Cost and Clinical Decisions

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The increasing amount of money devoted to health care is well recognised. From 1949-78 health care expenditure at 1975 prices increased from £2.38 billion to £5.47 billion[1]. As a proportion of the Gross Domestic Product it increased from 3.4 to 4.85 per cent, and as a proportion of government expenditure from 35.9 to 44.4 per cent during the same period. These trends have continued.

At a service level Abram[2] showed that expenditure on radiological services increased at 6 per cent p.a. over the 10 years 1968-77, a figure matched by the pathology services over the same period.

A service that can consume all the money made available to it and needing an additional 1 per cent a year just to stand still, requires the utmost efficiency in the deployment of its resources. No well is bottomless, and inefficient use of resources ultimately means denying some patients the care they need.

Doctors, it is suggested, would use resources more efficiently if they heeded costing or budgetary information. This approach is intrinsically unrealistic; doctors are not trained to appreciate financial information and they work in a health service in which costs for individual patients are not made explicit. A more appropriate solution to the problem is suggested.

Over the past 10 years, many studies, seeking ways of encouraging doctors to become more cost-conscious, have been carried out.

An extended review by Eisenberg and Williams[3] classified six different strategies used for this purpose. They were: education, peer review with feedback, administrative changes, participation, penalties, and rewards. Virtually all the methods reviewed influence doctors to act with greater economy.

Leaving aside the possibility that only reports with positive findings are published, it seems relatively easy to influence doctors to improve their use of resources. Almost any activity with this end seems to be successful, suggesting that doctors are either excessively receptive to these ideas and extremely flexible in their outlook, or perform so inefficiently that any change is for the better.

The almost universal success in altering doctors’ behaviour patterns may be another example of the ‘Hawthorne Effect’, first documented in 1930 when a sociologist examining ways of improving efficiency among workers came to the conclusion that the specific methods tried were less important than the fact that someone was taking an interest.

So the question changes from whether doctors can be influenced to act more efficiently, to the way in which all doctors can be influenced to act more efficiently always.

Doctors and Costs

The argument for giving doctors financial information follows from the fact that the major part of Health Service expenditure is generated by clinical decisions or relates to clinically-determined activity[4]. It is suggested that 50-80 per cent of health care costs are controlled by physicians[3], though studies[5] have shown that few physicians have accurate knowledge of actual costs.

These statements do not imply that the physician can influence this proportion of health care costs directly. A more realistic and detailed view points out that 87 per cent of costs generated by doctors are fixed (salary of staff, equipment and buildings) and not subject to short-term changes[6].

It has been repeatedly and strongly argued that doctors ought to take a greater interest in the financial consequences of their actions. Harper[7] suggested four reasons for this. (a) Cost information is another measure of doctors’ care. (b) Knowledge of the costs of treating various diseases is useful in planning. (c) High-cost care indicates a need for investigation to try to reduce it. (d) Identification of scarce resources.

It is also hoped that better cost information may pay for itself in better decisions by clinicians about the allocation and use of resources[8]. If doctors were more accountable for expenditure it would lead to better use of resources[6]; a clinician should be responsible for using resources to the best possible degree, since he must maintain clinical standards in the face of financial restraint[7].

Problems of Cost Information for Doctors

Giving doctors financial information to help in containing costs might cause problems. According to Bartlett[6], there are few incentives to use NHS resources efficiently. Clinicians do not have the time, skill, or inclination to assess the cost of their own activities. By training, experience and motivation, the average clinician is mainly concerned to do his best for the individual patient[9]. Clinicians view budgets ambivalently. While they can appreciate the need for economic use of resources, they do not wish commercial considerations to dominate decisions about patient care.

This view is shared by patients. ‘A sense of market values, an instinct for business efficiency, a cost-effective approach to his own patients, are the last things the average doctor wants to develop, or the individual patient wants his doctor to have’[10].

Most doctors have no training in financial matters, and
making costs a part of their decision-making process will be new to them and will not appeal to patients. Will any doctor fail to prescribe a drug or order an available test he thinks the patient needs, because of cost constraint?

Even if a doctor is likely to be influenced by such considerations, there are problems in costing the activity of an individual doctor. Routine financial systems do not produce this kind of information. It is possible to use the ‘Standard Accounting System’ (the accounting system used in the NHS) to provide ward costs, but even this would require some modification. At present, to cost the care of an individual patient requires the development of a separate costing system. Even if the majority of doctors was likely to be sensitive to this information it is not available.

Solution

Direction is not a feasible method; doctors practise as individuals and their actions cannot be dictated by any management structure. To get them to become more cost-conscious requires encouragement, not instruction, discussion, not dictation.

It is unrealistic to expect all doctors to change their behaviour permanently, but, if more efficient use of resources is to make any real difference, most will have to improve for an extended period, and this will require fundamental changes in attitudes and practice. Changes on this scale can come about only if the concepts of financial management are taught early as a fundamental principle of medical practice and continually reinforced by either exhortation or reward. It seems unlikely that this course will have much appeal. Success is more likely if some existing factor of a doctor’s work could be employed to promote the efficient use of resources.

The overriding concept that dictates a doctor’s decision is good patient care. This might be defined as ‘the maximum improvement in health for the minimum interference’. Interference with a patient embraces laboratory investigations, therapies of all types, stays in hospital, and visits to out-patients and general practitioner.

Though it is recognised that the resources available for health care are limited, costs do not usually enter directly into the definition of good patient care. To have added the phrase ‘at least cost’ to the definition would suggest an administrator’s viewpoint rather than a doctor’s.

Consideration of costs does enter into patient care at one point. If two procedures, or two treatments, bring about the same result, common prudence suggests that the cheaper one should be chosen. To ask a doctor to choose one mixture of cost and effectiveness against another mixture of lower cost and lower effectiveness, given that both are available, goes beyond his training and inclination.

A possible approach lies in the relationship between decisions and costs. The costs generated by the doctor arise out of his decisions and it is not possible to separate one from the other. It is possible to modify the decisions he takes by considering the costs of the alternatives. It is more feasible to affect the costs by influencing the decisions he makes.

Though the latter apparently relegates cost consideration to the back row, in practice it makes little difference, as wasteful patient care is usually poor patient care. Efficient use of resources and good patient care are the same thing. Wasteful medical care is not only expensive but potentially harmful to the patient.

Inefficient use of resources means spending more to achieve the same end. This implies more investigations, all of which entail some risk. Venesection may result in thrombosis of the vein, or damage to the median nerve. Using more drugs than necessary implies an increased risk of adverse effects or interactions with other drugs. Longer hospital stays have social costs relating to absence from work, caring for the family, time spent by friends and relatives in visiting, and, of course, increased waiting times for others on the waiting list. Out-patient visits, too, incur social costs for time off work and expenses of travelling.

It is assumed that doctors are capable of ordering optimal care for their patients, but any deficiencies will be remedied only by better training and education. Better means of attaining optimal care will bring about efficient use of resources without any direct consideration of costs.

Cost control has become a question of the quality of medical care. Improving the quality of care is the agreed goal of all doctors, and improvement by review and increased education is now in the mainstream of medical training. The desire to improve and use the most appropriate methods for the solution of a given problem is the hallmark of a profession and the appeal to professional standards is one that finds ready acceptance.

Motivation is a complex matter. Factors such as self-interest, self-esteem, tradition, the desire to attain common goals and the need for professional acclaim have all been suggested as possible motives for better patient care. Recognising that cost control is likely to result from better medical care, a suitable strategy would be to examine the motivations for better care and then encourage and support those factors that motivate the best patient care. Thus in one manoeuvre patients, doctors, administrators and politicians could all be satisfied that the best health care within available resources was being provided.

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