

Previous private psychiatric treatment among public mental patients: a preliminary local survey

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There has been considerable concern over disturbances to the public-private equilibrium in local health care provision. We investigated the situation among mental patients. Only 11.5% of new patients presenting to a public general hospital psychiatric unit had consulted a private sector psychiatrist previously. Of these, 60% had moved to the public sector for financial reasons and the same proportion had had their last contact with private care within the previous three months. There were no dominant reasons for choosing the private sector initially. No particular privately practising psychiatrist's patients were more likely to seek public treatment subsequently. The results are analysed and the implications discussed.

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Introduction

Recently, Hong Kong medical practitioners in private practice have voiced their concern over the declining number of patients seeking their service as a result of a drift towards public health care. A survey was conducted to determine the existence or otherwise of this in connection with the field of psychiatry, and, if it exists, the magnitude.

Subjects and methods

The sample comprised 200 consecutive new patients presenting as outpatients or consultation referral cases to the psychiatric unit of a non-university-based public general hospital over a six-week period. The case doctors were asked to complete a simple questionnaire regarding previous patient contact with private psychiatric care, the reasons for consulting privately practising psychiatrists, and those for changing to the public sector. The patients' future plans on where to seek follow up treatment were also investigated. The doctor completing the questionnaire was asked to write down the full name of the doctor whom the patient had consulted. A senior member of the department then confirmed whether or not that doctor was a psychiatrist.

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While the collection of information as to previous illness and treatment, the reasons for the current presentation, and patient views on future treatment is an essential and routine part of history-taking, extra effort was made to ensure adequate rapport before this was done.

Results

Of the 200 patients studied, only 23 (11.5%) had consulted a psychiatrist in private practice before. Three patients failed to name the psychiatrist(s) whom they had consulted. The remaining 20 patients mentioned a total of 18 private-sector psychiatrists. The reasons given by patients for initially consulting a psychiatrist in private practice and for subsequent attendance at a public clinic are outlined in Tables 1 and 2.

Discussion

Limitations of the present study

Being just a pilot study, the survey was crude and preliminary. The proportion of patients who had had previous psychiatric care in the private sector had been expected to be considerably higher than the number found. Had the low figure been anticipated, the sample size would have been expanded significantly. Statistical analysis of the results was precluded by the small number of relevant patients. There was also room for improvement in the design of the questionnaire.

Table 1. Reasons for consulting a psychiatrist in private practice (n=23)

Reason(s)*	No.	(%)
No need to wait a long time for the first appointment	4	(17.4)
Convenience, eg. more flexible consultation hours, geographical proximity	2	(8.7)
More privacy compared with attending a public clinic	2	(8.7)
Have learnt from others that the psychiatrist in question is very competent	3	(13.0)
Others	12	(52.2)

*Choice of more than one reason was possible

Despite these shortcomings, the study serves to show, or at least suggest, that fewer than one eighth of new patients presenting to the public psychiatric service had consulted private sector psychiatrists before. Private care was sought initially for a variety of reasons (Table 1), while financial considerations constituted the most important cause for turning to the public sector (Table 2). For many, this switch took place soon after their last contact with private sector care—60.9% had last seen a private sector psychiatrist within the previous three months. Thirteen per cent of those who changed intended to receive simultaneous attention from psychiatrists in both sectors.

Table 2. Reasons given for transferring to the public sector for treatment (n=23)

Reason(s)*	No.	(%)
For financial reasons	14	(60.9)
For a second opinion	2	(8.7)
Apparently not responding well to treatment obtained from the private sector	2	(8.7)
Sudden deterioration in mental condition	2	(8.7)
On the suggestion of the privately practising psychiatrist, who had not elaborated the reason	0	
Others	7	(30.4)

*Choice of more than one reason was possible

Psychiatric care: overseas and local delivery systems

In the United Kingdom, the vast bulk of medical care for mental patients is provided by the National Health Service. In comparison, psychiatrists in the private sector play a conspicuous role in Canada and the United States. It is interesting to compare two adjacent southern hemisphere developed countries: Australia and New Zealand. They have different health care delivery systems, while psychiatrists in the two countries are similarly trained. Private practice is much more developed in Australia, where there are twice as many psychiatrists and half as many psychiatric beds (both per capita) as in New Zealand. Singapore, which shares many economic and demographic characteristics with Hong Kong, has a mental health service largely provided by the public sector, but with contributions from private and voluntary organisations.¹

In Hong Kong, public facilities provide the bulk of medical services, particularly specialist and inpatient care. On 1 December 1991, the Hospital Authority, a statutory, quasi-governmental body was established to manage all public hospitals in Hong Kong. It assumed from government departments the management of the 38 public hospitals and related institutions existing at that time.² According to the latest available data, the Hospital Authority provides 3% of primary health care, 92% of secondary and tertiary care, and 100% of extended and long term services in the territory. The corresponding figures offered by the private sector are, respectively, 70%, 7.9%, and 0%. The remainder is made up by the Department of Health, and in the case of primary care, some non-governmental organisations.³

Under the Hospital Authority, considerable changes have occurred in the provision of public psychiatric care. Presently, there are 11 full time and three part time psychiatric clinics, and about 5000 inpatient beds. Organisation into service clusters and the development of clinical protocols and outcome indicators have taken place.⁴

There is no specialist mental health service offered by the Department of Health, but private practice has always been an important part of the specialty. Approximately 35 doctors with postgraduate psychiatric qualifications run their own practices. The family physician system is virtually non-existent in Hong Kong, but many general practitioners and some specialists other than psychiatrists (notably neurologists) do have a considerable number of neurotic or even mildly psychotic patients under their management. To all

intents and purposes, no inpatient beds in local private hospitals are designated for the mentally ill, but an occasional psychiatric patient is accommodated in a 'general' bed. In the private sector, individuals can choose their doctor freely. This has been considered a two-person transaction⁵ following the supply-and-demand principle.⁶

Different patient groups use the public and private practice sectors

It has been proposed that privately practising psychiatrists treat more short term and neurotic cases, while fewer chronic, mentally retarded, acute organic, violent, and suicidal patients are seen.⁶ A study that investigated the use of private psychiatric services in Australia found that females were greater users than males, except in childhood, where the opposite was true. Service use was lowest for childhood and for the elderly, and highest for the 35- to 44-year age group.⁷ A group in Denmark found that psychotics constituted 52% of the patients at a public outpatient psychiatric clinic, 25% of those seen by privately practising psychiatrists, and 12% of those receiving service from general practitioners.⁸ A longitudinal study of all patients seen in the first five years of a Canadian psychiatrist's private practice revealed that depression was the single most common diagnosis and psychoses were comparatively rare. Personality disorder was found in a significant proportion of patients.⁹ In general, these overseas findings are in line with recent local opinion on the psychiatric morbidity of different communities and populations in Hong Kong.¹⁰⁻¹³

In the present sample, 60% of those who transferred to the public sector for treatment did so for financial reasons. The situation is reminiscent of the two-tier system in American psychiatry: one for those with insurance, and one for the poor and the severely disabled.¹⁴ In Hong Kong, health insurance cover for psychiatric disorders is minimal, but it appears likely that there is a similar two-tier system in our psychiatric care: those who can afford it and whose illnesses are not too disabling tend more to seek treatment in the private sector, whereas those who are poorer (or become so as the mental disorder progresses) and those who develop severe symptoms are more likely to receive public psychiatric service.

Particular characteristics of Hong Kong society and the different effects of various psychiatric illnesses on the earning capacities of the sufferers probably explain the existence of a gradual, steady shift from private to public psychiatric care. In economic terms, the demand for service in both sectors is comparatively constant

and the respective market shares relatively stable. There is no demonstrable evidence of the public sector encroaching on the private one, at least from the clients' viewpoint. The magnitude of any reciprocal drift is uncertain. Some patients keep shopping around between the public and private sectors. A formal survey is needed to confirm these impressions.

As mentioned already, while Australian and New Zealand psychiatrists receive similar training, their psychiatric care delivery systems are different. Private practice is much more developed in Australia, where the combination of more psychiatrists in private practice and fewer public hospital beds for the mentally ill is considered to cost less than the New Zealand system, which supports only public sector, hospital-based services.¹⁵ Based on this comparison, can we say that the existence of a substantial private element is more cost-effective and probably beneficial to all parties (patients, psychiatrists working in all settings, health administrators, and taxpayers)?

Conclusion

Pending the availability of further findings, there seems to be a healthy public-private equilibrium in local psychiatric care provision. The magnitude of any drift between the two sectors needs to be ascertained and confirmed by future studies, as does the proportion of patients who seek treatment from both.

Thirteen per cent of the patients in the present survey who switched from private to public care intended to return to the private sector for further treatment. All wanted to receive public psychiatric service at the same time. Our unconfirmed impression is that a substantial proportion of patients straddle the public-private interface of health care. Although not in the majority, they make proper liaison between specialists in the two sectors essential, at least with regard to individual patient management. The fact that a majority (60%) of those who later sought public psychiatric service had had their last contact with the private sector within the past three months also emphasises the need for adequate clinical communication between the doctors in the two sectors.

The present survey at least provisionally disproves any 'competition' for clients between psychiatrists in private and public practice. On the contrary, it suggests the need for more collaboration in effecting better patient management. Significant changes are anticipated in the specialty in the years to come. Sub-specialisation, medicalisation, privatisation,

feminisation, and organisational diversification have been identified as major trends in American psychiatry.¹⁶ At least some of these will occur in Hong Kong. Closer liaison among psychiatrists from all fields will definitely go a long way towards serving clients better and preparing the profession for the challenges ahead.

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