

**The Economics Of Healthcare:
Looking At The Big Picture**

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I. Why Study This Stuff

- A. Economics Affect Every Aspect Of Life: The Production And Distribution Of All Goods And Services
- B. Healthcare As An Economic Product
 - 1. Free markets are best for most products and services but not healthcare – why?
 - a. doctors profit from their own decisions
 - b. knowledge of the consumer gives unfair advantage to providers
 - c. we have separated the consumer from payment
 - i. insurance is not a good thing in all cases
 - ii. distribution and outcome are not closely related
- C. Three Societal Products We Do Not Know How To Evaluate Their Performance
 - 1. Education – at all levels
 - 2. Corrections – prisons
 - 3. Healthcare

Question: Since money is clearly not the answer by itself, how do we evaluate the product?

Answer: We don't know
- D. The Reality
 - 1. Healthcare is a mixed public forum/private market product which involves shifts in pooled versus non-pooled money

2. Without control on the individual of having to pay for the product – the society must set the rules, i.e. European style healthcare
3. Many nations farther ahead in setting the rules and the public accepts this – will we??
4. There needs to be a total overhaul of the liability situation – i.e. no nation has ever sued its way to greatness
5. The expectation that healthcare can solve all of societies' ills is ridiculous – not everything is a disease

II. Macro Facts To Know

A. Medicine Is Not Suffering From Its Failures But Its Successes

1. People live longer then ever
 - a. magic number is 47 – Shakespeare, 1900
 - b. now current number is 78
 - c. if you are a 40-year-old male, you have a 60% chance of living to 80
2. This leads to the largest economic question in all of the 17 western democracies
 - a. the dependency ratio is driving all governmental decisions
 - b. this is the number of people working versus the number being cared for
 - i. the people sitting in the wagon versus those pulling the wagon
 - ii. healthcare is the most visible and variable component of dependency ratio shift because care needs go up exponentially as opposed to food and shelter which are inflation adjusted

B. The Rest Of The Civilized World

1. Who spends what
 - a. US – 16% GDP
 - b. Canada – 10.8%
 - c. Britain – 6.9%
 - d. Singapore – 4.5%

2. Canada, Britain, and Singapore all have better male longevity, female longevity, and lower infant mortality than the US
 - a. no simplistic answer
 - b. states are all different – Louisiana vs. New Hampshire on infant mortality
3. What do they do that we don't?
 - a. criteria based care
 - b. scientific not a social decision, i.e. breast cancer

III. The US Today

A. Expenses

1. During World War II healthcare was about 3% of GDP – WWII changed everything
2. Less than 10% of people had medical insurance
3. Doctors tried to keep down costs
4. There were less than 1/30th the number of drugs that are available today – Hamburger economics

B. Population And Service Explosion

1. Estimated total US population of 282 million
 - a. 42 million uninsured
 - b. 240 million insured
 - c. why are we concerned and not ophthalmology
2. The uninsured are not who you think they are
 - a. 78% of those uninsured are native born US citizens
 - b. young working adults with entry-level jobs are the most likely to be uninsured
3. Cost of the uninsured in 2001 (per the Institute of Medicine)
 - a. total \$99 billion (Health Affairs)
 - b. this is 1/10 the total US healthcare expenses of 1 trillion dollars

- C. Who Pays For The Uninsured
 - 1. 35% go uncompensated (health system)
 - 2. 38% public assistance (tax payers)
 - 3. 27% paid out of pocket (the patients)
- D. The Moral Question #1 – Can A Country Such As The United States Continue To Spend \$3,570 For Every Man, Woman, And Child For Healthcare And Still Have 42 Million Uninsured?
- E. Moral Question #2 – Why Should The Burden Of Uncompensated Care Fall On Emergency Medicine And Hospitals? If The Federal Government Feels Healthcare Is A Right, Then They Should Distribute The Financial Burden As They Do With Schools, Defense, Etc.

IV. Where Is The Money?

- A. Emergency Care Is 1.9% to 2.1% Of The Total Healthcare Spending In 2001
- B. Medicare Spends More Money On EKG And EKG Readings Than All Emergency Care
- C. Intensive Care Occupies Some 15% to 18% Of The Healthcare Dollar – Why??
- D. In 1965 Medications Were 3% to 4% Of the Healthcare Costs In 2003 Medications Are 22% Of Healthcare Costs The Fastest Rising Costs Are:
 - 1. Drugs
 - 2. Testing
- E. End Of Life Care Is Not Saving The Patients And Is Killing US As A Country
 - 1. 50% of the healthcare dollars spent on you in your life will be spent in the last 90 days

F. Moral Question #3 – When Is It Time To Die? – We Are The Only Country Which Does Not Carry On The Debate

1. The feeding gastrostomy tube is the paradox of our time – this is our true moral dilemma

G. We Are The Bargain As Well As The Safety Net Of The Healthcare System In The United States!!!

V. Numbers For the Emergency Physician

A. Visits

1965 – 37 million

2002 – 109 million – and rising

1. Things are looking up – no shortage of patients

2. We even have our own TV show

1970 – Marcus Welby

1995 to present – ER

B. Hospitals With EDs

1975 – 5,200 with ED

2002 – 4,200 with ED – an outcome desired by the Feds

1. Is this good or bad? – depends – the greater the volume per ED, the easier it is to supply services

2. Very small hospitals are ok to die in, but no place to live in

C. Physician Supply In Emergency Medicine

1972 – One Residency Graduate – Bruce Janiak, MD At Cincinnati – One Program

2003 – 1300 Graduates From 146 MD & DO Programs

1. Is this good or bad? – depends

2. Area maldistribution is a problem

3. Work hours going down – some sex bias in this

D. Emergency Physician Incomes

1. 30% variance by state – Ohio vs. Pennsylvania or

Maine

2. Flat rate specialty
 - a. we do not “build practices” in the classic sense
 - b. maximizing income in about 4 to 5 years
 - c. no real property ownership

3. Income
 - a. 160 scheduled hours per month - \$219,000 (does not really include all hours)
 - b. average emergency physician - \$198,000 - \$204,000 – why?
 - c. 85% of emergency physicians are within 25% of this number

4. Fixed cap on revenue
 - a. it doesn't matter what you charge, this is what you get
 - b. clearest reason for professional organization

5. Expenses
 - a. doctor cost
 - b. billing
 - c. malpractice
 - d. office overhead

6. Falling EBIT (EBIT DA) (Excess Before Income Tax Adjusted for Depreciation and Amaturization)
 - a. return per patient flat – increased expenses = decreased EBIT
 - b. most large groups now run on a 2% to 3% margin of gross
 - c. the largest threat to emergency medicine is rapidly rising costs that no one is willing to cover
 - d. the next place the money is going to come from is doctor wages

 - e. what happened to the big groups

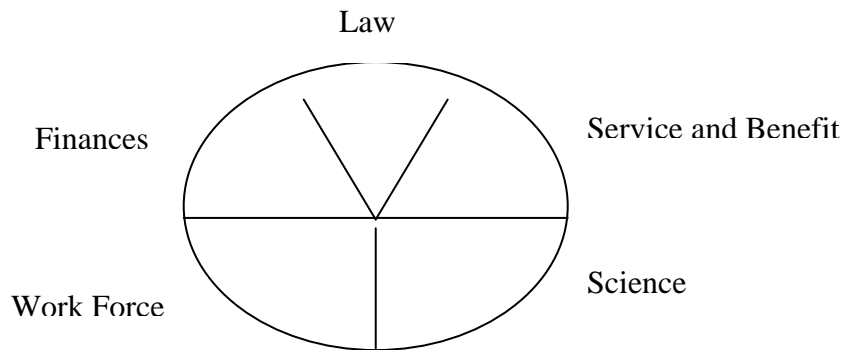
7. Malpractice costs
2003 – South Dakota \$1.90 per patient
2003 – Dade County Florida \$26.00 per patient

Do doctors in South Dakota really know 15 times as much as doctors in Florida???

Single largest reason small groups may not make it is the malpractice cost

VI. Intelligent Approaches To the Problem

A. No Approach That Does Not Recognize All 5 Elements Of Healthcare Will Work



B. Changes In All Areas Must Happen At The Same Time

C. Emergency Physicians Will Only Succeed If We Emphasize The Following In The Debate

1. Central Hub Theory – the ED is the interface between inpatient and outpatient care
2. Cost vs. change
 - a. emergency medicine is high change - not high cost
 - b. we are a fixed cost industry – cost per patient decreased by volume
3. Productivity and resource utilization must be defined so that average cost comes down
4. Value added services will make us more of a desired location for services

VIII. Conclusion

A. If Not Us, Who?

B. If Not Now, When?