

The Price of Quality  
and the Perplexities  
of Care

Avedis Donabedian, M.D.

Nathan Sinai Distinguished Professor  
Of Public Health  
University of Michigan

*The 1986  
Michael M. Davis Lecture*

CENTER FOR HEALTH  
ADMINISTRATION STUDIES  
GRADUATE SCHOOL OF BUSINESS  
DIVISION OF BIOLOGICAL SCIENCES  
UNIVERSITY OF CHICAGO

## *THE SPEAKER*

Dr. Donabedian is widely recognized for his work on the measurement of quality of care. His approach to classifying the components of quality has been applied in virtually all quality evaluations during the last 20 years. Dr. Donabedian received his doctoral degree from the American University of Beirut. He received a master's degree in public health from Harvard University, and joined the faculty of the University of Michigan in 1961. He was appointed professor of public health economics in 1964, and professor of medical care organization in 1966. He is the Nathan Sinai Distinguished Professor of Public Health, and was recently named the first recipient of the Baxter American Foundation Prize in recognition of his pioneering research.

## *THE OCCASION*

Dr. Donabedian delivered this lecture at The Ambassador West, Chicago, on May 9, 1986.

My topic today is "The Price of Quality and the Perplexities of Care," a subject that suggests distress, bewilderment, anguish. Everywhere we seem hard pressed by the challenge that the economic calculus poses to our self-image, our cherished values, our proud autonomy. We live, it seems, in the worst of times. And yet, as I hope to show, this is also a time of hope and renewal — an opportunity to reexamine our responsibilities and our mission, so we can move forward, cleansed and rededicated, into an even brighter future.

Above all things, quality has been, and must remain, the object of our most ardent devotion. Stated most simply, it is our ability to improve the health and well-being of those for whom we care.

The relation between quality and cost, though capable of breeding endless complexity, is also simple in its fundamentals. Three aphorisms can encompass it. First, quality costs money. Second, money does not necessarily buy quality. Third, some improvements in quality are not worth the added cost.

It should be clear to everyone, though sometimes we seem to forget it, that more quality must cost more: in technical resources, creature comforts, knowledge, skill, time, attention, dedication. Being so precious, it does not come cheaply; but I am convinced that people, if informed, are willing to pay the price.

But because of two failures, in ourselves or in our circumstances, money does not necessarily buy quality.

First, there may be failures in clinical management. Should there be an admixture of harmful components in the care we give, quality is reduced, while cost goes up — a consequence that is doubly reprehensible. Perhaps more often (through self-protection, self-interest, ignorance, faulty judgment, or merely inattention) some of the care we provide, though not clearly harmful, makes no appreciable contribution to health and well-being. We can choose to call care that is wasteful, without being harmful, poor quality or not. But, unless it is forced upon us, it is a betrayal of our responsibility to our patients, since, through increases in premiums, or taxes, or the prices of the things they buy, they must pay the added cost.

A second reason why money may not buy quality is a failure in system design or administrative management. The fault occurs because the materials and services that clinicians use to devise and implement their strategies

of care can, themselves, be produced more or less cheaply.

The total cost of care, therefore, is influenced by two types of efficiency: "production efficiency," which pertains to the ability of management to produce materials and services at low cost, and "clinical efficiency," which pertains to the ability of clinicians to use materials and services most effectively, without waste. Both efficiencies influence cost, and, therefore, the ability to provide care and enhance quality. In addition, "clinical efficiency," because it embodies clinical judgment, is an integral part of the definition of quality itself.

So far, we have been on ground both familiar and congenial to clinicians. Our third aphorism moves us into more hazardous territory. We now face the possibility that some care which may be good for our patients will be disallowed as a diminution of, rather than an addition to, quality. This seeming paradox occurs because of a reasonable, though largely undocumented, presumption that as additions are made to the care of any given patient, there comes a point when the added improvements in health and well-being attributable to the added care are simply "not worth" the added cost of that care. There is a trade-off between quality and cost, or, to put it another way, there is now a new definition of quality, one which involves an exchange between cost on the one hand, and achievable improvements in health and well-being on the other. Now we may have to stop short of the maximum attainable benefit to health and well-being that the health care sciences place at our command, a conclusion seemingly at odds with our deepest convictions, and one from which many of our most intractable perplexities ultimately derive. But, before we address these perplexities, let us examine the two models of quality that our three aphorisms have engendered.

The first of the two models we may call "maximalist." It says that, for each patient, we must aim for the highest improvement in health and well-being that the health care sciences allow. The only other stipulation is that we do so without waste, at the lowest possible cost. Because in doing so we serve both our patients and society, this is an objective to which we can, indeed *must*, commit ourselves unreservedly, passionately. In pursuit of this, we may face perplexities of knowledge and implementation, but the moral directive under which we function is unambiguous and familiar: we owe

our primary allegiance to our patients individually, and we do the best that can be done for each, limited only by the resources allowed us. Any moral perplexities inherent to this model either seem tractable, or are concealed.

The second of the two models we may call "optimalist." Though seemingly threatening, this is not totally unfamiliar at that. In the past, clinicians regularly had to adapt their care to the valuations that patients placed on its cost and its expected consequences. Thus, some got more and others less, but in each instance subject to the patient's wishes. The result was a disparity in care for rich and poor, privileged and underprivileged, that was painful to all concerned, and which the clinician was expected, even at some personal sacrifice, to mitigate rather than, as sometimes appears now, to countenance or enforce. Fortunately, since these dark ages, we have moved, using various means, toward increasingly more equal access to care. But, now, a new discrepancy has emerged. Individual patients whose expenses are reasonably well covered, expect and ask for more of the benefits that they imagine health care can provide, with less concern for its cost. At the same time, those who have undertaken to pay for care have asked us to watch over its cost, though it is not clear precisely what they ask.

When those who pay for care ask us to be effective and efficient, they simply reinforce what we ourselves must wish, must *demand*, that we do. But when they ask us to stop short of the best that can be done because the extra margin of benefit is not worth the added cost, they confront us with a dilemma which ought to cause us the sharpest distress. For, now, our several responsibilities are at odds with each other. Our responsibility to our patients demands that we do the best for each, as each defines the "best." Our social and institutional responsibilities demand that we stop short of the "best." Though it is true that, over the long haul, the social optimum may be the best for all, we are charged with caring for individual patients, now and in the near future. Thus, as every moral person should be, we remain discomfited, torn, and perplexed. It is not because our selfish interests are at stake, but our values, our mission, and our self-respect.

It is now time to look more carefully at our perplexities so we can understand their nature and, who knows, perhaps find a way out. For though I open with perplexities, there are also salutary consequences to our

concern for cost, and some certainties in which our early perplexities may come to rest.

Perhaps our most immediate concern when the margin of financial discretion narrows is that the level of quality will fall and the concept of quality, itself, will be impoverished and deformed. As the noose seems to tighten, almost by instinct we tend to jettison those aspects of care that contribute to patient comfort and satisfaction, while we cling to the core of technical procedures which is our peculiar domain. On the contrary, there are others, more attuned to the market, more wily, perhaps less scrupulous, who counsel that we play up the more seductive surface attributes of care, while we mute the deeper strengths whose consequences are hidden or delayed.

Our defense against these extremes is to reexamine what we have traditionally aimed for and the means we have used. We may find it more useful, in many circumstances, to relinquish a possibly misguided emphasis on technical care, and to substitute models of social management that, quite possibly, are more meaningful to our patients, for example when they are old, disabled, and institutionalized. There is also hope in the prospects for more healthful living, since health is the decisive antidote to the cost of illness. In this case, however, we may be only postponing to a future date burdens even greater than we bear today.

Besides such fundamental redirections of objectives and methods, much of what we do now can be done more efficiently. Here, the responsibility of clinicians is primarily to bring about changes in practice that reduce cost without injury to health. Beyond that, not only must they cooperate with managers in allowing innovations in the methods of production, but actually to *insist* that these be made, and even to lead the way. At the same time, clinicians must stand watch over all such innovations, not to obstruct, but to make sure that quality is not thereby compromised. Meanwhile, managers need to help create the environment within which all forms of efficiency can be fostered and advanced.

The beginning of wisdom is a recognition of our own infirmities. That is why the circumstances under which we work should not constantly demand the heroic disregard of self-interest that only the fortunate few can long sustain. We must find new organizational forms that encourage good practice without undue reductions in income or unjustified exposure to legal suit.

In all these ways, invention follows upon necessity, a necessity that we may come to bless rather than curse.

There is another perplexity that we face daily; it occurs because the fractionation in our system of care runs counter to what should be the seamlessness of our responsibility for our patients. This is a dilemma which manifests itself most clearly when a patient no longer needs the services that only a hospital can provide and must, therefore, go to another place. Should we be content to make the decision that a hospital is no longer needed, without concern for the quality of care at the alternative site? Similarly, is it no concern of ours if the alternative is not as accessible or convenient, financially or otherwise? Can we comfortably wear the blinders that the sanguine insurer is so pleased to pass out, or should we balk?

The answer is clear; individually and collectively we must inform our patients of the choices being forced upon us, and serve as advocates for their cause. However, at the same time, we must demonstrate our sympathy with the broader social purposes that have engendered these choices by leading the movement toward a more integrated system of care — one that assures a progression from site to site without injury to quality or to financial protection. Thus, our capacity to serve is reconciled to our broader responsibility, and we find peace, while our patients enjoy better health. We see, once again, that there is a way to success through adversity, but only if our response is responsible and creative, not merely obstructionist.

Perhaps even more fundamental than any of the perplexities I have mentioned so far is a perplexity of values: of our ability to value, and of the choice among alternative valuations.

A commitment to the interests of individual patients requires that individuals put a value on both the costs and expected effects of care. The responsibility of the clinician is to inform and guide, not to dictate. A greater respect for cost merely heightens our awareness of a necessity that has been always there, so that our care may become more precisely attuned to the patient's informed choices. We may, of course, face perplexities of implementation, for example as to how to obtain informed, responsible choices, or as to when precisely to stop adding care to care, so we do not transgress either what the patient defines as optimum, or we believe to be the maximum realistically achievable. By

contrast, any attempt to calibrate care to socially determined optima raises serious problems of valuation, of equity, and of moral choice.

To begin with, no precise exchange between costs and effects can be made without placing a monetary value on the effect, which means placing a money value on human life and welfare. Is it possible to do that? And, even if possible, is it permissible? We now face not only a perplexity of means, but, more fundamentally, a perplexity of ends.

Furthermore, social valuations, when made, almost inevitably come in conflict with the valuations individuals place upon themselves. I have referred already to the discrepancy occasioned by the collective financing of health care. A discrepancy may also occur because society takes into account the consequences to others when care is or is not received by some. For various reasons, society may value, perhaps inequitably, some categories of individuals over others: the young as compared to the old, for example, or the productive as compared to the ostensibly "unproductive." The social distribution of health is also a collective concern, so that in the interests of equity access to care may be encouraged for some but not others.

In all these circumstances, individuals are more self-centered in their valuations, and they expect that the clinicians they have trusted will serve *them*, in the particular, rather than humankind in general. Society assails the hallowed compact between patient and practitioner whenever it asks the practitioners to provide less to those who are their patients in the interest of those who are not. Since, now, the very foundations of our professional life are at stake, we have good reason for alarm, and a compelling cause to find a way out.

Alas, our search for solutions is hampered by still another perplexity, one that like a sinister darkness surrounds and permeates all the others. It is the perplexity of our ignorance.

To begin with, we have insufficient knowledge of the nature, magnitude, and distribution of the problem which we presumably face. For though there is a presumption that everywhere care is excessive, wasteful, misguided, ineffective, and harmful, and though there is much anecdotal evidence to support the allegation, we have not systematically assayed the situation as a whole. Nor do we know what the balance sheet would show if all the savings from improved efficiency were

to be applied to the insufficiencies in care that our investigation would almost certainly reveal. We are swept on as much by sentiment as by fact when we believe that much care is harmful or useless, and that some of what is useful we cannot afford in any case.

But even if we knew all the particulars of the problem we face, we could still fail to apply the proper remedy because, all these years, the clinical sciences have grown in irresponsible ignorance of the financial implications of their discoveries. We have seemed to find, and we have taught, strategies of care, first with insufficient proof of effectiveness, and then with an eye *only* to effectiveness, without regard to cost. We have created a standard of prodigal medicine, of spendthrift care, far removed from the ideal of parsimony to which every self-respecting clinician ostensibly owes allegiance.

If we cannot say precisely how much added health we can expect to obtain in return for added quantities of care, we do not know when to stop; nor can we tell what is lost when we are made to stop short of what we believe to be the "best." Consequently, we can neither honestly guide our patients, nor persuasively inform public policy. We can only appeal to the arcane mysteries of our privileged role, unfortunately at a time when people are less and less inclined to believe us.

What are we, then, to do?

One solution, which many of us have been tempted to encourage, is for society to retreat from its interventive stance by underwriting only a minimum acceptable level of care for those with limited means, and by replacing on the shoulders of all others individually much of the financial burden that society had collectively consented to assume. It is true that, for most of our patients, we could then revert to a seemingly less troubled past, a time when we adjusted our care to each patient's valuation of individual costs and private benefits without external constraints. But we would also lapse into those fundamental inequities against which we had rebelled in the first place. The notion that we would countenance, as an explicit goal of public policy, a permanent disparity in the effectiveness of care available to the rich and poor, should be an insult to our professional ideals and sensibilities. The added perplexities of inequity exact too high a price. There must be some other way.

The paramount responsibility of the health care professions, I believe, is to advocate the most effective

level of care that the health care sciences permit. This is our unique, our indispensable role. No doubt, there will be many instances in which patients individually, or society as a whole, for various reasons, including cost, will decide to settle for less than the most effective care. These are decisions that as a collectivity we must accept, provided their consequences are fully understood and openly ratified. At the same time, we are obligated as individual practitioners, not to do anything that runs counter to the interests of our individual patients without their knowledge and concurrence, insofar as either they or we have a choice in the matter. In this respect we must be unshakable, no matter what the consequences.

But we cannot play the role of private or public advocate for the best that health care can offer unless we have, at the same time, dedicated ourselves to rooting out ineptitude and wastefulness in our own work. We must do this so clearly, so forcefully, that no reasonable person can any more doubt our undivided dedication to this purpose. Fortunately, we do not lack the means. A vast armamentarium of devices for quality monitoring and cost containment awaits our until now reluctant hands.

But all that store of methods, and what would be all that frenetic activity, are only a band-aid for a much deeper wound. The illness is in the science of health care itself, in those who have developed it, and in those who have taught it, glorious though all these have been. What is needed most decisively, most fundamentally, most urgently, is nothing less than a remaking of the clinical sciences themselves. We need to discover and to teach a new science of parsimonious health care, a science whose precepts are so deeply ingrained that any departure from them, by signalling a failure in quality, would cause the acutest discomfort. At the same time, if we had a more perfect science to base ourselves upon, we would know for certain which judgments on our work were well-founded and fair, and which idiosyncratic or arbitrary. Appeals to privilege or autonomy would no longer be necessary.

The new science of parsimonious health care would also place at our fingertips the information about cost and effect that would be needed both to advise our patients and guide public policy. Then we could say what can be gained from the resources that we request, and what is lost when the means are denied us. When

people are fully persuaded that they can come to us for the plain, unvarnished, disinterested truth, we can confidently let them decide what they cannot afford and what they can.

By placing the basic flaw so deeply in the foundation of our science, I do not mean to ignore the vital importance of how we design the system of health care in which we work. As we continue to tinker, and sometimes significantly to reform, we must be guided by one compelling purpose: to achieve an identity between our own legitimate self-interest and that of our patients. This is the only rock on which we can build; all else is shifting sand. We must, therefore, stand adamant against all that threatens this precious bond. But, in the spirit of a loyal opposition, while we oppose, we should also propose.

Ultimately, it is in our highest ideals that our salvation lies. It is in their service that we shall find our freedom; in obedience to them, our cherished autonomy.

Having conquered all that is unworthy in ourselves, we shall have nothing left to fear.

## **Acknowledgements**

I wish to thank the Graduate Program in Health Administration at the University of Chicago for doing me the honor of inviting me to deliver this Michael M. Davis Lecture for 1986. I also thank the following sponsors who have supported my explorations in quality assessment and monitoring: the Commonwealth Fund, the W.K. Kellogg Foundation, and the National Center for Health Services Research. Needless to say, the opinions expressed in this paper are not meant to represent either the sponsors of this Lecture or those who have supported my other work.