

Providence Journal Op-Ed: "Emergency rooms and healthcare reform"

By Brian J. Zink, MD

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## Brian J. Zink: Emergency rooms and health-care reform

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By BRIAN J. ZINK

In a Jan. 19 editorial ("Our medical future") on health-insurance reform and the impending Scott Brown senatorial election in Massachusetts, the writer notes that if health-care reform fails: "Hospital emergency rooms — in all their chaotic, costly and inefficient glory — will increasingly be where primary medical care is provided."

Emergency department (E.D.) providers have been a remarkably adaptable, efficient and seemingly infinite source for care when patients with acute illness and injury cannot gain access to their "regular" care. Despite a never-ending onslaught of patients, we manage to deliver high-quality care and are the place of last resort for many. It does indeed cost money (paid by our hospitals) to maintain a community resource available 24/7/365, however, the money spent in the U.S. on Emergency Department care is a minuscule fraction of overall health-care expenditures.

Providing affordable and accessible health care for all of our citizens is one of the most vexing problems of our time. The current debate in Congress on health-insurance reform is far from settled, but the short-term consequences for E.D.s will be the same whether the legislation as described passes or does not pass — visits will increase.

If it does not pass, we will have increasing numbers of uninsured citizens who are forced to use the E.D. for their health care. If legislation as proposed does pass, E.D. visits will also increase at least for several years, since the increased insurance coverage to be afforded to many people is not coupled with increased access for care.

Consider, for example, the Massachusetts health plan that was rolled out in late 2006. One consequence (or perceived failure) of the Massachusetts health-care reform is that the number of E.D. visits has not declined. A report from spring of 2009 noted that the number of Massachusetts E.D. visits rose to more than 2.4 million between 2005 and 2007, up 7 percent. The cost of care associated with those visits was estimated at \$973 million. This was entirely predictable, and the answers to the problem can be found in our past and our present.

The U.S. post-World War II experience demonstrated that when the population is provided increased access to care through expanded insurance coverage, the demand for medical services increases. When the Medicare and Medicaid programs were enacted into law, in 1965, many elderly and poor citizens who previously had no health insurance tried to access doctors and clinics for their acute and chronic medical problems.

As is the case now, there was a shortage of primary-care doctors and these new patients turned to hospital emergency departments for care. E.D. visits increased almost a third, from 29 million in 1965 to 43 million in 1970. What we have failed to learn from the history of Medicare and Medicaid is that unless access to primary care and the number of basic health-care providers is increased in proportion to the increase in insurance coverage, E.D.s will become much busier. Passing laws to increase health-insurance coverage is just the first part of the equation. The second part is making provisions to increase access to care. If we fail to do this, it is like selling 10,000 tickets to a concert in an auditorium that seats 5,000.

A 2009 article in the Journal of the American Medical Association helps to debunk the commonly held belief that the problem of emergency-room crowding and overuse is mainly due to uninsured and indigent patients. The study found that the uninsured do not appear to use E.D.s at a higher rate than insured patients, do not over-use the E.D. for non-urgent care, and are not the main reason for E.D. crowding. The authors cite the shortage of primary-care physicians and clinics as a key problem in access to care for all patients, not just the uninsured.

E.D.s become the default venue for health care when the system cannot meet basic needs. Especially in the after-hours world, E.D.s are usually the only game in town for people who are injured or sick.

It has become customary for policy-makers and politicians to blame patients and E.D.s for heavy use and high costs. In reality, the patients are just voting with their feet — going to where they know they can get medical services even if they have to wait a bit. And emergency-care providers are just doing their federally mandated duty.

The Emergency Medical Treatment and Active Labor Act (EMTALA) of 1986 requires that every individual who presents to an E.D. for evaluation must receive a screening examination, regardless of the problem or condition or ability to pay. Emergency-care providers take this egalitarian responsibility seriously, even if it means that our E.D.s are sometimes bursting at the seams.

E.D. providers understand that they are the safety net, and the default solution in access for a health-care “system” that is circling the drain.

Unless we want emergency visits to increase even more, we will need to support and fund ways to provide health-insurance coverage and access for all people. We welcome legislation, initiatives or programs from government or insurers that will improve access to care through the development of community-based primary care and medical homes. We will continue to be there day and night for the ill and injured citizens of Rhode Island, but a few less people in E.D.s would suit us just fine.

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