates (4th century BC) and Galenus (2nd century AD), whose works had a decisive bearing on thinking about sickness and health in

Western society until the 19th century, emphasised the importance of good health and also urged the careful preservation of health, irrespective of care of the sick and the treatment of disease. In the drive for individual perfection, moderation and self-control were the characteristics of a life-style that might be regarded as 'healthy' in more than one sense and which was also expressly designed to result in the preservation and protection of health.

When the Dutch physician Johan van Beverwyck wrote his *The Treasure of Health* in 1636 - for many years a highly popular medical encyclopaedia for laymen - he formulated as axiomatic what De Swaan (1982) was cogently to sum up three centuries later as a 'mild medical regime': the medicalisation of daily life, in which people needed the knowledge and help of medicine even before birth. Nor does Van Beverwyck leave any room for doubt about the importance of prevention: 'in our depraved century insufficient consideration is paid to the preservation of health and people fail to perceive that health is a hidden treasure until they fall ill. It would be better to guard this treasure carefully than to have to incur the difficulty and danger of searching for it after it had been lost' (1992 [1636]: 10).

The image of health as a treasure has of course become a cliché, but given the medical possibilities at that time it was certainly an adequate image. Health falls into a person's lap, a gift granted him by fate - or, if one wills God - and which he has not needed to do anything about. His task is to preserve and maintain that treasure as effectively as possible in order to prevent the natural equilibrium between the 'humores' and the correct relationship between heat and cold and moistness and dryness from being disturbed. The message of 'the treasure of health' is health information and education ahead of its time, even though the concern then was more with the preservation than the promotion of health.

The rules of life laid down by the Greek and Roman philosophers and physicians and the advice of Van Beverwyck and his colleagues were directed to the educated and prosperous upper stratum of society, where people had the resources and the time to occupy themselves with looking after their health; for these people limitation and moderation were also an assignment and not a euphemism for poverty and hunger. Throughout history - and still today in the greater part of the world - health is not, however, a treasure to be guarded but a capital to be worked with. Health - preferably good health - was and is required in order literally to remain alive. The body and its strength must be used in order to earn one's daily bread. Under a system of national insurance that realisation has to a large extent been lost or has at least lost its cutting edge, but in the history of health insurance compensation for loss of earnings has been at least as important as the reimbursement of the medical expenses themselves (Van der Velden, 1993).

Until recently, the link between sickness and poverty has been a very close one in world history, to the point that illness was in fact a luxury that only the wealthy could permit themselves. The change brought about in many countries by the introduction of universal health insurance has been so pronounced that gradually the picture has arisen that *sickness is one of the few luxuries that the relatively poor can now permit themselves*. In the form of the Invalidity Insurance Act (WAO), as a form of compensation for loss of earnings, sickness could even become a mechanism for escaping permanently from the threat of poverty.

The idea of health insurance arose in the 19th century when the instrumental use of health as a means of production was at its peak. The health of the worker was used and consumed in a manner that virtually excluded any realistic possibility of recuperation. Long and regular hours of physical labour were required on a daily basis simply for subsistence. At national level the

process of industrialisation and associated urbanisation as it were 'consumed' public health: a process the consequences of which evolved into a problem that was to enter history as 'the social question'. The sad paradox shrouded in that social question was the fact that it was precisely the workers who were least in a position to care for their health, even though they required their health the most since physical labour was their only capital. They were required almost literally to eat into their capital. Precisely where the value of health was particularly great, there could hardly be any realisation of health as a value.

10.2.1 The value of health

The question as to the 'most important things' in life has connotations of *values* and *goals* but not so much of *means*. In the second half of the 20th century health has itself become a value in Western society and, as indicated by research, for many people in fact the main asset. This means that health has to a significant extent become the guiding principle for action. Health has taken on the guise of a general principle for the ordering of life, a guideline for individual action and behaviour. Health consists of taking personal initiative and of valuing oneself, in which sense it has obtained not just a deontological but also an ontological character: assignment and outcome at once.

A guideline for action is also always a guideline for judgement and assessment, both of one's own action and health status and that of the behaviour and health status of others. Health as a value does not therefore just mean health as a goal to be pursued - i.e. working on health - but that it also forms a criterion for measuring food, water and air as well as situations, circumstances, plans, options and finally also people. Is something or someone healthy, does certain behaviour contribute to health, are certain circumstances or products potentially damaging to health, do these plans do sufficient justice to health? In this way *health* acquires the status of a *social mechanism for regulation, proposing technical and practical choices on the basis of scientifically founded statements, which choices are also morally legitimated*.

This may be illustrated with the aid of an example. Smoking has always been subject to all sorts of rules relating to decency, etiquette and propriety. Not until epidemiological research had incontrovertibly shown that smoking leads to a greatly increased risk of lung cancer and cardiovascular disease did smoking become an inadvisable form of behaviour that was best avoided. Active non-smoking policy did not, however, really take off until it became clear that passive smoking also constituted a potential threat to health. Although that risk is exceptionally small for adults it nevertheless exists, thus virtually producing a moral imperative to prevent smoking: not just the health of the smoker is threatened but also that of the non-smoker. The non-smoker needs to be protected from the consequences of behaviour which in itself is reprehensible from a health viewpoint and which needs in any case to be discouraged. The freedom of the smoker can perhaps be set against his own health but not against the freedom and health of others.

10.2.2 Living in the service of health

Values can never be achieved by taking the path of least resistance. Something that is nice, easy or enjoyable, which is a matter of course or which is possible only in the way in which it has manifested itself can never acquire the quality of a value. A value must make a difference and it must make a difference to work at a value. Conversely a value will always suffer competition from a catalogue of other possibilities requiring less input, exercise, restraint, planning or conscience or for which less resistance (fear, anger, greed and jealousy) needs to be overcome. The realisation of values always calls for a certain degree of courage and discipline and even renunciation. Something needs

to be sacrificed and an input is required. Healthy living is considerably more difficult than living with or in terms of the 'hidden treasure' of health. The transition from the instrumental value of health to health as a fundamental value is therefore coupled with an extremely far-reaching change in sign: instead of health simply being in the service of life, this gives way to the much more complicated situation of life being in the service of health.

What in fact does this mean, *life in the service of health*? For the individual it means at first sight little more than the equation of 'healthy' with 'good': health has become an *ethical* category. But health has become an *aesthetic* category as well: what is 'healthy' or appears so is also 'beautiful'. The ethical category renders health into a *value*, which has to be worked on, while the aesthetic category converts it into a *good* or commodity, i.e. something to be acquired, maintained and improved. Health is not just a treasure which one receives or capital one puts in but also a product produced by medicine, health care and the health industry. Health as an economic good exists for both the sick and the healthy.

What gives 'health' such an important place in individual existence today is the conjunction of 'commodity, value and truth' that it encapsulates. Health was able to become an important value thanks to the development of science (i.e. the 'truth' criterion), while as a value it in turn also promoted the advancement of science. The 'value character' of health has in part become possible by scientific progress but the success of health as a 'commodity' in turn stimulated science and reinforced health's status as a fundamental value. This trinity of strengthening and development presupposes a recognition of the interest in and entitlement of the individual to the best possible health and of course the existence of a reasonable level of prosperity. The striking and growing difference in the development of health and health care between Western and Eastern Europe in the era of the Cold War is, accordingly, also the result of an ideological as well as an economic contrast (Feachem, 1994).

At societal level, the isolated position occupied by health as 'the most important thing in life' has seen it evolve into one of the few communal and general frames of interpretation that still enjoy a widespread currency, perhaps not as an all-embracing system of meaning but as a generally identifiable and universally accepted and hence also socially integrative frame of reference. In a plural society 'health has become one of the fundamental frameworks of interpretation and, more importantly, one of the few communal frameworks of interpretation.... Whereas there is steadily less consensus on moral issues, the normative element of the concept of health enjoys increasingly widespread endorsement.... The question of the good life is therefore primarily interpreted by many people as a health problem: we are not healthy in order to live, but live in order to be healthy' (Ten Have, 1988: 122).

Why is it that health is able to occupy such a special position as a communal and individual framework of interpretation? Ten Have (1988) gives the answer when he draws attention to the *growing scientificity* of health. A transactional relationship has as it were evolved: a relationship of mutual dependence and interaction between science as a generally accepted social framework of interpretation - a relevant method of interpreting reality - on the one hand and the health ideal as a generally accepted norm on the other. Science confirms and strengthens the health moralism and also provides it with direction and content. Seen in this context health is no longer simply the embodiment of a value but also the embodiment of truth. This gives exceptional force to thinking about health: precisely in plural and inherently relativistic societies the connection between a value and truth is no longer present or conceivable in virtually any area. Health is the great exception, health is a shared value, it overcomes diseases by way of its embeddedness in truth.

10.2.3 The concept of health, health as concept

The concept of health has a wealth of connotations. Health not only represents itself but also serves a vicarious function for many other things that people consider important in life. Health is the chief metaphor for all that is good, beautiful and worth pursuing and, consequently, a vehicle for individual and social change. The range of connotations and differences in weight that people assign to the various connotations not only reveal the individual differences in health perception but also delineate the various health 'subcultures'. Where one person will establish a link between health and beauty the other will see a close relationship between health and nature and opt for a responsible diet rather than a fitness centre or cosmetics.

Little research has been done in this area. On the basis of statements by patients of non-official healers, Aakster (1980) distinguishes approximately the following aspects of health:

- a. actual absence of complaints and disorders or fears thereof;
- b. absence of functional impairments; ability to do everything a 'normal' person can do;
- c. you feel happy, free, creative and safe in doing everything you do, the entire day;
- d. independence of others;
- e. inner and outer harmony.

Rolies (1988) has converted an analysis of ideologically-oriented writings on health into an overview of attitudes on health, in which, freely translated, health stands for:

- youth (as life-style);
- fitness and vitality (etymologically health is also related to 'wholeness!');
- clean, pure, natural;
- beautiful, attractive (the aesthetic quality of the healthy body in perfect or perfected condition);
- being competent, functioning effectiveness, being able to do what you want;
- being outgoing and social, having room to be open for others and taking an interest in the world (sickness implies a narrowing of the time, space and social life; illness makes people more self-absorbed);
- being intact, in harmony, in balance.

Aesthetic, energetic, effective, efficient, balanced and 'genuine': these are the connotations of health as an ideal. In this regard not being ill is a necessary but not a sufficient condition. Health is more than that. First and foremost health stands for autonomy, being independent, or non-dependence, for the ability to choose freely. Autonomy may be regarded as an operationalisation of individualism (Lukes, 1973), of which health is both a precondition and the expression. The Groningen professor of psychiatry W.K. van Dijk provided an interpretation of illness over 20 years ago that provides a kind of mirror-image of health in just this sense. He defines *illness* as:

- a. impotence and a curtailment of freedom and autonomy;
- b. functional insufficiency and deficiency, shortcomings in physical and/or psychological functioning;
- c. disorganisation or disintegration, undermining of inner unity and co-ordination;
- d. disadaptation, incapacity to adjust actively to the demands of the moment and the environment;
- e. changes of perception and awareness of the passage of time, disruption of the normal orientation towards the future;
- f. obstructions to development, risk of state of rigidity and fixation (Van Dijk, 1973; Health Council, 1986).

In Van Dijk's definition illness is clearly related to a reduced and decreasing freedom to shape one's life individually as one sees fit and to do so unaided. Illness is a fundamental impairment of human autonomy. This was already the case but is perceived to a much greater extent in the present day because the normative significance of personal autonomy has grown so markedly (Metaal, 1992). The threat posed to autonomy by illness has therefore become accentuated and, to a greater extent than before, it is this that generates anxiety about illness.

In addition the epidemiological transition of course means that illness is no longer essentially associated with rapid, severe and often fatal infections at a young age but with chronic and degenerative disorders at a later age. In the same way that the World Bank's *World Development Report 1993* stresses the dangers to the health of children and their mothers in the Third World (and their consequent inability to achieve autonomy), the *Dutch Public Health Status and Forecasts* of the National Institute of Public Health and Environmental Protection (RIVM) (1993) places the emphasis on the dangers faced by an ageing population. The perspective shifts from mere survival to the ever lengthening of life-expectancy and the quality of life, threatened by debilitating chronic diseases in old age.

Illness, particularly chronic disease, threatens autonomy more than the patient's life. It is the decline and loss of autonomy that is most feared by 'modern' patients. The heroism of the modern patient lies in maintaining his autonomy vis-à-vis his illness and certainly also vis-à-vis health care. This is something very different from the heroism of the acceptance of and submission to suffering as evidence of the autonomy of the immortal soul. Modern thinking on health and illness provides greater room for 'holism' than for 'holiness'.

The concept of autonomy emerges clearly in the report *Choosing and Sharing* (1991) of the Dunning *Choices in Care* Committee in the definition of health as 'the capacity to function normally in society'. In determining the capacity to function normally the Dunning Committee draws a distinction between an *individual* approach (i.e. the subjective determination of needs with respect to the contribution of care to the individual's health), a *professional* approach (the objective determination of the input of care on the basis of what is technically feasible) and a *community-oriented* approach (i.e. oriented towards participation). It is interesting that the Committee no longer directly contrasts the concept of health with 'illness' but relates it to 'care', thereby leaving room for 'health care' in the strict sense of the word in addition to the customary interpretation of health care as care of sickness and the sick. The Committee creates as it were a triangle between health, care and illness, in which health and illness are not just related to one another but health and illness both - independently of one another - have a relationship with care. This is also increasingly the reality: health care is the care of sickness and the sick but also the care of the health of the healthy. The Dunning Committee opts in favour of a relativistic social definition of health based on a continually changing conceptualisation of health in society which in turn is comparatively independent of the conceptualisation of illness. The definition of the Dunning Committee is also more dynamic and flexible than the celebrated WHO definition of 1946, which similarly defines health independently of illness, but also, in a fairly absolutist manner, equates health with a condition of 'complete physical, mental and social well-being and not merely the absence of disease and infirmity'. At the level of the individual the WHO definition finds a representation in the biopsychosocial health and illness concept of Engel (1977).

The WHO definition of health is relevant not so much as a description of the condition of a single individual but as an injunction to governments not to define health policy too narrowly. Good physical health set in conditions of

bondage and suppression cannot be regarded as a good social operationalisation of the concept of health. The individual approach as distinguished by the Dunning Committee is also reflected in the continuation of the WHO definition: 'The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being'. This also reflects the government assignment formulated later in Article 22 of the Dutch Constitution to take measures to promote public health.

Essentialist definitions of health have little to commend them since health is primarily finalistic and perfectionistic in nature. Moreover, at the level of the individual it is primarily a 'sensitising concept' - not a 'definite concept' - that obtains content and meaning in the light of the possibilities and circumstances of the individual, in the same way that at the level of society it is an interpretation of the 'capacity to function normally', i.e., normally in the given time and culture.

Conceptually, health may be approached from various angles. Seedhouse (1986) distinguishes four types of health theories:

1. health is an ideal state of perfect well-being (an end in itself);
2. health is the physical and mental fitness to do socialised daily tasks (a means towards an end);
3. health is a commodity which can be bought or given (an end for the provider, a means for the receiver);
4. health is a personal strength or ability (developed as a personal task).

None of these approaches is right or wrong, true or untrue, in itself. They each illuminate 'health' in a different way and from a different angle. They stand in critical relation to one another and to any form of realisation of health policy. In the first theory each form of illness is a denial of the ideal, while in the last theory even the worst disease may be irrelevant for feeling 'healthy'. The second theory focuses not on the illness itself but on the obstacles created as a result of it, while the third theory is primarily concerned with the restoration of health by means of intervention.

In addition Seedhouse distinguishes three approaches designed to increase health:

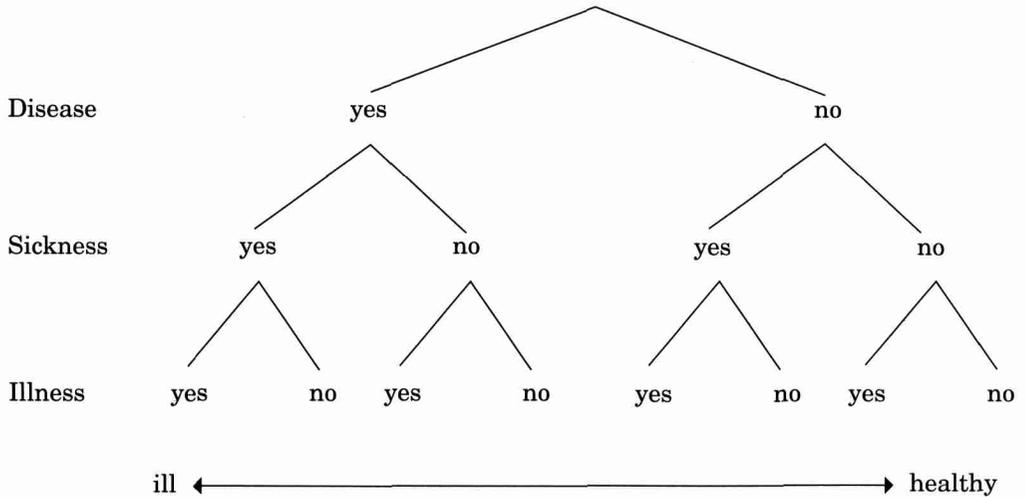
1. the sociological approach, aimed at the recognition and control of external health factors;
2. the medical science approach, aimed at prevention and cure on the basis of knowledge of normal standards and causes of disease;
3. the humanist approach, aimed at the personal realisation of health, more or less independently of objectifiable illness phenomena.

As a common factor in all these theories and approaches Seedhouse sees the necessity for creating the most favourable possible conditions for health, especially the prevention or elimination of obstacles towards being, remaining or becoming healthy. In his vision 'work for health ... (is) essentially enabling' (...) 'Health in its different degrees is created by removing obstacles and by providing the basic means by which biological and chosen goals can be achieved. A person's optimum state of health is equivalent to the state of the set of conditions which fulfil or enable a person to work to fulfil his or her realistic chosen and biological potentials. Some of these conditions are of the highest importance for all people. Others are variable dependent upon individual abilities and circumstances. The actual degree of health that a person has at a particular time depends upon the degree to which these conditions are realised in practice' (p. 61).

Seedhouse's vision of health centres on the individual, the person and development, contains both universal and specific elements and also clearly places

health in the context of the capacity to participate socially. The illness counterpart of this vision of health is provided by Feinstein (1967) in the formula $I = f(D \times P \& S)$. This reflects the fact that illness in a practical sense (Illness), as the experience of the individual patient, may be viewed as a function of the interaction between 'Disease' (illness in a medical sense) and the Patient in his (living) Situation as host of the disease. The disease is the independent variable and the significance of P & S can only be determined once we have been confronted with the Illness in a specific case.

Van den Heuvel (1981) has set out the complexity of the relationship between sickness and health in a diagram in which the concept of 'disease' (i.e. the medical/biological concept of illness) is related to both 'sickness' (the socially determined concept of illness) and 'illness' (i.e. the subjective perception of being ill or having complaints).



At the level of the individual the analysis can commence at each of the three levels, but the questions and problems are quite different in each case. By their nature the external series (yes/yes/yes, no/no/no) are not complicated; for the diagnosis and treatment of disease the non-recognition and non-diagnosis (yes/no/no) is a problem; for health care the category without 'disease' but with the feeling of being ill and also the social recognition of disease (no/yes/yes) is also a problem, but then of a totally different order. The picture is in fact of course a good deal more complicated, as the diagram does not take account of unclear answers (perhaps yes, perhaps no), various forms of co-morbidity, handicaps or special circumstances. In particular, the diagram reveals just how complicated the relationships are even at a descriptive level.

10.2.4 The unexpected consequences of health as the most important value

In the 1970's a series of articles was published in *Medisch Contact* (the official journal of the Royal College of Physicians in the Netherlands) under the heading 'Objectives of Health Care' (1979). Many attempts were made at that time to define the concept of health. Kuiper provides a survey of the many attempts in the literature and Van Mansvelt tries to arrive at a synthesis: 'health is the condition in which the human individual is capable of independently integrating into his existence all the desires and burdens, requirements and capabilities that he is required to deal with both independently and in contact with his environment, and, in doing so, to further his self-realisation in dialogue with others and his environment, until he has achieved his authentic end as a psychosomatic unit.' Health then is no longer an accidental treasure or a gift from the gods or even an instrument for survival but a condition of dynamic

equilibrium in a life-cycle that is regarded as an assignment. A striking feature of the definition is of course the attempt to incorporate the finite nature of existence in a way which, at the least, suggests that the psychosomatic unit is less than the person itself and that there is therefore possibly also some form of life after death.

In general it is taken that the acceptance of health as the most important value in life almost inevitably implies the denial of death or at least a taboo on dying, in that life no longer obtains its meaning from the prospect of a higher life after death, so that the end of life becomes the most feared moment. Where health is the highest value no positive significance can be assigned to death. This is how it appears but not how it is, and this is becoming increasingly clear. In terms of the vision of health as the most important value in life it is logical and also increasingly acceptable psychologically that when life can no longer serve health, the time of the body is over. It has fulfilled its task and can be given up. Where the progress of science makes it difficult for the body to let go of life, life itself - i.e. the individual - can opt to leave the body. This is in fact what is increasingly happening under the heading of 'euthanasia', a choice that will be increasingly made in the future. It has long since been commonplace to opt consciously in favour of the creation of life, and it has become increasingly common to opt during life for personally desired but medically unnecessary interventions (e.g. abortion, sterilisation, plastic surgery, sex-change, or growth inhibition and promotion) (Schnabel, 1978). There is no reason why this process of the gradual enlargement of autonomy and control over life should suddenly come to a halt at death. Life is in the service of health, but health is in the service of the autonomy of the individual.

The desire to obtain a grip over death is the inevitable consequence of the limited capacity to maintain a grip over life. In epidemiological terms the *compression of morbidity* has failed; life-expectancy is rising more rapidly than the life-expectancy free from complaints and disorders (RIVM, 1994). Old-age is not without infirmities; indeed it is increasingly clear that infirmities come with old age. They seem in a growing number of cases to be genetically programmed. The solution lies in the *compression of mortality*, and as a choice that will become a great success. People will be able to take leave of the 'night-light' model - i.e. the slow expiry of life - that is now threatened by medical advances by switching to the 'lemming' model (Schnabel, 1992), i.e. the self-selected end at a self-selected moment. Popularly this is in Holland already known as 'the pill of Drion', the suggestion to make safe and effective euthanasia available to people of old age, who would like to die (Drion, 1992). The actual termination of a meaningful existence will be reached when health is no longer attainable, especially when the loss of autonomy becomes overwhelming. The loss of autonomy will be the gain of euthanasia. The greatest fear is that this trade-off can no longer be made oneself because mental autonomy will have been lost by that point. In this situation of deficiency the codicil acts as a social reminder of that autonomy.

10.2.5 Health and health care

The link between health and health care would not be so important in social terms if health care were a simple market of supply and demand. That is not so for two reasons. As health problems become more serious and urgent, health care becomes more intensive and expensive in terms of both services and products. Because health care is in principle offered at individual level, the provision of health care is expensive in both absolute and relative terms and in many cases too expensive for those who need it.

The present form and scale of health care has only been made possible by the system of (social) insurance: the need and demand for health care have been

freed at individual level from the constraining laws of purchasing power. At the level of society as a whole the supply and price of health care have, however, again become a problem on account of the large absolute and relative appropriation of national income. Increasingly, the allocation of scarce resources in health care is conducted on the basis of indication criteria: the market mechanism is replaced by the mechanism of necessity, degree of urgency and severity.

With the exception of the report by the Dunning Committee, health care is rarely given a place in the various definitions of health and illness. Nevertheless it is important to do so because the debate about the demarcation between illness and health derives its relevance in large measure from the desire to limit health care, particularly when it comes to collectively insured health care. People are of course at liberty to use their freely disposable private income for any kind and degree of health care they wish. With the aid of specific 'funnel criteria', the Dunning Committee attempted to determine the scale of a socially insured basic package of care on the basis of necessity, feasibility, effectiveness and personal payments and responsibility. Such an attempt was previously made in the National Health Council (NRV) report *Limits to Care* (1986) and, in a broader framework, also in the report by the Scientific Council for Government Policy (WRR) *Re-evaluation of Welfare Policy* (1982), which also extends to physical and mental health care.

None of the reports really achieves its own aims, which is directly related to the multiple nature of health as 'commodity, value and truth'. Anyone seeking to limit health as a 'commodity' is seeking to keep health as a 'value' at the same high level and rapidly discovers that the criterion of 'truth', i.e. the scientific appraisal of efficacy, is of limited application and relevance. 'Commodity' and 'value' do not coincide with 'truth', even if the latter is an important principle of regulation: if something is evidently no longer to be brought into relation with the truth principle, it loses a significant degree of 'value' and will in many cases also no longer be interesting as a 'commodity'. An important element of health care is, however, not greatly affected by the truth criterion, but, as care, comes under the domain of 'commodity' and 'value'. Put differently, the high status of the 'genuine' cure is a result of the coincidence of 'commodity', 'value' and 'truth', but that does not mean that where there is no or only limited coincidence no valued or necessary health care can be offered. In quantitative terms, evidence-based medicine remains much smaller than the collective sense of the profession, which need not be at variance with the truth principle but appears instead to be determined by tradition and considerations of fairness and justice, especially in those instances where the truth principle cannot be meaningfully put into effect in a positive sense.

We are concerned here with the transfer of the results of biomedical science to medicine, healing and care of the sick. This problem also comes to the surface in the International Classification of Impairments, Diseases and Handicaps of the WHO. Impairments are totally bound up with 'truth': they are by definition determined scientifically. This applies to a lesser extent to the definition of disease and particularly to disabilities: as defined units or associations they are already to some extent determined by health as a 'value' and in their approach by health as a 'commodity'. This applies even more to handicaps: the 'truth' criterion is dominant in respect of neither the conceptualisation nor the approach. Handicaps may necessitate a great deal of care, whereas impairments are often unrelated to care. There appears an increasing need to expand the ICIDH system with a fourth category, namely consequences or contingencies. By this I am referring to the importance of potential handicaps for people other than the patient himself: members of the family, the partner, colleagues and carers. As impairments lead to more serious and protracted handicaps, the consequences of those handicaps also become more relevant for others

apart from the patient. The consequences define the autonomy still left to the patient as well as the restrictions put on the autonomy of others by force of the patient's illness.

In health care the handicaps are often the point of departure, diseases the point of application, disabilities the point of measurement and impairments the end point: the basis of the diagnosis. Fundamentally, outside the field of health care, in the area of science and clinical research, the sequence is of course exactly the other way round.

10.2.6 A general rule

If we review the present state of affairs it is fair to say that one general rule appears to apply, namely that health must be well cared for and that this includes respect and care for the health of others. The individual, society and government find themselves linked and bound on this score. The general rule of care for health is fleshed out with special rules for good care, based in particular on scientific information, subject to the provision that science can itself be the source of a new practice or the touchstone of an existing practice (i.e. 'evidence-based medicine' or the 'collective sense of the profession') (Kaasenbrood, 1995).

The general rule has a formal character (specific forms of behaviour are neither ruled out nor rendered obligatory) and the special rules above all form part of a learning process: scientific information can change and may also mean the reversion to previously adopted standpoints. In itself this need not be a problem as long as the information can be presented as 'better', in the sense of being based on greater scientific insight, and can therefore make a greater contribution than the old information to the preservation and promotion of health - i.e. to the realisation of the general rule.

Just how effective this combination of a formal general rule and changeable special rules is emerges if one seeks to conduct a comparable operation in other fields, e.g. 'welfare'. This cannot be done: the assignment of promoting individual and collective welfare cannot be operationalised with the aid of universally valid scientific statements capable of being converted into practice or replaced without problem by new and more specific statements. There is no scientific consensus - i.e. no generally accepted paradigm - and hence no normal science in the field of welfare. It remains an area of opinion, ideology and hence pluralism. Everyone is free to pursue his or her own welfare and to hold opinions about social welfare in general, but the lack of a coherent scientific foundation means that social welfare is incapable of generating consensus. The special rules of social welfare consequently remain political and ideological rules subject to changes in opinion. General consensus cannot be achieved or, more precisely, the statements cannot themselves generate the consensus. There is nothing against formulating health or health policy in terms of welfare, as occurred in the Dutch government in the 1970s, including the appointment of a co-ordinating Minister for Welfare Policy, but it needs to be borne in mind that the concept of welfare is not sufficiently 'hard' or 'evidence based' to have connotations of truth in addition to value. Efforts to treat welfare in terms of a 'commodity' have largely failed. The commodities proved mainly to be services and activities for which there was little - and then highly selective - demand. The concept of 'welfare' therefore does not unite but divides. In so far as it fails to do so we rapidly find ourselves back in the field where scientific truth is dominant - which turns out largely to coincide with the field of health and health care.

10.3 The difference between physical and mental health care

The determination, confirmation, monitoring and preservation of health have become one of the most important tasks of physical health care. Much of the concern, especially in primary health care, is with reassurance or, where that cannot immediately be provided, with excluding the possibility that something might not be in order. In the case of mental health care, there is no real equivalent for monitoring and, to a large extent, screening. Unlike physical health care, mental health care does not have an objective measure of health: knowledge of 'healthiness' does not therefore provide a criterion for the determination of 'illness', disease and the fact of cure. If anything the converse applies. Knowledge of 'illness' - in fact primarily recognition of behaviour or feelings that are regarded as inadequate in the given situation in terms of intensity, duration, form or content, provides the precondition in mental health care for discovering what is evidently normal. The recognition of the boundary enables the core to be determined.

In line with the difference in orientation between physical and mental health care, there is no doubt that by its nature physical health care is available and indeed necessary for all, while mental health care is available for all, but ultimately necessary for only a limited part of the population. In organisational terms this manifests itself in Dutch mental health care by the positioning of such care in secondary health care, i.e. as a form of specialist treatment. Moreover, the general practitioner is not the only one to make referrals to mental health care. There is a comparatively high proportion of self-referral while a considerable number of referrals originate with schools, social work, child protection, company doctors or the police - in other words via agencies that establish contact with the system of mental health care on account of the severity or duration of what they consider to be abnormal behaviour.

This immediately spotlights another relevant difference between physical and mental health care. The more serious the problem - and the more that self-insight is affected - the more it will be others apart from the patient who observe that help is required. *Persuasion and cohesion* form part of mental health care, meaning that an active approach of outreach is often expected on the part of the latter with respect to those often referred to as 'care avoiders'. Conversely it is also true that if someone indicates he has psychological problems, he does in fact have them - in many cases there is no source other than the person concerned to determine that there are problems, which is not to say that they always need to be treated, let alone in the way that the applicant for mind health had in mind himself. It is not without significance that the imitation of both mental and physical symptoms (factitious disorders) is regarded as a problem for mental health care. In the case of physical symptoms this of course only applies once it has been determined that these symptoms are being simulated.

'Health refers to the optimal functioning of an organism. There are two reasons why optimal 'mental' functioning cannot be straightforwardly defined. In the first place there is a quantitative problem: we do not know all the ways in which people are able to function mentally and consequently we never know whether certain mental processes or forms of behaviour are 'optimal'. Secondly, the notion of optimal mental functioning involves moral opinions. There is no way of assessing the validity of those opinions by scientific means' (Van den Hout, 1988). Theoretically and empirically there is therefore - at least on a scientific basis - only room for the treatment of 'suboptimal' functioning. It is therefore typical of mental health care that the severity and duration of the disorder can generally be better determined than the degree and scale of that disorder, in that the latter assumes the existence of a fixed norm or value in relation to which the gap can be determined. Looking at the

severity in fact means looking at the consequences of a certain form of behaviour, at the reactions of the environment or, alternatively, the absence of any contact with the environment. In physical health care the point of reference is in principle *objective*; in mental health care the *intersubjective* is predominant. No 'values' can be determined independently of the person himself; 'values' - but then with a different meaning - determine what the significance is of the behaviour displayed or the story told.

In practice the differences are not absolute. In the case of physical health care, the contact with patients and deciding what the matter is, has much in common with what is described here as 'mental health care'. This is logical for although the patient has a body this is not the full story, even in the case of strictly somatic disorder. The patient is also a person and as such he is a possible prospect for mental health care. On the other hand, there is a growing trend in mental health care itself to objectify the nature, severity and duration of the disorder, and the more biological in nature the disorder - or at least if it responds to intervention at that level - the more this succeeds. The patient may coincide with his 'mind', but the mind is contingent to the brain. In mental health care, the technological orientation is becoming more pronounced, while in physical health care the interactive and participatory moments are becoming increasingly important.

A typical feature of the difference between physical and mental health care is the way in which research into and with the patient is carried out. In the case of physical health care research is based on the *principle of exclusion*: in response to the question as to what is wrong more and more possibilities are systematically excluded, until the process of reduction leads to a diagnosis and a starting point for treatment. In mental health care the research is determined by the *principle of inclusion*: the concern is to obtain steadily more insight into the patient and his background until the process of adduction permits the formulation of an indication and the drawing up of a treatment plan. The diagnosis upon completion of the treatment is therefore more important in mental health care, that is it must afford more certainty than in the case of physical health care. As the need for the inclusion principle is reduced, mental health care becomes more technological in nature, which is not to say that the step towards the systematic exclusion of alternatives is always taken. What is saved is, above all, time and not the patient.

Although marked efforts are being made in mental health care towards the development of evidence-based medicine, in practice this proves largely confined to the experimental determination of the efficacy of (in particular) psychiatric drugs and, to some extent, also psychotherapy. In the field of diagnosis and, increasingly, also treatment we are seeing the development of consensually based guidelines and standards (Kaasenbrood, 1995). The international acceptance of a multi-axial diagnostic system for the classification and description of mental disorders (DSM III, since replaced by DSM IV), the unification of the psychiatric language, has given an enormous boost to scientific research into psychiatry and more generally mental health care. Nevertheless the collective sense of the profession, as this has evolved over the last two centuries, remains important in the field of diagnosis and treatment.

If a problem presented by the patient himself for treatment in mental health care is not accepted as meriting treatment, there is much less likelihood of a sense of relief on the part of the applicant than in the case of physical health care (although there will also not be any relief in the case of physical health care if the patient still feels that something is the matter and that the cause is not psychological). If a problem is rejected by the system of mental health care, the individual in question is also rejected, or at least this is how it will be perceived in the first instance. Expressed more strongly, whereas non-treat-

ment is regarded as a positive performance by the system of care in respect of somatic disorders, in the case of mental health care it is often condemned as a sign of selectivity and lack of productivity. This does not contradict the fact that medical intervention is not sought quickly and certainly not readily in mental health care. The need to cross that threshold in itself indicates that it is no longer an issue as to whether something is wrong but what must happen (even though it will often be difficult to clear the next hurdle and to get some action!).

In contrast to physical health care, mental health care exists in the eyes of the citizen not primarily for himself but for others. This attitude is also largely reflected in that of the government, which - at least until recently - encouraged the citizen to follow the wise advice of a benevolent medical regime and, above all, to seek help in good time for complaints with a view to the preservation of physical health, but rapidly tended to emphasise personal responsibility when it came to mental health. Among the government, too, there is concern about an over-ready and casual uptake of mental health facilities, although an active attitude is expected in relation to people who 'genuinely' need help but do not seek it or even expressly refuse it. Where, therefore, the citizen is encouraged to pay particular attention to his objective physical conditions, the system of mental health care is warned to deal sparingly with subjective requests for health on the part of a citizen.

10.4 The development of a concept and system of practice in mental health care

The American concept of 'mental health' itself replaced the then fairly new concept of 'mental hygiene' at the start of the century. Not by accident the concept of 'mental hygiene' harks back to the efforts to prevent infectious diseases by certain measures and behaviour. The success of these efforts provided a model for mental health care, giving it a boost and channelling it in a new direction, in the same way that the success of modern somatic medicine in the second half of the 19th century led to lunatic asylums being changed into hospitals.

Mental hygiene and mental health started as a movement to improve the lot of (institutionalised) psychiatric patients. The protection of the mentally ill was the primary goal but attention was rapidly extended from just the individual whose mental health was impaired to the mental health of people under threat and the social factors threatening them (Schnabel, 1995).

In the case of individuals whose *mental health was actually impaired*, the system should provide prophylactic care and after-care to an admission in a psychiatric institution (this care should also cover some financial support and help with social reintegration). In the Netherlands however psychiatric prophylactic and after-care got off to a very hesitant start around 1910. Initially this mainly took the form of after-care, with little if any medical element. Prophylactic care, aimed at avoiding the need for admission, dates from the 1930s and after the war the Social-Psychiatric Services were to become the most important outpatient facility in mental health care at municipal and provincial level. The were independent from the psychiatric hospitals and the relationship between the two tended to be at best distant and in many cases outright hostile.

With respect to individuals whose *mental health was threatened*, the concentration was initially on children from unfavorable family and social backgrounds who were at risk of turning to crime. The first Medical Educational Bureau was established in the Netherlands before 1930. This bureau was modelled along American lines, with a marked psychoanalytic orientation.

The Child Protection Acts of the turn of the century were aimed at the same kind of 'rescue work', but without any medical input or psychological vision. Right through to the present time, youth care continues to be approached along separate medical, social and legal lines, and in many respects these separate approaches are based not so much on the nature of the children's problems as on the way in which these problems are tackled and the care is funded.

From the prevention of mental illness it is a logical step to the *preservation of mental health*, as undertaken for example by the Advice Bureaus for Personal and Family Problems from 1930 onwards (concerned with combating divorce and the preservation of the family) and leading in May 1940 to the establishment of the first Institute for Medical (later Multi-Disciplinary) Psychotherapy, intended to help people cope with the psychological consequences of an air attack.

The international movement for mental health was vigorously continued after the Second World War in the form of the *promotion of mental health*. Initially this was mainly social in orientation but later became more individual in nature, in the sense of personal growth. Almost unobserved a parting of the ways took place in the 1960s. On the one hand a development became discernible consisting of the rapid advent and professionalisation of a large number of forms of *individual psychotherapy*, while on the other hand there was a broadly based *welfare policy*, based on educational and sociological principles, with strong government support. Psychotherapy sought and found its place in health care, while welfare policy itself became a mainstream activity. For a brief period health care was even regarded as a form of welfare work.

What psychotherapy and more generally ambulatory mental health care have in common in the 1970s with welfare work as a whole is an aversion to psychiatry and a nearly outright of the existence of psychiatric problems and psychiatric patients. In the debate on the development of the Regional Institutes for Ambulatory Mental Health Care (RIAGG's) in the 1970s, psychiatry disappeared under the broad heading of psychosocial problems and deviant behaviour. The debate between the medical and the social model ultimately remained unresolved, although it is clear that in (mental) health care the medical model eventually obtained the ideological upper hand in a modern biopsychosocial variant. The social model lost ground in the growing awareness that it is unable to come up with any satisfactory analysis of an approach towards the problems at the level of the individual. In terms of the medical model, the social model fails as it offers neither a diagnosis on the individual patients level, nor an effective intervention on the level of the individual therapist.

When ambulatory mental health care (with the exception of the care and treatment of drug addicts and alcoholics!) was organised and regionalised in response to political and government pressure in the 1980s in the form of RIAGG's, demands were almost immediately made for a more 'psychiatric' content (to deal with severe problems) in an originally 'psychosocial' (i.e. multidisciplinary) concept. The RIAGG's met this demand relatively quickly and in the mid 1990s the gap from psychiatric hospitals had become so small that there is intensive co-operation virtually everywhere now and in a growing number of cases an amalgamation of the two. It is expected that after the year 2000 the majority of RIAGG's and psychiatric hospitals will have merged into regional providers of mental health care.

The RIAGG's gradually have become more 'psychiatric' but at the same time the psychiatric hospitals have become more 'psychosocial'. Although the composition of their population has changed markedly over time, a more important factor has been that the method of treatment and care has changed.

Where formerly the psychiatric hospital was a closed building it has increasingly become an open organisation with specialised treatment facilities, short-stay admissions, part-time treatments, sheltered housing facilities, rehabilitation programmes and outpatient facilities. The RIAGG population is more sizeable and broader than that of the psychiatric hospitals but also covers virtually the entire population of those hospitals, in many cases not just in terms of the type of diagnosis but also in terms of the individual patients. Increasingly characteristic of the psychiatric hospital's organizational structure is the nature of the functions that are carried out (intensive treatment, assumption of responsibility for daily life, temporary asylum) and no longer the presence of a psychiatric diagnosis as such. The RIAGG has a less extensive range of patient-oriented functions (diagnosis, treatment, support, admission, mediation) but is able to exercise these functions on behalf of a greater number of patients.

Paradoxically for the most serious group of psychiatric patients - i.e. those most handicapped by their mental disorder in terms of their personal and social functioning - the character of the care provided by RIAGG's and psychiatric hospitals has increasingly come to resemble welfare work. Treatment often takes the form of support in finding housing, employment, the maintenance of contacts, management of money, handling one's own household and personal care. The psychiatric disorder remains the point of departure and cause but the care is concerned to only a minor extent with the disorder itself. The attention focuses increasingly on the patient's handicaps in personal and social functioning. It is no accident that the multi-axial classification of DSM III and DSM IV - as international standards in psychiatry - distinguish the problems of the psychiatric patient in terms of symptomatology (special disorders of behaviour, affect, mood, perception or thought), deviant personality features (i.e. the characteristics determining identity), physical problems, the existence of stress factors (loss of partner, problems at work, etc.) and the level of general functioning over the past year.

An important aspect in this regard is the sequence of the five axes of the classification as these also determine the legitimation of mental health care. Where there are no diagnosable symptoms or clear personality disorders there is no task for mental health care. Attention to stress factors, physical problems and general functioning only becomes relevant when and where psychological problems have been established. This does not eliminate the fact that the existence of somatic problems, stress factors or problems in various areas of life can mean that account needs to be taken of the development of psychological problems resulting from those factors (or also where the latter are the unrecognised cause). In roughly 30 percent of their consultations, general practitioners established the existence of psychological as well as physical problems and in roughly 10 percent of cases solely psychological and psychiatric problems (Verhaak, 1995).

Mental health care is concerned with 'special' people in ordinary situations and welfare work with 'ordinary' people in special situations. Experience has shown that 'special' (i.e. in psychological terms diagnosable) people often also end up in special situations. There are numerous people with psychosocial problems (e.g. difficulties at work, school, in the family and in relationships) but only a small proportion also have psychiatric problems. Of the latter, the vast majority also have problems in other areas of life. In addition they also often suffer from more or less serious physical problems and handicaps. They are particularly susceptible to the double-effect of the *law of persistent misery* and the *law of mounting distress*: serious psychological problems are often protracted, occur in many areas of life and are often associated with physical problems. An important assignment of mental health care is aimed at preventing the accumulation of such problems and curtailing their duration.

10.5 The special role of the government in mental health care

Mental health care has always had close links with the public sector. The oldest psychiatric hospitals in the Netherlands arose in the 15th century as municipal foundations, not always managed by but certainly under the direct supervision of the municipal executive. These were places of safe custody for people whose conduct debarred them from participation in society. At that stage there was no such thing as medical treatment; the issue of the medical treatment of 'lunacy' did not affect the organisation and aims of the asylums until the 19th century. Numerous proposals were then made for the construction of modern, humane institutions, where efforts at cure could also be made. In 1849 the first mental institution in the Netherlands built in accordance with the new insights into the needs of the 'insane' was opened at Santpoort by the Province of North Holland, replacing the totally obsolete municipal institution of Amsterdam (Kerkhoven, 1996).

Explicit responsibility on the part of the government for the insane was first spelled out in the Civil Code of 1811. The Lunacy Act was introduced in 1841. On the one hand this underlined the therapeutic nature of the treatment, while on the other it left no doubt about the crucial role of the courts in deciding on involuntary commitment - until 1900 and beyond the only possible form of admission. The Lunacy Act also provided for the state supervision of lunatic asylums, or what was later to evolve into the Chief Medical Inspectorate for Mental Health.

During the course of the 19th century the national government was particularly concerned with the care of 'state' patients, especially delinquents and soldiers with psychiatric problems. Special institutions were built for this purpose and in the 20th century a special state regime ('forensic psychiatry') was set up for delinquents classified as psychologically disturbed. Ordinary mental institutions came under the responsibility of the provinces, but were in fact largely administered by private, confessional bodies. The costs of the nursing were borne by the provinces and later, more particularly, by the municipalities (as part of poor relief). In this regard it should be noted that each of the three parties (the state, provinces and municipalities) sought as far as possible to pass on the financial consequences of their own responsibilities to the other parties and, in any event, to ensure that the utilisation of their own resources remained as limited as possible.

Apart from 'public' mental health care, which was primarily poor relief for compulsorily admitted patients, university psychiatry (aimed especially at biological research) evolved only after 1890 and more particularly - in fact going back to 1880 - private psychiatry and psychotherapy which, after 1910, was to be largely psychoanalytical in nature for over 50 years (Groen-Prakken, 1993). Even before the turn of the century there were special, private facilities ('sanatoriums') for the residential care and treatment of psychologically disturbed members of well-to-do families. It was not until after the First World War that mental institutions began to admit patients not just on a compulsory but also on a voluntary basis, to operate both closed and open departments and to deal with both 'neurotics'; and 'lunatics'. The phenomenon of the private pension, sanatorium or convalescent home gave way to the concept of the psychiatric 'institution' with broader admission facilities than the former institutions.

The National Assistance Act (Bijstandswet) and the Exceptional Medical Expenses Act (AWBZ) gradually provided the psychiatric hospitals with improved funding arrangements in the 1960s. After 1970 the system of mental health care became the subject of government policy and, as in the case of health care in general, efforts were made to develop policies aimed at the funding, capacity planning, regionalisation, quality control and ultimately also the

position of the patients. The national government took the initiative to bring about change, making use in particular of the instrument to improve the financing base. The admission of the psychiatric hospitals - and later mental health care in general - to the AWBZ regime completed the process of recognition of mental health care as part of regular health care.

The special relationship between the government and the system of mental health care has traditionally been characterised by four aspects:

- the government's responsibility for *public order*: the problem here is formed by people whose unintentional and uncontrolled behaviour constitutes a danger to themselves, to others, to public safety or to the undisturbed course of urban life. The government intervenes in *crisis* situations by removing and isolating the cause or provocation;
- the government's responsibility for the *poor*: in the course of the 19th century the municipalities assumed increasing responsibility for poor relief, especially for the funding side. The institutional population was largely poor or destitute, as they were unable to care for themselves and their personal maintenance. The government worked on the basis of the *chronic* nature of their condition and assumed responsibility for the *continuity* of their existence. Many of the changes in what were later to be known as psychiatry or mental health care arose out of the desire of or necessity for the government to reduce the costs of poor relief. The advent of a system of psychiatric prophylactic and after-care as part of the Amsterdam GG & GD (Municipal Health Service: a government agency!) in the 1930s, known internationally as the 'Querido-model', was a direct but inventive result of the desire on the part of the municipality of Amsterdam to limit the cost of keeping Amsterdam citizens in psychiatric institutions by reducing the number of admissions;
- the government's responsibility for the maintenance of *civic freedoms*: until the 20th century, admission to a mental institution was possible on compulsory grounds only. This involved the deprivation of freedom and necessitated involvement on the part of the civil authorities (i.e. the Mayor) and the courts. There was major concern about the risk of the undeserved deprivation of freedom and an unscreened medical decision (Lunacy Act 1841, 1884; Special Admissions to Psychiatric Hospitals Act (BOPZ) 1994). Conversely, in instances where a delinquent exhibited signs of a mental disorder, particularly if these had been present at the time of committing an offence, the government had a need to call in psychiatric help in order to establish the facts and do something in response (forensic psychiatric laws from 1925 onwards). The *conflicts* at the boundary between freedom of action and freedom to act so typical of the psychiatric field created the need for a special relationship between the government - especially the judicial system - and psychiatry at an early stage;
- the government's responsibility for the *availability of facilities*: admissions, particularly where compulsory, must also be feasible in practice. The government must have the certainty that sufficient help is available for those considered by the courts to be in need of help. The government consequently becomes responsible for the quantitative and qualitative availability of the necessary facilities. This applies especially to the *custodial* (i.e. closed) facilities. Although involuntary admissions now amount to no more than 15 percent of all admissions, the ability for such patients to be admitted immediately remains unquestioned. In this regard societies interest take precedence over the interest of the individual patient as well as over the interests of the individual carer or care organisation.

The government's constitutional duty to promote public health is reflected only very indirectly in this elaboration of the special relationship between the government and mental health care. Apart from the strictly private sphere of people with sufficient funds to consult physicians, the care of people with psychological problems did not assume a medical character until comparatively late, very gradually and in some cases not at all. The government's attention

concentrated on cases where a danger was posed by certain forms of behaviour or incapacity (i.e. mental deficiency, dementia). The measures were in line with this, namely *monitoring and custody*. The chief consideration was *social*, not medical (Schnabel, 1995).

A conscious improvement in the *care* of those held in institutions was already undertaken in the first half of the 19th century, particularly in an educational and moral sense; *treatment* in the modern, medical sense of the word did not become possible until the second half of the 19th century, when *diagnosis* was also placed on a more systematic basis. It was at this point that the psychiatric institutions began to resemble hospitals. Bed-nursing came into vogue, the minders became nurses and the doctors wore white coats. During the course of the 20th century the gap between private practice and the 'public' institutions gradually narrowed, particularly on account of a change and relaxation in admission practice, the advent of ambulatory mental health care and certainly also the improvement in the financing arrangements. As the aspect of poor relief gave way to patient care, greater emphasis was placed on research, treatment and cure.

Psychiatric treatment did not become really effective until the advent of psychopharmaceuticals in the 1950s. During this same period - and partly as a result - a sociotherapeutic and an environment/group approach began to evolve, while in addition psychotherapy began to split up into many new forms. Later there was a return to electroconvulsive therapy and in fact also to the 19th century notion of 'moral treatment', i.e. the personal guidance and support of patients as citizens in society (resumption of employment, sheltered housing, psychoeducation). Finally the 1980s saw an international standard for the classification of mental disorders (DSM III and later DSM IV) and the advent of in vivo brain research. That research strengthened the biological claim of psychiatry but is still of virtually no significance for the provision of care in practice. Most of the drugs used in psychiatric practice are not the fruits of systematic research in biological psychiatry. Their psychiatric effectiveness was established by way of serendipity.

In those countries where mental institutions were converted into a form of mental health care the role of the government also changes. The responsibility for public order and preservation of civic freedoms remains, but the responsibility for the availability of the facilities takes on a different complexion. In fact the entire mental health care system assumes a different complexion: where formerly it was an ultimate remedy for an extremely small proportion of the population, it now becomes a facility that must be sufficiently available and accessible for anyone in need of such care and who could benefit from it on the basis of a medical indication. A *necessary evil* changes, at least in part, into a *desirable good*. From a marginal facility for people on the fringes, mental health care shifts towards a basic facility at the heart of health care.

Since 1970 the various government coalitions have placed particular emphasis on the *improvement* and *extension* of mental health care. The improvement has manifested itself in the complete transfer of mental health care to the AWBZ, in a large programme for the construction and renovation of psychiatric hospitals, in the provision of training, improvements in the system of registration and patients' rights. The extension has applied especially to the differentiated nature of new facilities, each with new facilities for a special target group, in the extension of outpatient and inpatient treatment facilities and the improved distribution of facilities throughout the country.

A policy of extension and improvement formed part of the gradually more conscious completion of the welfare state but was at the same time also a form of implementing the rights of those insured under the AWBZ. Another factor

consisted of the changing social and scientific attitudes towards the nature of psychological problems as well as the greatly increased possibilities for psychopharmacological, psychotherapeutic, socio-psychiatric and psychosocial care for psychological problems. Finally the results of the increasingly reliable epidemiological surveys indicated that psychological problems were much more widespread and also more resilient than previously thought.

The circle appears nearly to have been closed again in recent years. The concept of '*public*' *mental health care* has been revived in almost its original sense, namely the attention and responsibility of the government for those who have become marginalised in society, partly because their psychological problems make it difficult for them to find a place in society and partly because the social networks in which the psychologically vulnerable found a certain degree of protection in the past have become so much weaker. The difference is of course that in the old system of public mental health care there was little actual health care, whereas in the new system this forms the point of departure. The new system is particularly concerned with people who are literally alone, who are not so much a risk as at risk: vagrants, homeless, truants, drug-users, dislocated foreigners, isolated and lonely elderly people and care-avoiders with evident psychiatric problems.

The interesting feature of public mental health care is that it implies an element of criticism of excessive aloofness on the part of government. The latter stimulates and regulates the entire mental health care system at *national* and, in part, also at *provincial* level, but public mental health care is primarily concerned with the active and practical input of the government - or on behalf of the government - at *local* level. Put differently, the government has increasingly come to regard mental health care as a regular part of ordinary individual health care and has tended to lose sight of the fact that mental health care in fact arose out of the realisation that there are people who, without wishing to do so and who are also incapable of correction, display socially harmful or at least seriously inappropriate behaviour.

Appendix

Scale and significance of problems in the field of mental health care in the Netherlands

I. General epidemiological data

Various screening programs in the Netherlands, the United States and the United Kingdom have indicated that the monthly prevalence of psychological disorders (i.e. all new and old cases in that period of time) is around 80 per 1,000 inhabitants and that the yearly prevalence is around 250 per 1,000. Taken over their entire lives some 32 percent of the population will exhibit psychological disorders diagnosable on the basis of the DSM. The conclusion in the literature is that psychological disorders are widely distributed throughout the population and, among a certain group, are common, repeated or protracted. In other words, while everyone may run into psychological problems, diagnosable disorders of a certain duration, severity and specificity are certainly not randomly distributed over the population (Hodiamont, 1986; STG, 1992).

American research has indicated that roughly 7 percent of the adult population finds itself grappling with a psychological disorder of more than a year's duration and that 9 percent indicate that their personal and social functioning is seriously hampered by a mental disorder. Very serious mental problems - psychosis and depression in the narrow sense - occur among approximately 2 percent of the adult population, while a further 2-3 percent face serious problems. In addition there are also more or less serious anxiety and mood disorders and adaptation, behavioural and personality disorders (Robins & Regier, 1991).

A high proportion (75-80%) of people with psychological problems turn to their general practitioner but do not always present the problems as psychological and the general practitioner will not always recognise them as such (Verhaak, 1995). Where this is the case (roughly 75-80%), the general practitioner will also generally be the one to treat them. Ultimately, the remaining 20-25 percent of psychological problems end up in mental health care - not always referred from primary health care - and a small proportion are ultimately treated as inpatients. In a simplified version of the 'filter model' (Goldberg and Huxley, 1980) the picture is roughly as follows:

Table 1 Annual prevalence of psychiatric and serious psychosocial morbidity in the Netherlands, number of cases per 1,000 inhabitants, all ages, excl. the mentally disabled

Population	250
Primary health care	180
Recognised in primary health care	140
Mental health care	60
Institutional admission	9

Put differently, there are around 900,000 treatment episodes in mental health care in the Netherlands on an annual basis, of which over 130,000 take the form of an admission (including the 45,000 patients) in psychogeriatric nursing homes). It should be noted that the 'production figures' of categories 4 and 5 have risen sharply in recent years. The RIAGG alone receives 250,000 new registrations per year and has at the beginning of the year already a total of 250,000 patients on its books. The increase in production is not equal to the

increase in the number of people to whom help is provided: an increasing number of people have comparatively brief episodes in various mental health care institutions each year (e.g. first in a RIAGG, then admission to a general psychiatric hospital, then day-treatment, then RIAGG - four episodes, one individual). Similarly the figure of 250 does not in fact refer to individuals but to individual disorders.

2. Selected key figures (for 1994) on the use of facilities (NcGv 1996; Ten Have e.a. 1995)

Psychiatric hospital: nearly 36,000 admissions per year (average of three admissions per bed per year) and roughly 11,000 chronic patients (admitted for more than two years, of which 8,500 longer than five years. Schizophrenia is the most important diagnosis for chronic patients). Of the admissions 90-95 percent are for less than one year. The most important source of referrals to psychiatric hospitals are the RIAGG's.

Psychiatric department of a general hospital (PAAZ): 17,000 admissions (average of 10 per bed per year), no chronic patients.

Addiction clinics: 7,000 admissions (average of 9 per bed per year), for both alcohol and drugs. Ambulatory treatment approximately 50,000 per year (half alcohol, half drugs).

Psychogeriatric nursing home: 17,000 new admissions (average 0.6 per bed per year) - one in three admissions stems from RIAGG-care of the elderly. Diagnosis mainly Alzheimer, mean age well above 80.

RIAGG: 250,000 new registrations, list of 250,000 (estimated active list 150,000). Of the new registrations roughly a third relate to youth care and a sixth to care of the elderly. A quarter of all registrations take the form of *one-off* contacts; 50 percent of discharges take place within three months.

Psychiatric outpatient clinics: 100,000 new registrations.

Independent psychotherapist: 12,000 new registrations.

3. Mental illnesses in relation to physical illnesses (RIVM, 1994)

Top-ten causes of death according to number of years of life lost:

8. *Suicide* - 45,000 years of life lost, i.e. an average of 30 years of individual life-expectancy per suicide.

N.B. by way of comparison: the no. 1 of this top-ten - coronary heart disease - results in 250,000 lost years of life, and lung-cancer (no. 3) 120,000. If suicide could be eliminated as a cause of death the average life expectancy in the Netherlands would increase by four months. If lung-cancer were to be eliminated the increase would be 10 months. Suicide is fairly rare (1,500 cases a year), but the demographic consequences are particularly pronounced.

N.B. The causes of death are recorded superficially; the relevance of such phenomena as schizophrenia and depression becomes visible only in respect of suicide.

Top-ten prevalence of diseases and disorders in 1990:

5. *Depression* - 250,000 - 300,000 cases (trend rising); 10. *Dementia* - over 100,000 persons (sharply rising trend to over 140,000 in 2010).

N.B. The most serious chronic and incapacitating physical and psychological disorders are lacking in the top-ten as they are still comparatively rare in absolute terms. In the case of psychological disorders this applies especially to schizophrenia, the risk of which over a person's entire life is around 1 percent and the annual incidence 0.2 - 0.3 percent. A significant proportion of the chronic patient population, both institutionalised and living in the community, in psychiatry is formed by people with schizophrenia. We are dealing here with around 50,000 people.

The top-ten do not include the various forms of *addiction*:

- Alcohol - 600,000 users of 8 or more glasses per day
- Sedatives and tranquillisers - 250,000 daily and chronic users (of the adult population 10% per year use benzodiazepines, 3% are chronic users)
- Hard-drug users - 25,000
- 'Problem' gamblers - 200,000

The figures do not include the 'mentally handicapped', accounting for roughly 7-8 per 1,000 inhabitants (100,000-120,000), of which roughly half are severely mentally handicapped. An estimated 30-50 percent of the mentally handicapped exhibit serious behavioural problems and psychological disorders. Their care is largely de-medicalised, but the funding comes under the AWBZ.

Top-ten most common new diseases and disorders in 1990 (incidence)(RIVM-1994):

9. *Depression* - 150,000 new cases (rising trend), of which roughly half depression in the stricter sense. The monthly prevalence of all forms of depression amounts to roughly 50 per 1,000 .

Co-morbidity with physical disorders

The psychological co-morbidity with physical disorders is substantial. Roughly 9 percent of people with serious somatic problems also have psychiatric difficulties; in total 25 percent have comparatively serious psychological problems. Of the people with a chronic physical disease, roughly 30 percent have psychological problems arising from the disorder or its consequences.

General practitioners frequently encounter psychological problems among their patients. An estimated 20-35 percent of the patients who visit their general practitioner display a diagnosable psychological disorder. Of all GP surgery contacts, the general practitioners themselves consider that 30-40 percent are not strictly somatic, while 10 percent are wholly or almost entirely 'psychological'. As an independent category psychological disorders are in seventh place in the top-ten GP diagnostic fields, but in the form of co-morbidity psychological disorders are frequent.

Mortality

The direct mortality from mental disorders is very low. In only 2 percent of the deaths the cause is demonstrable a mental disorder. The majority of the suicides are considered to be caused by mental problems.

4. Some special groups and situations

Psychotrauma victims

Roughly 5-10 percent of Dutch women aged 20-40 have been seriously traumatised as a result of sexual abuse by relatives before the age of 16 and over 6 percent of women aged under 60 have suffered serious to very serious physical violence at the hands of their partner on a number of occasions. Psychotrauma-victims are covered by epidemiological studies of psychological disorders but are not easily identifiable as such in psychiatric practice. The consequences of experiencing violence (sexual, physical, during a war or due to an accident) often prove more serious and long-lasting in a psychological sense than previously thought. Specialist care in this area is well developed but the prevention of developing a trauma is still an unresolved problem.

Sickness-absence and employment disability

Under the old employment disability (WAO) regime, incapacity for work on psychological grounds was the second-largest category (28%) after disorders of the musculoskeletal system (29%). In lower age-groups it was even the most important category. In terms of ordinary sickness absence, psychological dis-

orders come in third place after mobility and respiratory disorders. Growing attention is being paid to the significance of stress and undue psychological loads in the work situation: roughly 40 percent of Dutch jobs - especially in the modern service, administrative and contact professions - are deemed to generate a risk of enhanced psychological stress. While the physical and environmental working conditions are steadily improving - and also systematically being checked - psychological stress is in general continuing to rise.

Children and young people

Dutch and international research has indicated that 26 percent of children aged 8-11 have psychological problems, 7 percent serious problems. Of every 1,000 children aged up to 19, 46 display evidence of psychopathology, 14 percent have development disorders and 26 suffer from unfavourable psychosocial factors.

Immigrants

There are indications to suggest that the incidence of psychological disorders is higher among immigrants than the rest of the Dutch population, but the figures are hard to interpret. The population structure of the immigrant groups differs from that of Dutch people, while the social status structure is also different. This makes it particularly difficult to conduct an effective comparison with 'comparable' Dutch groups.

5. Costs of mental health care

Taken as a separate diagnostic category, 'psychological disorders', including care of the mentally handicapped, is the most important separate cost item in Dutch health care. In 1988 it accounted for nearly 20 percent of all health care costs. In 1994 3.3 billion guilders were spent on inpatient psychiatry, 2.8 billion on psychogeriatric care, 0.5 billion on 'semimural' mental health care (i.e. sheltered housing and part-time treatment) and over 1 billion guilders on ambulatory care, of which 650 million guilders for the RIAGG's. All together about 7.5 billion guilders, about 12 percent of the total expenditure on health. For psychotherapy as such the costs in 1994 are put at 150-200 million guilders, i.e. 2-3 percent of the total costs of mental health care, or 4-5 percent if psychogeriatric care is not included.

The costs of care for the mentally handicapped amounted in 1994 to over 5 billion guilders, of which the larger part (over 80%) was required for the care and support of over 30,000 mentally handicapped persons in institutions and 15,000 in sheltered housing facilities.

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Discussion

Introductory comments by A.H.M. Kerkhoff and J. Lomas

The author of this paper could not be present at the conference. Mental health had been selected to illustrate the implications of broadening the definition of health and health care, since the existence of two distinct approaches in the Netherlands (hospitals and community mental health centres) which define the boundaries of health in different ways provides a research design. It is not an entirely satisfactory design, because of the complicated fashion in which diseases and problems are intertwined. Furthermore, the paper did not discuss community mental health in any detail, but focussed on hospital care.

Definitions of health

The concepts of health as a value, a commodity and a medical phenomenon were seen as dynamically related. Health has become a metaphor for all that is good, because of the high value we place on personal autonomy. The health of the individual and the health of society are intimately related: one can only be healthy in a healthy society, so the individual (and the doctor) has a responsibility to keep society healthy. The World Health Organization definition of health neglects this duality and focuses on the individual. The proposal to add a fourth category to the International Classification of Impairments, Disabilities and Handicap (impact on others) was seen by one participant as its most important contribution. The choice of care to be provided depends upon community values, e.g., in the potential choice between psychiatric hospitalization and incarceration. Mental health tests the extent of solidarity (consider socioeconomic differences, not much explored by the paper) and symbolizes the extent to which a government or society cares. Redefining the relationships between the individual and society seems essential, in a return to the classic question: does the individual exist to serve society, or the reverse?

Communication problems

The different conceptions of health often impair communication. Current discussions of the welfare state see health as a value, while health care providers see health care as a truth. The result is that the social policy analyst cannot easily talk to the health care manager. Ministers of Finance see health as a commodity. Mental health exemplifies the drift from commodity to value, and there is even some evidence of the emergence of health as truth, in the tremendous advances in effective psychotherapy. The commercial sector markets products like sunscreen under a value definition of health, and we should recognize that this has an impact on consumer perceptions and utilization (but should not necessarily accept the market's definitions).

Essential (core, medically necessary) health care

Four recent phases were delineated, with particular reference to North America:

1. when the goal was access (1960-90), it was *whatever hospitals and doctors do* (a professional definition). The unit was thus the care sector (doctor's services, hospital care, etc.);
2. under the influence of the RAND Corporation (mid-1980s), it was *appropriate care*, e.g., Evidence-Based Medicine. The unit became the service;
3. where decentralization was underway, it was defined as assurance of *minimum standards*. This was a floor concept, with care described in rather broad terms;
4. in the era of cost containment, *maximum entitlement* is defined. This ceiling concept must be much more precise, defining individual services. Thereby, this approach converges with the second phase. But effectiveness depends entirely on context, and we end up discussing only socially defined services like tattoo removal, and with a terrible monitoring mess. Such a mess is currently found

in the United States (with its attempts to micro-manage health care), and there is a risk that it could happen in the Netherlands.

Defining 'essential' services

A suggestion that we should distinguish between preservation of health (which need not be covered) and restoration of health (which must be covered) was criticized on the grounds that effective preventive services like immunization would always be excluded. If there is the perception that the Dutch health care system is out of control, defining essential health services might help to re-create consensus. But it was argued that placing formal limits on basic care is expensive and divisive, and will not achieve cost control. Defining the borders of health care does not address the main issues, and it is better to be flexible at the borders of care. We all carry around operational definitions in our heads, so why get fancy? Perhaps we should reverse the process and start by asking where we have solidarity now (easier to define for physical than for mental care), cover that and not worry until we encounter problems in expanding coverage. Other participants argued that failure to define the basic benefit package amounts to leaving it open-ended (comprising everything that is done now plus everything that might be done in the future) and could lead to problems in the future, when society is no longer willing to pay for more.

Role of guidelines

The Netherlands Minister of Health commissioned a report on the relationship between quality and cost containment, hoping that there would be evidence that guidelines could achieve both: we might be able to get more health from the same budget. This seems optimistic, but not hopeless, given the good motivation of Dutch doctors. There is no logical relationship between cost and quality control: practice guidelines may *increase* costs if aimed at quality, because more care may be added than removed. Medical associations are often reluctant to cooperate in development of guidelines when the main goal is cost containment, but need not worry as long as the approach is symmetrical (aiming at both cost and quality control). Implementation of evidence-based medicine should help to improve the quality of care, but will offer no easy tools for defining the basic package. A key question is how to implement an ethic of evaluation in the medical profession.

Government-profession relationships

We should separate the areas of profession-payer conflict from the areas of agreement; there are substantial areas in which they have similar interests, e.g., everyone agrees that value-for-money is a Good Thing.

Information

We can become enchanted with the need for information, but there is no assurance that it will ever answer our questions. The value of information generally seems higher when you want it than when you have it. Grey areas can never be made black and white, and the real question is to define how large the grey area is; there is evidence that it may constitute 21-70 percent of physical health care. We should be realistic in our objectives, defining how far we can go: we want the 'least worst' solution.

Questions

1. *What is a useful definition of health to be used in determining essential health services?*

A relatively narrow definition, that does not encompass all of 'quality of life' but is limited to aspects that can be directly addressed by health services.

2. *The increasing emphasis on the subjective valuation of health makes it difficult for the public to differentiate between 'objective' need for care and individually determined demand. Will this affect solidarity?*

Very possibly yes, given the variation among individuals' priorities and the expansion of health care into 'softer' areas. This may be an argument for maintaining a narrower definition of health.