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Editorial

Cost-Effectiveness of Psychiatric Care

Health economics has become extremely relevant to clinicians and their patients in this era of marketplace medicine. Studies on the costs and benefits of health care have been an academic interest for decades, but in the late 1990s cost-effectiveness assumes a much more strategic perspective in the rationing of care that is taking place as a result of managed-care-driven protocols and methodologies.

Cost-effectiveness analysis, a type of cost-benefit analysis, endeavors to measure the relative value of different treatment options. If we are ever to move from the "managed cost" mentality of the current marketplace, it will be through cost-effectiveness analysis that informs decisions on resource allocation, making "managed care" a true possibility. These are major issues for the practice of psychiatry. What will psychiatrists be paid to do, and how much will various services be worth? Do we provide "added value" in comparison with nonpsychiatric physicians or nonmedical mental health professionals (1)?

For cost-effectiveness analysis to have an enduring impact, it is critical that the measurement of unit costs and their ultimate translation into the cost of episodes of care are accurate and true, meaningful and valid. Major methodological concerns are raised in the article by Wolff et al. in this issue of the *Journal*, as there are no arbitrary or standard rules for cost-effectiveness analysis. The different methods used in measuring costs can dramatically influence the results. Costs, because they are numeric and seemingly "absolute," have an illusory objective quality. Depending on who pays the bills and the incentives in the marketplace, there can be major differences of opinion about the cost of care, which lead to different resource policy recommendations. Differences in cost-effectiveness should reflect true differences in interventions or treatments, not different methods of measuring costs or benefits. Recently, a consensus panel has produced guidelines on cost-effectiveness analysis to improve the comparability and quality of studies (2).

One example of how cost-effectiveness analysis can help rationally inform the resource allocation dilemma is in the study reported in this issue of the *Journal* by Fontana and Rosenheck in the Department of Veterans Affairs (VA); a standard unit cost method was used to compare three models of treatment for patients hospitalized for posttraumatic stress disorder (PTSD). The results of this study strongly suggest that longer-term inpatient treatment for PTSD is both costly and ineffective in comparison with specialized shorter-term units. One caveat is in the comparison of an inpatient program that lasts for "months" with one that lasts for "weeks" and does not take into account the current inpatient length-of-stay paradigm for most psychiatric care, which is "days." At some point in our endeavor to reduce costs, we inevitably reach a floor of inpatient care below which it is extremely perilous to descend. Again, we need cost-effectiveness analysis to help determine objectively the point at which we skimp on psychiatric care and create costly overruns for other medical services as well as other sectors in our society, such as criminal justice. These cost offsets are important to measure, since they ultimately prove the value of what psychiatry has to offer.

The VA study underscores the need to follow patients longitudinally across settings in order to measure costs and outcomes. The VA has special advantages because there

is one payer, there is a standardized method for measuring unit costs, and the researchers are excellent.

There is today great debate on the confidentiality of such individualized data collection and the threat that this may pose for the privacy of the doctor-patient relationship, a cornerstone of medical ethical practice. We, as a profession, must be careful that in the effort to protect core values, we do not jeopardize the evidence for the value of the care we provide.

Managed care has underscored the fact that we live in an information age. In the competitive marketplace, information is critical for the decisions that are made to ensure clinical integrity and fiscal solvency. Psychiatric care competes with other medical care for scarce resources and must demonstrate convincingly the positive value of our treatments. We must show that mentally ill patients will suffer serious consequences if untreated and that other costs will increase if inadequate access to treatment is the result of poor benefits or managed care denials. Most of the voluminous data on psychiatric treatment today are contained in private databases collected by the private payers and by the behavioral managed care companies. These companies use these data to enhance their competitive position. The validity and accuracy of the data and the use to which the data are put are of vital interest to psychiatrists and our patients. We need government more than ever to oversee this collection of data to ensure its privacy and confidentiality and to be able to verify this information independently and assess the validity of the policy decisions recommended by private payers in the interests of cost containment.

We live in a political marketplace as well. Who will pay for what, and how much, is the subject of a political struggle that plays out not only at the federal level, with Medicare reimbursement, but state by state and employer by employer. The added value of psychiatric care must be strongly articulated through the use of excellent information, well-designed studies, and valid findings based on cost-effectiveness analysis approaches. Vigorous advocacy to counteract the inaccurate information and stigma in our society about mental illness and its treatments must be countered by the information that is at our disposal to demonstrate the value of what we do.

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