EDITORIALS

Teaching About Cost-effective Use of Medical Resources

Still Trying After All These Years

Two articles in this issue describe efforts to help clinicians consider economics when making clinical decisions. Kravet et al. describe a conference where the principal goal is to teach clinicians about hospital finance,[1] and Weiner discusses dilemmas facing clinicians who care for uninsured or underinsured patients.[2] The authors of both articles: a) presume that clinicians are insufficiently informed about specific economic factors when making difficult clinical decisions; and b) suggest that more information would be helpful. These presumptions and concerns are not new. I first became aware of the importance of economic factors in making clinical decisions as a resident and junior faculty member in the 1970s. Many medical centers were investigating the increasing costs of medical care and the need to evaluate cost-effective clinical strategies. Seminal publications by clinicians, economists and senior medical educators[3–6] were discussed widely amongst my colleagues. In this environment, I participated in a study and coauthored a paper[7] that: a) demonstrated that clinicians were insufficiently informed about specific economic factors when making clinical decisions; and b) suggested that more information would be helpful.

I would like to put these two articles in a historical perspective and to suggest reasons why continued effort is important. In 1960, health care costs comprised slightly over 5% of the gross national product. Medicare and Medicaid were enacted in 1965 and many commercial insurance plans adopted Medicare's usual customary and reasonable payment structure. Within a few years, it was obvious that this payment structure was inflationary.[8] Coincidentally, the first good evidence supporting drug treatment of hypertension was published. As the number of doctor visits and diagnostic tests and the cost of drugs began to increase, the prevalence of stroke and other complications of untreated hypertension fell.[9] Clinicians and others began to consider the most cost-effective tests and treatments for a host of diseases for which multiple expensive and effective treatments now existed—a recent *User's Guide* reviews the methodology of studies designed to make these determinations.[10] In the early 1980s, two separate factors accelerated the movement toward containing health care expenditures. Foreign competition, especially from automakers, forced employers to reexamine the rising costs of private health insurance and many negotiated lower rates with insurance companies. At the same time, the Reagan administration restrained the rate of social spending. In response to this squeeze from both the private and public sectors, investigators examined data showing a wide variety of practice patterns and suggested educational interventions and other remedies to teach clinicians how best to use limited resources.[11–13] Results of these interventions were varied, but the consensus was that changing physicians' behavior was difficult.[14] Despite all of these efforts, by 1990, health care costs comprised 13% of the gross national product. The increase in health care expenditures slowed down in the 1990s for several reasons. Unfortunately, this appears to have been a temporary reprieve and the issues discussed in these articles are once again prominent and important.[15]

The article by Kravet et al. describes a monthly multidisciplinary conference, in which abstracts of clinical and financial/administrative information (drawn from the charts of patients discharged from the hospital) are reviewed by medical students, residents and faculty. "Invited guests" included a range of hospital financial and administrative staff. The structure of the conference includes a brief clinical presentation, a review of the itemized hospital bill, and a facilitated discussion of relevant issues related to coding, cost-effective decision making and other economic issues. The goals of the conference are to improve understanding of hospital reimbursement and resource management, and to emphasize the importance of collaboration among the entire health care team in providing efficient, effective health care.

The article by Weiner discusses the dilemmas that we face when caring for uninsured or underinsured patients. The problems of the 44 million uninsured and the even larger number of underinsured in the United States have been described frequently in both medical journals (listed in the article's bibliography) and in the popular press.[16] The author summarizes the federal laws and regulations that relate to uninsured and underinsured patients—particularly the ones concerning waiving of fees and undercoding. He then suggests a framework for working with the patient and the local charity care system or safety net provider. He concludes that to best serve their patients, physicians must also address issues of social justice outside of the office and advocate for changes that would benefit these patients.

Both papers describe the importance of the "pragmatic" and personal nature of the doctor's interaction with

the patient. Doctors deal directly with patients in a way that most hospital administrators, legislators, and insurance company employees do not. Sam Walton, the founder of Wal-Mart, was well known for dropping in unexpectedly to talk directly to front line employees. He also sometimes posed as a salesclerk to have an opportunity to talk directly to customers. He emphasized the importance of this management technique in his autobiography: "The folks on the front lines—the ones who actually talk to the customer—are the only ones who really know what's going on out there. You'd better find out what they know. This really is what total quality is all about."[17] Similarly, the conference described by Kravet et al. brings the detached world of the hospital administrator together with the pragmatic personal world of the clinician. He emphasizes the benefits to the clinicians in learning about economics. I suspect the administrators derived equal benefit from learning more about the "customer."

Like Weiner, I too feel that clinicians "who actually talk to the customer" can use this advantage to advocate for change. I was at a meeting last month in which a group of physicians discussed health policy with state legislators. One of the physicians pointed out that uninsured patients are charged full rate for testing at his hospital, but insurance plans get a discounted rate. The legislators thought that this was done so that the hospital could claim a higher bad debt and seemed surprised that many of our patients, like the one described in Wiener's article, will forego care to avoid being pursued by a collection agency. A productive discussion about methods to address this disparity ensued.

Why does it seem difficult to get clinicians to employ decision analysis and other evidence-based tools to use resources optimally? Weiner stresses the difficulty in dealing with patients in a hurried environment. Some blame the backlash against HMOs, but at our institution, we have been able to teach residents about cost-effectiveness in the context of a managed care environment.[18] I believe that there are many factors that cause physicians to use resources sub-optimally.[14,15,19] However, I wish to emphasize one factor that has been actively discussed by leaders and members of the Society of General Internal Medicine this spring: pharmaceutical company advertising and support of educational and research efforts.[20–22] Much like the literature on cost-effective decision making, there is a long history of investigation of the effects that advertising, gift giving and industry-sponsored education have on the practice patterns of physicians. It has been repeatedly demonstrated that these efforts lead clinicians to use new and more costly treatments over equally effective alternatives.[23–25]

Lastly, I think that the juxtaposition of these two articles—one on teaching resource management and the other on care of the uninsured—fortuitously highlights the *best* reason to continue to train clinicians to use resources cost-effectively: the consensus that universal health care in the United States will not occur until we deal with the problems of expensive, variable, and cost-ineffective care. In 1974 the economist Victor Fuchs described this linkage logically and forcefully by pointing out that it determines "Who Shall Live."[5] This message was emphasized by Lester Thurow, another economist, a decade later[26] and by many others since. This spring, the physician David Blumenthal restated this point and additionally argued that rising health care expenditures inexorably increase the number of uninsured as employers cut back on health care benefits.[15] I strongly agree with these authors.

It's been a long time since I started incorporating cost effective decision making into my teaching and practice, and even longer since I went to high school with Paul Simon, but I'm still trying after all these years. It's the right thing to do. — **Robert L. Braham, MD,** *Division of General Medicine, Columbia Presbyterian Medical Center, New York, NY.*

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