Hong Kong Journal of Psychiatry (1995) 5, 50 - 51

COMMENTARY ON
"DIFFERENT PERSPECTIVES IN SETTING PRIORITIES FOR DEVELOPMENT OF PSYCH-IATRIC SERVICES IN HONG KONG"

The article gives a very interesting account of how the author sees the dichotomized perspectives of the clinician and the public health planner in the planning of psychiatric service developments. From his discussions, however, I can discern elements of heterogeneity in both groups.

As reflected in the article, clinicians' views tend to differ depending on whether they are working in mental institutions or more in the primary care/community setting. Although epidemiological analysis of psychiatric morbidity and mortality is the common tool, current knowledge is far from perfect, and different groups of clinicians tend to emphasize on different aspects of this body of information. It can therefore be inferred that the conclusions of different clinician groups on service priorities would be different.

On the other hand, public health planners are described to be taking into account a multitude of factors including epidemiology, cost-benefit of service programmes, politics, and availability of resources. It is however apparent that depending on how one understands and weighs the various factors, this common approach may yield vastly different results.

The situation is further complicated by the blurring of demarcation between clinicians and public health planners. In the Hospital Authority Head Office, development of clinical services falls within the purview of not one but a group of executives, many of whom have medical, though not necessarily psychiatric, background.

On the other hand, input from psychiatrists are provided by the Co-ordinating Committee (COC) in Psychiatry, where all Chiefs of Service in psychiatry are present. Recommendations from the COC on service priorities serve as important information influencing decision makers including Head Office executive and Hospital Chief Executives (HCEs). Although the COC members are psychiatrists themselves, as collective body they are also adopting much of the public health planner's perspective of cost-benefit, politics, resource availability etc. in formulating recommendations. Two members are actually HCEs themselves.

Given this blended background and perspectives among decision makers many of whom are simultaneously clinicians and managers, it is difficult to see pure manifestations of the opposing perspectives in real life as described in the article. I have not witnessed "these two professional groups (clinicians and planners) do not agree with each other in the setting of priorities" happening any more frequently than disagreements among clinicians themselves, or among managers themselves. I agree completely that it is important to bear in mind the two possible perspectives, but the strict application of such model to explain past decisions or forecast future ones in our particular setting may not be too fruitful.

Taking the example of the priority areas as described by the author under the respective headings of "priorities from the clinician's perspective" and "priorities from the public health planner's perspective", my recollection is that all are considered important by clinicians and managers alike. On the other hand, there are

many improvement initiatives not listed in the article, which have certainly been accorded very high priorities in the past few years, including :

(1) development of psychiatric clusters and local service networks;
(2) improvement of hospital environment for psychiatric patients; and
(3) development of clinical protocols and outcome indicators.

In terms of resource consumption (which includes the time cost of senior psychiatrists putting their heads together in meetings and implementing changes in their departments), these programmes are no less demanding than say development of psychogeriatric services. In terms of content, they are certainly both clinical (e.g. liaison psychiatric coverage of Caritas Medical Centre by Kwai Chung Hospital) and managerial.

This serves to illustrate my argument that in terms of priority in service development, both the clinician's and planner's perspectives are currently applied in an integrated fashion by a considerable group of clinician-managers who shape the decision making process in the Hospital Authority. In what proportion the clinician's or the planner's perspectives operate within each individual's mind to explain his particular inclination, is no more relevant than :

(1) in what proportion the institutional or the community perspectives in psychiatry are in his mind; or
(2) in what proportion the interest of his own department or the interest of the whole organisation are in his mind; or
(3) in what proportion the importance of a particular initiative (say sub-specialty) or other initiatives (sub- specialties) are in his mind; and so on.

Therefore, a more accurate analysis of the priority setting process will likely involve a detailed look into these various factors, together with other environmental and organisational factors such as the prevalent community values, government views, congruence with the strategic directions of the Authority, and availability of resources and expertise.

As far as the Hospital Authority is concerned, services for the mentally ill and mentally handicapped have been recognised as one of the ten highest priority areas. In its Corporate Plan to the Year 2000, the Authority has also set give strategic directions including the seamless health care system outcome-focused care, community partnership, organisational transformation and infrastructural innovation and development. These are very broad parameters by which programme suggestions will be evaluated, but the content and context of the programmes themselves have to come from clinicians.

Instead of using a 'dichotomized perspectives' model, I would prefer to view the current decision making process on psychiatric service development as an interative and learning model drawing on the possibly widely different perspectives and expertise of all involved parties, with whatever historical, educational, experiential, social and political reasons that might have given rise to such differences in the first instance.

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