HEALTH ECONOMICS, POLICY, AND MANPOWER – ISSUES AFFECTING THE FUTURE OF PSYCHIATRY

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Overview of health economic issues

Today, healthcare costs are escalating worldwide. It is clear that healthcare economics is complex, and one particular complexity is that it has become a commercial enterprise.

A developing society with limited resources provides its people with basic, one-size-fits-all services. But when society advances and prospers, treatment or management becomes individualised or customised. The practice of Medicine has thus evolved from the idea of one doctor treating many patients at the primary care level, to that of many specialists and subspecialists managing single patients at the secondary and tertiary levels. There is also a proliferation of allied health professionals or workers, technicians and managers.

However, when society becomes developed and affluent and more resources are available, the latest investigations, machines, drugs and procedures are introduced as necessary. This becomes the new baseline of one-size-fits-all services that are expensive, because of new facilities and market forces as well as medico-legal issues and defensive practices.

Besides that, people are also living longer and older with chronic and degenerative diseases that require long term treatment and care. What is untreatable in the past is treatable now. There are also more diseases and disorders identified because of new discoveries, changing concepts and thresholds, and medicalisation of existential human imperfections and sufferings. We now have so-called lifestyle diseases and disorders, and addictive habits or behaviours. Mental health, wellness and illness problems are gaining prominence and recognition as well. Preventive screenings, early treatments and aesthetic Medicine have been also been added into the equation.

Training future doctors

Medical practice has been changing, for better or worse. Likewise, the nature and purpose of medical education and training are not static and have been undergoing changes as well. Medical schools, including those in Singapore, have been revising their curricula and contents; directions and emphases; tools and methods of teaching or training (for example, problem-based learning and virtual reality) so as to remain relevant in the dynamic healthcare landscape.

Based on the growth of knowledge and advancement in management alone, medical courses have been extended for both undergraduate (for example,

disruption for a Bachelor of Science course or research project) and postgraduate studies and training, as well as the introduction of lifelong continuous medical education or professional development. These changes have resulted in dilemma and tension between the broad-based generalists and the super specialists across all disciplines and subspecialists within each discipline.

The oath and pledge we doctors take are person-centred, emphasising a compassionate approach to cure, care and comfort of our patients and the special fraternity within the profession. The Declaration of Geneva, most recently revised at the 173rd World Medical Association Council Session held in Divonne-les-Bains, France in May 2006, states:

At the time of being admitted as a member of the medical profession:

- *I solemnly pledge to consecrate my life to the service of humanity;*
- *I will give to my teachers the respect and gratitude which is their due;*
- *I will practise my profession with conscience and dignity;*
- *The health of my patient will be my first consideration;*
- *I will respect the secrets that are confided in me, even after the patient has died;*
- *I will maintain by all the means in my power, the honour and the noble traditions of the medical profession;*
- *My colleagues will be my sisters and brothers;*
- *I will not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient;*
- *I will maintain the utmost respect for human life;*
- *I will not use my medical knowledge to violate human rights and civil liberties, even under threat;*
- *I make these promises solemnly, freely and upon my honour.*

Nonetheless, environmental and economic factors, and administrative policies have made it difficult for us to honour our oath and pledge. We have no complete control on how we practise Medicine nowadays, as administrators and management often have the final say. Clinical language and terminology have been replaced by business terms such as: corporatisation, chief executive officer, case manager, case mix, customer service, costing, packaging, marketing, health industry, clinical technology, entrepreneurial research, medical tourism, added value, key performance indicator, performance bonus, and a whole host of other economic jargon.

In this digital age, increased computerisation effectively facilitates management on one hand but on the other hand, it stifles flexibility and controls how procedures should be followed. Internet-savvy consumers are no longer passive patients as well. Consequently, there seems to be no place for altruism in this day and age.

With regard to training future doctors, planners may consider the following issues:

Healthcare needs in terms of numbers and ratios

A country's healthcare needs will depend on the demographic changes and projections including size of citizens and foreigners, and their anticipated lifestyles. The ageing population, retirement and savings schemes, family support, independent living, quality of life, substance abuse should also be accounted for.

One possible miscalculation in Singapore's projection of doctors needed and the capping of intake into local medical schools is the one-size-fits-all doctor to population ratio. This error probably came about as several factors had not been taken into consideration. These include the discovery of new diseases and medicalisation of living problems (as previously mentioned), and also attrition due to migration, retirement, sickness and death.

Healthcare costs in Singapore are also increasing. To manage these costs, we currently have Medisave, MediShield and Medifund, which are supplemented by other types of health insurance. Apart from these existing schemes, what are our policymakers' healthcare financing plans for the near future?

In the past, one doctor treated many patients (as whole persons), but now, many doctors treat one patient (as divided parts). We need to ask how we practice or intend to practice at primary healthcare level, secondary specialist level, tertiary super-specialist level as well as at the teaching, training and research levels.

Naturally, the training of future psychiatrists is related to the training of future doctors.

Training future psychiatrists

We need to decide the roles of future psychiatrists. Are future psychiatrists going to be holistic and a team leader of other trained professionals? Or are they going to retreat into the medical model of diseases, doing nut-and-bolt or assembly line jobs?

Once we have defined their roles, we should determine what future psychiatrists need to know. We have been against the division of mind and body, but now we are dividing the "mind". What are the territorial boundaries and medico-legal implications in practice? Are we going to be DSM symptoms checkers and be persuaded to prescribe specific drugs for specific diagnosis approved by the US Food and Drug Administration? Will there be

greater demand for psychotherapy, medication or genetic intervention in the future?

Despite the availability of different postgraduate models and programmes of training for doctors, what matters most is to avoid inbreeding of both confusion and supposed experts that could eventually lead to stagnation of progress. Novices and trainees in Psychiatry have been silently struggling to truly understand the specialty under great disparities in clinical teaching and practice, in terms of diagnosis and treatment. Questionable didactic applications of certain diagnostic systems and algorithm prescriptions add to the tangle.

The nature of psychiatric illnesses or problems depends on the understanding or rationalisation of the interrelation, interaction and integration between the individual, his environment, body and mind, neural circuits and mental functions, as well as past and present life experiences and events. Hence, clinical conceptualisation depends on the patient's biological or psychosocial construct or theoretical model of disorder employed. Although the current approach for psychiatric diagnosis is phenomenological, it should not be synonymous with atheoretical. The foundation of Medicine is based on the diagnosis and management of a patient's illness according to the aetiology, ie, pathogenesis and pathophysiology. We also need to determine what is primary or secondary in the development of the illness.

Therefore, with regard to training, one should possess sufficient curiosity that is necessary for creativity, diligence that is necessary for achievement, and an open mind that is necessary for growth. We need to clarify, verify and rationalise what we do for the patient.

It is essential to learn as much as possible when you are young and inexperienced, including lessons that are taught by patients – to truly know and understand them, and not based on their rating scales. Once you become a consultant, you may be too proud or shy to learn. As a result, you would not be able to teach or avoid teaching what you do not know. A worthy consultant is a resource person, and he should remain humble and continue learning.

The often-quoted evidence-based Medicine framework is a standardised and statistical guide. Its application is a bottom line one-size-fits-all approach. Advanced or improved management would have to be individualised and customised, which calls for personal experience that have been built up rigorously over the years. Evidence-based Medicine should be complemented by experience-based Medicine. The pharmaceuticals' persuasive powers, which are driven by profits, should be kept in mind as well.

The classification of mental disorders is atheoretical, syndromal, and by consensus inclusion. Not all mental disorders are diagnosable and they often are forced into pigeonholes. Rigid adherence to the International Classification of Diseases, in particular DSM, leads to thinking in the box and stagnation.

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We should not be complacent or smug, just because it does not seem to matter whether a correct diagnosis is made, proper treatment is given, the patient may or may not respond, is not likely to die, does not complain – and no one is wiser. Besides the reading up on medical information, it is also necessary for us to continue seeking answers or solutions to problems in clinical research.

Finally, healthcare should benefit all and not exclusively kept for those who can afford treatment. It should be remembered that we mostly acquire experience and skills from subsidised patients in the beginning of our medical careers. We teach and preach that we should "first do no harm", that is: no harm by what we do to the body, no harm by what we say to the mind, but also no harm by what we charge to the pocket. We need to be conscious that there is mutual influence between the lifestyle we have or desire and the way we practice our profession. SMA

Dr Chee is an emeritus consultant at the Institute of Mental Health. He joined its predecessor, Woodbridge Hospital in late 1967. He is a general psychiatrist, trained in UK and taught by his patients. He believes that Psychiatry may appear woolly but it is multifactorial, multidisciplinary, person-centred and therefore holistic.