TOP TEN LIST

TEN BEST WAYS TO DO BAD ECONOMIC ANALYSES IN PUBLIC HEALTH

With apologies to David Letterman, and thanks for editorial assistance to Elizabeth Kirby and for their insights to the following Internet contributors:

Judith Vessey, Boston College
Kate Kvale, WI Dept of Health and Family Services
Richard Miller, WI Dept of Health and Family Services
Stephanie Sansom, Centers for Disease Control and Prevention
Pam Costa, Centers for Disease Control and Prevention
Scott Grosse, Centers for Disease Control and Prevention
Ann Conway, Wisconsin Association for Prenatal Care
Anonymous Internet correspondent

R.S. Kirby, November 2003

Number 10

Worship the sacred cows

The federal poverty rate measure is sacrosanct – and means the same thing in all regions and cultures across the United States.

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Number 9

Deduce – It's elementary, my dear Watson

First assume "ceteris paribus" – all other things being equal. Then, following completion of your analysis, interpret and apply the results as if no heroic assumptions were made.

Take a lesson from the clinical trialists – they've been doing the same thing with evidence-based practice for years!

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Number 8

What you see is what they got

Charges for health care services always reflect the actual cost to the provider or agency to provide those services.

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Number 7

Profits, or prophets?

Increasing health care costs are solely the result of inflation.

And, since you believe this, you also understand that the cost of microcomputers continues to increase – today's new Dell costs more than the original TRS or Apple IIe.

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Number 6

Can't you read?

Economic jargon should always be used excessively in any MCH report. For example:

'MCH professionals show "willingness to pay" for cost-effectiveness research, provided the "contingent valuation" does not exceed the economists' "indirect costs" for the "standard gamble" that "QALY" results will be forthcoming.

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Number 5

Cost savings is all that matters

Economic analyses show that prenatal care is not directly associated with better birth outcomes.

It would be best to conclude that, since prenatal care services are a cost center in agency budgets, public health programs should not invest in these services for their clients.

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Number 4

Try to make it real – compared to what?

Economic data in dollars and cents can always be analyzed validly with no conversion or adjustment, even from differing sources or over time.

As an economic historian from the University of Mississippi once said, when asked if his labor data were in "real dollars" – "How would I know about 'real wages'? I teach at Ole Miss!"

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Number 3

From conceptual to operational definition, in one easy step!

Race and ethnicity can always be used as proxy measures for income or socio-economic status.

Corollary: any observed difference in pregnancy outcomes or health care utilization across race/ethnic groups must be due to differential income and wealth.

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Number 2

I know a cost when I see one!

The following terms are all synonymous – and can and should be used interchangeably:

Cost-benefit
Cost-efficient
Cost-effective
Cost-equity
Cost-utility

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Number 1

It's all done with smoke and mirrors

There is only one essential difference between health statistics and health economics:

In order to do statistics, you need data!