About Benefits and Costs

Edited by Leon Gordis

Clinical vs. Financial Managers

The high cost of providing health care and the concomitant growth of the managed health care industry has blended the fields of economics and medicine in a manner that places for-profit companies solidly in the halls of hospitals, clinics, and private physicians' offices. Paul Samuelson defined economics as "the study of how men (*sic*) and society end up choosing, with or without the use of money, to employ scarce productive resources that could have alternative uses, to produce various commodities and distribute them for consumption, now or in the future, among various peoples and groups in society. It analyzes the costs and benefits of improving patterns of resources allocation."

On the face of it, using cost-benefit analysis to define health care goals makes good sense, especially since resources are increasingly limited. However, problems can occur when the interpretation of the analysis is within the purview of market managers, rather than patient managers.

Inherent in cost-benefit analysis is the assumption that the variables are commensurate; that is, they can be measured in the same unit of measure, ideally dollars. However, because this assumption is not entirely accurate, an alternative approach is used. Cost-effectiveness analysis addresses elusive intangibles, such as quality of life and pain and suffering, that cannot be evaluated in commensurable terms. Some costs, such as treatment expenses and lost salary, are measured in dollars; other costs, such as mortality (years of life lost) and morbidity (pain and suffering), are measured subjectively but given numerical value. Effectiveness, the other side of the coin, includes outcomes such as gained years of life and decreased morbidity.

Generally, greater effectiveness costs more. This leads to the basic question: Is the benefit worth the cost, or are the cost savings enough to justify accepting a lesser benefit? Next we must ask, from whose perspective? The patient's? The clinician's? The managed care administrator's? Society's? Each has a different perspective that can change depending on what role is being played at the time of the decision. For example, the clinician might think differently as a patient. The key is who manages the decisionmaking process.

Cost-effectiveness analysis assumes that the costs and benefits are valued equally by all and that what is good for all is good for one. Obviously this is not always true. While cost-effectiveness analysis is based on target populations, in practice decisions about care are made during each clinician-patient encounter. Because each encounter is different, the clinician's responsibility to the patient is often at odds with her responsibility to society. If the clinician is a salaried employee of a managed care corporation, the manager of the care is not the manager of the finances, and an even more difficult situation might arise.

Cost-effectiveness analysis is based on comparing two or more alternatives of care. Clinical, service, and cost outcomes are usually considered. Clinical outcomes include variables such as years of life gained or lost and functional status of the patient. Service outcomes involve patient satisfaction with facilities, professionals, and staff. Cost outcomes involve the dollars paid for services and complications of the therapy.

With managed care growing rapidly, cost outcomes are the primary units in decisionmaking. This can be harmful to patients. For example, administering an injection once a week to a child is much less expensive than a surgical procedure. However, the child may have an intense fear of injections to the point of having nightmares and behavior problems. In that case, the more costly procedure would be the most effective.

Most purchasers of health services or insurance choose the least expensive option. The assumption is that the clinical outcomes will be the same in all options. When economics dominate decisions, cost takes priority. Other outcomes are seriously considered only when costs are level among competitors.

In a market economy, service outcomes are likely to be considered next. Decisions are made based on waiting time, types of facilities, and other factors. The relative value of these service outcomes can be measured by inexpensive surveys of patients to determine their perceptions of care. The inherent danger of using market values is that a short waiting period in a nicely furnished office probably is considered better than a long waiting period in an unpleasant office, with less attention given to the clinical outcome. Actual physical outcomes, which require expensive and extensive clinical trials and comparisons, are considered last.

Our society is in danger of allowing financial managers to dictate clinical practice using the economic tool of cost-effectiveness analysis. This tool can assist in clinical decisions, but the final determination must remain in the hands of the clinician.

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