European Union government legislation affecting psychiatric practice

Jim van Os and Jan Neeleman

Although the process of psychiatric reform is taking place across Europe, national political, economic and historical factors determine to a large extent the manner and pace of its implementation as well as its final shape. The degree of centralisation of health care systems and the degree of prominence of primary care affect how efficiently change can be achieved. Various forms of professional resistance may, in different degrees in European countries, hamper the implementation of community care. The widely varying contexts in which psychiatric reform takes place throughout Europe, should provide a fertile area for future comparative research.

Common endeavours

All European countries are at different phases of the post-asylum stage, and there is a movement (to varying degrees enshrined in official government legislation) to organise psychiatric services along the principles of sectorisation, bed reduction in the large mental hospitals, creation of district general hospital (DGH) psychiatric units, consumer participation, and the establishment of a comprehensive and integrated system of community care that should be needs-led, population-based, and scientifically evaluated. While the language is firmly in place and at a local level many impressive achievements along these lines have been described throughout Europe (see Rowland *et al*, 1992), observers in many countries have argued that, on a national level, rather than benefiting from the post-asylum legislative reform measures, the chronic mentally ill have been victimised in the process (Mangen, 1987; Wallace, 1987; Kunze, 1977; Jones & Poletti, 1985). In some countries (e.g. The Netherlands and Germany) various forms of community care, provided by voluntary organisations and municipalities, were available at a comparatively early stage and given a prominent place in service provision; in most, however, developments have been slow, giving rise to a patchy development of voluntary services attempting to fill the gaps.

Which legislation for which health care system?

The health care systems of the European Union (EU) countries may be divided roughly into those which are organised according to a national health service system on the one hand, and, on the other hand, those which are funded through social and private insurance schemes, regulated under social security law (Pieters, 1990). The clearest examples of the former may be found in Italy, Portugal and the UK (before recent government initiatives), and of the latter in Belgium, The Netherlands, Germany and France. The Irish, Spanish and Danish systems are hybrid, while the Greek and (current) British systems are in a state of flux.

The basic feature of national health service legislations is equal access to all health care which is free at the point of delivery and funded and controlled centrally, although various restrictions may exist to contain costs. It is not surprising that legislation most affecting psychiatric practice was introduced in Italy and the UK, both countries with such top-down regulated health care systems. In Italy, and more recently in Spain and Greece, psychiatric reform was introduced simultaneously with vital reorganisation of the national health care systems. Such a 'fresh start' contrasts with the situation in some other EU countries, such as Belgium, Germany and The Netherlands, where the existing insurance-based health care systems positively hamper endeavours towards psychiatric reform (see below).

While in the NHS-systems, health care provision is the responsibility of the government, in the insurance-based (i.e. social security based) schemes, there is a split between health care providers (private hospitals, self-employed general practitioners) and health care purchasers (insurance funds). Negotiations between these two parties are to a variable extent controlled by central or local government. Public insurance (for those who are employed or unemployed) falls

Psychiatric Bulletin (1994), **18**, 390–394

under social security legislation and is contributed to by employers, employees and the government. The clearest examples of such systems may be found in Belgium, France, Germany and The Netherlands. These systems are often very complicated, with hundreds of different insurance schemes (e.g. Germany and France), and frequent extensions of insurance against individual risk to new, 'jigsaw puzzle' (Giel, 1987), areas of liability. National legislation in these countries has proven to be a very weak instrument to promote changes in psychiatric practice, because of the open ended system of financing with only marginal government influence. In countries such as The Netherlands and France, frequent 'notas', 'memorandi' and 'ordonances', carrying the weight of official guidelines, were issued in the hope that change would ensue. Most, however, have been widely ignored (Bennett, 1991).

Factors determining implementation of legislation

In Table 1 a (subjective) selection of some of the more recent initiatives in EU countries is presented. It can be seen that legislative initiatives differ widely, but also that factors hampering progress are remarkably common. First, although mechanisms for monitoring progress were in place in many countries, formal evaluation (i.e. controlled comparisons making use of the scientific method) has not been achieved in any country. Thus, only indirect evidence (at least until very recently) is available whether patients are on average doing better or worse with the legislative changes, which may hamper progress to the next stage of change. For example, in Italy, the absence of firm evidence feeds the continuing debate whether law 180 was correct or flawed, and whether it was or was not correctly implemented. In Germany, the very extensive 'Model Psychiatry Programme', which ran for five years at an estimated cost of 270 million D-Marks, was severely limited by the fact that it could not produce adequate evaluative research data (Cooper, 1987).

Spiralling health costs, and policy makers' reluctance to recognise that reorganisation of services beyond hospital closure requires expenditure in its own right, has not facilitated psychiatric reform, as legal initiatives in EU countries are increasingly backed by budgetary reduction (or at best redistribution) rather than net budgetary growth. A premature return to the pre-asylum era with services only for the dangerous, the disruptive, or the wealthy, is a real threat, especially in countries with rapid reduction of hospital beds and a minimum of alternative community services (Goldberg & Tantam, 1989).

In Britain, GPs are often regarded as the key figures in terms of health promotion. Vocational GP training, comparable to the British, exists in The Netherlands, Denmark and (recently) Spain and Ireland. However, in, for example, Belgium and France GPs are essentially 'specialists by default', and in countries such as France, a GP practice closely resembles a small, commercial business with only minimal scope for involvement in legislative reform of mental health programmes. In those countries with a more organised primary care system, access to secondary health care is generally tightly controlled by family physicians, who also ensure that adequate communications exist between different parties involved with the patient. Apart from limiting doctor shopping and soaring costs, this will clearly benefit public health primary prevention programmes. However, it must be recognised that in social security based systems such as The Netherlands and Spain, access to secondary health care is generally easier for the privately insured, which effectively means that there is a two-tier system, comparable to the situation which is arising in Britain with long waiting times for patients of non-fund-holding GPs and opportunities for queue-jumping for patients of the fund-holding practice.

In countries with insurance-based systems, reimbursement may be provided by item-of-service. Such schemes are not conducive to changes in traditional psychiatric practice, as, for example, a hospital-daily-fee system creates a 'perverse incentive' for the in-patient sector to maintain high bed occupancy rates, and it may lead to over-supply of out-patient services by office psychiatrists on the basis of profitability rather than need. In France, Belgium and (to a degree) The Netherlands (but not Germany), global budget schemes have been introduced, so that savings in the in-patient sector may lead to additional income in the out-patient sector. Often, however, private hospitals and office practitioners continue to be funded through the old form of reimbursement.

Promoting legislation affecting psychiatric practice is also not expedited by the overall trend towards decentralisation in the countries of the EU as with each stage of decentralisation a new level of public administration is created between national government legislation and the group it targets (Mangen, 1987). Countries with a federal structure, such as Germany, have only limited central power and responsibility over health and social policy, and the autonomy of the individual *Länder* (member states of the federation) in Germany hampered the movement of psychiatric reform in the early '70s and '80s (Cooper, 1987).

https://doi.org/10.1192/pb.18.7.390 Published online by Cambridge University Press

Table 1. Some legal initiatives affecting psychiatric practice in EEC countries*.

Country	Initiative	Target	Outcome
Germany	1975 report of expert commission appointed by parliament in 1971	Led to ambitious four-year 'Model Psychiatric Programme'; results however not suitable for evaluative research due to lack of baseline data.	Reduction in beds, upgrading psychiatric hospitals; improvement in patient treatment and patients' rights; more social and work therapy programmes, but major problems in planning and coordination of out-patient and community services remain.
Italy	1978 'law 180' passed (without prior evaluation)	Legislated for rapid closure of psychiatric hospitals, to be replaced by general hospital psychiatric units and a network of community centres.	Uncertain. Successful implementation, in the spirit of the law, appears to have been limited to small and medium-sized towns, mainly in the North.
Denmark	1976 bill and 1977 White Paper	Transfer of responsibility for state mental hospitals from central government to the counties; new psychiatric systems of community care to be in place by 1990.	Progress faltered due to, among others, difficulties in coordination and cooperation between health and social services.
The Netherlands	1983 creation of community mental health centres; restructuring of all out-patient care	Attempts to reorganise ambulatory out-patient care and facilitate cooperation between in-patient and out-patient services.	Strong divisions and lack of coordination between intramural, semimural and ambulatory sectors remain. Ambulatory services accused of taking on 'lighter pathology' only.
France (Belgium)	Mid-80s: global budget schemes for in- and out-patient services	Ended rigid separation of resource allocation to in-patient and out-patient services, where savings in one sector did not lead to additional funds in the other.	Initial results positive: helped to reduce bed capacity and develop additional out-patient services. However, still no integrated sector budget, lack of community provisions, professional resistance, little coordination of agencies or evaluation of initiatives.
Spain	1983 Steering Group on Psychiatric Reform and 1986 General Health Act	Introduced new system of psychiatric care centred around mental health centres, general hospital (GH) psychiatric units and defined 'health areas'.	Uncertain; definite progress in all 'autonomic regions', but, among others, serious lack of funding undermines process of reform.
Basque country (Northern Spain)	1983 Law 10/1983 and 1983 blueprint for new system of psychiatric services; 1990 revision	As above for Spain, with special emphasis on old age psychiatry, community rehabilitation and addiction programmes	75% of acute admissions now in GH psychiatric units; a range of rehabilitative 'intermediary' structures have been created; primary and secondary drug addiction prevention programmes now in place.
Greece	1983 Law 1397; 1984 CEC directive 815	Phasing in of new NHS. Introduced new system of psychiatric care with creation of community mental health centres, GH psychiatric departments and psychiatric catchment areas	Considerable progress, but not all objectives met: catchment area not been put into effect, only half of proposed number of beds in GH psychiatric units created, and the development of extramural facilities has not kept pace with the restriction of the role of mental hospitals

*: for references see: Cooper, 1987; Haerlin, 1987; Schrameijer, 1987; Sarantidis *et al*, 1992; Pedersen, 1987; Rössler & Salize, 1994; Barres, 1987; Duran *et al*, 1991; Van Os *et al*, 1992

A flexible federal structure, however, can also have advantages. For example, in Spain's federal structure, authorities in the Basque country (Northern Spain) were able to develop, around 1983, their own imaginative programme of psychiatric care, adjusted to local needs.

Professional resistance to change and co-ordination has played an important part everywhere. In the large rural areas in France, where the mental hospital can be the major employer, local authorities are anxious to curtail bed reductions and job losses; in the former West Germany, hospital staff trade unions played an important part in deciding the level of bed closures (Haerlin, 1987). In the same country, a powerful lobby of office practice neuropsychiatrists providing out-patient treatment has resisted the development of psychiatric out-patient clients at psychiatric hospitals or general hospital psychiatric units, even though appropriate out-patient treatment for the chronically mentally ill is far from satisfactory (Tyrie, 1992; Rössler & Salize, 1994). The services of multidisciplinary staffed *Poliklinïken* in the former East Germany, that often were able to provide a comprehensive out-patient treatment for the chronically mentally ill, have now largely been replaced by those of office psychiatrists (Rössler & Salize, 1994). Similar circumstances prevail, to varying degrees, in other EU countries. In The Netherlands, (and to a lesser extent in Belgium) the web of rules and regulations governing a range of intramural, semimural (e.g. day hospital) and extramural services creates conditions that facilitate self-interest rather than co-operation, and was identified by the 1987 Amsterdam Advisory Council for Mental Health as the main reason for lack of continuity of care. What it takes to bring together insurance companies, local politicians, service providers and clients' organisations has been described by Gersons and colleagues (1992).

Dutch observers, commenting on British community provisions, noticed that they appeared better equipped to deal with chronic psychotic patients, while the Dutch provisions were geared more toward the psychological needs of less disturbed patients (Hest & Wolters, 1992; RIAGG, 1992). The same can be said for ambulatory services in other EU countries such as Belgium. Van Os & Neeleman, (1994a & b) and Van Os *et al*, (1993) have commented on the widespread differences in the content of psychiatric training in EU member states, (psycho-analytical) psychotherapy playing a prominent part in many Continental countries. Given a similar type of proposed legislative change in two countries, it is possible that the particular interests and ideas of psychiatrists in each of the two states shape to a certain extent the way in which care is delivered, and to whom.

Conclusion

Changing psychiatric practice through national legislation has not (yet?) given rise to a national European success story, as in most countries the scope for change through legislative reform is limited. This sounds pessimistic, but there may be a positive side to it as well, as decentralisation and local autonomy have, as mentioned earlier, given rise to innovative and flexible care programmes in many countries (see Rowland *et al*, 1992). Indeed, it has been argued that, in the absence of strong central legislative guidelines, a 'natural' consensus on new mental health services will eventually emerge, based on the practical experience and research of a wide diversity of teams, each working and experimenting in their own way (Holloway, 1990).

Interestingly, with the purchaser and provider split, the British NHS is becoming more comparable with the systems in The Netherlands, Germany, Belgium and France, where either public or private insurers purchase health care for their insured and where, as a result, insurers (in the British context: commissioning agencies of the health authorities, fund-holding GPs and also interested insurance companies) are in a position to negotiate the cost of health care. The organisation of the new British NHS, with its continuing tight controls of access to specialist care and its new internal markets, resembles the Dutch system closely, particularly with insurance companies in the latter country being given powers to negotiate directly with the providers the price, content and site of health care. However, as far as psychiatric reform is concerned, *Caring for People* has imposed much stricter legislative directions on service innovation and reorganisation than in The Netherlands. Such differences in the degree of central planning, as well as contrasting psychiatric traditions in otherwise rather similar health care systems in the two countries, constitute interesting material for a future international comparison of the determinants of outcome of psychiatric reform.

Acknowledgements

We would like to thank all of those who provided us with helpful information, particularly Dr M. de Hert, Dr R. Gonzalez-Oliveros, and Dr W. Rössler.

References

BARRES, M. (1987) Sectorisation and overcapacity in France. *International Journal of Social Psychiatry*, **33**, 140–143.

BENNETT, D.H. (1991) The international perspective. In *Community Psychiatry: The Principles* (eds D.H. Bennett & H.L. Freeman). Edinburgh/London: Churchill Livingstone.

COOPER, B. (1987) Mental health care models and their evaluation: the West German experience. *International Journal of Social Psychiatry*, **33**, 99–104.

DURAN, E. & BLANES, T. (1991) Spain: democracy followed by devolution. In *Mental Health in the Global Village* (eds. R. Araya & L. Appleby) pp 54–68. London: Gaskell. (Royal College of Psychiatrists).

GERSONS, B., VAN DE GRAAF, W., RIJKSCHROEF, R. *et al.* (1992) The mental health care transformation process: the Amsterdam experience. *International Journal of Social Psychiatry*, **38**, 50–58.

GIEL, R. (1987) The jigsaw puzzle of Dutch mental health care. *International Journal of Mental Health*, **16**, 152–163.

GOLDBERG, D. & TANTAM, D. (1989) The public health impact of mental disorders. In *Oxford Textbook of Public Health* (Eds W. Holland & R. Detels) pp 267–279.

HAERLIN, C. (1987) Community care in West Germany: concept and reality. *The International Journal of Social Psychiatry*, **33**, 105–110.

HEST, F.P. & WOLTERS, R.J. (1992) Deeltijdbehandeling in Engeland en Wales. *Tijdschrift voor Psychiatrie*, **32**, 354–361.

HOLLOWAY, F. (1990) Caring for People: a critical review of British Government policy for the community care of the mentally ill. *Psychiatric Bulletin*, **14**, 641–645.

JONES, K. & POLETTI, A. (1985) Understanding the Italian experience. *British Journal of Psychiatry*, **146**, 341–347.

KUNZE, H. (1977) Psychiatrie-Reform zu Lasten der chronischen Patienten? Entwicklungstendenzen der stationären Versorgung chronisch Kranker in England, den USA und der Bundesrepublik Deutschland. *Nervenarzt*, **48**, 83–88.

MANGEN, S. (1987) Mental health policies in Europe: an analysis of priorities and problems. *International Journal of Social Psychiatry*, **33**, 76–82.

PEDERSEN, B. (1987) Housing and employment: rehabilitative measures in Denmark. *The International Journal of Social Psychiatry*, **33**, 137–139.

PIETERS, D. (1990) *Introduction to Social Security Law of the Member States of the EC*. Brussels: Bruylant.

REGIONAAL INSTITUUT VOOR AMBULANTE GEESTELIJKE GEZONDHEIZORG (RIAGG, 1992) *RIAGGs in Cijfers*, Amsterdam: NVAGG.

RÖSSLER, W. & SALIZE, H.J. (1994) Longitudinal statistics of mental health care in Germany. *Social Psychiatry* (in press).

ROWLAND, L.A., ZEELAN, J. & WAISMANN, L.C. (1992) Patterns of service for the long-term mentally ill in Europe. *British Journal of Clinical Psychology*, **31**, 405–417.

SARANTIDIS, D., KLADOUCHOS, V., TRIPODIANAKIS, J. *et al.* (1992) The reform of psychiatric care in Greece: 1983–1989. *European Psychiatry*, **7**, 251–257.

SCHRAMEIJER, F. (1987) New comprehensive mental health authorities in The Netherlands. *International Journal of Social Psychiatry*, **33**, 132–136.

TYRIE, C.M. (1992) Mental health services in Germany. *Psychiatric Bulletin*, **16**, 40–42.

VAN OS, J., GALDOS, P., LEWIS, G., MANN, A. & BOURGEOIS, M. (1993) Schizophrenia sans frontières: concepts of schizophrenia among French and British psychiatrists. *British Medical Journal*, **307**, 489–492.

—, & NEELEMAN, J. (1994b) Mental illness in Europe. *British Medical Journal* (in press).

—, OSACAR, A. & SEGOVIA, M. (1992) Rehabilitación de los manicomios? *Anales de Psiquiatria*, **10**, 383–388.

WALLACE, M. A caring community? *Sunday Times*, 3 May 1987.

*Jim van Os, *MRC Training Fellow and Honorary Lecturer, Department of Psychological Medicine, King's College Hospital and Institute of Psychiatry, London SE5 8AF; and* Jan Neeleman, *Senior Registrar, Maudsley and Bethlem Royal Hospital, Denmark Hill, London SE5 8AF*

*Correspondence: Institute of Psychiatry, De Crespigny Park, London SE5 8AF

https://doi.org/10.1192/pb.18.7.390 Published online by Cambridge University Press