

EUROPEAN PERSPECTIVES

Demand and supply for psychological help in general practice in different European countries

Access to primary mental health care in six European countries

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Background: The general practitioner is usually the first health care contact for mental problems. The position of a general practitioner may vary between health care systems, depending on the referral system (gatekeepers versus directly accessible specialists), presence of fixed lists and the payment system. This may influence patients' expectations and requests for help and GPs' performance. In this paper the effects of working in different health care systems on demand and supply for psychological help were examined. **Methods:** Data were collected in six European countries with different health care system characteristics (Belgium, Germany, the Netherlands, Spain, Switzerland and the UK). For 15 consecutive contacts with 190 GPs in the six countries, each patient completed questionnaires concerning reason for visit and expectations (before) and evaluation (after consultation). General practitioners completed registration forms on each consultation, indicating familiarity with the patient and diagnosis. General practitioners completed a general questionnaire about their personal and professional characteristics as well. **Results:** Practices in different countries differed considerably in the proportion of psychological reasons for the visit by the patient and psychological diagnoses by the GP. Agreement between patients' self-rated problems and GPs' diagnoses also varied. Patients in different countries evaluated their GPs' psychological performance differently as well, but evaluation was not correlated with agreement between request for help and diagnosis. In gatekeeping countries, patients had more psycho-social requests, GPs made more psychological diagnoses and agreement between both was relatively high. Evaluation, however, was more positive in non-gatekeeping countries. Individual characteristics of doctors and patients explained only a relatively small part of variance. **Conclusions:** Health care system characteristics do affect GPs' performance in psycho-social care.

Keywords: health care systems, primary mental health care, general practitioner, psychological stress

The GP usually is the first contacted professional for patients, suffering from mental health problems. In many cases the GP is the only contacted professional. Only a proportion of these patients will be recognized by the GP as being mentally ill and a relatively small proportion of these recognized cases will be referred to specialized mental health care.¹⁻¹¹

This state of affairs has been modelled in Golberg and Huxley's 'pathway to psychiatric care' (figure 1), in which patient's decision to visit a doctor is the first filter to be taken, the GP's recognition of the patient's problem as a mental health problem the second one and the GP's decision to refer the third.⁵

The position of GPs varies considerably in different countries. Therefore, in different health care systems, patients' expectations as well as GPs' task performance regarding mental health care may differ and permeability of the first filters may differ as well.¹² In this paper, differences between the health care systems of Belgium, Germany, the Netherlands, Spain, Switzerland and the UK are considered.

One of the most conspicuous differences between health care systems is the 'referral system'. In the Netherlands, Spain and the UK the GP is a gatekeeper. In these circumstances a patient cannot consult a medical specialist directly. This is in contrast with the systems in Belgium, Germany and Switzerland, where patients may decide for themselves what kind of care to look for and where they have direct access to specialists. In such cases

visiting the GP is just one option, alongside consulting a psycho-therapist, psychologist or psychiatrists, for a patient who feels emotionally distressed.¹³⁻¹⁵ In European countries with a gatekeeper system, GPs are more inclined to consider the treatment of patients with psycho-social problems primarily a task for the GP.¹⁶ It might be hypothesized that in a gatekeeper system, patients will consider the discussion of mental health topics with their GP more relevant than in systems where patients can choose freely to visit a psychiatrist.

A gatekeeper system is generally associated with a 'fixed list' system. When patients are registered with a GP, their doctors will probably have known them better and for longer than general practitioners who do not have lists. Less time has to be spent on routine questions, so there is potentially more time for psychological investigations. Furthermore, acquaintance and previous experience with a patient might make it easier for a general practitioner to recognize and respond to signs of mental distress, such as frequent attendance, and to detect somatized emotional distress.

Another important health care system characteristic that may determine a GPs position is the 'payment' system. In the case of self-employed doctors, especially those working on a fee for service basis (Germany, Belgium, Switzerland), the instrumental treatment of physical disease might be more remunerative than listening to and counselling patients. This would not be the case for doctors on a fixed salary (as is the case in Spain). Self-employed doctors may choose to maximize their workload, whereas doctors who are employed may feel less time pressure and thus conduct longer consultations.

Health care system characteristics may thus determine to some extent the conditions within which GPs deliver psycho-social care, their attitudes and their task perceptions. More specifically: a gatekeeper system should affect a GP's task perception; a fixed

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list system implies more time and better personal acquaintance with patients; salaried GPs are expected to have more time for their patients and to engage less in activities competing with psychological anamnesis and treatment.

This paper reports an analysis of the consequences of national health care system characteristics on the several levels and filters of Goldberg and Huxley's model. The general research questions are:

- To what extent do health care systems determine the accessibility of the pathway to mental health care, more specifically:
 - the relevance attached by patients to discussion of psychological problems (filter 1);
 - the psycho-social requests they make in the consultation (level 2);
 - the psycho-social diagnoses made by GPs (filter 2);
 - recognized psycho-social requests (level 3);
- Is the psychological performance of GPs evaluated more positively in countries with 'broad' pathways to mental health care (Gatekeeper task for GP; fixed lists; salaried GPs) than in countries with 'narrow pathways' (free access for specialists; no lists; self-employed GPs)?

In addition to health care system characteristics, individual patient and doctor characteristics play a role in the search for help and treatment for mental problems. Women are more likely than men to consult a doctor.^{14,17,18} Unemployment makes consultation more likely for men in the case of emotional distress,¹⁹ but unemployment has no significant effect for women.²⁰ Presence of depression may be associated with both a high expectation²¹ of and dissatisfaction with medical care.²² GPs' psychological diagnoses depend on the characteristics of the patient and the GP. Female, middle-aged, and less well educated patients are all more likely to receive a psychological diagnosis.^{10,20} In the last study, the unemployed and people with state health insurance also had a higher probability of a psychological or social diagnosis. Older doctors and doctors with an interest in psychiatry tended to identify the emotionally distressed patients more accurately.^{5,23,24} Doctors with a patient-centred attitude made more psychological and social diagnoses.^{24,25} Incidentally, doctors from different countries appeared to differ in this respect: Netherlands doctors were more patient-centred than UK doctors, who in turn were more patient-centred than Belgian doctors.²⁶ These effects on an individual level have been taken into consideration in the analysis of the supply and demand of mental health care in different countries.

METHOD

Data collection

To address the research questions, data were collected in 1997 in Belgium, Germany, the Netherlands, Spain, Switzerland and the UK.²⁷ Between 27 and 43 GPs from each country participated. GPs were at random approached on a nationwide basis in the Netherlands, Belgium and Germany. In Spain GPs from one region (Malaga) were approached. In the UK, practices involved in earlier primary care research and in Switzerland, GPs taking part in quality circles, were invited to take part in the study. Each GP collected data on 20 consecutive doctor-patient contacts during consultation hours on different days of the week. A camera was installed with a fixed position in the consultation room. The recording was only stopped when a patient did not give consent for the recording. In general it took two or three days to complete data collection in one practice. Before and after their consultations, patients completed questionnaires. GPs registered relevant data immediately after the consultation. All GPs completed a questionnaire concerning their attitudes, task perceptions, and working style.

The position of the GP differs in each of the participating countries. Belgium is characterized by having a very high density

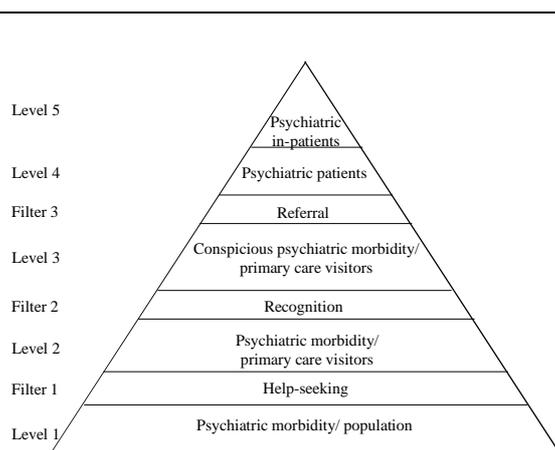


Figure 1 Model of Goldberg and Huxley

of doctors. GPs have to compete with medical specialists who provide outpatient care and are directly accessible. In Belgium, doctors are paid directly by their patients. In Germany, the density of primary care providers is relatively high, although not as high as in Belgium. There is also direct access to medical specialists and German GPs receive a fee for service payment. In Switzerland, the position of GPs is comparable with that in Germany. In the Netherlands the GP is a gatekeeper. Patients must first contact their GP who has to decide whether to make a referral to a medical specialist. About 50% of patients are publicly insured and GPs receive a yearly flat capitation fee for each publicly insured patient on their list and provide all the services needed. The other 50% of patients are privately insured. In their case, GPs receive a fee for treatment for each consultation. In Spain the GP is also a gatekeeper but here doctors are employed by the District Health Service. In the UK, GPs are gatekeepers. Their income is a complex mix of fees and allowances as specified in their contract with the National Health Service.

Variables

Measurement instruments are described in great detail in the final report of the European Communication Study.²⁷ All questionnaires were translated from Dutch to English, German, French and Spanish, translated back to Dutch, and discussed with the coordinators in each country. A brief description follows.

■ Dependent variables

i) The relevance patients attach to psycho-social issues during the consultation: 4-point scale with a reliability (Cronbach's alpha) of 0.83. Patient indicated the relevance of help on the following items:

- help for anxiousness,
- help for emotional problems,
- explanation of emotional problems,
- support for the difficult time patient has.

ii) Performance: Patients indicated on the same items (again: 4-point scale) whether the GP had undertaken any action (Cronbach's alpha 0.80).

iii) Psycho-social requests for help made by the patient: Reasons for the visit as noted down by the patient and coded according to the categories of the International Classification of Primary Care (ICPC).²⁹ Reasons coded within the chapters P (Psychological) and Z (Social) were taken into account.

Psycho-social diagnosis was measured by the diagnosis as registered by the GP. Diagnoses were coded in ICPC. P and Z diagnoses were taken into account.

The agreement between a patients request for help and the GPs diagnosis was determined by comparing a patients reason for the encounter with the GPs diagnosis. If both stated at least one psycho-social reason for the encounter/diagnosis, the case was considered to be one in which a patients psycho-social request for help had been recognized by the GP.

Independent variables

i) Patient questionnaire:

- age;
- gender;
- employment status (having a paid job);
- education level (patients reported low (primary school only); moderate (secondary school); high (university/vocational training)).

ii) GP registration per patient:

- how well does the doctor know the patient (5-point-scale);
- how long has the patient been registered as another indicator of acquaintance with the patient.

iii) From the GP questionnaire the following relevant GP characteristics were obtained:

- socio-demographic characteristics (age, sex, solo or group practice);
- urbanization (large city; small town; suburban; urban/rural; rural);
- GPs number of years of experience;
- booking intervals when making appointments, indicating the possible amount of time reserved for a patient;
- cooperation with social workers (never/seldom; < three times/year; once/1-3 months; > once/month), indicating a GPs interest in psycho-social care;
- the GPs psycho-social task perception;¹⁶ a scale of seven psycho-social case scenarios on which the GPs indicated whether the GP was always/mostly/seldom/never the doctor of first contact (Cronbach's alpha = 0.90);
- GPs' patient-oriented attitude. A 7-item scale, measuring disease-centred vs. patient-centred attitudes (Cronbach's alpha = 0.65);
- fulfilment of a vocational training.

Representativeness

Background characteristics of our sample was compared with those of the population of the larger European Task Profile study.¹² Results are extensively reported in the final report.²⁷ To summarize them: those GPs who could be readily engaged in time-consuming research (group practice, large city, smaller workload) were somewhat over-represented in this sample.

About 20% of the patients who were invited to participate declined to do so. Among the non-responders there was a slightly higher proportion of females, an over-representation of reasons for the encounter concerning the female genital system, and an under-representation of musculo-skeletal and respiratory symptoms. There were no differences in age, psycho-social background of complaints as rated by the GPs, or psychological or social symptoms.

Analysis

Differences between the six countries were analysed by means of analyses of variance. Differences were assessed using the Scheffe Post Hoc analysis.

Because of the hierarchical data structure (15 patients with the same GP; 30 GPs within one country; six countries) the independent effects of patient characteristics, GP characteristics and the different position of the GP in the six countries were assessed by step-wise multi-level analysis.^{30,31} At the country level, the country with the lowest score on the dependent variable served as the reference group.

RESULTS

Table 1 gives the distribution of patient characteristics in each country. The proportion of male patients in Spain was less than in the other countries. Germany and Spain had more patients with a low level of education than other countries. Spain and the UK had relatively many patients without a paid job. Belgian doctors indicated knowing their patients best, Netherlands doctors the least.

Table 2 gives the distribution of relevant GP characteristics. The Netherlands and Spanish samples included more female GPs. GPs from Belgium, Germany and Switzerland were working more frequently in a solo practice. Spanish and British doctors were more often recruited from urban areas, while the German and Swiss practices were relatively often from rural areas. In Belgium and Germany appointment schemes were frequently lacking, in Spain and Switzerland patients were only allowed to consult a GP by appointment. Time was abundant in Belgium and Switzerland and scarce in Spain. Cooperation with social workers was often present in Spain and the Netherlands, but rarely in the UK. Vocational training was usual for almost all the German, Spanish, Netherlands and British GPs but less common in Switzerland and Belgium.

Table 3 presents the distribution of the dependent variables: the relevance attached by patients to psycho-social issues and patients' perception of GPs' performance; psycho-social requests for help put forward by patients, psycho-social diagnoses made

Table 1 Socio-demographic characteristics of patients included in the study in six different countries

	Belgium N=522	Germany N=780	Netherlands N=487	Spain N=495	Switzerland N=595	UK N=441
Age (mean)	486	497	467	490	497	482
Sex						
Male	44% ^d	43% ^d	36%	30% ^{a,b,c,e,f}	41% ^d	45% ^d
Education level						
Low	29% ^{b,c,d,f}	49% ^{a,c,d,e}	17% ^{b,d,f}	64% ^{a,b,c,e,f}	29% ^{a,c,d,f}	[6%] ^{a,b,c,d,e}
Average	42%	31%	54%	19%	60%	[54%]
High	29%	20%	29%	17%	11%	[40%]
Employed	44%	49% ^d	49% ^d	35% ^{b,c,e,f}	53% ^d	53% ^d
Patient known by GP	3.8 ^{c,d,f}	3.7 ^{c,f}	3.4 ^{a,b,e}	3.5 ^a	3.7 ^c	3.4 ^{a,b}
Number of years listed	10.7 ^{b,c,d,e}	8.0 ^{a,f}	8.2 ^{a,f}	7.5 ^{a,f}	7.1 ^{a,f}	10.1 ^{b,c,d,e}

a: Significant difference with Belgium; b: significant difference with Germany; c: significant difference with the Netherlands; d: significant difference with Spain; e: significant difference with Switzerland; f: significant difference with UK.

by GPs and agreement between a patient's request and the GPs' diagnosis.

There were no differences between the patients from the different countries regarding the relevance they attached to various psycho-social issues; there were considerable differences, however, regarding the proportion of patients presenting with a psycho-social request for help. In Switzerland and Spain this proportion was larger than in Belgium or Germany. Accordingly, Swiss and Spanish (and also British) doctors made more psycho-social diagnoses than the Belgians or Germans.

This situation was partly reflected in the agreement between patients' registered requests for help and GPs' diagnoses. Swiss and British GPs made a psycho-social diagnosis in nearly in all the cases in which a patient noted down a psycho-social request for help. The same was true for the Netherlands GPs. However, in Belgian and Spanish consultations, a psycho-social request from the patient was often not associated with a psycho-social diagnosis by the GP. On the other hand, Swiss, German and British GPs frequently gave a psycho-social diagnosis in the absence of such a request by the patient.

Belgian, German and Swiss patients were more satisfied with the GPs' performance regarding psycho-social issues than were patients in the UK, the Netherlands and Spain.

Table 4 presents the results of a multi-level analysis in which possible explanatory determinants at the patient and doctor levels are considered.

The degree in which patients considered the discussion of psychological topics relevant was mainly affected by patient characteristics. Female patients, younger patients, patients with less education and patients known longer by their GPs attached more value to these aspects than their older, male, better educated counterparts. Patients in urban areas valued the discussion of psychological topics more highly than patients in rural areas. Patients whose GPs were less patient centred attached more relevance to psychological topics as well. Differences between countries did not add to the explained variance.

More or less the same patient and GP characteristics that contributed to the explanation of variance in the relevance attached by patients to psychological care, were related to the evaluation of the GPs' psychological performance. Contrary to the estimated relevance, however, we found a country effect. All countries, especially Switzerland, Belgium and Germany, differed significantly from Spain, rated lowest.

Requests for psychological help were made more frequently by young patients, women and by patients who were well known to their GP. Doctors in urban areas and GPs who cooperate with

Table 2 GP-characteristics included in the study

	Belgium N=31	Germany N=43	Netherlands N=31	Spain N=27	Switzerland N=31	UK N=27
GP's age	45 ^d	46 ^d	45 ^d	39 ^{a,b,c,e}	48 ^d	43
GP's sex (% male)	74% ^{c,d}	74% ^{c,d}	48% ^{a,b,f}	44% ^{a,b,e,f}	71% ^d	85% ^{c,d}
% solo	68% ^{b,c,d,f}	36% ^{a,d,e,f}	20% ^{a,d,e,f}	0% ^{a,b,c,e}	61% ^{b,c,d,f}	0% ^{a,b,c,e}
Urbanization						
Large city	22% ^d	17% ^d	20% ^d	56% ^{a,b}	13% ^d	47% ^b
Small town/suburban	42%	36%	50%	44%	48%	36%
Rural	36% ^{d,f}	48% ^{d,f}	30% ^d	0% ^{a,b,c,e}	39% ^d	17% ^{a,b}
GP's years of experience	18 ^{b,c,d,e,f}	10 ^a	13 ^{a,d}	9 ^{a,c,e}	13 ^{a,d}	13 ^a
Appointment scheme (% always)	24%	41%	65%	92%	97%	75%
Minutes for consultation	20 ^{b,c,d,f}	13 ^{a,d,e,f}	10 ^{a,d,e}	5 ^{a,b,c,e,f}	19 ^{b,c,d,f}	10 ^{a,b,d,e}
Meetings with social work at least each 3 mnth	44% ^d	57%	66%	85% ^{a,e,f}	51% ^d	38% ^d
Psychological task perception	310	308	343	322	305	355
Patient-centred attitude	35	36	35	37	38	37
Vocational training						
Yes	52% ^{b,c,d,f}	85% ^a	91% ^{a,e}	92% ^{a,e}	68% ^{c,d}	87% ^a

a: Significant difference with Belgium; b: significant difference with Germany; c: significant difference with the Netherlands; d: significant difference with Spain; e: significant difference with Switzerland; f: significant difference with UK.

Table 3 Dependent variables: differences between countries

	Belgium	Germany	Netherlands	Spain	Switzerland	UK
Relevance of psychological issues	171	168	159	162	167	151
Patients' perception of GP's performance	216 ^{c,d}	206 ^d	188 ^{a,e}	177 ^{a,b,e}	222 ^{c,d,f}	195 ^e
% patients with request for psychological help	6% ^e	5% ^{d,e}	9%	12% ^b	12% ^{a,b}	11%
GP's psychological diagnosis	13% ^{d,e,f}	15% ^{e,f}	17% ^{e,f}	22% ^{a,e,f}	38% ^{a,b,c,d}	34% ^{a,b,c,d}
% psychological requests and psychological diagnosis	59% ^{c,e,f}	78%	91% ^a	70% ^e	93% ^{a,d}	96% ^a
% psychological diagnosis without psychological request	10% ^{b,e,f}	21% ^{a,c}	14% ^{b,f}	19% ^f	30% ^{a,b,c,d}	27% ^{a,c}

a: Significant difference with Belgium; b: significant difference with Germany; c: significant difference with the Netherlands; d: significant difference with Spain; e: significant difference with Switzerland; f: significant difference with UK.

social workers receive more psychological requests for help. After controlling for effects on patient and doctor level, in Switzerland and UK more request for psychological help had been put forward than in Belgium.

The GPs psychological diagnosis is again related to patients gender, urbanization of the practice and being known by the GP, although the number of years patients are on the list is negatively related. Doctors with much experience have more psychological diagnoses. After controlling for variables at patient and GP level, doctors from each other country recorded more psychological diagnoses than those in Belgium.

The agreement between doctor and patient (GPs making a psychological diagnosis where the patient put forward a psychological request for help) was only related to GPs' years of experience and the country. Agreement was lower in Belgium than in all other countries (after controlling for patient and GP characteristics; fixed booking intervals had an effect which disappeared after entering the countries as variables).

A psychological diagnosis without a psychological request for help was determined by patients' gender and negatively by urbanization. Doctors with more years of experience had more psychological diagnoses without a psychological request for help. Again, the different countries had a significant effect, all countries differing from Belgium.

In the case of patients' assessment of relevance and performance, variables on patient level had a relatively high weight. Psychological diagnoses and agreement or disagreement between psychological diagnosis and patient' request for psychological help were mainly determined by the different countries as explaining variable.

DISCUSSION

Result summarized

In this paper, the pathway to psychiatric care from patients' expectations to GPs' psychological diagnoses has been described

for six countries in which the circumstances under which GPs work differ.

The relevance attached to psychological issues by patients did not differ markedly between countries, but in all other respects the countries differed from each other. Marked differences could be observed in patients' requests for help, GPs' diagnoses, the degree of agreement between a patient's request and a GP's diagnosis and patients' evaluations of GPs' performances.

Broadly speaking, Switzerland and the UK show relatively more psychological requests for help and psychological and social diagnoses by the GP, with considerable agreement between GP and patient in cases where a patient reported a psychological request; in these countries, GPs relatively often make psychological diagnoses while patients put forward physical symptoms. In most respects, Belgium and Germany show the opposite pattern. Spain resembles Switzerland and the UK regarding the high proportion of psychological requests and diagnoses, but there was more mismatching between psychological requests and somatic diagnoses. The Netherlands resembles the UK and Switzerland in the high proportion of agreement in the case of a psychological requests.

Patients' evaluations, however, follow more or less the opposite pattern: patients from Belgium, Germany and Switzerland had the highest ratings for GPs' psychological performance; Spain, the UK and the Netherlands had the lowest.

In general, the individual characteristics of patients and doctors explained a relatively small part of the variance, especially when diagnosis was concerned. The different countries remained important determinants for all but one of the dependent variables (patients' assessment of relevance) after controlling for these characteristics at the patient and doctor levels.

Methodological considerations

As mentioned in the method section, although we aimed at representative national samples, there was a selection bias,

Table 4 Regression coefficients of six dependent variables in a multi-level analysis (three levels: patient, doctor, country)

	Relevance	Performance	Request for psychological help	Psychological diagnosis	Agreement psychological diagnosis and request	Diagnosis without request
Patient						
Sex	0,117	0,142	0,345	0,244		0,285
Age	-0,006		-0,018			
Education	-0,146	-0,158				
Known by GP	0,047	0,061	0,187	0,140		
Years on list				-0,018		
GP						
Urbanization of practice location	-0,064	-0,072	-0,292	-0,185		-0,150
Vocational training						
Fixed booking intervals						
Meets social work regularly		0,150	0,198			
Years of experience				0,278	0,883	0,256
Patient centredness	-0,126					
Country						
Belgium		0,547	a	a	a	a
Germany		0,541		1,414	2,301	1,556
Netherlands		0,339		0,910	3,294	0,820
Spain		*		0,898	2,008	0,906
Switzerland		0,573	0,979	1,756	3,547	1,783
UK		0,333	1,043	1,332	2,998	1,023

a: Reference group
Only significant (p<0.05) coefficients mentioned.

especially regarding the participating practices. We have taken these possibly confounding factors into account in our model, so they could not have affected the final results. However, Swiss doctors were explicitly invited because of their activity within quality circles and this might have caused a selection effect which might explain some of the positive results for these GPs. The random sampling of consultations is considered successful, as each practice collected consultations during a number of consecutive days.

Another possible confounding factor might have been a different interpretation of the questionnaires or registration forms in the different countries through cultural differences. It might be for instance more common to be critical of authority in Anglo-Saxon countries than in the Mediterranean region. We took precautions to minimize such cultural bias by using – where possible – internationally validated instruments and – when such instruments were not available – by making translations and counter-translations in careful collaboration with our local partners. Although cultural differences and sampling bias have doubtless played some part, we have no indications of a systematic bias.

A final methodological remark should be made concerning our dependent variable ‘psychological diagnosis’. A limitation of this study is the lack of an actual identification index or outcome measures. Therefore, this study is not about GPs’ correct identification of mental disorder but rather GPs’ sensitivity (their tendency to make a psychological diagnosis) for mental disorder and on the congruence between patient’s requests for help and GPs’ diagnosis.

Premises reconsidered

Let us now consider the results in the light of our premises. The gatekeeper system (which implies a fixed list of patients), existing in the Netherlands, Spain and the UK, was expected to increase the number of requests for psychological help and psychological diagnoses. However, the supposed mechanisms behind the expectations were not always confirmed. The GPs in countries with a fixed list (the Netherlands, the UK, Spain) appeared to know their patients less well than the GPs in countries where a fixed list is not a necessary feature of general practice. The number of minutes allocated to an average consultation was less in Spain or the Netherlands, where a GP’s income is independent of interventions capable of being declared than in Belgium and Switzerland, where time was equated with money. However, planned (allocated) time was somewhat longer than realized time in Belgium, Germany and Switzerland while the opposite was the case in Spain. The UK and the Netherlands were the most strict in keeping to allocated time in practice.

Health care system and accessibility of psychological care

The high percentage of psychological requests for help in Spain and the UK and the low percentage in Belgium and Germany confirmed the expectation that a gatekeeper system would facilitate patients to bring forward psychological problems although Switzerland, which has not a gate keeper system, clearly did not fulfil this expectation.

The percentage of psychological diagnoses in all countries exceeded the Belgium percentage by a factor of at least two. After controlling for other variables, the percentage psychological diagnoses in the gatekeeper countries the Netherlands and the UK remained significantly higher than for Belgium, but the same can be said for the non gatekeeper countries Germany and Switzerland. The same pattern can be found in the agreement between a GPs diagnosis and a patients request for help. The phenomenon of psychological diagnosis without a psychological request was most common in Switzerland and Germany and least common in Belgium.

Fixed lists were expected to produce greater numbers of psychological diagnoses. That was indeed the case in the UK and to a certain extent in Spain, but not in the Netherlands. Switzerland, on the other hand, with no fixed list system had the highest proportion of psychological diagnoses. Salaried GPs in Spain were also expected to make more psychological diagnoses. In this respect they were again outstripped by their fee for service colleagues in Switzerland.

Thus, the relationship between the health care system characteristics on the one hand and the proportion of psychological requests and diagnoses on the other did not always conform with our expectations. Concerning the accessibility of the pathway to mental health care, Belgium and the UK confirm our hypothesis that a gatekeeping system with fixed list is favourable for a broad pathway to mental health care: in Belgium, GPs are not gatekeepers, they cannot make money by discussing psychological problems and do not need to have fixed lists. Their patients make few psychological requests, GPs make few psychological diagnoses, and they miss many of the requests made by their patients. In the UK, patients are on a fixed list, they need to visit their GP to obtain a referral, and a GP is paid to listen to patients. These patients make relatively many psychological requests, GPs make many psychological diagnoses, and they seldom miss a psychological request. Spain and the Netherlands on the gatekeeper side and Germany on the other side follow this picture. Swiss doctors, not working in a gatekeeping system, however, behave like British doctors in psychological matters. But we mentioned already a possible selection effect in the recruitment of Swiss doctors.

Patients’ evaluations

However, the patients in different countries are not very satisfied with the mere fact of mental health care provided in a gatekeeping system. Considering patients’ evaluations, another picture arises in which division between gatekeeper and non gatekeeper countries is followed more strictly, but in *exactly the opposite direction* from above.

The performance of GPs in non gatekeeper countries were evaluated as better than the performance in gatekeeper countries. In Belgium, where only half the requests for psychological help were associated with a psychological diagnosis by the GP, patients were most positive about the help they received for emotional problems. Patient evaluations were the lowest in Spain, UK and the Netherlands, although GPs combined many more psychological requests with a psychological diagnosis than in Belgium. A possible explanation might be the greater emphasis of doctors in the latter countries on building relationships with their patients, as is expressed in the larger amount of time spent with their patients. These patients do not focus on their GP’s susceptibility for psychological problems or agreement between their psychological request and a GP’s diagnosis, but on other aspects in their evaluations and these might be aspects outside organization of the health care system.

Discussion

The limited partial confirmation might be explained by the weak foundation of our premises described above, but it does not explain our finding that patients in countries with the most unanswered requests for help were the most satisfied.

We know that patients’ assessments of quality are perhaps more strongly related to affective rather than instrumental components of the consultation and that patients may not, understandably, be effective at judging ‘scientific’ aspects of quality.^{32,33} However, as Fairhurst and May³⁴ have commented, what is valuable about the consultation may be hidden from the patient and the quality of the consultation may only become apparent in the long term. Also, satisfaction, in patients who are emotionally distressed, cannot be fully assessed without

including all the patient expectations of the doctor in the equation.²¹ The patients in this study who were satisfied despite not having their emotional needs met, may have had other expectations of the consultation which were clearly met. Evaluations are most positive in countries where GPs offer longer consultations times. As GPs become more dependent on their patients (as is certainly the case in Belgium, and to a lesser degree in Germany and Switzerland as well), they might be inclined to please their patients more than doctors who in a number of respects are less dependent on their patients. The part played by these different factors may become clearer when the recordings of the consultations have been examined.

These aspects cannot be captured in professional standards, but they belong to the *tacit knowledge of medicine*. They may belong to the best practice medicine has to offer and fall under the label *the art of medicine*. On the other hand, they may be contrary to the science of medicine (such as not indicated medications, unnecessary diagnostics). In this respect, Grol and colleagues²⁶ have warned against *defensive medicine* in situations where GPs need to retain their patients' allegiance. It will be a challenge for health care policies in future to distil *art* from *defence* when concocting the magic formula for evidence-based mental health care from a patient-centred perspective. Allocated time for the patient should be an important ingredient!

On the other hand, we have to acknowledge that simply making more psychological diagnoses, especially when they are in accordance with the patients' request for help is an important aspect of quality of care but not a sufficient condition. A broad pathway to mental health care, to use Goldberg and Huxley's terminology, should be accompanied by a mutual trust and understanding between doctor and patient that makes the pathway suitable for a pleasant ride.

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