From the CEO

Forecasting the Future

By Barbara Baldwin, M.P.H.

The catastrophic crash of the U.S. economy beginning in 2007 caught millions of people by surprise, both in its timing and its severity. It is easy to look back now and see indicators of approaching calamity: Housing prices were on a steep downward trajectory, investment earnings became losses, and the dirty secrets of the banking and investment world became common knowledge. Several elements of the economy crashed at once, and many of us were left wondering, "What happened?"

An interesting point is that some people saw it coming. They saw the signs, interpreted them correctly, and made adjustments to mitigate the financial damage in their lives. Why didn't most people and institutions act similarly? That question is so multifaceted that it is impossible to address in a brief article. However, we can briefly explore how we might learn from that experience by imagining a future that may not be the one you wish for, but is in the realm of possibility. This can be done by examining trends and indicators over which we have very little, if any, control and asking, "What if?" The late management guru Peter Drucker said, "I don't forecast. I look out the window and identify what is visible, but not yet seen."

At this time, the American public and the millions of stakeholders are consumed with what health care reform legislation may yield. This is a monumental effort to observe and attempt to influence, but there are other, perhaps less overarching, trends, policies, and existing philosophies that can greatly influence the face of healthcare in the future. It is a useful, yet sometimes uncomfortable, exercise to speculate on the possible effects of the clues right in front of us. Discussions like this can help individuals and organizations to be nimble and successful in the event that the desired future does not develop. Two guidelines make this work. First, the outcomes do not have to be probable, just plausible. Second, one must suspend disbelief at certain possibilities and challenge your current thinking.

I will review a few trends and ideas that have been around for several years and are gaining traction that could affect your life and the practice of anesthesiology. Some will make you cringe, but consider for a few minutes not that they will never happen (which we said about a prohibition against balance billing

noncontracted patients for emergency services), but what would happen if they did?

1. **Increased involvement and independence in providing health care by non-physician providers, combined with a shortage of physicians.** In 2006, the Association of American Medical Colleges recommended a 30 percent increase in U.S. medical school admissions by 2015 to keep pace with the demands for physician services as the baby boomer generation ages and physicians in that group retire. Between 2006 and 2009, enrollment has increased only 6 percent and, if it grows at the same pace, the total increase between 2006 and 2015 will be about 20 percent. Because it can take up to 14 years to educate and train new physicians, allied health professionals who are trained in many fewer years have a distinct advantage in increasing their numbers. Coupled with increased emphasis by the government on utilizing nonphysician practitioners to fill practice gaps, the ratio of physicians to nonphysician providers is becoming increasingly skewed towards the latter.

   A 2006 study, *Physician Supply and Demand: Projections to 2020,* commissioned by the Department of Health and Human Services, Health Resources and Services Administration (HRSA) Bureau of Health Professions (BHPr), projected that the need for physicians will increase by about 22 percent between 2000 and 2020. (ftp://ftp.hrsa.gov/bhpr/workforce/PhysicianForecastingPaperfinal.pdf.) In an earlier study (2003), "Changing Demographics and the Implications for Physicians, Nurses, and Other Health Workers," researchers predicted an increased demand for physician services under various scenarios from 28 percent to 40 percent. The demand for nurses may increase from 41 percent to 50 percent. (http://bhpr.hrsa.gov/healthworkforce/reports/changedemo/.) The higher projections were based on a scenario where universal health care is enacted.

   Expansion of the scope and use of nonphysician clinicians is one of the elements in the current health care reform proposals most objectionable to physicians. We worry that patients will not receive the care that they need (and therefore suffer harm or even death) because the non-physicians don't know what they don't know. Only time will tell if this is a justified worry. This trend has been growing for over 30 years and has gained public, if not professional, acceptance in many aspects of health care.

2. **Changing methodologies in payment for anesthesia services.** Lawmakers have a persistent lack of understanding of the premise and

methods of determining anesthesia charges. Although it is not a difficult concept, it vexes them that anesthesia payments vary for the same procedure, which injects an element of unpredictability in projecting expenses. They would prefer to have one answer to the question, "How much does the anesthesia for an appendectomy cost?"

In 2003, a resolution was considered in the ASA House of Delegates (authored by CSA Past President J. Kent Garman, M.D., M.S.) which proposed that the ASA develop a new methodology for paying for anesthesia services that explored the idea of global fees. The resolution was soundly defeated. A special reference committee was convened at the ASA meeting in 2004 to review alternative methodologies, but the House of Delegates voted not to pursue any changes. This issue could return during or after health care reform legislation.

In February 2009, the Centers for Medicare & Medicaid Services (CMS) announced site selections for the Acute Care Episode (ACE) demonstration. ACE is a new hospital-based demonstration that will test the use of a bundled payment for both hospital and physician services for certain heart and joint inpatient episodes of care to improve the quality of care delivered through Medicare fee-for-service.

The goal of the ACE demonstration is to use a bundled payment to better align the incentives for both hospitals and physicians, leading to better quality and greater efficiency in the care that is delivered. The demonstration will also test the effect that transparent price and quality information has on beneficiary choice for select inpatient care.

Five hospitals are participating in the demonstration projects and early results indicate that some savings can be derived. One result is that fewer specialists are called in, a practice that has yet to be shown to be advantageous or detrimental to patients. (http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/ACE_web_page.pdf.)

3. **Increase in procedures provided in ambulatory facilities.** Every year procedures are added to the list of procedures approved by Medicare for use in ambulatory surgery centers. According to *American Medical News,* 70 percent of all surgical procedures performed in the United States in 2000 were done in outpatient facilities, compared to 15 percent in 1980. Every year the number of procedures approved by Medicare for ASCs increases, and the effects are felt in acute care hospitals. As the proportion of inpatients decreases, non-physicians will seek expansion of their scopes of practice more aggressively.

The trends briefly discussed above do not portend a grim future for physicians. They are intended to prompt "what if" discussions among members so they may brainstorm possible futures. By incorporating creativity and adaptation, anesthesiologists can have satisfying careers and continue to provide high quality care as the future becomes the present.

Call for Submission of Resolutions to the House of Delegates

Any CSA member may submit a resolution to the House of Delegates (your elected representatives) on any issue that you deem important. A resolution is a proposal that the CSA undertake an activity related to a current issue of concern to anesthesiologists. For example, a resolution might recommend that the CSA develop a guide on issues that should be addressed when contracting with a billing service. For assistance in formulating a resolution, you are welcome to contact Johnathan L. Pregler, M.D., Speaker of the House of Delegates.

The House of Delegates will meet on Saturday, May 15, as part of the CSA Annual Meeting at the Newport Beach/Costa Mesa Hilton, Orange County, California. An Issues Discussion Forum (formerly the Reference Committee) meets prior to the House of Delegates to hear testimony on all matters to be considered by the House. For more information, contact the CSA office at 650-345-3020, 800-345-3691, fax 650-345-3269.

The deadline for submissions is March 15, 2010.