What Politics May Be Telling Us About Cost-Effectiveness Analysis

by Daniel Carpenter

Using Cost-Effectiveness Analysis to Improve Health Care: Opportunities and Barriers

by Peter J. Neumann
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Like many tools of contemporary economics, cost-effectiveness analysis (CEA) has found greater success in the academy and among government policy analysts than it has in the “real world” of health services. Journals in medicine, public health, and health policy are ever heavier under the weight of articles using CEA. Yet, as Peter Neumann complains in his timely and accessible new book, no state government has adopted formal CEA in its health programs, managed care plans seem averse to using formal CEA methods, and many federal regulatory agencies seem bent upon using other criteria for their decisions. Why?

Neumann walks his readers categorically through the possible explanations and tries to weigh the relative force of factors impeding CEA's entry into U.S. health care. He succeeds admirably at setting forth a laundry list of possible explanations, ranging from ethical concerns, to legal and liability issues, to political opposition. In doing this, Neumann offers something of a lay introduction to CEA in all of its intricacy, and a historical survey of its development in the past few decades.

His eventual culprit is “politics” and “political opposition,” although Neumann is never quite clear about what these terms mean. Resistance to CEA has a “political nature” (p. 7); the best explanation for CEA’s limits is based “not in methodological or legal barriers, but in Americans’ penchant for medical innovation and our distaste for limits—and in our deep-rooted suspicion of governments or corporations that impose them” (pp. 57, 108).

The problem in this volume is that this basic statement never receives the fundamental support it needs. We do not, in Neumann’s book, receive a sustained analysis of how a cultural or political opposition to limits—as opposed to dissatisfaction with CEA as actually practiced; as opposed to a preference for adaptive, decentralized consideration of costs; as opposed to political failures on the part of its supporters; and as opposed to concerns about tort liability—is responsible for CEA’s short reach in the United States.

The reader’s best chance for getting this kind of analysis comes in Neumann’s sixth chapter on the failure of Oregon’s experiment with CEA as part of its state health insurance system reform. If the reader is to believe Neumann’s central claims, then this chapter should be the heart of the book (p. 57). Yet Neumann’s study of Oregon is just twelve pages long, largely informed by citation of secondary sources. His core assertions—(1) that “formal CEA itself played little role in the actual plan” and (2) that CEA “proved so controversial and difficult to implement that it was abandoned early in the process” (p. 60)—are never elaborated or demonstrated.

Neumann states that Oregon’s ranked list of treatment-disease pairings was “widely criticized within the state because of counterintuitive rankings” (p. 60), but he fails to show us...

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why and how this is true. Beyond this, he never addresses or answers some questions that a reader interested in a causal story would want to know: Where did the criticism come from—the media, politicians, organized interests, health providers, pharmaceutical companies, or some combination of these? (Put differently, just how “wide” was the criticism?) How, specifically, did “wide criticism” prevent or hinder the inclusion of formal CEA? Why, specifically, was the ranked list never submitted to HCFA for approval? This chapter (along with several others) cries out for the sort of independent research that would have substantiated Neumann’s claims. Why wasn’t a set of interviews done? Why not track the fate of CEA through news coverage or through task force records? Why, in a chapter so central to the argument, does Neumann rely entirely on other scholars’ brief and impressionistic treatments?

One alternative explanation for CEA’s failure lies in the success of something else: a more adaptive, implicit, and decentralized approach to rationing. Implicit rationing has been with us for some time, and many (including David Mechanic) believe that this process of “muddling through elegantly” serves us well. Neumann briefly considers the possible benefits of informal optimization (p. 87). Yet he ought to have considered implicit rationing as a behavioral and political substitute for formal CEA. Perhaps implicit adjustment is superior as a learning process (not unlike the arguments made for federalism as a political system). Perhaps concerns about professional autonomy are more easily managed through “implicit rationing.” And finally, perhaps implicit, nonformal CEA permits optimization that genuinely incorporates patient heterogeneity (as most cost-effectiveness analyses still fail to do). As Neumann himself admits (p. 87), there is no evidence that formalizing cost-effectiveness trade-offs in ways now practiced by CEA advocates produces greater optimality in health care outcomes than does implicit, decentralized adaptation.

Neumann might also have given more consideration to organized political and economic opposition to CEA, perhaps from health professionals and perhaps from pharmaceutical companies. Some of his evidence in fact supports such an explanation (PhRMA’s opposition to NIH and AHRQ analyses in 2003, for example), but Neumann does not explicitly consider this.

Future research, following Neumann’s lead, should flesh out what exactly “politics” and “political opposition” mean. Is it possible that those who complain about CEA are raising informative concerns, concerns that we as health policy scholars ought to consider? Is it possible that critics are acting not out of ignorance of CEA’s benefits but with a genuine appreciation of how CEA systematically gets it wrong? Is it possible that those who resist CEA have as their alternative model not a world without limits, but a world where those limits are confronted much more locally, experientially and pragmatically?

Peter Neumann has, then, provided students of health policy with a commencement of sorts, a guide into understanding the political and economic failure of CEA. Yet he fails to persuade us of his fundamental message, that “the United States’ failure to use CEA is driven more by its own cultural, political and institutional conditions than by the technique’s inherent methodological shortcomings.” If politics is telling us something informative, and if the message of CEA critics is less about resistance to limits and more about resistance to centralization and formalization, then CEA’s “methodological shortcomings” may be more deeply implicated in its failure than academics want to believe.