

# Cost benefit in psychiatry - a debate

Stephen Tyrer and Geoffrey Wallis

The North East and Midland Divisions of the College joined for their Annual Meetings in York in September 1993 to debate 'Psychiatrists should implement only those treatments that have proven cost benefit'.

## Proposers and opposers

Professor Alan Maynard, Health Economist, University of York, proposer, said that the purposes of spending for health were to reduce morbidity and delay mortality but resource allocation was based on beliefs rather than facts. Embarrassment about provision for the mentally unwell in the community had replaced embarrassment about institutional provision. Psychiatrists had failed to evaluate policies for patient care and to link with health service researchers. A review in 1988 of the literature on economic evaluations in mental health reported only seven trials of uneven quality. Specific serotonin reuptake inhibitors in the treatment of depression gave a nice example of the way in which psychiatrists, like economists, were led astray. Trials indicated that they were more effective than the tricyclics and in overdose appeared "to have no adverse effects on organic function" but they were 30 times more expensive than the tricyclics and meta-analysis showed that this superiority was "illusory". Effectiveness claims for psychiatric care were based on casual empiricism, where there was good evidence on effectiveness it tended to be ignored and National Health Service purchasers of psychiatry were as ignorant as the providers. Inefficiency wasted resources, deprived potential patients of care from which they could benefit and was unethical. Unethical practitioners should have their licence to practise removed. Their duty of care required proven cost effectiveness but a paper in the *British Medical Journal* in August 1993, showing differences between English and French psychiatrists in the diagnosis and treatment of schizophrenia, indicated that the treatment of this illness was inefficient. If psychiatrists failed to implement only those treatments that had proven cost benefit, purchasers should not contract with them.

Dr Fiona Caldicott, President of the College, opposing, said that what had brought us into medicine was helping people and enjoying science. Nobody took up psychiatry because he or she wanted to be a cost benefit analyst. We were not engaged in making profits. We should talk of benefits to the patient and the patient's family rather than cost. She asked how you measure recovery of the depressed patient, whether you would withhold treatment for certain patients, such as the elderly and those with learning disabilities, and what would the public and patients think if treatment could not be offered because of cost. Studies showed that psychological treatments significantly shortened in-patient treatment of physical illnesses but the benefits of psychotherapy and the cost of caring for dangerous and disruptive patients and patients whom we could not cure were particularly difficult to measure. Patients who overdosed needed long and expensive treatment. Psychiatrists, in a complicated working life, had to judge the needs of the patient and the patient's family but they did consider cost and the College had set up a committee on audit.

Professor Sydney Brandon, Postgraduate Dean, Leicester University, did not know why he had been chosen as seconder for the motion but appreciated that Professor Maynard needed a psychiatrist in this role. The subject was complex in methodology and collection of data. Contrary to the spirit of the motion, Osler had said "Use a new drug while it is still effective". Health managers could not estimate the cost of electroconvulsive therapy compared with that of drugs. When deep insulin coma therapy was shown to be no more effective than barbiturate narcosis in the treatment of schizophrenia, the profession responded. ECT had been shown to be cost effective and antidepressants, in a time of increasing rates of depressive illness, were cost effective in reducing length of stay in hospital and preventing suicide. Behaviour and allied therapies were effectively replacing benzodiazepines in the treatment of anxiety.

Mr Lionel Joyce, Chief Executive, Newcastle Mental Health National Health Service Trust,

seconding Dr Caldicott, wondered whether Professor Maynard should resign or whether there should be a health economist on committees for the appointments of psychiatrists. A study had shown that psychotherapy for patients aged over 65 in general wards saved money but did not interest managers. The auto-immune deficiency syndrome and child sexual abuse had attracted funds and currently mentally disordered offenders and cognitive therapy was doing well in this way. He asked what would be the popular choice in 18 months' time. Some people gave as their business 'earning a living' and others thought that psychiatrists should implement only treatments that were 'sexy' but psychiatry had moral and social obligations to extend benefit as far as possible to relieve distress and disturbance regardless of media interest.

### Speakers from the floor

Several thoughtful contributions underlined lack of the information in the NHS and difficulty of comparing the cost benefits of particular treatments, such as community v. institutional care and treatment by an anaesthetist v. treatment by a psychiatrist for pain.

Professor John Cox considered that cost benefit analysis brought pressures such as user empowerment but users would not want the main determinant of their treatment to be cost benefit. Professor Nicol Ferrier pointed out that the selection of patients for clinical trials was often rigid and any therapeutic benefit emerging from them was difficult to measure and not apparent at first but might appear later. Professor Greg Wilkinson cited financial problems associated with the diagnosis and treatment of myalgic encephalomyelitis.

### Summing up

Professor Brandon said that the cost of psychiatric services was escalating throughout the world. At the inception of the NHS mental health had been almost excluded and currently Hillary Clinton in the USA was likewise thinking of trying to exclude it from the health budget.

Professor Maynard said that the NHS was dominated by accountants and doctors while economists mediated in very complex issues. The ancient Greeks had recognised the importance of spending on health. We should argue for more expenditure on the basis of effectiveness and not revert to categorising as dead, relieved or not relieved. Expenditure on information in the NHS amounted to £25m per annum but league tables of performance were based on poor sample size and bias. Little was spent on research and development and even less on evaluation. There were philosophical issues on trying to improve the length and quality of people's lives. Commercial pressures resulted in unnecessary investigations and treatment. Cost effectiveness should not be seen as threat but should help clinicians to target their resources and the doctor/patient relationship should not be influenced by commercial factors. Without cost benefit analysis the Treasury might direct change.

Dr Caldicott concluded that we were limited by lack of information and evaluating the cost of treatment was difficult. She agreed with Professor Maynard that more research and development was required. Accepting the motion would exclude innovation in treatment, so that we could not try new drugs or methods of psychotherapy. Nevertheless we needed good costings of the care we delivered.

### Outcome

After the discourse had flowed with surprisingly little passion but intense interest an unexpected degree of consensus between the two sides emerged. Mr Joyce had prophesied that in this gathering the motion was bound to be lost and in the final show of hands its defeat was overwhelming.

Stephen Tyrer, *Consultant Psychiatrist, Royal Victoria Infirmary, Newcastle-on-Tyne, NE1 4PL, and Prudhoe Hospital, Northumberland, NE42 5NT; and Geoffrey Wallis, Consultant Psychiatrist, Harrogate Clinic, 23 Ripon Road, Harrogate, HG1 2JL*