ation, was amended to restrict coverage by excluding individual policies or Medi-Cal or Medicare. Coverage does extend to four kinds of insurance companies: health-care services (HMOs, California Blue Shield), hospital service plans (Blue Cross), all disability class commercial insurers, and self-insured employee welfare benefits plans. Nevertheless, family members are not covered, and employees are covered only if diabetes education has been chosen as an included benefit by the buying contractor. Since most group coverage is negotiated through collective bargaining, employee representatives must urge for coverage of diabetes education in order for individuals to receive this benefit.

One source of concern for physicians and educators is the lack of an insurance code for obtaining reimbursement for outpatient diabetes education. Spokespersons for Blue Shield of California and the California Medical Association have indicated that they know of no immediate plans to include an education code in the roster. One member of the Diabetes Control Program Adult Health Section for the California Department of Health Services indicated that failure to establish a reimbursement code is the most effective way to paralyze the legislation.

In the face of strong positive testimony at the resolution hearing, and as a result of significant trades for support on the floor of the Governing Council, the resolution passed and is now official APHA policy. The Action Board will make sure that the recommendations are followed up and acted upon by the association. The Public Health Education Section will continue to work with other APHA sections and affiliates to build on the foundation laid by this resolution.

The resolution as it now reads suffers from the same limitations as the California Diabetes Education Insurance bill. It falls short of the intent of the task force to make a strong statement for third-party reimbursement for health-education services in medical care, in the workplace, and in the community for the sick and for the well. It does not define the role of usual providers of care versus the role of the health-education specialist. It does not define professional standards of practice. It primarily addresses fee-for-service systems without taking into account the strong support of the public-health community for alternative health-care structures, such as HMOs. Rather than cutting through the ambiguity that plagues the reimbursement question, our resolution fell prey to its force. The section does not intend to end its efforts here; in fact, we have just begun to take action.

RESPONSE

AN ECONOMIST'S VIEWPOINT

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The logic underlying Resolution 8219 is that disease is bad and its prevention or amelioration is desirable; that "health education services [are needed] to support changes in health behaviors and the environment," which in turn promote health; and that "current reimbursement policies... constitute a major barrier to the supply and utilization of these services." Therefore, (1) if one removes the cost barrier, (2) health-education services will be utilized in greater numbers, (3) behaviors will change, and (4) health will improve and in a "cost-effective" manner.

Close inspection of this argument suggests a number of ambiguities and uncertainties. As an economist, I am disturbed by several assumptions implicit in the recommendation, including the three fundamental assumptions: (1) patient education is effective, (2) patient education is cost-effective, and (3) direct reimbursement is a desirable means of rectifying the perceived insufficiency of patient education. I must emphasize that, in challenging the recommendation, I am not striving to present a comprehensive assessment of the recommendation or even, within the confines of this essay, a wholly balanced one. Rather, by concentrating on economic considerations, and negative ones at that, I hope to inject some balance into the larger argument within the community of public-health educators.

IS PATIENT EDUCATION EFFECTIVE?

To begin with the first assumption, that patient education is effective, my reading of the literature suggests both conceptual and empirical difficulties with this generalization. "Patient education," much like "medical care," covers a myriad of interventions, some of which are undoubtedly effective while others are not. The effectiveness (or ineffectiveness) of many interventions has never been assessed. Like curative medicine, patient education may well include some interventions that are actually hazardous to the physical or psychological health of patients.

On the whole, educating patients on health behaviors may be a valid, health-enhancing enterprise. I question, however, whether "professional standards of practice," intended to guide quality health education, are sufficiently honed, rationalized, and monitored to implement the proposed reimbursement policy.* Is the issue of the effectiveness of all, or even most, patient-education activities truly resolved? Is the knowledge base sufficient to warrant a blanket endorsement of third-party insurance coverage? I shall leave it to colleagues much more knowledgeable than I to discuss the intricacies of defining and measuring effectiveness.[1,2] Let the above stand simply as a reminder that the effectiveness of patient education is far from an open-and-shut case. This theme reverberates throughout the remainder of my comments.

IS PATIENT EDUCATION COST-EFFECTIVE?

The second assumption is that patient education is cost-effective. Despite APHA's citation of 15 references to support its assertion that "such education services are a cost-effective and integral part of health care" (they do not indicate which references correspond to which adjective), evidence on cost-effectiveness is limited in both its quantity and utility. A review of the medical and health literature has uncovered relatively few studies of the cost-effectiveness of patient-education efforts.[3] Of these, many are structurally flawed at a most elementary level. For example, many purported cost-effectiveness studies fail to compare the program in question with any alternative efforts. Yet implicit in cost-effectiveness analysis (or in the adjective "cost-effective") is comparison: program A is cost-effective because it costs less than alternative means of achieving the same outcome or because it achieves more of the desired outcome than alternative activities at comparable levels of cost. Strictly speaking, there is no such thing as inherent cost-effectiveness.[3] Informally, we may think of a given program as "cost-effective" because it "seems reasonable" to us. That is, consciously or subconsciously, we compare it with our subjective standard of acceptability and find that it meets or exceeds that standard. For a formal analysis or a formal assertion of cost-effectiveness, however, the standard of comparison must be explicit and objective.

Within the health-education literature on cost-effectiveness, even those contributions that avoid the most elementary pitfalls of analysis often fall prey to the conceptual and technical inadequacies that plague cost-effectiveness analysis in all areas of health and health care. To name only a few, effectiveness is often poorly defined and even more poorly measured; the analysis of costs confuses costs and charges or expenditures, misses the less obvious opportunity costs, fails to deal with certain quantitatively intangible costs (eg, costs of pain and suffering), and mixes costs of existing activities with those of prospective ones; analysts do not use discounting to account for realization of costs and benefits in the future; significant analytical or data uncertainties and assumptions are neither adequately identified nor studied for their implications.[3]

The bottom line is that there are few studies that stand up to rigorous inspection. Some individual analyses provide convincing (or at least strongly suggestive) evidence that individual patient-education activities are cost-effective, but the existing literature cannot possibly be used to make an objective case for the broad generalization that "patient education is cost-effective."

If the jury is still out on the issue of the overall effectiveness of patient education, it must necessarily be out on cost-effectiveness, and it will have to remain out until it reaches a verdict on effectiveness. As the name suggests, cost-effectiveness analysis has two components: assessment of costs and determination of effectiveness. Without meaning to downplay the difficulty of cost analysis, which is invariably beset with numerous conceptual and data problems,[3] I have always had the suspicion that determination of effectiveness is the more difficult piece of the puzzle. Yet in health education today, as in so many other areas of health and social welfare, we seem all too ready to label a spiritually uplifting effort as cost-effective. Indeed, I sense that we often invoke the adjectival benediction "cost-effective" with greater ease than we use the word "effective" alone. This is like putting the cart before the horse—before the cart is built.

The reader can choose whether or not to accept the interpretation of one health economist of the evidence on cost-effectiveness. As an economist, I cannot help but appeal to the marketplace and ask the reader to contemplate the profundity in a simple question: If patient education is cost-effective (and worthy of third-party reimbursement), why does the market not buy it, or buy more of it? Specifically, why do not third parties systematically reimburse for patient-education services? Whether their objective is profit—as is the case for the private insurers—or cost containment—the cross borne by Blue Cross and Blue Shield, Medicare, and

*Three "professional standards" issues bother me: (1) Who is to define precisely which "group and individual education services [are] integral to the care of patients"? (2) Who are the "usual providers of care" for health education, and would anyone want to restrict them to, or for that matter exclude, the usual providers of medical care? In the past, APHA has adopted a liberal stance toward designation of health-care providers, supporting a variety of nontraditional health professionals as substitutes for or extenders of the dominant providers. Here, the APHA seems to be advocating restriction of care provision to the existing professional—and interest—group. (3) What are the relevant "professional standards of care" and how would they be monitored and enforced? The presence of three areas of ambiguity in a one-sentence recommendation is a source of substantial concern.

Medicaid—they are seeking efficiency in the use of health-care dollars. If a patient-education service was demonstrably cost-effective—that is, if it accomplished a health goal less expensively than alternative interventions; or if it reduced the total cost of case management; or if it produced a new health benefit that the public valued more highly than its cost—why would not the third parties leap to include the service among their covered services? One can argue that the management of these organizations is inadequately informed or conservative, but management may also be wary of abuses of a "license to educate," concerned about the effectiveness and cost-effectiveness of patient education.

The task, it seems to me, is to invest in high-quality research on the effectiveness and cost-effectiveness of a variety of important patient-education services. If solid research produces evidence that such services are cost-effective, the next step would be a marketing one. Findings would have to be disseminated to the third-party executives who control the nation's health-care pursestrings. As an economist, I have faith that, were patient education demonstrably cost-effective, management would see the light and boardrooms from Washington to Chicago would be flooded with born-again health educators.

IS THIRD-PARTY REIMBURSEMENT THE BEST WAY TO FINANCE PATIENT EDUCATION?

Now let us turn to the third assumption: direct third-party reimbursement is a desirable means of rectifying the perceived insufficiency of patient education. "Direct" here means fee-for-service reimbursement. That is made clear in APHA's basic recommendation: "[Third parties should] pay for these services *separately when they are delivered...* " (my emphasis). There is near unanimity among health economists in the opinion that traditional fee-for-service and cost-based third-party reimbursement is the principal villain in the cost-of-health-care drama.* APHA has echoed this theme in its support of prepayment mechanisms (eg, through HMOs). Yet here, in policy statement 8219, we see the APHA endorsing a financing mechanism that has fallen into disrepute (at least among the academic cognoscenti, if not the medical profession at large).

Why? Would it not make more sense for APHA to advocate the further growth of prepaid capitation schemes (again, HMOs)? If health education is truly cost-effective—if it promotes health less expensively than alternative health-care interventions or if it simply helps to contain costs—it should evolve as an integral component of HMO care, since it would be in the economic and health interests of patients and their providers.[4]

There is a further ironic twist to APHA's advocacy of Resolution 8219. It comes at a time when cost-based reimbursement of hospitals is on the wane, when we may be standing on the brink of a revolution in hospital financing, on the verge of reimbursement based on DRGs (diagnosis related groups). The idea behind DRGs is simple. Hospitals will be reimbursed lump sums on a per-case basis rather than receiving, for example, $265 per hospital day plus $25 per x-ray plus 25¢ per Q-tip. As with HMOs, DRGs are intended to reward efficiency. The hospital will earn more net revenue (or lose less) if it finds a mix of services that treat the given condition at reduced cost.[5] Again, if health-education services are truly cost-effective, it will be in hospitals' interests to incorporate them into the care provided.† Why is APHA putting its health-education eggs into a seemingly discredited financing basket, one that may ultimately prove to be outmoded?

One possible reason comes readily to mind. It derives from a principle known among the general public as "if you can't beat 'em, join 'em." Notwithstanding HMOs and DRGs, we live in a world of fee-for-service and cost-based medicine, one increasingly characterized by third-party payment. That system causes important distortions in the kinds of health-care services people seek and where they seek them. Much ambulatory primary and preventive care—generally paid for directly out of patients' pockets—is ignored or deferred, while insured inpatient secondary care is overutilized. Much as we might like to believe that "need" and common sense are the sole engines that drive the demand for health-care services, a wealth of theoretical and empirical evidence assures us that patients go where the insurance dollars flow.[6,7] Even the organizational darling of the liberal health-care community, the HMO, has been shown to be subject to the same impure motivations. On the whole, HMOs do provide more preventive services than the fee-for-service system, but not necessarily due to the cost-effectiveness of such services. The financing scheme that probably delivers the most preventive care is the small subsector of the fee-for-service system in which primary care is fully insured. It appears that it is the existence of insurance, common to both HMO-type prepayment and first-dollar fee-for-service coverage,

*Cost-based (also charge-based) reimbursement is the institutional (especially hospital) analog to the individual provider's fee for service.

†There is one important exception to that rule. If health education served to decrease the need for later episodes of hospital care, it might be socially cost-effective but inconsistent with the economic incentives confronting a DRG-reimbursed hospital. The DRG reimbursement mechanism rewards efficiency during a hospital stay, but it also has the perverse incentive of encouraging later rehospitalization, in that hospitals are reimbursed per admission (though the readmission must not appear to be the adverse result of the earlier care). In this manner, the DRG incentive is much less rational than that embedded in the HMO.

that drives patients to demand primary and preventive care. When providers profit directly from delivering such services, as they may in first-dollar fee-for-service coverage, the economic mechanism is structured optimally to promote the utilization of primary and preventive services[8] and to risk the overutilization of such services.*

In effect, one can read APHA's Resolution 8219 as a surrendering to the dominant third-party fee-for-service and cost-based reimbursement system, at least on this particular policy battlefield. That system may be wrong—it may be the leading contributor to the medical-care cost crisis—but it exists, and it diverts care from the primary and preventive variety (which is generally least well insured). Therefore we should use its incentives to encourage utilization of preventive and ameliorative health-education services. Remove the cost barrier, and health-education services will be utilized in greater numbers, behaviors will change, and health will improve.

This is the charitable view of APHA's motivation in adopting Resolution 8219. There is much to commend it. At the same time, one cannot overlook an alternative, or perhaps additional, motivation, one that is sufficiently lacking in purity that, if present, is undoubtedly in part subconscious. Third-party fee-for-service reimbursement would have two certain effects and one possible effect. The first certain effect is that the utilization of health-education services would increase. As Laurence Seidman[9] has illustrated in a most eloquent and entertaining parody on health insurance, when people are offered something free, they will consume more of it, and whenever possible a higher quality of it (including amenities in quality). The corollary to this is the second certain impact: the insurance program will enrich the providers of that something, namely, health education. The possible effect is that the public's health would improve enough to justify the expenditure.

As an advocate of much health education, it truly pains me to raise this possibility. I have no doubt that, in their hearts and minds, the proponents of the policy see this as a mechanism to promote the health of the public. Nevertheless, I would not be fully responsive to my assignment in this essay were I to fail to acknowledge the evidence, from analysis of other health-policy proposals, that emphasizes the element of professional group self-interest. There is a body of theoretical and empirical evidence that large professional health associations have supported pieces of legislation, in the guise of concern for the public's health, that would primarily serve the economic interests of the professions represented by the associations, often to the detriment of the public's economic interests.[10] Virtually across the board today, one sees health professional associations lobbying for licensure or certification and reimbursement of members' services. Whose interests are most at stake here? Invariably, the associations ground their arguments in "the public's welfare," but many analysts would claim that only the betterment of the economic welfare of the associations' membership is assured by such steps.[11]

*As an economist, I define overutilization as utilization for which the total costs of services exceed the total benefits of providing the services. In this definition I include both readily measured monetary benefits and costs and difficult-to-measure social and intangible personal benefits and costs.[3] Overutilization does not refer solely to care that produces no results or negative ones; it includes care conferring positive benefits that are not worth the social costs they require.

CONCLUSION

I began by challenging the assertions in the policy recommendation that health-education services are effective and cost-effective. My skepticism is a response to what I believe to be the unwarranted generalization; it does not reflect a belief that few or even any specific health-education services are neither effective nor cost-effective. On this I remain an agnostic, and that is the thrust of my concern: we just do not know. That lack of knowledge makes me reluctant to advocate a mechanism that would surely, perhaps dramatically, increase the utilization of such services and the nation's expenditures on them.

In criticizing APHA's generalizations on health education, I have employed several economic generalizations that might themselves be found wanting. I have argued, for example, that the market would adopt such health-education services as were demonstrably cost-effective and, therefore, that the market's lack of enthusiasm for such services is itself an index of their perceived cost-effectiveness. In the economist's dreamworld of perfectly competitive, fully informed, rational consumers and providers, this perception would be unassailable. In our real world of imperfect competition and lack of full knowledge and even rationality, the generalization can be accepted only for the germ of truth it contains (which I firmly believe it does). Consumers and health-care financing organizations may well be myopic; they are certainly not perfectly informed; and it is undeniable that our nation's health-care system—our health care ethic—has a distinct medical-care technological/professional/treatment bias. If I may indulge in two more generalizations, physicians are not schooled to protect and promote the health of patients; they are trained to repair organ systems. Similarly, consumers are reared to rely passively on those physicians and their medical system for the (after-the-fact) protection of their health. (As has been noted frequently, there is a delicious irony in referring to the consumer as "patient.") In such an environment, it is fully believable that health promotion and primary care, through such mechanisms as health education, will not

receive the attention that they deserve in an objective sense. Even demonstrably cost-effective education may have trouble competing with quite inefficient but nevertheless "sexy" medical therapies.

These considerations complicate the picture. To my way of thinking, however, they serve primarily to reinforce the call for more serious research into the health and economic implications of health education, both in its conventional patient-counseling format and through less traditional mechanisms (such as the use of the mass media);[12,13] and they echo the need for attention to the marketing of findings on the cost-effectiveness of specific health-education activities.

By contrast, Resolution 8219 lacks vision. In its all-too-ready ends justification of means, it causes APHA to fall into the trap of supporting two aspects of the status quo that the Association has criticized previously, and with good reason: traditional fee-for-service and cost-based third-party coverage and restriction of reimbursement to "usual providers of care." Both APHA and the field of health education can do better.

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RESPONSE

VIEWPOINT OF THE AMERICAN HOSPITAL ASSOCIATION

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American Public Health Association Resolution 8219 recommends the inclusion of patient-education services in health-benefit packages as well as separate payment for health-education services. As staff of the American Hospital Association (AHA), we shall respond to those recommendations as they relate to hospital-sponsored patient-education services.

Resolution 8219 succinctly describes the contribution of patient education to effective medical care; however, the resolution overlooks the fact that patient-education services are often provided as an integral part of other types of medical care, for example, acute inpatient treatment. In addition, the resolution does not recognize that the appropriate method of payment for services is often determined by the setting in which services are provided and the method of payment used for other, related services.

Before discussing payment issues in detail, we want to mention recent AHA activities related to payment for patient education.

AHA ACTIVITIES

The AHA established a Center for Health Promotion in January 1978. Its mission is to support patient, community, and employee health-education programs sponsored by hospitals; expand an employee health program for AHA staff; assist member hospitals in developing