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### Geld voor GGZ : de financiering van de geestelijke gezondheidszorg en de invloed van geld op de zorgpraktijk (1884-1984)

Bakker, C.T.

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## **SUMMARY**

In this study it was examined to what extent developments in the practice of mental health care were influenced by changes in the financing system. To that end, the legislation, organization and financing system were explored (chapters I and V); and at six different stages in the history of mental health care, the scope and practice of mental health care have been thoroughly researched (chapters II through IV and VI through VIII). The practice is divided into accommodation, nourishment, treatment and personnel.

### *I Legislation, organization and financing of the asylum care and outpatient services through World War II*

Chapter I describes the financing system, the actual funding, and the financial scope of the asylum care and the outpatient services through World War II, against the background of socio-political changes and economic developments.

Initially, the asylum care legislation consisted of the Insanity Law and the Poor Law. Among other things the Insanity Law (1841) ordained that in case of admission legal authorization was required. The law provided for a State Inspectorate and made the provinces responsible for providing sufficient accommodation facilities. Some provinces (Noord-Holland and eventually also the three northern provinces together) acted as asylum entrepreneurs. Other provinces only entered into a contract with existing or future asylums. In these contracts, among other things, the purchase of a fixed number of beds was guaranteed. The Poor Law charged the municipalities with the payment of the poor patients nursing costs.

The asylum building funding was partly a public matter. Provinces (and on a much smaller scale also municipalities) financed asylum building by guarantees, loans and grants. Private parties also provided building funds. These were often religiously inspired initiatives, in which a form of 'pillarization' (*verzuijing*) can be recognized. Investing in this sector was relatively safe, because purchase and payment were guaranteed.

The asylum exploitation funding was mainly a municipality matter. The municipal payment obligation covered about three quarters of the total amount of patients. The provinces (and up to 1924 also the government) granted subsidies; on average 20 percent of the total nursing costs. Each province made its own arrangements with the asylums. These arrangements had no legal basis.

Patients and their families (spouses, (grand)parents or children) paid according to their means. Municipalities were obliged to pay part of these revenues to the provinces and the government, as a form of compensation for the provincial and governmental subsidies.

The asylum administrations and the provinces together determined the

nursing rates, which were fixed for a long period; inflation correction didn't take place. During World War I the asylums got into great financial problems and this led to a joint asylum assembly. Together with the joint provinces the assembly introduced a new way of calculating prices (tariffs), based on business results. Despite the municipalities paying the bill, they had no say in this.

This organically grown asylum financing system was firmly-rooted and in general persisted until the introduction of the Exceptional Medical Expenses Act (*AWBZ = Algemene Wet Bijzondere Ziektekosten*; 1968).

Through a few decades also outpatient facilities for people with mental problems arose: family care, pre- and aftercare facilities, counselling centres for alcohol abuse, child guidance clinics (*MOB = medisch opvoedkundige bureaus*), centres for family and marriage problems (*BLMG = bureaus voor levens- en gezinsmoeilijkheden*) and institutes for medical psychotherapy (*IMP*). These were mainly private initiatives, some based on religion and in some provinces in close relation with the home nursing services.

The outpatient mental health care organization and financing strongly differed from the asylum care; legislation did not exist. Most of the initiatives started on a small scale and made use of existing facilities, for example the office of the local health service. The financing followed the same pattern as the financing system of other forms of social health care that came into being in the same period (like the infant care and the tuberculosis prevention). The services started out of idealism; caretakers did their job for free. However, without extra money the services could not survive. Municipalities took over or decided to grant a subsidy.

This way a maze of private (and public) initiatives arose, supported by as many different funds: private parties (through legacies, gifts, contributions etc.), municipalities and provinces, and from 1934 onwards also the Prophylaxy Fund, a prevention fund adjusted by the Sickness Law (1930).

The inadequate legal embedding had several disadvantages. In the first place it led to a confusing network of services (a so-called 'patchwork'). In the second place the annual grants caused serious business risks. However, this financial system also persisted for a long period. From 1970 onwards the system was gradually replaced by the *AWBZ*.

## *II The second Insanity Law*

After the introduction of the second Insanity Law (1884) the number of admissions grew rapidly. It cost the government a great amount of money and led to anxious reactions. In chapter II the background of this growth is researched and the relation of this development with changes in the financing system is established.

Within a short time seventeen new asylums were founded. Economic

growth, among other developments, made this possible. The 'pillarization' was also an important influence. Because of the pressure the law laid upon provinces to provide more admission capacity, the second Insanity Law can be seen as a catalyst of this development. The number of admissions grew quantitatively and relatively (compared to the population). The suggestion is made that supply created demand. However, at close sight the fact that new 'beds' were almost immediately occupied, could be interpreted as a signal of formerly latent demand as well.

The annual costs per admitted patient also increased. This actual growth was unravelled too. First, the alleged increase of costs itself was analysed. This proved to be necessary, because source material learned that in contemporary reviews no difference was made between tariffs and actual costs. Several expenditure items appeared to not have grown as much as contemporary authors presumed, others appeared to have risen predominantly because of trends.

Eventually one growing expenditure item remained important: the personnel expenses. During this period these expenses grew relatively from less than twenty up to fifty percent of the total cost and expenses. This growth was caused by trends, by changes in the admission numbers and developments in mental health care content. The asylum care had to resemble hospital care and this demanded a training for nurses. Mental health nursing education arose and more and better educated (and therefore more expensive) personnel was appointed. These changes also took place in general hospital care. Economic growth made the developments possible. Even contemporary authors noticed that it could be a general social phenomenon. Society prospered and more money was spent on health care, including on care for the insane.

### *III A new way of calculating prices (tariffs)*

In chapter III the period before, during and after World War I is analysed. Due to the war inflation some asylums were at risk of going bankrupt. The financial problems brought the institutions together. The solution laid in a new way of calculating tariffs, not based on contract agreements made in the past (sometimes a very long time ago), but on the annual exploitation: a more or less open-ended funding. At the end of the financial year provinces and asylum administrations only had to agree about which expenses were justified.

The new way of calculating tariffs made it easier for the asylums to get business results without too many losses, or even put aside some money for lean years or for future renovations (although this was considered a form of making profit, which wasn't *bon ton*). Finally after the difficult war years there was money for maintenance in arrear and eventually it became possible to introduce new treatment programmes such as the sleep

therapy and the appointment of asylum departments for voluntary admission. Asylums with such a department were renamed 'mental institution' (*psychiatrische inrichting*).

It is hard to prove that there was a direct relationship between the new way of calculating tariffs and the introduction of these new treatments, which in due course were considered to be important improvements. Apart from the inflation, the largest sum of money went to personnel expenses patients did not directly benefit from, such as reduction of working hours, social security and pension premiums. These were features of the first serious prosperity growth in our country.

#### *IV The Frederiks-committee*

Chapter IV discusses the great depression. In 1934 the world-wide economical crisis of 1929 resulted in the establishment of a national retrenchment committee for the asylum care, led by the general secretary of the Home Department Office, K. Frederiks. The Frederiks-committee compared the business results of the mental institutions with the results of the (very inexpensive) state asylum in Woensel. Although Woensel could calculate such low rates because it disregarded requirements made by the State Inspectorate, most of the other asylum administrations were told to economize on their expenses. The Frederiks-committee itself worked out a proposal to intensify the use of capacity; a building stop was imposed with immediate effect.

The economy measures in the mental institutions were, among other things, administrative changes: expensive loans were converted into cheaper ones, depreciation costs were diminished or left out of the business exploitation, the maintenance expenses were cut. Sometimes the nourishment expenses were lowered.

However, the largest amount of money was saved by cutting down on personnel expenses. For a great part this was due to governmental decrees, but the institutions also took measures. Firing personnel rarely occurred, salary reduction did. Student nurses for example received a lower initial salary, certificated nurses who wanted to continue their jobs, were accepted as supernumerary personnel on students wages. Male nurses with marriage plans (whose salary would increase) were kept on a string.

The transfer of patients to cheaper nursing homes caused great expectations, as did the family care and the transfer to society itself (by investing in well-organized pre- and aftercare). Though these measures were examples of false retrenchment: the provisions also cost money and they attracted new groups of patients. Moreover, they were mainly financed from other sources and therefore the expenses remained invisible.

The economy measures presumably caused the patients little annoyance. The fact that mental institutions sustained maintenance in arrear, did not

become visible only until the outbreak of World War II. The measures had, particularly for the salaries of (nursing) staff, great consequences, which patients probably hardly noticed. Also because in the same period the so-called 'more active therapy', especially the main part, i.e. the occupational therapy, was introduced. This made part of the personnel measures less visible: some tasks usually performed by paid members of the staff (for example in the kitchen or the laundry), were now carried out by patients. Resulting in patients getting treated differently than before. No matter how one judges these measures - contemporaries were predominantly enthusiastic - they gave the mental institution society at least a new élan.

*V Legislation, organization and financing of the mental health care after World War II*

Chapter V deals with the changes in the financing system after World War II. At first little happened; the Reconstruction got priority. The reconstruction programme was organized by the Department of Reconstruction, which provided the means and the rules, and the Ministry for Social Affairs, which developed a framework for (mental) health care reconstruction programmes.

The laws regulating the financing of mental health nursing hardly changed. In 1950 the Sickness Funds Decree of 1941 was also applied to the first 42 days of admission in a mental institution. In the beginning it only concerned a small group of patients. The arrangement was extended in 1955 and 1964 to 70 and 365 days respectively. Price dispositions made by the shortly after the war very powerful Directorate of Prices (Ministry of Economic Affairs) were either of short duration, or only partly applicable to the mental hospitals. The Financial Proportion Act (*Financiële Verhoudingswet*; 1960) made an end to the most severe objections adherent to the municipal payment obligation.

The financing system itself remained untouched. The General Social Security Act (*Algemene Bijstandswet*; 1965) substituted the former Poor Act, but for the mental health financing system this made no difference, nor for the tariff calculating system. Like the costs paid by the municipalities, rates paid by the sickness funds were also determined by the provinces and the mental hospitals together. The State Inspectorate either hardly changed. In 1947 the Inspectorate was indeed transferred from the Home Department Office to the Ministry for Social Affairs (later called 'Social Affairs and Health'), but in terms of content nothing changed.

These things are comprehensible because after a short swing (the so-called 'breakthrough' notion) the political climate returned to the pre-war dispositions. There certainly were plans for the mental health care, but all of them got stuck into conservatism. A large part of the mental health care (the private initiatives) still had strong ties with its denominational back-

ground and clung to achievements of the past, not willing to accept governmental interference. On the other hand during the post-war period more 'de-pillarized' assemblies arose.

Though the construction of the welfare state had already begun. In 1968 this development gained momentum when the AWBZ was passed. A new legal framework was created for the institutional mental health care financing. From that day on this was a matter of state government. The first 365 days of admission were still paid for by the sickness funds, but after that the new AWBZ took over. The tariffs were now determined after negotiations between mental health care assemblies and the Health Insurance Fund Council, or between individual mental institutions and local sickness fund offices (*verbindingskantoren*). The Central Institution of Hospital Tariffs (*COZ = Centraal Orgaan Ziekenhuistarieven*) functioned as arbitrator. This institution consisted of representatives of the sickness funds, the mental institution and hospital assemblies, and a few independent experts. This model empowered the health care sector, although the *mental* health care lacked influence.

After World War II the outpatient mental health care gained more governmental subsidy and this guaranteed growth. Yet the complexity of this structure also grew rapidly and for the individual organizations the business risks did not disappear.

After the AWBZ financial system was implemented for the institutional mental health care, the law also step by step became operative for the outpatient services. The pre- and aftercare services (now renamed social psychiatric services) commenced in 1970. The MOB followed. Next, with the aid of the AWBZ, a large outpatient mental health care reconstruction operation started: the so-called regionalization. In the early eighties everywhere in the country outpatient services were merged into regional institutions for outpatient mental health care (*RIAGG = regionale instituten voor ambulante geestelijke gezondheidszorg*). The tariff calculating system of the AWBZ was adopted by the outpatient services.

From the early seventies the COZ had warned that the new financing system could lead to an immense tariff increase because of the open-ended funding. Yet, this very same institution kept issuing new directives which created the possibility of growth, also for the mental health sector. But in the early eighties the economic depression and the huge increase of health expenditures required the government to intervene in the tariff calculating system. After the introduction of the 'budgeting' (in 1983 in the hospitals, after 1984 also in the mental health care) the open-ended funding eventually changed into input financing.

#### *VI Reconstruction*

After World War II more money became available for the mental health

care. With reconstruction money from the government the damaged mental institutions could be patched up. The government allowed the mental institutions to charge an extra percentage on top of the usual nursing tariffs, in which already an amount of money was calculated for depreciation. This extra money was destined for so-called 'renewal funds'. The outpatient mental health services obtained more means, i.e. prophylaxis money and later also state subsidy. Chapter VI describes how the extra money was exactly spent.

The institutions used the reconstruction money and the renewal funds to restore the damage, to rebuild pavilions and to apply technical renewals, but sometimes also to create new provisions on behalf of - for example - the more active therapy. Contributions of the sickness funds and increased nursing tariffs paid for psychopharmacological and other therapeutic changes: during this post war period psychiatric patients faced an increasingly varying scope of therapeutic provisions.

The size of the outpatient mental health care could grow vigorously thanks to extra money from the new Prevention Fund and later on also because of the state subsidies. These provisions obliged the institutions to clarify the size and the content of their activities. But this proved to be very difficult, because every organization employed its own registration system.

Especially the introduction of the renewal funds can be considered a sign that the administrative reflection on the mental health care had changed. Renovating obsolete buildings, expansion of only quantities (number of beds and treatments) weren't the issue anymore. Renewal and improvement became the adagio. Contemporaries considered these changes a major improvement.

However, the question remains if this was only a rhetorical matter, or did financial scope really lead to improvement? The answer is hard to ascertain, because during this time more money was also spent on personnel expenses that had no direct relation with mental health care. Trends such as social security, salary improvement and the introduction of the five days, 45-hours working week greatly accounted for the increase of mental health costs. Here we can see a general social development: the beginning of the welfare state. Institutions had to follow this trend, because personnel was scarce. Even the growth of the personnel was linked with it: this was partly caused by the shorter shifts. Moreover, these shorter shifts made it more difficult to fill in vacancies. This also concerned the outpatient services.

#### *VII A new financing act: the AWBZ*

In 1968 the AWBZ was introduced and in chapter VII the consequences of this for the institutional mental health practice are examined. The con-

clusion is drawn that prosperity growth in the middle of the sixties led to a health care growth (in size as well as in expenses). This was also true for the institutional mental health care, in any case as to the expenditure. This growth mainly took place before the AWBZ was introduced and had nothing to do with the new legislation. A lot of new and higher expenses for the institutions would also have been made without a new law. It concerned higher life standard expenditures, that during this period also have been incurred in other sectors of society (for example the introduction of television). Furthermore, because the new law started with a too small budget, the sector immediately created budget overruns. This led to a call for moderation.

A considerable part of the growth concerned the personnel expenses. They were largely due to inflation and other trends. Even the expansion of the personnel could only be partly retranslated into 'more hands to the bed', because simultaneously the average working time diminished and part-time jobs gradually became operative in the institutions. However, the level of education did change structurally: the amount of educated nurses increased and student nurses were higher educated before they started their study. This also happened elsewhere in society.

The mental health financing was now a governmental matter. For years new calculation models were developed to determine nursing tariffs and increase percentages. The model eventually employed by the COZ used duration of hospitalisation as a measurement. Short-term admissions produced more grades compared to long-term admissions. For chronically ill patients less means were available. At the end of the seventies it became clear that a lot of long-term departments were in a bad shape. 'Action accommodation psychiatry' was created to make up arrears.

### *VIII Forced to cooperate*

From the mid sixties the government set two, and later on three or four objectives for the outpatient health care: the fragmented structure had to disappear, the accessibility had to improve, the expenses had to remain manageable and the amount of admissions had to decrease.

In chapter VIII is shown how the AWBZ was deliberately deployed as policy instrument to achieve this multipurpose goal. Improving the structure wasn't very difficult. There was a great consensus about the question what the problem was. The structure was a complex and inconsistent patchwork and the financing system impeded the solving of this problem. Almost everyone agreed on the solution: by means of 'regionalization'. However; about the way this regionalization should take shape, the opinions differed. Especially the IMP found it hard to accept the forced cooperation.

The second political goal was also more or less realised. The outpatient mental health service grew substantially after the new financing structure was applied to the sector. Especially after the implementation of the RIAGG there was a flood of clients. The RIAGG was a lot easier accessible for the Dutch citizen than the former outpatient services.

However, because the RIAGG predominantly attracted new patient groups the number of admittances did not decrease. Thus the third goal was not achieved, nor the fourth, that was linked with it, despite the fact that the introduction of the RIAGG had to develop without extra costs. Once the founding years were over and the personnel directives for the RIAGG were established (in 1984), the outpatient mental health care grew rapidly, in size as well as in expenditure. The growth partly was on behalf of the inflation, but it also became manifest in a growth of the number of permanent functions, that was linked with an extended demand.

### *Conclusion*

In this chapter the conclusion is drawn that the institutional mental health care was based on a legally firmly-rooted financing system with a long duration and that the outpatient mental health care had to deal with a somewhat chaotic financing system without legal basis. From the end of the sixties onwards this all changed; for both sectors the AWBZ became the financing system. The fact that in spite of the discontent which certainly existed, both systems could last for such a long time, could be explained by the lack of public pressure to change it. The expenses were relatively low and therefore the political necessity to intervene in the structure was also non-existent.

Throughout the entire period the changes in mental health care practice were considered. To begin with it is noticed that during the investigated period the expenses for the mental health care as a whole never decreased nor even stayed the same. The growth consisted of three elements: price development, volume and content of care.

The fact that a large part of the mental health expenditure growth was caused by price development (especially in the seventies of the twentieth century), is an obvious conclusion, but this wasn't recognized by historians before. The mental health care is a very labour-intensive sector and in such sectors price developments create a fly-wheel effect.

Up to World War II the volume development was the most important cause of expenditure growth. At the end of the nineteenth century about one to thousand inhabitants was admitted to an asylum. In the following three decades the amount tripled. The highest admission numbers were reached in 1939, when more than 0.3 percent of the population was admit

ted. During the world war the number decreased, and at the end of the fifties it was back at the old level. After that the number decreased again, among other things by the disappearance of mentally handicapped and people with dementia, to eventually get stuck at a little over 0.1 percent of the population.

The outpatient mental health service growth is less easy to establish, because only from the beginning of the eighties of the twentieth century rather usable registration systems were made use of. After this sector had also been based on a legally firmly-rooted financing system, an enormous increase took place. Between 1980 and 1995 the amount of annually enlisted clients grew from almost 90.000 up to more than 240.000.

In the end the actual expenditure growth - the expenses per nursing day, or per patient or client per year - points to the direct link with the care practice. The increase of the actual price had a relatively autonomous character, more or less linked with the growing prosperity and apart from the current financing system. Mental health care business administration also played an important part. This hasn't been recognized by historians before. The asylum bookkeepers pointed to the importance of their accounting activities for the economic health of the institutions and therefore eventually also for the size and the content of care. The legal anchorage of the mental health care was very important for the continuity of business and among other things this has determined the volume growth. A few examples illustrated that the mental health care practice was also determined by the way the tariffs were calculated.

Changes in accommodation, nourishment and treatment were to a lesser degree determined by shifts in the financing system. Accommodation only became a serious expenditure item when after World War II extra money for renewal funds became available. The part of the expenditure item 'nourishment' decreased during the decades and this was interpreted by the price inelasticity of nutrition. The treatment expenses took such a small part of the business results, that changes in the way the patients were treated were very difficult to measure. An exception was made for the introduction of psychopharmacological treatment during the fifties.

The personnel expenses growth was the most visible change. Naturally more and better trained personnel cost more money. But above that mainly trends caused the growth, though they were always followed with some kind of delay.

In the end the conclusion is drawn that legal anchorage was of great importance for the mental health care growth. The way in which the money was available, was of secondary importance. Changes in mental health care content were only partly linked with changes in the financing system.

It was often a matter of coincidence, which was rather connected with socio-economical and demographic developments. However, because of a lack of political interest in this subject, the mental health care often trailed right behind social trends. Therefore the dynamics of the mental health care practice are described as a 'somewhat delayed mirror of the welfare state'.