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Medical or Social Responsibilities?

(Some Notes on the Multi-Functional Social Roles of the
Psychiatric Outpatient Clinics in Hungary)

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Statistics give somewhat more precise informations about these symptoms and support the facts that are well-known to the public:

There is a steady yearly increase in the take-up of disability pensions because of psychiatric diseases; the number of those being on sickness leave because of mental hygienic problems is on the rise; patients' turnover in the mental wards of hospitals increases continuously; and the number of suicides per 10.000 inhabitants has nearly doubled during the past two and a half decades.

It is hard to determine precisely, how far are the worsening statistical indicators direct expressions of the deteriorating health conditions, and to what extent do they reflect the social recognition of those conditions. Even if there are various explanations for the numerical increase of mental disorders, and even if the phenomenon is regarded as a result of several factors, it is sure, that, after a long period of total ignosance,¹ the problem has "taken root" somehow. Therefore, it is relevant to pose the following questions:

1 It was a general conviction and an important part of the ideology of the Stalinist era, that socialism in itself will automatically eliminate all the social and mental disorders, including alcoholism, delinquency, suicide, and all forms of social and personal disadvantages. That ideology played a great role in the decisions of the central authorities of abolishing the former social networks and institutions of meeting needs on a community level.

What kinds of social answers have emerged under the pressure of massive needs? What solutions have been found to provide treatment and protection for at least those, who suffer from medically recognized and acknowledged mental disorders? Are the existing health care institutions capable of meeting these challenges? What kinds of conflicts and of solutions do emerge from the fact, that it is obvious in the overwhelming majority of cases, that mental disorders are often no others, than medicalizations of otherwise unrelievable existential problems and tensions? In other words, how does the system cope with the task of answering people's need who seek help in the only legitimate form of expression, namely that of a disease? Effective curing would therefore require the simultaneous answers on two levels: that of medical interventions and the "treatment" of the social environment.

It should be added, that the medicalization of social and individual constraints - as is well-known from the literature - is a general "civilizational" phenomenon, rooted in the relative advantages accompanying the patient - status in modern societies. Therefore, it would be a grave and inadmissible oversimplification to say, that the social political expectations toward public health stem only from the underdevelopment and "white spots" of the institutional social policy in Hungary. It is more likely, that those gaps and dysfunctions of the system increase the burdens and demands that fall on public health. They also underline, that becoming a "medical case" is almost the only way today, through which one can get help, exemption, protection

and some sympathy, without suffering the accompanying side-effects of being stigmatized as a "welfare case". The double challenge, i.e. the inseparable entwining of needs for medical treatment and social support has to be faced by each and every institution of the Hungarian public health system.² We have, however, concentrated our analysis only on one type of services, namely, on the functioning of the recently developed network of psychiatric outpatient clinics.

There were several considerations guiding our choice.

The first reason is obvious. In the social process of slowly acknowledging mental disorders as diseases, the relatively new network of outdoor psychiatric services has played an outstanding role. Through their mere existence and activities, psychiatric outpatient clinics have been acting as important catalysts in revealing those disturbances, and what is more, in "legalizing" and "legitimizing" them. It was exactly this catalyst role, that drew out attention to them. By virtue of their professional function, psychiatric clinics are those institutions of the health care system, that are primarily meant to "accept" mental disorders, without being in a position of handing them over to any other forms of services. In one way or another, they must provide some therapeutical answer and some treatment.

² The topic was discussed in more details in: Julia Szalai: Inequalities in Access to Health Care in Hungary; Social Science and Medicine, Vol.22. No.2., 1986.

We were interested in this respect in a closer examination of the circumstances of fulfilling the basic functions of cure and care in those institutions. How much are psychiatric outpatient clinics capable of meeting the mass demands they have to face? What are their possibilities and limitations in accomplishing their double function: i.e., that the medical treatment provided by them is unquestionably accompanied by a direct social meaning.

There were other considerations, however, which also played some role in choosing the survey area.

There are heated debates in Hungary nowadays about the deficiencies of the public health care. Though the debates are influenced by a more general international discourse, their foci are around those chronic shortages and the general state of underdevelopment of the services, that are shortcomings characteristic to the malfunctioning of the state-socialist redistributive systems. One frequently cited reasoning in giving explanations is to blame the population because of its medical "overconsumption". Namely, that the main source of the problems could be identified in the wrong behaviour of people, who use the various forms of medical provisions too much, too often and to an unnecessarily large extent. This type of arguments is obviously value-loaded, however. Since if one speaks of "overconsumption", then the qualification implies a perception of the "sufficient" and the "right" extent. And that distinction implies a drive for exact definition of the boundaries between health and disease. Those boundaries are, however, culturally determined. There are

no objective criteria independent from space and time to give definitions, that hold everywhere and for ever. Therefore neither in public opinion, nor among the physicians themselves can one find a full consensus, as to what an extent can a particular complaint be regarded as "natural condition" ("health"), and what are the criteria of qualifying it as a medical need ("disease"), i.e. a case "to be treated" by health care institutions. That holds for all the types and forms of complaints.

There is not a single organic complaint, however, where the lack of consensus and the passions and debates around qualifying the case would be as striking and heated, as in judging mental problems.

Is it worth curing, if somebody cannot sleep? Is headache a complaint in the medical sense of the word? Should these and similar symptoms be treated as diseases or as matters of the individual's morale and attitude? The question is not theoretical, since it has serious practical consequences on the running of services. Namely, should a social answer be given and a network of medical institutions established to mitigate the widespread complaints, or should we try to solve the problem by "training" the people who suffer from those complaints? Should we try to accustom them to a healthier way of life through improving self-discipline and making loose morals more stringent?

Since "mental problems", the "impalpable" phenomena and complaints precipitate mostly in psychiatry, provided, that they are given medical attention at all, the lack of social consensus and the passions around the people suffering from mental problems obviously get over to the psychiatric clinics specialized in the treatment of such problems.

The aim of our survey was to reveal the mechanisms that push psychiatric clinics to the bottom of the medical prestige-scale not quite independently of the above indicated ambivalences of public opinion. As to be a patient at the bottom of this scale is something to be ashamed of, similarly, to work there means to renounce the various privileges of a physician's career.³

We were aware of the fact, that low prestige is only one side of the coin, however. In their bottom-position, psychiatric clinics gain some freedom and with it, some rank, too. Since they are the legitimate institutions of exemption, they cannot be forced to follow the rigid rules prevailing generally in the hierarchical system of health care. Therefore they are able to provide some social protection, that gives them a special type of prestige. Psychiatry is an area, where the efficiency indicators otherwise used in health care do not normally apply so much, and where the management requirements are less stringent. In other words, this is the institution which can "escape" of the generally applied strict administrative control and gain some autonomy. And as a consequence, it has the potential of paying more attention to the patient's need and less to that of the authorities.

³ The ambivalent position of psychiatry is indicated, for example, by the fact that in 1982, 6,2 per cent of physician's posts in psychiatric clinics remained vacant, while the proportion of unoccupied posts in the general polyclinic network was only 2,2 per cent in the same year.

We finally found this duality and the following ambivalent status of the psychiatric clinics the most exciting and important problem of our survey. This duality could be described as the constraints of two diversive forces, namely the degradation of status within the health care system and the relative autonomy obtained in a fight against the forced tracks. It can be characterized, as the contradictory manifestation of having no prestige on the one hand and gaining prestige according to a different order of values. This duality can also be described in terms of clashes between various functions of a given health care institution. And it also can be seen as a significant product born out of the struggle between the institutionalized hierarchies and the informal social movements against these hierarchies.

What ever set of aspects is selected, the most important questions remain the same.

How does the network of psychiatric clinics handle the dilemmas and conflicts stemming from the above indicated dualities? We had the hypothesis, that some would place the emphasis on adjusting themselves to the written and un-written rules of public health care. They will regulate only in the attendance of their patients, but all aspects of their activities with as little conflict as possible. Whereas others seem undertake the conflicts stemming from "being an exception" and place the emphasis of their activities on the social protection of their clients. One of the basic aims of the research was to find explanations for their different options. We thought, that

the multifunctional operation of psychiatric clinics and their position on the boundary of "medical" and "social" provisions offer the "playing field" within which these shiftings in emphasis are possible. And while it is very interesting and important to describe the general characteristics that follow from the double function of psychiatry itself, it is also very important to indicate the shifts in emphasis offered by the duality, as well, as the differences stemming from them.

A brief history of the institution and its functions

The rapid increase in the number of psychiatric clinics in Hungary has been taking place in the past two decades. On the one hand, the development programme was an organic part of the general policy on health care that in the 1960s tried to expand medical provisions through the rapid organization of the network of polyclinics.

On the other hand, special professional reasons also played a role. Modern psychiatry strongly has criticized the treatment of psychotics in hospitals from many aspects. It became a widely accepted programme that the only humane and efficient way of treating psychotics can be their social rehabilitation and that their treatment must be embedded more and more into the natural environment of their normal everyday life. The emphasis should be shifted from the mental wards to the outpatient service, as otherwise the ways of getting back to society will become restricted and blocked.

The professional considerations were entwined with equally important economic reasons in Hungary. It seemed, that the expansion of the outpatient services in order to meet the increased demands, would be a less expensive and somewhat faster solution than to invest into the modernization of the old system. In the light of both, the economic and professional considerations, the idea was that the provision in the psychiatric outpatient clinics must "substitute" for hospital care as fully as possible. In practical efforts, however, the emphasis had been shifted to the economic side of the substitutional relation.

Nevertheless, the actual developments of the past two decades have changed the former conceptions to some extent. Parallely with the increase of the number of and turnover in the psychiatric outpatient clinics, there was a somewhat bigger increase in the number of patients treated in mental wards. Instead of a planned substitution, the new type of institutions (independent psychiatric outpatient clinics) was integrated into the system with partly a new "profile". Namely, nearly half of the patients visiting the clinics suffer from neurosis, a disease that due to its nature requires exclusively outdoor treatment. It can be said, that through the development of the psychiatric network, a disease, that has been almost untreated previously in the medical sense, gained "ground" and obtained - although to a very limited extent - some kind of a medical solution.

The two types of institutions are only partly alternatives of each other. With the passage of time their distinct nature has become more pronounced. In the psychiatric outpatient clinics, the relative number of women is higher, while most of the patients treated in mental wards are men. The psychiatric clinics are the institutions mainly for the young middle-aged persons, while in mental wards the number and proportion of persons above 60 years of age are constantly on the rise. More than 25 per cent of the patients treated in psychiatric clinics for a longer time suffers from depression or neurosis, while schizophrenia, the most classical mental disease, can be seen on the case-card of only one person out of five. Schizophrenia is just the "mass disease" in mental wards of hospitals at the same time.

All these facts indicate that although psychiatric outpatient clinics were planned to have a substitutional function, they satisfy different needs. They have become institutions opening the gate for an unmet mass demand of the population, and that demand has found its way; moreover, it has to be met increasingly.

Obviously, the proliferation of functions is not a process without conflicts. Partly, because it creates uncertainties and confusions in the orientation of psychiatrists working in the psychiatric clinics. According to the prevailing norms of the profession, both, in training and in general thinking, the "real" professional cases are the psychotics, whereas they have to meet neurotics day by day. Another source of confusion is, that the classical means and methods of psychiatry are generally not

suitable for curing neurosis. At the same time, modern psycho-therapeutical methods ensuring the appropriate treatment of the disease can rarely be applied amid the given rigid organizational frameworks, without the relevant preconditions of time and space. A further source of confusion and conflicts is, that in spite of the fact that the overwhelming proportion of patient turnover is represented by neurotics, psychiatric outpatient clinics cannot be regarded to be the institutions where basic provision for neurosis is given. Various estimations in the literature and our own calculations indicate that outpatient clinics today receive only 5-7 per cent of those who suffer from neurosis - and this percentage can hardly be regarded as a proportion high enough to call it "basic provision".

Therefore, the existence of psychiatric clinics and the rapid increase in their numbers and patient turnover do not produce a harmony between demand and supply. These institutions must operate in the constant belief of insufficiency and with a constant uncertainty about their real functions. Consequently, as with other institutions of public health, the uncertainties and the attempts made at decreasing the pressure from outside put various mechanisms into action. These mechanisms result in shifting the responsibilities and attempting at handing the patients over, contributing to the maintenance of the system of patient-rotation, instead of good and effective care.

The functions of psychiatric clinics in the everyday reality - similarities and differences

We chose two different psychiatric clinics for a more detailed empirical survey; one in the capital, Budapest, and one in the countryside.⁴

Our preliminary considerations, knowing the above described processes, related mainly to the possible differences between them. Expected differences were supported by the fact that in Budapest, in spite of the district-system of patient reference, patients are relatively free to choose from a set of medical institutions. In the towns of the countryside, however, there are usually just a few health care institutions to choose from, and, what is more, these institutions have to serve not only the given town, but also the population living in the villages around them. Thanks to the flow of informations and to the well organized public transport system, distance cannot be a real obstacle in using health institutions of the capital. Whereas the relatively

⁴ Our survey was based on a data sheet which was specially designed for collecting all the information recorded on case-cards in psychiatric outpatient clinics. The data sheets were filled in by nurses on the basis of case-cards. In this way breaking of medical secrecy could be avoided, as later we were working only with unidentifiable questionnaires bearing no names of the patients. This work could not have been carried out without the help of nurses. Based on their deep knowledge of the area and the consultations conducted with the physicians working in the given institutions, the nurses also completed the sometimes scanty notes on the case-cards. In the end, we obtained a picture from these questionnaires, that was much richer in information than the purely diagnostic therapy-related and scanty case records. Through them we could also trace the way of patients, their case history and some stations of their career into the "outside" world.

great distances themselves can represent a serious restrictive factor in seeking medical help in rural areas. As a consequence of the marked regional differences, we expected meaningful differences in the composition of the patients of the two institutions, both, with regard to their social and medical characteristics.

We assumed, that the Budapest example would clearly demonstrate the low status of psychiatric clinics within the public health system and that it would clearly indicate the effects of this low status on social selection. Namely, that one relatively easily can avoid the stigmas of "attending a psychiatric clinic", if he can afford it. Thus, according to our hypothesis, the users of psychiatric outpatient clinics will be those, who have been pushed out from the "distinguished" health institutions and who represent the feeble strata of society.

In case of the psychiatric clinic of the countryside, we expected to see the signs of the above-mentioned double functions of less purely medical activities in a combination with more of a social intermediate role of the clinic. We also expected to reveal the effects of the physical and social distance between town and village in the social stratification of patients, a dimension, that is very important in the social structure of present Hungary.

Our expectations of marked differences were also increased by the fact that each of the two psychiatric clinics represents a typical landmark in the history of development outlined above. In addition, the physical and personal conditions for their

activities are also quite different. The psychiatric clinic in Budapest was established at the beginning of the 1950s; the psychiatric clinic in the countryside, being a "product" of the "development boom", opened its gate in 1969. While the number of adult inhabitants is 40.000 more in the assigned district of the clinic of the countryside, than in the capital⁵, there is only one physician working in the former institution, while there are four of them in the latter. At the same time, the number of patients visiting the country clinic in one year, is exactly the double of the corresponding number in the case of the Budapest clinic.

Taking into account all these facts, it is really surprising and noteworthy, that we have found more similarities than differences between the two psychiatric clinics in a great number of fundamental aspects. As it will be seen later in more details, ~~the~~ the composition of patients is similar according to ~~to~~ their age and sex; the proportion of those who are economically active at the time of their attendance, is nearly the same in both cases; there are no significant differences in the structure of diagnoses, especially if the frequencies of the dominant or the strongly "underrepresented" groups of diseases are considered, etc. Therefore, it may not be an exaggeration, if these similarities are regarded as general tendencies that are typical of the entire

⁵ According to the figures of the 1980 Census, the number of inhabitants over 14 years of age was nearly 80 thousand in the district of the psychiatric clinic in Budapest, while the corresponding figure was nearly 120 thousand for the country psychiatric clinic.

network of psychiatric outpatient clinics in Hungary. The differences which were experienced mainly in the patient-related "semi-medical" procedures (sickness benefit, pensioning off for medical reasons, patient-protection intermediate activities, etc.) or in the depth of knowledge about the non-medical problems of patients, are considered as models. These models demonstrate the above indicated shifts of emphases, and the selections between the medical and social functions of the psychiatric services. As it will be shown, each of the two clinics represents a considerably different type of the possible solutions to the social challenge.

Demographic profile

Similarities of the demographic compositions have to be mentioned first among the commonalities.

If a short answer ought to be given to the questions, whose needs are satisfied by psychiatric clinics, we could say, that the primary "users" of the clinics are the young middle-aged people, first of all women, being generally in full-time employment at the time of their attendance.

64 per cent of the patients of the psychiatric clinic in the capital women, out of them 42 and 62 (!) per cent, respectively, are between the age of 30 and 50 years.⁶

⁶ Beside the similarities of the tendencies, the concrete numerical proportions are different in many ways. We have not enough space here to analyse all the reasons in details. We would only refer to the fact that the above described different characteristics of the two psychiatric clinics play a decisive role in this respect. It is an important factor that the time difference between the opening of the two psychiatric clinics is nearly two decades. Therefore the demographic profile of the

The majority of patients (83 per cent in the capital and 99 per cent in the country psychiatric clinic) has been under treatment for years. Nevertheless, they also fall in this wide age group at the time of their first attendance: the proportion was 44 per cent in the case of female patients in the capital, while it was 66 per cent country women.

The dominance of the middle generation is similar (although somewhat less significant) among men, as well. 41 per cent of the male patients in the psychiatric clinic of Budapest and 54 per cent of them in the country clinic were older than thirty, but younger than fifty at the time of the survey. The same proportion of the patients of the Budapest clinic and 61 per cent of them in the country clinic belonged to this age group at the time of their first visit.

There is one more striking similarity between the age pyramids of the two psychiatric clinics. We can hardly find very young patients (under 20 years of age) and persons over 60 among those attending them. In the year of the survey, 2,5 per cent of the male and 1,6 per cent of the female patients were below 20

clinic in the capital has already "taken shape", while that of the country clinic is showing signs of the most burning needs that were rushing through its gate upon opening. It is also important - and it directly influences the age composition - that in the surrounding of the country psychiatric clinic there are no alternative institutions reducing the burdens by offering the same medical or social services. We should also take into account the sub-cultural effects of the differences in the social environments. Because of different lifestyles and values, patients in the countryside (mostly in the villages) receive medical treatment at a later stage of their disease and thus in a graver condition, while those in the capital take medical assistance more gradually and at an earlier stage.

years of age in the psychiatric clinic of the capital, which otherwise had a more even age composition. The corresponding proportions in the country psychiatric clinic are negligible - they were 0,5 per cent and 0,1 per cent, respectively.

Patients above 60 years of age accounted for 14,6 per cent of male patients and 24,3 per cent of female patients in Budapest. The relevant in the country clinic were almost identical for the two sexes, with 7,5 per cent, and 7,6 per cent, respectively.⁷

Since it is commonly known, that health condition (in all of its interrelated aspects) is worsening with age, the absence of old patients is astonishing. It could be expected that old people would be represented among psychiatric patients in a considerable proportion. The fact, that it is not the case, can primarily be explained with cultural reasons. The dyssomnia, memory defects, confused conditions and general weak health of old people are not considered as problems which would give them right to be treated. These complaints and symptoms are regarded by the social environment and even the physicians (and, understandably enough, even by old people themselves) as cumbersome "accompaniments" of life which often provoke sorrow or a smile from other people, or in worse cases irritation and impatience. Until old people are useful for the family and/or for the community, or until they themselves do not get broken in the belief of their "uselessness", nobody thinks of the treatment of their complaints and problems.

⁷ The ratios of people above 60 years of age among the adult population of the two areas were 22, 31 and 19 and 23 per cent, respectively.

Besides cultural reasons, another serious factor, which prevents old people from getting to a specialist is that they are limited in their physical motion - hence the alarmingly low proportion of old patients in the country psychiatric clinic as compared to the proportions in Budapest.

The sharp breaking lines of using the clinics by age groups are more clearly shown in Table 1, where the age composition of the patients in the two psychiatric clinics can be seen related to the appropriate proportions of the population.

Table 1.
Number of patients in the psychiatric clinics per 1000
inhabitants of the appropriate age and sex in the survey areas

Age	Psychiatric clinic in Budapest			Psychiatric clinic in the countryside		
	Male	Female	Together	Male	Female	Together
15 - 19	5,4	7,5	6,4	1,4	0,5	0,9
20 - 29	18,4	20,5	19,4	14,7	17,6	16,2
30 - 39	27,2	36,3	31,8	28,1	51,0	39,6
40 - 49	19,3	40,6	30,9	38,5	61,6	50,4
50 - 59	15,4	25,8	21,2	33,8	36,6	35,3
60 - 69	10,4	19,0	15,4	13,0	16,1	14,7
70 and older	12,1	18,4	16,4	1,4	3,9	2,9
Together	16,7	25,1	21,3	22,2	31,3	27,0

Diseases

Further similarities of the functions and profiles of the psychiatric outpatient clinics can be discovered, if we turn our attention to the facts indicated by the composition of diseases in the two institutions.

As it can be seen from Table 2., neurosis and schizophrenia are the first two most frequent diseases among both, men and women and both, in the Budapest and the country psychiatric clinic. Neurotics account for nearly half, while schizophrenics for more than one fifth of the patients treated in the institutions. The proportions are, however, different for the two sexes (the primary reason is that neurosis is a typically female-, while alcoholism is an overwhelmingly male-disease), but the tendencies are clear and identical. The only real differences between the two psychiatric clinics emerge in the proportions of the depressed. However, as it was explained by the psychiatrists themselves, it is due definitional disagreements.

Table 2.
The distribution of patients in the two psychiatric clinics
according to their diagnosis, by sex

Diagnosis at the time of registration in the psychiatric clinic	Psychiatric clinic in Budapest			Psychiatric clinic in the countryside		
	Male	Female	Together	Male	Female	Together
Schizophrenia	24,9	19,9	21,7	30,4	17,0	22,3
Depression	5,1	6,7	6,1	13,5	17,4	15,8
Organic diseases	9,8	8,6	9,0	8,0	5,7	6,6
Dementia, Senilis psych.	2,7	5,6	4,6	1,0	1,1	1,0
Alcoholism	5,6	1,3	2,9	13,7	1,4	6,2
Neurosis	38,9	48,3	45,0	25,2	53,8	42,5
Psychopathy	8,1	4,8	6,0	5,3	1,6	3,1
Sine morbo	4,9	4,7	4,8	2,9	2,1	2,4
Total	100,0	100,0	100,0	100,0	100,0	100,0

Although the acceptance and treatment of the typical old-age psychoses (such as dementias, senile psychoses) would be psychiatric tasks, given the low proportion of the old-aged, their typical diseases are also "under-represented" in the psychiatric clinics.

The mentally disabled or the alcoholics are representing a boundary case from the point of view of their proper institutional place. The low proportion of alcoholics and patients suffering from psychosis as a result of alcoholism, is an "organizational product", which is in connection with the differentiation of the network of psychiatric clinics. There has

been a recent tendency to develop special services for the treatment of alcoholics, and to separate them from the "ordinary" psychiatric clinics. However, it is worth noting that the boundary lines between alcoholism and other psychiatric diseases seem obscure, according to our data. Therefore the selection of the patients among the special institutions with the "appropriate function" is quite questionable, even from a strictly professional point of view. Our data show, that more than one third of the patients treated in the alcoholic treatment centre suffer not only from alcoholism, but from another diagnosed psychiatric disease, as well. While at the same time, the case-card of every fourth patient treated in the psychiatric clinic, indicated serious alcohol overconsumption or fully developed alcoholism. If we phrase it differently, it means, that for about 25-50 per cent of the patients it is not precisely predetermined, which institution should be responsible for their treatment. But the decisions are made. The significantly distinctive social character of these two types of institutions (e.g. the characteristically lower level of education of patients treated in the alcoholic treatment centre and the significantly higher proportion of unqualified workers among them), the different weighing of their "protective" and "administrative" functions, and the differences between their social judgement and reception, all refer to the fact, that the institutional placement of patients is depending rather on the processes of social selection, than on the dimensions of professional arguments.

The essential differences in the activities and composition of patients within the psychiatric clinic and alcoholic treatment centre operating frequently under the same roof were even more sharply underlining the importance of similarities, which could be experienced in most of the institutions of the psychiatric clinic network, nearly independently of the differences in their environment and social composition.

As they are health institutions, the most direct "quality" of their users is the disease itself. The patients' age, sex, the job what they do in the outside world, their family conditions, financial situation, etc. are all only indirect factors from the point of view of psychiatric clinics. In their patient-role all the other relationships and facts of the patients' life are only "secondary characteristics". Looking from this aspect, the most important of the recorded similarities is what the trends of the frequencies of the diseases show, i.e. the uniformities of needs.

Even more important are the differences, which, in turn, appear in the answers given to these needs. It was mentioned previously, that the two psychiatric clinics represented two characteristically different types in this respect. According to our preliminary expectations, the psychiatric clinic in Budapest was "much more medical", while the country psychiatric clinic was a "social-oriented" institution to the maximum of possibilities. This was indicated to us by a number of facts.

Social responsibilities - taken over or refused

Among the indicators of showing the different attitudes regarding the acknowledgement of social responsibilities, measures of "keeping" patients or "pushing" them forward can be mentioned first. The Budapest psychiatric clinic was bearing the signs of the previously described revolving-door system. The activity of the country psychiatric clinic was not characterized by that drive at all. They usually have not sent their patients to other institutions and have not tried to shift the responsibilities on to any other medical units. It can well be seen from the indices of how many times have patients visited one institution or the other since their first attendance.

"Transitory traffic" is very intense in the Budapest psychiatric clinic: 30 per cent of the patients visited the institution only once and then they got lost (from the point of view of the psychiatric clinic.) In the country psychiatric clinic (in the vicinity of which, as it was mentioned earlier, there is no other specialist than the one in the clinic, where the relationship between the physician and the patient is more intimate and personal, and where doctors know local circumstances so well that upon hearing the name of a given workplace they already know what the case is about), the protective function of psychiatric provision is given a priority. In this way the patients remain the patients of the same institution; only 8 per cent of the patients was seen once, while the majority returns to the clinic at least twice or three times a year.

The proportion of registered patients (i.e. the proportion of those who are under the "own authority" of the institution and who are kept an eye on), is also significantly different. Only 41 per cent of the patients visiting the Budapest psychiatric clinic in one year, are considered as "own" patients. The relevant ratio is as high as 96 per cent in the country psychiatric clinic. Service is also less formal there: all the patients are regularly called on and their condition is regularly checked. The differences of orientation are even more striking in judging neurosis, which has a boundary position from the psychiatric point of view. The only thing that the Budapest psychiatric clinic really considers as an obligation, is to keep psychotics under their own medical control. Regarding neurotics, the warning letter "G" can be seen⁸ only on 13 per cent of their case-cards. With regard to the country psychiatric clinic, all the attending psychotics are all under regular control, and that holds also for the great majority, i.e. 91 per cent of the neurotics.

Obviously, it is not independent of the frequency of a patient's visits, what and how detailed informations can the physician learn about the his/her life, working relations and family conflicts. The proper number of visits is a necessary, but not a sufficient precondition for that. It is an other important factor, whether the specialist responsible for the treatment

⁸ This letter indicates that the calling back of patients and the performance of medical check-ups at relatively regular intervals is the obligation of the institution, and that this obligation must be fulfilled in an organized manner, not leaving it to the patients' discretion.

considers such "social" bits of information as parts of his job and therapeutical activities. As almost everybody has problems in private life, it is especially true of the psychiatric patients, for whom such private problems can be either the triggering reasons or the consequences of their disease. Therefore, the fact, whether remarks of such nature were written on the case-cards or not, can be considered as the indicator of social openness and problem-consciousness.

The two psychiatric clinics are different in this respect, as well. We saw references to the patients' family conflicts or other difficulties on only one third of all the case-cards in the Budapest psychiatric clinic, while this proportion was two out of three case-cards in the country clinic.

It also turned out from our interviews and observations that these bits of information are "alive" in the country psychiatric clinic, while they are used at best only occasionally and in a significantly depersonalized form in the Budapest clinic. In the country clinic (where the alcoholic treatment section and the psychiatric section share the same building) the daily work of doctors and nurses in both sections includes social intervention. In addition to the medical treatment activities, all kinds of social political activities from labour exchange to benefit procuring are delivered.

We could cite other differences in the attitude towards "the restoration of the ability to work", as well.

The extent to which a given health care institution undertakes the social aspects that are inavoidably inherent in medical treatment activities, can well be indicated in today's Hungary with perhaps one of the most sensitive means of measurement, namely: the number of patients taking up sick-leave with the preconditional support of a given institution. As far as the support of sick-leaves is concerned, the psychiatric clinics, as it was mentioned earlier, are in general more liberal than the majority in public health care.⁹

However, the two places of our survey are different in the extent of liberalism. It is well demonstrated in Table 3. It can be seen that the percentages of patients taking up sickness benefit are significantly different even in the case of the same disease. For example, there was a 20 per cent difference in the proportions of economically active schizophrenic men who have been declared to be incapable of working by the two institutions. Similarly, a 17 per cent difference was obtained in the case of neurotic female patients.

The differing attitudes towards justifying the case "entitled" for sickness benefits are, however, best illustrated by the situation of those patients, who were sent to the psychiatric clinic for examination, and with whom no psychiatric diseases were found in the end. Nevertheless one third of these patients was put on the sick list and given sickness benefit in

⁹ Health care institutions are strictly controlled and administratively regulated from time to time because of authoritative interventions aiming at reducing social security costs.

the country psychiatric clinic, while in the case of the one in Budapest, none of the male patients, and only 7 per cent of the female patients got the required certificates.

Table 3.

The proportion of patients who were in employment and given sickness benefit, in selected diseases and by sex, for the two psychiatric clinics examined

(Percentage proportions of those who were supported in taking up sickness benefit in the given year)

Diagnosis	Budapest psychiatric clinic			Country psychiatric clinic		
	Male	Female	Together	Male	Female	Together
Schizophrenia	38,2	34,7	36,5	58,3	35,3	48,8
Depression	36,4	31,8	33,4	63,2	51,9	54,8
Alcoholism	22,2	33,3	25,0	25,0	16,7	23,4
Neurosis	37,0	34,4	35,2	45,9	51,8	50,5
Sine morbo	-	6,9	4,3	35,7	25,0	30,0
Total	33,3	31,9	32,5	41,3	47,6	45,4

The different extent of undertaking the social function is expressed most markedly in the question of pensioning someone off for medical reasons.

Earlier in this paper, psychiatric clinics have been described as institutions used primarily by the economically active, working middle-generations of the population. However, this description is only true at the very moment of registering the patients. What the institution provides for them is not necessarily in the interest of restoring the ability to work by all means: for example, a considerable proportion of the patients has become disability pensioners between their first visit and

the time of our survey. We considered this fact as a most meaningful manifestation of the special protection that the institution could provide. Now we should stop for a moment. One might raise the question: why is it a protection (and whether is it a real protection at all), if the patients are declared to be invalid and thus withdrawn from the labour market at the age of 30 or 40. What we should in fact say is, that there is no other way to provide protection, and despite all its disadvantages, this solution is in fact a real protection with under the given circumstances. The doctors and nurses in the psychiatric clinics also talked much about this controversial situation. The ideal case would be to find easier and more suitable jobs for their patients, that could be done within conditions, that are better fit to their reduced abilities. That would require more flexible organizational frameworks, much better working conditions, and less stringent rules of efficiency requirements. The only problem is that such rehabilitative places of work (or in other words: places of work operating according to other norms) simply do not exist. It is impossible to find a job in the cottage industry and there is only a very limited number of jobs that can be done part-time - and all these "privileges" can be obtained only through desperate fights.¹⁰

¹⁰ About the complicated economic, social and political processes and conflicts in connection with declaring a patient invalid see: Julia Szalai: Early Exit from Employment (The Hungarian Case) in M. Rein and M. Kohli (eds.): Early Exit from the Labour Market, Cambridge University Press, coming.

Consequently, the only solution is to declare these sick people invalid. At the same time, this protection can be provided only amidst constant fights and in the crossfire of conflicting interests. Using a somewhat strong wording, we could say that only a peripheral and stigmatized institution (and psychiatric clinics are of that character) can provide this kind of protection in greater proportions.¹¹

The concrete proportions relating to the pensioning off for medical reasons are shown in Table 5, by the columns indicated with odd numbers. The figures in the Table indicate, that 14-29 per cent of the patients in the capital between the age of 30 and 60 years become disability pensioner during the psychiatric treatment. The relevant ratios for the country clinic are, as follows: every second or third of their male patients, and every fifth or sixth of the women have taken up pensions since their first attendance. These frequencies are especially expressive, if indications of the patients' none-psychiatric morbidity are also taken into consideration. We collected data in both psychiatric clinics on all those diseases (gastric and digestion system, respiratory, cardiovascular, allergic, etc. diseases), which are also known to the psychiatrist in connection with the individual

¹¹ These processes and contradictions are similar to those that can be experienced in some other specialized institutions of social policy, such as the youth protection institutions, old people's homes or the chronic sections in hospitals.

It is true that these specialized institutions provide some solution to a given conflict in life, protect and ensure some safety, but they do it at the cost of being pushed to the periphery and getting segregated. Separated from the "normal" world, these institutions and their patients are given the specific "privilege system" of protection.

patients, although the particular disease is not treated by him. Obviously, our data do not indicate the precise extent of polimorbidity, as whether the doctor knows about the disease is not the same, as whether the disease exists or not. (Even though, as the lower limit of an estimation of polimorbidity, we can accept the obtained indices: there was some information about at least one more disease of not psychiatric order of 32 per cent of the case-cards in the Budapest psychiatric clinic and on 49 per cent of them in the country institution. In the middle-aged active population, where the proportions relating to the pensioning off for medical reasons "jump", the non-psychiatric morbidity looks as follows:

Table 4.
Percentage proportion of patients who suffer also from (a) non-psychiatric disease(es) within the group of economically active patients in some age-groups and by sexes

	Budapest psychiatric clinic			Country psychiatric clinic		
	Age groups			Age groups		
	30-39	40-49	50-59	30-39	40-49	50-59
Men	32	30	49	39	57	68
Women	21	30	43	37	51	60

What these proportions mean is, that in the life of at least thrity to fifty per cent of the middle-aged working patients other medical persons also play a role due to other kinds of diseases. Being aware of this fact, it becomes especially

interesting that if such patients are pensioned off for medical reasons, then this happens almost exclusively because of their psychiatric disease, i.e. at the initiative of a psychiatrist. This holds true of more than four-fifth of the pensioning cases in the Budapest psychiatric clinic. These data are still more pronounced in the country psychiatric clinic: here the proportion is above 9/10 both, for women and men. (The more detailed distributions according to age-groups are shown in Table 5.).

In other words, the exit from employment through pensioning off for medical reasons, will be legitimated to a considerable extent by means of the psychiatric diseases, or, on the institutional side, through psychiatric clinics. And this is, in fact, the most essential protection that can be provided under the present conditions, to at least the patients under treatment in such psychiatric clinics. However, we can remember that the number of those who are untreated and who are wandering for help from one place to the other is significantly larger than the number of actual patients.

Whether the provision that psychiatric clinics offer can be labelled "social policy" or not, is a question of secondary importance. What really matters, is, whether those in trouble receive any kind of solidarity and protection anywhere at all. This is the way, how it becomes a special privilege if somebody undertakes the stigma of a psychiatric disease and a special kind of defencelessness if he "gets rid" of it.

Table 5.

The proportions of patients pensioned off since their registration in the psychiatric clinic, and among them, the proportion of those who were pensioned off for psychiatric reasons, by sex and age groups (per cent)

	Men		Women	
	Proportion of those who have been pensioned off since their first visit	Within the previous proportion of those who have been pensioned off for psychiatric reasons	Proportion of those who have been pensioned off since their first visit	Within the previous proportion of those who have been pensioned off for psychiatric reasons
BUDAPEST PSYCHIATRIC CLINIC				
- 29	8,1	100,0	4,5	100,0
30 - 39	28,6	74,1	19,8	71,4
40 - 49	18,6	87,5	18,4	76,7
50 - 59	11,6	100,0	14,3	100,0
60 - X	7,3	100,0	7,3	100,0
Total:	13,9	82,1	13,0	82,6
COUNTRY PSYCHIATRIC CLINIC				
- 29	30,3	100,0	22,2	100,0
30 - 39	38,9	96,5	16,0	92,5
40 - 49	41,5	89,6	24,4	88,6
50 - 59	54,2	86,6	29,8	92,3
60 - X	35,7	92,9	6,9	60,0
Total:	42,1	91,4	21,6	90,9