SCANDINAVIAN FAMILY CARE AND PSYCHIATRY*

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IT IS generally agreed today that a large proportion of family or general practice, variously estimated at from 10 per cent to 50 per cent, is essentially within the field of psychiatry. It is also certain that, unless the family practitioner is prepared to treat his psychiatric invalids, most will go untreated, as there can never be enough specialist psychiatrists to undertake this work, and it would be wrong if they were asked to do so. Experience of family care under National Health Service conditions in Britain since 1948, and in North America during 1962 (Rorie, 1963), convinced the writer that standards of psychiatric practice at the hands of the family practitioner, are determined in large part by the conditions of service under which he works.

If one takes the British and American conditions as two extremes, the former being comprehensive and 'free' to the patient, and the latter involving payment of the physician for services rendered, it seems that the health services of Scandinavian countries might provide a mean between the two. The purpose of this study was to compare the physician's handling of psychiatric illness outside the hospital in Denmark, Sweden, and Norway, with that in the United Kingdom, with special reference to the differing conditions of practice in the various countries.

The method of study was to undertake a month's tour by road through the three countries, seeking interviews with family practitioners and also with psychiatrists, and assessing standards of psychiatric care and the effects thereon of conditions of service under which the practitioner worked.

Social conditions and medical practice

The populations of the three countries visited are relatively small

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in relation to the geographical area, and, although they are closely related historically and socially, there are noticeable differences in their various health services. These differences can be related to several factors, the most obvious being geographical distribution of population, economic wealth, and ratio of medical practitioners to population.

While the family practitioner of Britain is becoming less of a generalist, relinquishing many of his specialist skills to the full-time consultant working from centralized hospital services, terrain and distance make it essential for the many isolated physicians of Scandinavia to be traditional general practitioners. They must retain their skills in minor surgery, gynaecology, and laboratory techniques as many practitioners do in North America, but which are superfluous to the great majority of practitioners in industrialized Britain. This inevitably limits time and interest in the handling of psychiatric illness, the more so because the fee-for-service system of remuneration has the fault of encouraging organic medicine at the expense of time-consuming psychotherapy.

Denmark differs from her two sister countries in having a flat, evenly populated countryside with relatively few cities, and so here centralization of hospital services might be envisaged as is the case in Britain. This would be quite impossible in Sweden and in Norway, where there exist many very isolated communities which must supply their own medical needs.

As in most European countries there is a grave and increasing shortage of medical practitioners throughout Scandinavia, and the constant drift to the cities leaves rural districts sadly under-doctored. Sweden is in the most critical of all shortages, having a population doctor ratio of about 1,200. Denmark and Norway are in the slightly more favourable ratio of 800/900, which compares with that in the United Kingdom. Each country has two medical schools training 150–200 practitioners annually, but this is barely sufficient to cover normal wastage. Sweden has had to import a large proportion of foreign medical ' labour ', and students from Norway have often to go abroad for training, and do not always return to practice in their native country on graduation.

Scandinavian countries are all advanced in degree of ' socialization ', and they are all proud of their claim that there are very few extremely wealthy or poor people, so that all can afford to pay something individually for medical care. In spite of this, however, one gained the impression that Britain's medicosocial system was in many ways more extreme. Discussing this with a Soviet representative at World Health Organization in Copenhagen I was told that, in Russian eyes, the British system of medicine was much closer to their own than any other. In a scale with extremes of U.S.S.R. and

U.S.A., the degree of 'socialization' were suggested as U.S.S.R., Britain, Denmark, Norway, Sweden and U.S.A. I could not disagree with this view.

It was very interesting also to hear that in the Soviet Union some recognition was now being given to the importance of personal relationships in medical treatment, and that Pavlovian concepts no longer monopolize the field of psychiatry.

Economic factors and medical practice

All three countries have similar comprehensive health services financed by compulsory contributions to a health insurance fund which, although not controlled by the government, is subsidized from taxation revenue. On the other hand, most provincial hospitals are financed by local rather than by central government sources. Economic differences between regions affect potential medical services. Both Denmark and Norway consider themselves relatively poor countries, and doubt whether their economy could support a fully comprehensive health service. In both there is a fear of abuse of a free service by the patient, and as described below, great efforts are made to distinguish between what is necessary and what is unnecessary in medical care. On the other hand, the average patient seems to accept the present economic facts and realities which control the provision of community medical services, and one does not hear of any great discontent on his part as is relatively common in North America.

Family practitioners are paid on a fee-for-service basis in Norway and Sweden, and on a capitation basis with a smaller fee-for-service payment in Denmark. Generally the patient is responsible for 25 per cent of the physician's fee, and 75 per cent is refunded or paid by insurance funds. Although the practitioner can charge what he likes, there are lists of approved fees on which refund is based. Costs of approved drugs are refunded on a similar basis.

The medical practitioner on the whole appears to be relatively more prosperous than his British counterpart. Certainly family practitioners are more content with their conditions of work, and the vast majority appear to be happy in the service. This may be due to the fact that there is, in both Denmark and Norway at least, still a high proportion of general practitioners to specialists. A ratio of seven to three gives them great bargaining power in negotiations with their governments. It was stated that in original negotiations, the overall remuneration for a doctor was calculated on a working day of eight hours, and fees were agreed accordingly. However most doctors work longer hours than this, and so can earn moderately high incomes. This is counterbalanced by a rate of taxation which is higher than in Britain and which rises so steeply after about £3,000

per annum that doctors simply reduce their working hours after this point. This will obviously aggravate the already present shortages in medical services.

Special fees are charged for work after 4 p.m. and for home calls. Night work is taken over by an emergency service provided by the hospitals, which relieves the practitioner of the 24 hours responsibility of the British doctor. There is, however, no special fee for psychotherapy by the family doctor, and while many do carry out this work, the temptation is always present to perform other simple office techniques by which three or more items of service are carried out at the same time.

As in North America, ancillary nursing help is common, but under a system in which the nurse can carry out simple items of investigation and leave the physician more time to carry on with other services, the employment of help ceases to be a charge on the practice and actually becomes a self-supporting source of income. This contrasts painfully with conditions in our country where the employment of ancillary help is at present a charge on the individual practitioner.

In Sweden although the system of remuneration is similar, three-quarters of the fee being refunded to the patient, the pattern of family care differs considerably from that in her sister states. There is a swing towards the American way of practice, with physicians working from well-equipped polyclinics, and tending towards specialization. Although several physicians were encountered who were practising personal care, I met none who would fit the traditional picture of the family doctor common to Norway, Denmark and the United Kingdom. It is probable, however, that they still exist in smaller country districts. The general impression was that doctors were moving towards clinics, hospitals, and industrial medicine, and in doing so were removing themselves from direct personal relationship with the patient and his family.

In comparison with her neighbours Sweden is economically prosperous, but this prosperity is not reflected in the provision of first line medical service. In spite of the fact that the government has organized a system of highly paid district doctors for country areas, many of these posts are unfilled and there are few applicants for vacancies. It is difficult to attract physicians from the urban areas. Similar difficulties are met in the provision of nursing services, and lack of staff makes it impossible to obtain full benefit from new hospital building programmes. Many departments have to close or refuse patients during the summer months as staff is not available.

In all Scandinavian countries the family doctor's practice is not so clearly defined as in Britain, and few could tell me for how many

patients they were at risk; the capitation basis in Denmark is based only on adults of over 16 years of age. The fee-for-service system elsewhere allows the patient to go from doctor to doctor with the same complaint if he so wishes, and this must mean much unnecessary duplication and expense. The danger of over-doctoring and of the physician carrying out unnecessary work is said to be controlled by professional committees who act as referees.

The virtues of the system were obvious in the industry and relative contentment of the profession, and one often heard the argument that a contented profession must be giving a better service than a frustrated one. In such a short visit it is impossible to give a valid judgment on this, but it must be recorded that without exception the practitioners visited were of as high a quality as found in the best in the United Kingdom and North America.

Prescribing trends and drugs

In a survey of general practice it has proved useful to study prescribing trends, and the opportunity was taken of visiting a pharmacist to discuss the subject while in Denmark.

Drugs are not provided free of charge in any of the Scandinavian countries, owing to fears of abuse, and also to anxiety about the expense to insurance funds. Generally there is a list of approved drugs, three-quarters of the cost of which is paid by the insurance body. Whether the drug is approved or not is independent of its efficacy, but dependent rather on the chronicity of the complaint for which it is administered. Hence it was that insulin was the first preparation to have insurance coverage, followed by corticosteroids in Addison's disease. An anomaly seemed to be present in that the latter drugs were not approved in the treatment of asthma or eczema, where the patient has to bear full cost. In the field of psychiatry there is obvious conflict. Drugs are allowable in the treatment of psychoses, though sometimes only on prescription of a specialist, and tranquillizers are approved in special cases of neuroses. Throughout the whole of Scandinavia there is strong resistance on the part of psychiatrists to the use of barbiturates. They are considered not essential to treatment and dangerous in the possibility of addiction. A further argument against their approval is that they are very cheap in any case, and can be paid for by all patients without hardship.

In a sample of approved drug prescriptions examined, approximately 14 per cent were for drugs used in psychiatry, the most popular being librium which made up five per cent of the sample. In spite of official disapproval, barbiturates were still being extensively used in non-qualifying prescriptions which did not attract insurance refund, and were estimated at 8 per cent of total prescriptions.

The most surprising feature was the absence from the approved list of drugs of antibiotic preparations. The explanation given for this was that such drugs are used only in acute illness of short duration, and so do not result in prolonged expense to the patient. At the time of writing, this subject is being discussed between the profession and the insurance authorities, and it is possible that these drugs will soon be approved, especially when their use in the treatment of chronic bronchitis over long periods is taken into account.

Rough pricing of prescriptions showed that the average cost was much the same as in Britain, approximately 8s. to 10s. per prescription.

After experience of prescribing under National Health Service conditions, one felt that there is some virtue in Scandinavian control of drugs. Most practitioners in Britain are conscious of prescribing many unnecessary drugs, but cling to their traditional licence in this matter. Control of prescribing by chronicity of complaint or by expense is probably not an ideal system, but control by accepted efficacy might well be justified.

Psychiatric services

In each of the countries visited calls were made at psychiatric units of general hospitals and at mental hospitals, and some information was sought on the psychiatrist's views on community treatment of neurotic illness.

Lack of trained staff has forced psychiatrists to concentrate their efforts in certain channels. In Denmark for instance, it seems that much work is being done in the field of the psychoses, and little energy and time is spared to cope with the neurotic invalid. Alcoholism and drug addiction present a much greater problem in all Scandinavian countries than they do in Britain. Special units are common for the former, and in both urban and country communities the average practitioner can count scores of alcoholics amongst his patients. They find it difficult to believe that in the United Kingdom the average practice holds only one or two current cases of alcoholism. Government regulations which have made alcohol relatively difficult to obtain, and severe sanctions against driving under the influence, appear to have had little effect in the control of the problem.

As previously mentioned, fear of addiction has almost excluded barbiturates from the proper treatment of mental illness. This contrasts vividly with practice in Britain, where such drugs are still widely used in large quantities and yet present relatively few problems of addiction.

Throughout all Scandinavia outpatient psychotherapy for the

neurotic invalid is a rare commodity due to lack of trained therapists. I was told in Sweden that there were only about 30 trained psychotherapists throughout the entire country, and in one provincial town the waiting time for outpatient treatment was as much as eight months.

Staff varies from one psychiatrist to seven patients in some fortunate small clinics, to a ratio of 1:315 in the larger state mental hospitals. Moreover it was reported that a recent survey of hospital emergencies showed that while medical and surgical items had not increased in a ten-year period, psychiatric emergencies had increased sevenfold. Time is not on the side of the medical planners whose duty it is to meet this growing problem.

While generally I could find little evidence of close collaboration between the psychiatrist and the general practitioner, two projects which point the way to better community mental care deserve special mention. The first of these was the Samso Project at Aarhus, Denmark. Here an investigation has been carried out during the past five years into the use of psychiatric services when given free and easy access through local general practitioners. A psychiatric outpatient service was started in the building where local practitioners have their consulting rooms, and a great deal of home visiting was carried out by the psychiatrists. This proved the value, both to the patient and to the specialist, of treating mental illness in the home rather than in the hospital. Much useful data was also collected on the incidence and prevalence of mental ill-health in a geographically delimited population.

The second, and perhaps the most stimulating experiment was encountered in Norway where, under the guidance of Dr Herluf Thomstad, group instruction of family doctors has for some years been undertaken. It was of special interest to find that this work stemmed from an attempt to reduce the hospital waiting list by specialist home visiting. It was soon realized that outwith the hospital and in the home, there was a tremendous field for useful research and treatment. The result has been a stimulus to family doctors to undertake care of their own mental cases in the home, with a reduction of cases requiring referral to hospital.

Comparisons and conclusions

The main object of this visit to Scandinavia was to compare standards of psychiatric care by the family practitioner and the effects thereon of his conditions of work. The first conclusion forced on one is that standards of medical care are determined in large part by social and economic factors in the country concerned, and not by academic medicopolitical ideals. In other words, what appears to be a good system in one country cannot be translated *en masse* to

another. Although the physician's training is important, the quality of his service is affected by the conditions of service under which he works.

Psychotherapy, which is such an important part of family care, is not encouraged by salary, but it is also discouraged by the fee-for-service form of remuneration where the system is not used to guide practice towards desirable channels. The result is that minor psychiatric problems, which could be easily and efficiently dealt with by the general practitioner, tend under both schemes to be diverted to the hospital service which is already overwhelmed with work.

It is a commonly expressed view that future family medical care should be limited to the fields of internal medicine and psychiatry, with increasing emphasis on prevention and early home treatment. This could best be achieved by conditions of work which include remuneration of the physician by salary (or capitation) basis, supplemented by a fee-for-service payment restricted to the above subjects—or to others thought desirable and necessary. Standards could be kept at a high level by the requirement that practitioners should qualify for these extra payments by undertaking regular postgraduate education. By this means it might be possible to prevent the continuous build-up of untreated mental illness which is threatening both domiciliary and hospital practice in most countries.

REFERENCE

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This study of the Hungarian health service is based on a two week stay in 1963 at the invitation of the Hungarian Health Workers Union. The authors found that the specialist and hospitals services in Hungary are relatively advanced especially in the field of traumatic surgery, a specialty in its own right staffed by highly trained ' traumatologists '. Psychiatry is in a less favourable state, hampered by poor facilities and antiquated regulations. Nursing standards generally are poor. The general practitioner although given a sound medical training has a lowly professional and financial status, he is supplied with equipment, nursing and secretarial staff by the state. A special emergency service deals with calls at night and on Sundays so that the general practitioners work roughly office hours, and they are free to undertake private practice in their spare time. Examinations in a doctor's consulting room are apparently confined to very basic procedures, and patients requiring rectal or vaginal examination or retinoscopy are referred to specialists. In addition, all children under fourteen are looked after by paediatricians, and obstetrics and ante-natal care are also considered outside the field of general practice. The referral rate to specialist and outpatient departments is thus high—70 per cent as opposed to six per cent in Britain. Psychological treatment in general practice is almost non-existent.