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Gert Schout, PhD, until 2012 Professor Public Mental Healtcare, School of Nursing, Hanze University of Applied Sciences, Groningen, the Netherlands. Now he is a senior researcher at the Department of Medical Humanities, VU Medical Center, Amsterdam, the Netherlands.

Gideon de Jong, MSc, Researcher, School Social Studies, Hanze University of Applied Sciences, Groningen, the Netherlands.
Correspondence to: Gert Schout, School of Nursing, Hanze University of Applied Sciences, Eyssoniusplein 18, 9714 CE Groningen, the Netherlands
E-mail: g.schout@vumc.nl

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PUBLIC MENTAL HEALTHCARE: TOWARDS A SUPERFLUOUS SAFETY NET

GERT SCHOUT,
GIDEON DE JONG

ABSTRACT

Public mental healthcare: towards a superfluous safety net
This paper contests the merits of Public Mental Healthcare (PMHC) and examines the mission and structure of PMHC as a service. A description of the mission and structure of PMHC as a service is lacking, and even reflections on the type of service provided are scarce. In market-driven healthcare systems, the power of self-care and informal care is overlooked leading to excessive forms of professionalism. The resources of civil society are also neglected and leading to a loss of quality and price increases. Thresholds, budget cuts and the inaccessibility of services that come with it, form the background of a safety net such as PMHC. Integrated and accessible care is not within reach for people with multiple and complex problems. The very existence of PMHC is related to the rise of commodification, consumerism and the decline of primary healthcare values.

This paper draws on a literature review and on theoretical and practical informed reflections. It argues for a revival of the values of self-care, informal care and primary healthcare.
We advance a description of PMHC that reflects the dynamics between this service and Primary Healthcare, Community Mental Healthcare, and the support that civil society can offer: PMHC is a safety net to counter the lack of an accessible, comprehensive, integrated and coordinated system of community mental healthcare, aiming for the health, wellbeing and inclusion of underserved groups. This description implies that if regular agencies had these qualities, PMHC would become superfluous. It is not the development of Public Mental Healthcare that is worth pursuing, therefore, but the development of services that would render Public Mental Healthcare superfluous.

Keywords

Public Mental Healthcare, Community Mental Healthcare, Primary Healthcare, Civil Society

SAMENVATTING

Openbare geestelijke gezondheidszorg: op weg naar een overbodig vangnet
Internationaal is er niet alleen weinig gepubliceerd over de Openbare Geestelijke Gezondheidszorg (OGGz), er is bovendien verwarring over wat het precies is en hoe het aangeduid kan worden. Een beschrijving van de missie en de structuur van de OGGz als uitvoerende organisatie die internationaal (h)erkend wordt, ontbreekt. Zelfs reflecties op dit type dienstverlening zijn schaars. In dit artikel wordt het bestaansrecht van de OGGz in twijfel getrokken en er wordt een beschrijving gegeven van de missie en de structuur van de OGGz als uitvoerende organisatie. In marktgerichte gezondheidszorgsystemen wordt de bijdrage van zelfzorg en mantelzorg gemakkelijk over het hoofd gezien. Dit leidt tot excessieve vormen van professionele inzet en navenante stijging van kosten; kosten die weer afgeremd moeten worden door productieplafonds, aanscherping van indicaties en drempels die de toegankelijkheid van de hulpverlening nog verder bemoeilijken. De ontoegankelijkheid van de hulpverlening vormt de achtergrond van een vangnet als de OGGz.
Bij gebrek aan generalistische en toegankelijke hulpverlening voor mensen met meervoudige en complexe problemen, ontstaat de behoefte aan een vangnet. Het bestaan van de OGGz hangt samen met commodificatie en de opkomst van een marktgerichte hulpverlening waarin de patiënt gezien wordt en zich gedraagt als consument, maar ook met de neergang van de eerstelijnszorg. Dit artikel, dat gebaseerd is op literatuuronderzoek en op theorie-praktijk reflecties, pleit voor een heroriëntatie op zelfzorg, mantelzorg en de waarden die verbonden zijn met primary health care.

Het artikel sluit af met een beschrijving van de OGGz die de dynamiek weerspiegelt tussen de eerstelijnszorg, de tweedelijns GGZ, en de hulpbronnen die de civil society op de been kan brengen. Deze luidt als volgt: de OGGz is een vangnet dat zijn bestaansrecht dankt aan het ontbreken van toegankelijke, generalistische en gecoördineerde hulpverlening, met als doel de gezondheid van achtergestelde groepen te bevorderen. Dit impliceert dat als reguliere instellingen deze kwaliteiten zouden hebben, de OGGz overbodig wordt. Daarom, steek geen energie in de ontwikkeling van de OGGz, maar steek die in het overbodig maken ervan.

Trefwoorden

Openbare Geestelijke Gezondheidszorg, eerste lijn, tweedelijns GGZ, Primary Healthcare, Civil Society

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INTRODUCTION

Public Mental Healthcare (PMHC) is a contested concept and any description of its merits and functions will give rise to all sorts of disputes (see for instance Rutz, 2006). This is reflected in public mental health policies all over the world as "in some countries, mental health policies are restricted to psychiatric services [while] a broader scope is preferable" (Patel, Flisher & Cohen, 2006, p. 380). These disputes cannot be settled by appealing to empirical evidence or logic, this certainly applies to the debate presented in this paper. Establishing an agency like the PMHC seems such a humane effort. In this paper we will demonstrate that not the development but the superfluousness of this agency is worth pursuing.

In most Western societies, PMHC facilities serve as a safety net for clients who would otherwise not receive any help. PMHC in the United States and other countries with market-driven healthcare systems serves as a safety net for uninsured clients and provides care that other agencies do not offer. Worldwide, the lack of a comprehensive, integrated and coordinated system of Community Mental Healthcare (CMHC) explains the need for a safety net such as PMHC (Schout, De Jong & Zeelen, 2011). PMHC provides care for all kinds of underserved groups such

as patients with dual diagnoses, illegal immigrants without insurance, mentally disabled and frail elderly people with complex health needs, isolated persons with poor daily living skills (Patel *et al.*, 2006).

Although the World Health Organization has defined mental health (see World Health Organization (WHO), 2001), a description of the mission and structure of PMHC *as a service* is lacking. The definition of the WHO (2001) reflects an ambition that is hard to realize: "A state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community". This definition embodies an ideal, not a service or a description of an agency. The aim of this paper is to explore the need for and merits of a safety net such as PMHC. In this paper we will question the existence of PMHC by rethinking the purpose and structure of this agency.

BACKGROUND: THE NEED FOR PMHC

The discrepancy between the WHO definition of Public Mental Health cited above and the reality of underserved groups is striking. More than 200 million persons live with a mental disorder in the world and in developing countries the proportion is higher as a result of persistent poverty-driven conditions, demographic transition, conflicts in fragile states and natural disasters, all of which push up the number of mentally ill persons rapidly. At the same time, over 50% of developing countries do not provide any care for persons with mental disorders in the community. These disorders lead to significant hardship, not only for those who suffer from them but also for their caregivers (often family members), given the lack of mental health resources found in developing countries (Reijneveld, 2005). Rightly, Reijneveld designates mental health as a public health issue. Not only do developing countries lack access to mental health services, but there is a worldwide need for a safety net for underserved groups. In low-income countries civil society serves as safety net (Hyden, Court & Mease, 2003), while in high-income countries the state steps into this role. This raises the question of whether this can be regarded as progress and if so, what are the responsibilities of the professional society and what are the responsibilities of civil society? And how can the two cooperate?

The WHO (2005) has issued a set of guidelines that calls for a community-based approach that allows easy access and availability for the majority of the population. Despite all this, Saxena, Thornicroft, Knapp and Whiteford (2007) characterize the resources for mental health as scarce, inequitable, and inefficient. Their argument, however, is focused on low and middle-income

countries. How can the need for a safety net be explained in high-income countries? A previous report from the WHO (2008) on Primary Healthcare (PHC) sheds light on this matter. While in low-income countries the need for a safety net like PMHC can be explained by a general lack of economic and political resources, in high-income countries the need for such a safety net can be explained by a lack of accessibility. The WHO criticized the equity and accessibility of healthcare in market-driven healthcare systems in Western societies. Services are fragmented and deal with single aspects of service and treatment. Social care (for housing, income and activities) and medical care (for addiction, mental and physical health problems) ought to be addressed simultaneously, but the complexity of rules and infrastructure and the budgeting of services hinder integrated care. Often regulatory barriers, thresholds, waiting lists and lack of insurance hamper access to healthcare (Schout *et al.*, 2011). Moreover, the WHO (2008) points out that professionals in a market-driven healthcare system hinder the involvement of civil society (see also Stadelmann-Steffen, 2011). In a market-driven healthcare system, providers of welfare and care look for ways to expand their services, not ways to activate informal care. When this entrepreneurship exceeds certain limits, budget cuts, waiting lists and thresholds are introduced to inhibit access to regular care and welfare. Barker and Buchanan-Barker (2008) point out how modern psychiatry with its focus on containing and curing madness has evolved into a mental health industry, where almost every aspect of human life is presented as a mental disorder. Market-driven incentives and existing uncertainty, as we will point out later on, drive up demand for professional deployment and in turn give rise to new barriers that hinder the accessibility of services. The call for an agency that deals with those who do not find their way through these barriers is born. This is the argument for PMHC in high-income countries in a nutshell.

METHODOLOGY

The discourse developed in this paper draws on a literature review and reflections informed by theory and practice. The number of international publications in scientific journals that deal directly with PMHC is limited (n=55 since 2002). The number of publications that address the accessibility of healthcare for underserved groups, however, is vast. The process of searching, narrowing down, reflecting, discussing and tentative writing in national journals, lasted for 2 years, and has led to the narrative presented in this paper. The objective was not to amass findings that could produce timeless and context free conclusions; rather, we focused on gathering facts, thoughts, views, reflections on PMHC and the systems adjacent to the PMHC, aiming for a narrative that helps to understand what's going on.

A superfluous PMHC – the narrative we present to postulate a way out of further commodification – can be viewed as an ideal type (Weber, 1949); an exaggeration of conditions that are not normally present in reality. This is done to promote theoretical understanding. Weber developed his notion of ideal types "to bring order into the chaos of those facts which we have drawn into the field circumscribed by our interest" (p. 105), in order to comprehend reality, to find the appropriate language for interpreting the actions the observed and to create generic concepts that "summarize the common features of certain empirical phenomena" (p. 100).

THE CASE OF THE NETHERLANDS: OVERCROWDED WAITING ROOMS AND BUDGET CUTS

In this section we will explore how market incentives convert healthcare professionals into entrepreneurs. The rise of professionalism that comes with this undermines the vitality of three systems: (1) self-care and informal care, (2) primary healthcare, and (3) community mental healthcare. We demonstrate this by analysing policy and practice in the Netherlands.

With a budget of €87.6 billion – over 10% of gross domestic product – healthcare is the largest and fastest growing part of the public sector in our country (CBS, 2012). There is a strong desire among policymakers to put a brake on this unbridled growth with new policies – policies, as we will demonstrate, that are actually accelerating the emerge of PMHC. The debate on limiting volume growth revolves around reduction of the insurance package, raising patient contributions and the role of insurance companies in cost containment, and introducing a degree of regulated competition. Rosenau and Lako (2008) point out that there is little reason for optimism that market forces will contribute to cost reductions in the Netherlands. They are even unsure whether the assumptions of economic theory apply to the health sector. The promise of lower public healthcare expenditure, enhanced cost containment and increased quality of service through market forces remain unfulfilled, both in the Netherlands and elsewhere (Gechert, 2010; Hsia, Kothari, Srebotnjak & Maselli, 2012; Okma, Marmor & Oberlander, 2011; Unger, De Paepe, Sen & Soors, 2010). Nevertheless, the Dutch government continues to develop more market incentives. The facts would appear to indicate that these incentives are leading to more expensive healthcare, but this does not seem to influence current policy. A recent experiment with free prices in dental care led to increased prices in this field (ANP, 2012). The idea that competition and free prices make healthcare more efficient and cheaper is not borne out by the facts. Competition turns every professional in healthcare into an entrepreneur, someone looking for new markets. Wherever there are new specialist treatment centres, unexplained increases can be seen in the numbers of

transactions carried out (Ten Have, 2011; Van Weel, Schers & Timmermans, 2012). Whether these extra transactions contribute to better health – or worse, cause harm – remains unknown.

In the era of public supply-driven funding in the health sector – the period prior to 2003 – institutions and professionals had an interest in patients not returning too soon. A fixed budget ensured that professionals looked for self-care and informal care wherever possible. Nowadays, professionals focus on initiating diagnosis treatment combinations (DBC) and turnover. This applies not only to the care provided in General Hospitals (funded by the *Zorgverzekeringswet* or Health Insurance Act, Zvw) but also for the long term care in home care and nursing homes (funded by the *Algemene Wet Bijzondere Ziektekosten* or Exceptional Medical Expenses Act, AWBZ). The institutions funded by the AWBZ need an indication of the intensity of care, preferably an indication with sufficient weight to finance their services. This has triggered an unprecedented rise in medicalization in the Netherlands, leading to ever larger claims through the Zvw and the AWBZ arises. The government has tried to limit these claims through budget cuts, waiting lists, thresholds, tighter indications and further rounds of cuts. The latest measure aimed at reserving the AWBZ mental retardation service for people with an IQ of below 70 is an illustration of this. Only people with an IQ lower than 70 are entitled to use facilities funded by the AWBZ. This type of measure drives actors further into the logic of disease, which focuses on symptoms, etiology, prognosis and therapy. This logic is related to a different logic: the logic of bureaucracy that focuses on monitoring, control, accountability, registration and transparency. According to this logic, the hours and minutes of professionals are only declarable if they refer to a diagnosis treatment combination (as indicated in the Zvw) or an indication for the intensity of care (as indicated in the AWBZ). The logic of the bureaucracy leads to the emergence of the disease logic and vice versa. So healthcare not only increasingly focuses on disease and treatment, it is also becomes less accessible and more expensive. Incentives to prevent disease and reduce production are lacking (see Figure 1).

In a way, healthcare professionals are being expected to jump over their own shadow. Of course, they should promote self-care, informal care and client autonomy, but at the same time they do not want to undermine the competitive position of their organization or make themselves redundant. Policymakers have high hopes that health insurance companies in the Netherlands can cut spending, but producing a full waiting room has become a reflex that cannot be curbed by insurance companies. The motivation to withstand market forces and profit maximization is too weak, however. This leads to three dangers: price increases, inaccessibility and declining quality. Prices increase because providers seek to expand their market share but also because patients act as consumers, claiming their right to all possible treatments. Prices also increase due to the

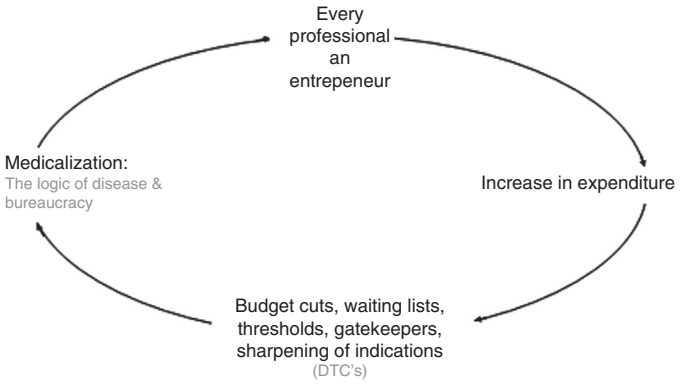

Figure 1: The need for a safety net

bureaucracy associated with market-oriented healthcare which produces higher administrative costs (Gelormino, Bambra, Spadea, Bellini & Costa, 2011; Marmor, Freeman & Okma, 2009; Okma *et al.*, 2011). Inaccessibility is caused by production limits, thresholds, indication barriers, patient contributions and gatekeepers that are meant to slow the unfettered growth that is being generated. Finally there is loss of quality due to over-diagnosis and over-production that do not serve health. This is illustrated in the figures of the country with the most market-oriented healthcare system, the United States. This country spends the most money annually per capita (almost US$7538) and performs poorly with a life expectancy of 78.2 years. In Japan, by way of comparison, people live almost 5 years longer (82.5) and spend considerably less on healthcare (US$2729 per capita annually)[1] (see also Muennig & Glied, 2010).

These three dangers are together producing a growing number of underserved groups; clients who cannot get past the barriers (gatekeepers, waiting lists, thresholds, indications) that have been put in place. Whether competition is suitable as a driver of healthcare or not, it sets in motion a logic that creates more markets and more turnover, processes that in turn need to be slowed down by barriers that govern a safety net like PMHC.

THREE FAILLING SYSTEMS

In this section we concentrate on the existence of safety nets in Western societies with market-driven healthcare systems. In a previous paper we have described the problems of fragmentation,

overspecialization, and counterproductive competition explaining the rise of PMHC (Schout *et al.*, 2011). In high-income countries with market-driven healthcare systems, services are tailored to insured individuals, the competition and specialization that comes along with it does not work well with integrated services and community-based provisions. A community-based healthcare system is difficult to establish in the context of consumers seeking the best prices and quality of health services (Unger *et al*., 2010). In order to understand what is going on we need to look more closely at the failure of three systems. There are three because clients have three kinds of resources before they are helped by PMHC: self-care and informal care, primary healthcare and the more specialized services of mental healthcare.

The first system is the system of self-care, informal care and the resources that civil society can offer. Not only are professionals in market-driven organizations disinclined to appeal to informal care, potential clients themselves do not see themselves as sources of strength and resilience. Furedi (2004) points out that individuals are uncertain and unable to deal with disappointment, setbacks, rejection, and stress, and market-driven organizations magnify this vulnerability. Furedi describes the rise of a therapy culture. Within this culture experts are the only legitimized authority for solving problems.

Furedi's empirically based research resembles the classical and theoretical informed research of Illich (1975, 1977) who described the age of the disabling professions, referring to the emergence of commodification and the rise of experts that comes with it. The professional dominance in his view undermines people's confidence in themselves and in their capacity to solve problems.

The second system is the system of primary healthcare facilities. The WHO (2008) notes that the provision of primary healthcare is obstructed and that health systems focus disproportionately on a narrow range of specialized curative care. Primary healthcare values need to be restored, it argues. Short-termism in healthcare policy is resulting in fragmentation and discontinuities in service delivery. A focus on tertiary care is hindering the involvement of primary care and community participation.

The third system refers to community mental health services that reach out to the community. In 2005, the WHO signalled the urgent need for countries to provide a network of community mental health services. Based on a study into the mental health system of 17 low and high-income countries, Wang *et al*. (2007) conclude that the unmet need for mental health treatment is especially pervasive in less-developed countries, but also extends to high-income countries. A shortage of mental healthcare providers, health plan barriers, the lack of recognition for mental

healthcare on the public-health agenda and in primary care, the centralization of services in big cities and large institutions, the stigmatization of mental illness, and a lack of coverage – all of these factors produce barriers to mental healthcare (see also Cunningham, 2009; Horton, 2007; Kathol, Butler, McAlpine & Kane, 2010; Knapp *et al*., 2006; Patel *et al*., 2006; Saraceno *et al*., 2007).

If the three systems do not cooperate, but act as segregated physical and mental health practices, clients with complex healthcare needs will experience the effects of discontinuity and fragmentation (Kessler, 2012; Schoen, Osborn, How, Doty & Peugh, 2009; Schoen *et al*., 2011). It is exactly these clients who are not helped easily through a narrow, curative-oriented environment and will end up in the safety net of PMHC.

Reaching out, making contact, gaining trust, mediating and guiding clients back to regular organizations – which together make up the core of PMHC – would appear to be such a humane effort, but it remains a stopgap for failing systems.

TOWARDS A SUPERFLUOUS PMHC

To understand the merits of PMHC, we refer to the study of Bauman (2004) on "Wasted Lives", the population of migrants, refugees and other outcasts. Bauman points out that social order creates exclusion. Castle walls, city limits, national borders, licenses, include those who have the proper requirements, but they also exclude those who do not (see also Marks, 2011). Only chaos encloses to everyone. In the field of PMHC we see this in the proliferation of new organizations, further professional specializations and the rise of new indications and contra-indications which determine and govern access to services. Bauman's argument refers to modernity: we do not advocate a return to the pre-modern world, nor do we seek to romanticize the past, but Bauman's argument can prevent us from stepping into the trap of creating new structures that in turn produce new social waste.

Following this line of reasoning would mean simplification – avoiding further specialization and fragmentation and resisting the emergence of new safety nets. The WHO (2008) advocates such a simplification. In order to yield better and more equitably distributed health outcomes, the WHO recommends spreading primary healthcare values to all countries: a community-based equitable healthcare system that seeks to integrate public health actions with primary care, a shift from tertiary to primary care and the involvement of civil society (see also Saraceno *et al*., 2007). These values are prominent in the figure of the seesaw (Figure 2).

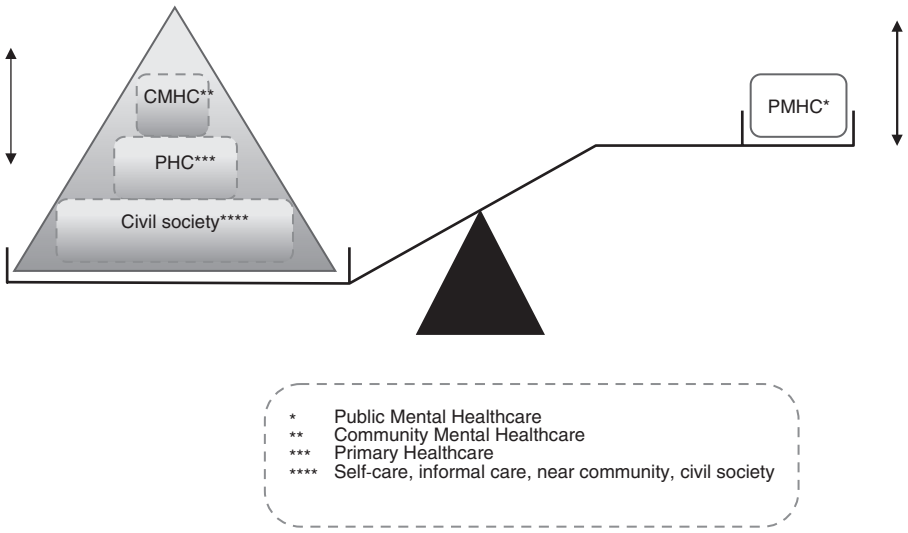

Figure 2: The dynamic seesaw, demonstrating an almost redundant Public Mental Healthcare

The seesaw demonstrates three forces: 1) the informal care provided by families, near communities and civil society, alleviating professional help in general; 2) primary health agencies alleviating community mental health, and finally; 3) community mental health agencies alleviating PMHC until it becomes almost superfluous. To achieve a superfluous PMHC, every client entering PMHC is a case to learn from. Why is this person not receiving informal support? Why is this person not being helped in the regular settings? Why is professional help called in? How can regular organizations learn to deal with clients with complex needs?

IMPLICATIONS FOR PRACTICE

If civil society is overlooked, if primary care is disregarded and, finally, if community mental health services are poorly prepared, and if in addition these three systems do not cooperate but act as segregated physical and mental health practices, the need for a safety net like PMHC is all the more urgent. These observations are important for nurses and social workers for various reasons. The majority of professionals in PMHC, PHC and CMHC are nurses and social workers. Furthermore, the essence of our conclusion is that the potential for self-care and informal care

is overlooked, causing excessive forms of professionalism to emerge. Enabling the potential of self-care and informal care is the core mission of the professionals operating in the field of social interventions (nursing, social work). Theoretical and practice-based reflections are required to initiate this debate, but leadership in care and welfare is required to bring this debate to the periphery of care practices and address the decline of primary healthcare values that we identify in other forums. It is for this reason that we seek to initiate this debate in *Journal of Social Intervention: Theory and Practice*.

We suggest a description of PMHC that reflects the dynamics between community mental healthcare, PMHC and the support provided by civil society. The description is not meant as a definition that will apply for all time and in all contexts, but rather as a means of understanding why a safety net like PMHC is needed and how it could come to be rendered virtually redundant. In this description, the existence of a PMHC refers to failing systems, either through a lack of resources, lack of access or lack of coverage. The worldwide absence of community mental health services and the neglect of civil society in high-income countries are at the root of this. We postulate PMHC as a safety net to deal with the lack of an accessible, comprehensive, integrated and coordinated system of community mental health that strives to achieve the health, wellbeing and inclusion of underserved groups. We have intentionally avoided the verb *"define"* and used *"postulate"* instead because this description is not meant as a permanent and unchanging definition, but rather as a narrative that can reflect the changing state of the three systems we described.

Following the argument of this paper, it is not the development of PMHC that ought to be our goal, but rather the vitality of civil society, primary healthcare and community mental health services. The vitality of these three systems can be viewed as the focus of the key disciplines in care and welfare (Anderson & McFarlane, 2010; McMurray & Clendon, 2010).

NOTE

1 Life expectancy figures retrieved from the CIA World Factbook 2009 and from the 2006 revision of the United Nations World Population Prospects report, for 2005–2010. Health expenditure figures are retrieved from The Directorate for Employment, Labour and Social Affairs, OECD Health Data 2011.

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