# Need For Continuing Cost-Effectiveness and Cost Utility Studies in Diabetes Care

Editor:

A recent issue of *Diabetes Spectrum* included a special section on economic issues in diabetes care and management. Included in the collection was the abstract of an often-cited paper by Elixhauser.[1] The Elixhauser paper notes deficiencies in studies evaluating the cost-effectiveness of care to prevent complications of diabetes mellitus. Although supportive of diabetes education and counseling, Elixhauser expressed concern that methodological weaknesses in studies that have been reported in the literature may lead to challenges by economically sophisticated policy analysts. Her conclusions were similar to a review we had conducted a few years earlier.[2]

Accompanying the abstract was a commentary by Jan Norman[3] suggesting that, "...a definitive study to prove that diabetes education improves health outcome is not necessary or affordable at this time." (p. 158). Norman's commentary reflects the frustration many providers feel with the managed health care movement. However, her conclusions may lead to abandonment rather than support for diabetes education and counseling.

Health-care costs remain out of control and it is almost certain that federal and private attempts to manage costs will continue. Diabetes experts are among many providers competing for the same resources. Health-care administrators need to use data in order to determine the best use of their limited resources.[4] A movement toward the development of empirically-based practice guidelines is beginning to take hold.[5] Without empirical data from well-designed studies, assertions that particular treatments are cost-effectiveness will not be credible.

Norman suggested that the effectiveness of diabetes education has already been proven in the Diabetes Control and Complications Trial (DCCT). However, the principle variable manipulated in the DCCT was not patient education. Rather, it was tight metabolic control. Certainly patient education and counseling contributed to this effective treatment, but the exciting DCCT findings cannot be attributed exclusively to health educators, and the DCCT data do not allow an estimate of the unique portion of the benefit attributable to educational services.

Virtually all areas of medicine and health care have been faced with the challenge of producing impartial outcomes data. Norman argues, "In this economic climate of scarce research dollars, one would have to question the judgment of using this limited resource to prove that diabetes education affects the clinical and economic impact of diabetes. This fact was already proved in the DCCT. Further research in this area could come at the expense of dollars invested to find a cure for diabetes." (p. 159) Outcomes research represents a very small piece of the total investment in diabetes investigation. However, the results of outcome studies are enormously important for selecting the care that will be given to virtually all patients with this illness.

All of us are frustrated by the economic realities of contemporary health care. However, the challenge is to prove the value of diabetes care using the best

scientific data. Until a cure for diabetes is found, we must continue to focus on methods for most effectively and efficiently using our resources to improve patient outcomes. That interest will best be served by new systematic and impartial outcome studies that use randomized designs, quality of life outcome measures, and thorough cost accounting. ■

Robert M. Kaplan, PhD
Department of Family and Preventive Medicine
University of California, San Diego

## • REFERENCES •

[1]Elixhauser, A: The cost-effectiveness of preventive care of diabetes mellitus. *Diabetes Spectrum* 2:349–53, 1989.

[2]Kaplan RM, Davis WK: Evaluating the costs and benefits of out-patient diabetes education and nutrition counseling. *Diabetes Care* 9:81–86, 1986.

[3]Norman J: Summary and Commentary. *Diabetes Spectrum* 8:158–59, 1995.

[4]Kaplan RM: *The Hippocratic predicament: affordability, access, and accountability in American health care.* San Diego, Calif., Academic Press, 1993.

[5]Eddy DM: Rationing resources while improving quality: how to get more for less. *JAMA* 272:817-24, 1994.