The Price of Modern Medicine: Are We Willing to Pay It?

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A large and growing share of the American total is spent, not on doctors and nurses, but on accountants, management consultants, and public relations specialists. Their contribution to the health of the American public is difficult to discern (unless one is trained in neoclassical economics and is able to see with the eye of faith).

R.G. Evans, 1990

How selfishly soever man may supposed, there are evidently some principles in his nature which interest him in the fortune of others, and render their happiness necessary to him, though he derives nothing from it except for the pleasure of seeing it.

A. Smith, 1759

All economic questions are consequences of some kind of scarcity. Scarcity implies that needs are always larger than means. Human needs are virtually unlimited, whereas the means to fulfill these needs are always limited. Scarcity inevitably leads to competition. Society will determine the various forms of competition which are ‘allowed’. Theoretically, a patient could demand a bronchoscopy by means of a Colt.45 pointed at the head of the pulmonologist (violent competition), or by proposing a trade: a fruit-basket (or 6 bottles of Meursault 74 for that matter) for a bronchoscopy (trade competition). In our society, however, we trade with thin, coloured sheets of paper which we call money. The number of sheets (i.e., the price) can be ‘left to the market’ (free market mechanism), or can be determined by a (usually complex) set of rules and regulations, usually implied in some form by governments or health insurance organisms.

This ‘economy-course-in-a-nutshell’ is about everything I knew from economics when I finished my training in medicine. Unfortunately, things have become a bit more complicated nowadays. However, doctors still are not trained in health economics, but in – this may come as a surprise – ... medicine! Am I too romantic if I state that still most medical students start their careers because they feel some of that ‘sacred stuff’ inside, that ‘interest in the fortune of others?’ I hope, and I think I’m not.

The problem, hence, is that we, doctors, have left the ‘money-stuff’ to others: accountants, management consultants, governments...: economists! The impact of this evolution on the public health status can be debated (in the United States, where the impact of ‘the economists’ on medical practice is probably the largest in the world, health economic parameters certainly are not the best in the world – almost 14% GDP health expenditure, = twice the European average, around 4,000 USD per capita health expenditure, = two to three times the European average, more than 13% annual growth of normal health expenditure, = almost twice the European average, whereas health outcome parameters, such as child mortality rates and potential years of life lost, are almost 50% worse), but is substantial, and here to stay.

Until the early seventies, this was not a problem: medicine virtually cost nothing, and there was plenty of money (and very few health economists). Since then, health care expenditure has risen dramatically, because of the progressive aging of the population (which was there first, by
the way), the increase in the standard of living combined with the desire for better health care, a better qualified (and better paid?) medical staff, and especially, the development and increased availability of expensive new medical techniques and equipment.

In other words, there has been a dramatic increase in needs (and in health-economists!), together with a relative reduction in means. To tackle this scarcity problem, doctors – whether they want it or not – have to become more conscious of the price of the services (and their complications) they provide. This seems more logical indeed than the opposite: to teach economists to treat patients .... Colt and Matsuo [1] therefore have to be complimented for their effort in calculating prospectively the hospital charges (i.e., a type of ‘price’) directly attributable to bronchoscopy-related complications in outpatients.

Although the intrinsic information contained in their paper may be too specific for the author’s institution, region, local health finance organization and country to allow for generalization, the real interest lies deeper: it reminds us doctors of the unavoidable need for increased ‘economic awareness’ of the things we are doing, and in which we are best: caring for patients.

Health-economic analysis of all aspects of medical practice undoubtedly will be a formidable task, but the blind economic paradigm demands it, and somebody will have to do it. And I by far prefer doctors to take command, instead of accountants. This is the price we modern doctors will have to pay: we’ll have to learn the economic language, instead of accountants having to learn the Co¬dex Medicus. We should pay the price.

Reference