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The Clinical and Economic Implications of Running a Psychiatric Outpatient Facility without the Continued Presence of a Psychiatrist

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ABSTRACT

Recruitment of psychiatrists to remote areas of a country is difficult. The consequence is seen clinically, patients do not get qualified care, and the facilities pay a lot for maintaining a rudimentary service. This is illustrated with data from an outpatient facility set up with one position as psychiatrist. The cost of maintaining the role of a psychiatrist by four stand-ins is the double of what one single doctor would cost, NOK 2,070,000 versus NOK 950,000 (NOK 100 = $12.50). The decisions made by four is difficult to streamline for patients at the facility and they encounter non-congruent treatment options.

INTRODUCTION

In a country with a social democratic health care system as in the Scandinavian countries, health care is supposed to cover all citizens at an equal level, regardless of where you live, age, sex, type of illness and personal wealth. This was originally based on the National Health Service in Britain [1]. There are important clinical and economic reasons for this system to fail due to geographical distribution of services, especially within mental health [2-5]. Norway is geographically very stretched out country. For instance, is the most northern county almost as big as Denmark. There is no psychiatric hospital with resident beds in the county and patients in need of a resident stay in a hospital setting have to be transferred to the nearby county, a travel of more than an hour by plane or some 8 to 10 hours by car. Often the transport is not feasible because of weather condition. There are six district polyclinical facilities throughout the county. Not all of them have resident beds. Patients in need of a closed door or coerced treatment cannot be handled in the resident area of the facility.

Urban and rural divide contribute to the difficulties described below. Psychologists, social workers, and nurses are employed in some psychiatric outpatient facilities where a psychiatrist is not present all the time. This would never be the case for an outpatient surgery. How may this come by?

Clinically

- Recruitment of psychiatrists is not sufficient to cover all outpatient facilities. The reduction in the use of old style asylums as a reflection of the "law 180" reform in Italy, demanded the deployment of outpatient facilities close to where people lived. These outnumbered the supply of psychiatrists.

- A psychiatrist is not deemed important. A consequence of the lack of psychiatric expertise may be that the other health professions continue to treat patients without use of medications and without exclusion of medical conditions as the reason for a referral to the outpatient facility.
- The role of the psychiatrist in the outpatient facility is one of controlling on-going medical treatment or instituting new if the psychotherapist deems it important.
- A polyclinic with resident beds needs a qualified doctor on duty all days (24/7). This is solved either by having this one psychiatrist on duty all days, which may be cumbersome or with a team of psychiatrists covering all days after a set schedule. Some of the members of the team do not live in the vicinity of the clinic, thus offering a phone discussion of cases and treatment options. The distance between the clinic and the dwelling of the psychiatrist on duty may be as between London and Vienna.
- Collaboration with GPs is deemed sufficient for the use and evaluation of psychotropic medications.
- A long distance from university clinics and bigger cities increases the shortage of psychiatrists who find it unsatisfactorily to practice without colleagues. This is also relevant for other medical specialities.

Financially

- Positions as psychiatrists may be divided between two to four colleagues covering all weeks of the year
- Doctors in training in psychiatry are employed to cover some of the aspects needed, but their work does not count as part of specialization in psychiatry. And several aspects of the work as a psychiatrist, as initiation of medication and coercion are illegal for the doctors in training. Although the use of doctors in training is important, they need experienced specialists for their training. Doctors in training get lower pay than the full specialist.
- Legal requirements force the clinics to hire psychiatrists through a recruitment firm. The cost of this is illustrated below.

Only psychiatrists and psychologists can set up a private clinical practice with reimbursement from the National Health Care System (NHS). Privat payment for treatment with a certified psychotherapist is legal, but the number of such practices are low in the same areas as the ones described above.

MATERIALS

One outpatient facility in Northern Norway is described as an example. The employees are psychologists, social workers and specialized nurses. There is one position for a fulltime psychiatrist. Four psychiatrist cover this position with one week each. None of them reside in Northern Norway. The outpatient facility is situated in a nearby building to the local somatic hospital. The psychiatrist is giving liaison psychiatric service to the somatic departments. Evaluation of patients referred to the hospital after a suicide attempt is the most frequent category.

Some patients must travel for more than two hours to get to the facility. Weather conditions may be such that appointments must be cancelled at short notice.

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Stipulated production demand on each counsellor is three encounters with patients five days a week. They have regular pay regardless of production level. The psychiatrist has a production demand of six encounters per day. No explanation is given for this discrepancy. There is no pay per service system.

The value of Norwegian kroner is set at NOK 100 = $12.50.

RESULTS

Pay for a fulltime psychiatrist is NOK 950000 per year before tax. A part time psychiatrist through recruitment firms may get NOK 850 per hour worked, i.e. NOK 850 x 40 hours per week x 45 weeks per year = NOK 1,530,000. The psychiatrists get travel and accommodation covered by the employer. The recruitment firm asks a surcharge on the hourly salary of NOK 300 per hour, i.e. NOK 300 x 40 hours x 45 weeks = NOK 540,000. Surcharge level is not openly stated, and differs between recruitment firms. The take-home-pay of the psychiatrist is always higher than the pay for a regular employed psychiatrist. There is a possibility of competitive setting of pay level. Especially when the facility or clinic risks closure for not following established rules or law.

The increased administrative costs for the facility and the firm by having to hire four psychiatrists are not calculated.

DISCUSSION

Health care providing is not straightforward. The materials in the present case show one of the problems. Giving equal service to all regions of a country is the aim sine qua non in Norway. At present no political party in parliament would propose the acceptance of unequal health service throughout the country. Certain preliminary factors must be present to achieve this goal. Psychiatrists are free to apply for a job wherever they choose. Payment is through the National Health Service (NHS) or as private practitioners without any reimbursements from the NHS. Psychotherapy, given by a psychiatrist or a qualified psychologist, consumes a lot of time per patient. At 1000 to 2000NOK per hour expenditure is high. One treatment session per week would consume a high percentage of the median income (450000 NOK) per year. The median income in big cities and agglomerations is higher than in rural and remote areas of the country. The cost to patients is relatively higher in remote areas, and the transport routes are more cumbersome and longer. No show for appointments is frequent because ferries do not run and mountain passes may be closed.

If you cannot turn up for your appointment, you may be scheduled for another appointment a week later. But at this polyclinic you will meet another psychiatrist as there are 4 of them having their own weeks. A psychotherapeutic process is hampered by changing the person you talk to. Getting in contact with the usual psychiatrist is inconvenient and they do not necessarily live in the same country, a fact that introduces another problem. Patient and therapist may have difficulties understanding each other. The subtleties of language is important for the depth of the therapy process. Four psychiatrists in stead of one make communication suboptimal. Creating consensus on social, diagnostic and practical ways of running a facility is not easy to come by. The four psychiatrists may not be aware of the inherent discrepancies they promote in their private way of doing psychiatric treatment. Other employees in the polyclinic experience that ways of working may be different from one psychiatrist to the next. The

flexibility presumed from the other employees complicates effective administration of the polyclinic. Increased costs to the polyclinic is a consequence of the slightly different systems under each psychiatrist. They are not included in the calculations above.

The organization of psychiatric services in remote areas, as described from the above facility, is found in other clinics too. Facilities wary in size and some also have a resident section. A somatic hospital is situated alongside the psychiatric clinic, but in just a few locations. They all by law need a psychiatrist in the staff. Facilities with a resident section need a psychiatrist 24/7, but the psychiatrist do not have to be present in the facility on a 24 hour basis. One facility has one psychiatrist working 24/7 for a complete week, which is irregular according to the law of working hours and conditions. Health practitioners are partly exempt from the law. A surgeon would hardly be asked to contribute with such a long working time. To explain the willingness to do such an effort, the high level of remuneration would be an answer. The facility gets necessary psychiatric service covered, but one might argues that the quality of the service might be reduced. As the quality of psychiatric treatment is harder to ascertain than the quality of for instance eye surgery, a psychiatric facility can run for a longer time without to many complaints. Work in a psychiatric polyclinic is based on cooperation with all the different employees, and it is difficult to pinpoint who would be responsible for the quality or lack of such. Delegation of responsibility is presumed from the psychiatrist to other staff members, but one psychiatrist would not be able to check all what is done by the other 15 to 30 staff members.

The psychiatrist's work may deteriorate to a situation where he or she just initiates and controls the medications given to all patients in the clinic. He or she would thus not use qualifications for therapy and testing. And with 4 psychiatrists changing every week the possibility of unnecessary and rapid changes in medication would increase.

CONCLUSION

The delivery of the psychiatric, psychological and social aspects of the field from the facility to the inhabitants of the catchment area depends on the presence of a psychiatrist. This is a requirement by law. Supplying psychiatric help to the public is a political aim sine qua non. Thus, the health administration must supply even if the cost of doing so is twice the cost of a resident fulltime psychiatrist, i.e. in this case NOK 2,070,000 versus NOK 950,000.

The case may be interpreted as a solution to an impossible combination of high quality mental health service and lack of specialists. You may then loosen the sine qua non principle, i.e start giving less and less qualified mental health service to the population. If you want the highest level of service, you have to live closer to the facilities. Just the same principle people accept when it comes to bakeries and cinemas. Or if you do not accept this solution, you would have to accept a higher cost of delivering this service at remote places. And the costs may even be divided between public and private purse. If you do not want to accept this we are back to a system giving so called equal service, which in reality is suboptimal.

Ensuring continuity of care and equality of medication practices are difficult and often patients are met by differing treatment philosophies. As the four psychiatrists seldom meet, contrary to the situation in a bigger facility, the public may be bewildered. The decision whether to continue or stop a treatment series may differ between the therapists [6]. It is cumbersome to contact one of the other therapists whenever prescriptions must be renewed or revised.

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Psychiatric treatment with due emphasis on somatic and psychological factors is not as clear cut as in an eye clinic. Non-adequate quality treatment is harder to pinpoint within a psychiatric setting. Even more so since the single psychiatrist cannot guarantee that patients treated by other health professionals are sufficiently investigated and monitored. And, when the psychiatrist is not there because of holes in the work schedule.

Society pays a high price, here the double price for keeping an outpatient psychiatric facility running with insufficient psychiatric coverage.

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