Executive Summary
Backgrounder
Published by The Heritage Foundation
No. 2092
December 28, 2007

The Crisis in America's Emergency Rooms and What Can Be Done

John S. O'Shea, M.D.

America's emergency rooms are in crisis.

Emergency medicine encompasses the care of patients with traumatic injuries or serious signs and symptoms of disease. Quick evaluation and rapid treatment of these patients obviously cannot be done on an "elective" basis. These services are invariably provided under the auspices of a hospital and are available to patients 24 hours a day, seven days a week.

Moreover, hospital emergency departments (EDs) are the only part of the health care system that is required by federal law to provide care to all patients, regardless of ability to pay. Yet a sizable number of patients who visit the ED do not require the level of care that an emergency room provides. In Maryland, for example, patients with non-urgent medical problems account for over 40 percent of ED visits.

Jammed with increasing numbers of uninsured Americans and enrollees in public programs, emergency rooms find their overcrowding further aggravated by outdated federal and state policies. Worse, while many emergency rooms are already operating at peak capacity on a day-to-day basis, the emergency medical system is incapable of absorbing the massive surge in demand for emergency medical assistance that would follow a natural disaster or terrorist attack.

Recent trends highlight the challenge:

- The emergency medical system is stretched beyond capacity.
- In most states, the system could not absorb the surge in demand that would accompany a pandemic, natural disaster, or terrorist attack.
- Recent increases in ED demand are driven by patients seeking care for non-urgent problems.
- Current conditions degrade the quality of patient care.
- Current conditions contribute to the uncompensated care burden on physicians.

A Better Policy. Beyond correcting federal and state laws and regulations, policymakers need to help hospital officials realign the economic incentives for emergency care, clarify the roles of hospitals and emergency departments, and restore a federalist approach to the provision of emergency care that clearly distinguishes between what is a public responsibility and what is a private responsibility and between what is the proper role of the federal government and what priorities should remain with the states. The states should have the primary role in setting rules for first responders.

This paper, in its entirety, can be found at:
www.heritage.org/research/HealthCare/bg2092.cfm

Produced by the Center for Health Policy Studies

Published by The Heritage Foundation
214 Massachusetts Avenue, NE
Washington, DC 20002–4999
(202) 546-4400 • heritage.org

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Specifically, policymakers should:

- **Rapidly expand private health insurance coverage.** Policymakers should move as many non-urgent patients as possible out of the emergency room to increase the capability to care for patients with true emergencies. Based on the data, private insurance coverage correlates with relatively low emergency room usage, and expanding public programs would only make conditions worse.
- **Focus on public safety as a key component in the delivery of emergency medical services and promote alternatives for urgent care.** In many respects, the delivery of emergency medicine should be viewed as a public safety function, particularly in the aftermath of a natural disaster or terrorist attack. State officials should plan accordingly. Beyond that, they should change any laws or regulations that hinder hospital specialization, the private expansion of free-standing emergency care centers, or urgent care options for individuals and families seeking treatment when primary care physicians are unavailable.
- **Separate emergency medical planning from laws governing hospital planning and construction and allow hospitals to specialize in the conventional delivery of care.** State officials should re-examine all state laws, including certificate of need (CON) laws, that may hinder the provision of emergency medical services. In a properly functioning system that distinguishes between emergency medical services and routine hospital functions, hospitals would specialize in the provision of conventional care, and robust competition would drive innovation, productivity, and improvements in quality of care.
- **Clearly define federal and state responsibilities, streamline financing, and improve the capacity and efficiency of emergency services.** While the Secretary of Health and Human Services should take the lead role in defining federal responsibilities, particularly in response to natural disasters and terrorist attacks, states should continue to exercise broad discretion over the provision of emergency medical services. States should also pursue medical liability reform.

Conclusion. America's emergency room crisis is complex. Simply throwing more taxpayer money at the problem will not solve this crisis. Reform of the emergency medical system will require fundamentally rethinking the role of the emergency department and its relation to the acute care hospital.

Generally, the failure to address the problem of emergency medical care degrades the quality of care for all Americans. Specifically, it jeopardizes critically ill citizens' access to timely, efficient, and highly competent emergency medical services while compromising the ability of the health care system to respond to disasters.

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Moreover, hospital emergency departments (EDs) are the only part of the health care system that is required by federal law to provide care to all patients, regardless of ability to pay.[1] A sizable number of patients who visit the ED do not require the level of care that an emergency room provides. In Maryland, for example, patients with non-urgent medical problems account for over 40 percent of ED visits.[2]

Jammed with increasing numbers of uninsured Americans and enrollees in public programs, emergency rooms find their overcrowding further aggravated by outdated federal and state policies. Worse, while many emergency rooms are already operating at peak capacity on a day-to-day basis, the emergency medical system is incapable of absorbing the massive surge in demand for emergency medical assistance that would follow a natural disaster or terrorist attack.

Recent trends highlight the challenge:

- **The emergency medical system is stretched beyond capacity.** From 1994 to 2004, visits to hospital emergency departments increased from 93.4 million to 110.2 million—an 18 percent

Talking Points

- America's hospital emergency rooms are plagued by overcrowding, misaligned incentives, and conflicting missions.
- Patients with non-urgent medical problems, especially in public health programs such as Medicaid, are driving the recent increases in demand for emergency services.
- Current conditions degrade the quality of care for all patients needing emergency medical services, leading to shortages in physician coverage, diversions of ambulances, and the boarding of patients in emergency departments.
- State and federal officials can reduce the burden on emergency departments by expanding patient access to private health insurance, separating emergency services planning from hospital planning, promoting private-sector alternatives for urgent care, and freeing hospitals to specialize in non-emergency medical care.
- Reform of emergency medical systems should be primarily a state responsibility, using existing funding wherever possible, with federal responsibilities confined to national problems, such as preparation for national disasters and terrorist attacks.

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jump. Meanwhile, the numbers of hospitals, hospital beds, and emergency departments have declined significantly.

- **In most states, the system could not absorb the surge in demand that would accompany a pandemic, natural disaster, or terrorist attack.** Global projections warn that millions could die in the next outbreak of pandemic flu. According to a recent report by the Trust for America's Health, a nonpartisan organization promoting public health, 25 states do not have the surge capacity to meet the number of hospital beds necessary within two weeks of the outbreak of a "moderately severe" pandemic flu, and 47 states lack the capacity to deal with a severe outbreak, such as the one caused by the devastating 1918 virus.[3]
- **Recent increases in ED demand are driven by patients seeking care for non-urgent problems.** Not surprisingly, patients with private health plans recorded the lowest usage of emergency room care. Medicaid and State Children's Health Insurance Program (SCHIP) enrollees use EDs at roughly four times the rate of privately insured patients and nearly twice the rate of uninsured patients or Medicare beneficiaries.
- **Current conditions degrade the quality of patient care.** Patients are "boarded," sometimes for hours or even days, in emergency rooms until a hospital bed becomes available. Ambulances are diverted from overcrowded emergency departments, losing precious time, with nearly one in six urban hospitals reporting that they are on ambulance diversion more than 20 percent of the time. There are also shortages of doctors providing on-call emergency services. Over 65 percent of emergency department directors report physician coverage problems. According to a 2004 survey conducted by the American Association of Neurological Surgeons, 46 percent of neurosurgeons limited their emergency medical practices, with 87 percent citing liability concerns.
- **Current conditions contribute to the uncompensated care burden on physicians.** More than 30 percent of all physicians provide emergency medical services, and 42 percent of self-employed doctors report that a major portion of their bad debt is attributable to delivery of medical services required by federal law, amounting to $4.2 billion annually.

A Better Policy

Beyond correcting federal and state laws and regulations, policymakers need to help hospital officials realign the economic incentives for emergency care, clarify the roles of hospitals and emergency departments, and restore a federalist approach to the provision of emergency care that clearly distinguishes between what is a public responsibility and what is a private responsibility and between what is the proper role of the federal government and what priorities should remain with the states. The states should have the primary role in setting rules for first responders.

Specifically, policymakers should:

- **Rapidly expand private health insurance coverage.** Policymakers should move as many non-urgent patients as possible out of the emergency room to increase the capability to care for patients with true emergencies. Based on the data, private coverage correlates with relatively low emergency room usage, and expanding public programs would only make conditions worse.
- **Focus on public safety as a key policy objective in the delivery of emergency medical services and promote alternatives for urgent care.** In many respects, the delivery of emergency

1. The Emergency Medical Treatment and Active Labor Act of 1986 requires that all patients presenting to an emergency facility, regardless of ability to pay, need to be screened for an emergency condition. If an emergency condition is found, the patient must be treated and stabilized before being transferred to another facility. 42 U.S. Code § 1395dd.
2. Maryland Health Care Commission, "Use of Maryland Hospital Emergency Departments: An Update and Recommended Strategies to Address Crowding," January 1, 2007, p. 31, at *http://mhcc.maryland.gov/hospital_services/acute/emergencyroom/ed_crowding_122006_report.pdf* (May 9, 2007).
3. Jeffrey Levi, Ph.D., Laura M. Segal, Emily Gadola, Chrissie Juliano, and Nicole M. Speulda, "Ready or Not? Protecting the Public's Health from Diseases, Disasters and Bioterrorism," Trust for America's Health *Issue Report*, December 2006, p. 21, at *http://healthyamericans.org/reports/bioterror06/BioTerrorReport2006.pdf* (May 9, 2007).

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medicine should be viewed as a public safety function, particularly in the aftermath of a natural disaster or terrorist attack. State officials should plan accordingly and also change any laws or regulations that hinder the private expansion of free-standing emergency care centers or urgent care options for individuals and families seeking treatment when primary care physicians are unavailable.

- **Separate emergency medical planning from laws governing hospital planning and construction and allow hospitals to specialize in the conventional delivery of care.** State officials should re-examine all state laws, including certificate of need (CON) laws, that may hinder the provision of emergency medical services. In a properly functioning system that distinguishes between emergency medical services and routine hospital functions, hospitals would specialize in the provision of conventional care, and robust competition would drive innovation, productivity, and improvements in quality of care.
- **Clearly define federal and state responsibilities, streamline financing, and improve the capacity and efficiency of emergency services.** While the Secretary of Health and Human Services should take the lead role in defining federal responsibilities, particularly in response to natural disasters and terrorist attacks, states should continue to exercise broad discretion over the provision of emergency medical services. Extra federal funding may be necessary, particularly in meeting national goals to deal with disasters or terrorist attacks, but policymakers should first re-allocate existing funding before devoting additional spending.

How Americans Get Emergency Medical Care

Emergency medical care is delivered through a complex, hospital-based system of emergency response and delivery. For many patients, the capacities of these systems are the difference between life and death. Yet these same daily responsibilities are stretching emergency medical systems to capacity, leaving little room to accommodate any large surge in demand from such disasters as a viral pandemic or a major terrorist attack.

Emergency medicine can be divided into roughly two broad areas: pre-institutional care and institutional care. Pre-institutional care includes the nationwide 911 emergency system, ground and air transport of patients to emergency care facilities, and treatment of patients at the scene or during transport. Personnel involved in this part of the system are often referred to as first responders and include police, firefighters, emergency medical technicians, and occasionally doctors and nurses. This first responder component is traditionally referred to as emergency medical services (EMS).

The institutional part of the system is most often associated with hospital emergency departments, but it also encompasses facilities that focus on providing lower-level or higher-level subsets of care, such as urgent care facilities geared to treating non–life-threatening injuries and specialized facilities such as shock-trauma centers and burn units. Regardless of setting, this part of the system provides the evaluation, treatment, disposition, and follow-up of patients.

National Disasters. Increasingly, public officials realize that the emergency care system also needs to prepare for and manage unexpected and catastrophic events, the scope and magnitude of which are inherently difficult to anticipate. Man-made disasters such as the terrorist attacks of 9/11, natural disasters such as Hurricane Katrina, and the threat of pandemic disease, bioterrorism, or even nuclear attack have properly focused policymakers' attention on the unready state of America's emergency medical system.

So far, government efforts have fallen short because addressing these demands requires tackling problems that cannot be solved by addressing them solely as homeland security challenges. They require addressing larger health care issues that affect federal, state, and local government organizations and policies and the practices of private-sector service providers.

Policymakers tend to treat the need for health care reform and disaster preparedness as distinctly separate public policy challenges. However, many of the issues that are essential to the daily operation of the nation's emergency medical services are also essential to disaster preparedness. These issues include:

- *Capacity of care.* Catastrophic disasters can place tens of thousands of lives in jeopardy, and the nation should be prepared to provide medical care for far greater numbers of people than medical service providers reach under normal circumstances.
- *Transportability of care.* In some large-scale disasters, many individuals may be displaced either voluntarily or involuntarily. Individual health care for millions will have to be portable enough to deliver services to them in a wide variety of locations and circumstances.
- *Uncompensated care.* In the aftermath of a disaster, many victims will be unable to pay for medical services. Means must be provided to compensate service providers for disaster care.

Yet this new focus on disaster preparedness comes at a time when hospital emergency departments are increasingly being diverted from their basic mission by a growing number of patients seeking attention for non-emergent medical problems in U.S. emergency rooms, often due to a real or perceived lack of access to primary care services elsewhere.

The Institute of Medicine, a branch of the National Academy of Sciences, recently reported that America's emergency medical system is stretched beyond capacity on a daily basis and lacks the surge capacity to deal with a disaster of any appreciable magnitude.[4] By any standard, this is a system in crisis. Therefore, any effort to develop an emergency medical system to meet the nation's needs in a disaster must address the fundamental infrastructure and capacity problems that already impede the everyday delivery of emergency medical services. Many of these difficulties can be traced to the unique developmental history of emergency medicine in America.

Misaligned Incentives. Emergency medical services, as well as hospital-based EDs, have evolved without an overall policy plan, and this has led to a misalignment of incentives that has placed hospital EDs in the difficult position of being simultaneously an essential community service, a major source of hospital business, and a reluctant provider of publicly and privately subsidized health care safety net services.

Until relatively recently, hospitals provided care only to the poor and the truly indigent—those without family members to care for them. By doing so, they established their role as an important part of America's social safety net. Hospitals were supported largely by philanthropy and were viewed as charitable institutions and places of last resort until well into the 20th century. However, the practice of medicine became more scientific; care became more effective; and by the 1930s, hospitals were increasingly attracting middle-class and upper-class patients who became a growing source of hospital income.[5]

Over the next several decades, clinical advances and financial incentives sustained the rapid growth of hospital EDs. By the late 1960s, emergency medicine was becoming a coherent professional field, and in 1979, it was recognized as a specialty by the American Board of Medical Specialties. Emergency medicine now includes the subspecialties of medical toxicology, pediatric emergency medicine, sports medicine, and undersea/hyperbaric medicine.

EDs were once staffed with inexperienced, often junior-level physicians and nurses or not staffed at all, but by 2003, board-certified emergency physicians were available at 63.5 percent of hospital EDs, and pediatric emergency physicians were available at 18.1 percent of hospital EDs. In 2005, the number of board-certified active emergency medicine specialists totaled an estimated 22,376.[6] The majority of the remaining EDs, especially in smaller suburban and rural hospitals, are staffed by physicians who are residency-trained and often board-certified in another specialty, such as internal medicine, family practice, pediatrics, or surgery.[7] Since recognition of emergency medicine as a specialty in 1979, the number of emergency medicine physicians

4. Institute of Medicine, *Emergency Medical Services: At the Crossroads* (Washington, D.C.: National Academies Press, 2006).
5. R. A. Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century* (Baltimore: Johns Hopkins University Press, 1989), pp. 30–39.
6. American Board of Emergency Medicine, "Examination and Diplomate Statistics," December 31, 2005, at *www.abem.org/public/portal/alias__Rainbow/lang__en-US/tabID__3373/DesktopDefault.aspx* (May 9, 2007).

(board-certified and self-proclaimed) has grown at twice the rate (79 percent) of the number of physicians in general (39 percent).[8]

Today, as medical science continues to devise ever more sophisticated and effective diagnostic measures and treatments, the system has come under increasing pressure to restrain the concomitant growth in health care spending. While this growing tension between capability and affordability affects every aspect of the current health system, nowhere is it more acutely felt than in hospital emergency departments.

There are several reasons for this. In virtually every state, the typical hospital emergency department is expected to complete three distinct missions:

- **Community service.** Among any emergency department's functions, the best understood is its role as an essential part of the local community's public safety and emergency response system, which also encompasses police, fire and rescue, and emergency transportation services. This community service function is what those outside a hospital view as the hospital's most important feature. Consequently, the availability and adequacy of emergency response to a large degree shapes public attitudes on any hospital-related policy issue.
- **Charity care.** Over the past half-century, hospital emergency departments have increasingly become the focal point for the continuing charitable aspect of health care delivery. Charity care has an ancient and honorable pedigree that can be traced back through the efforts of prominent nurses, such as Florence Nightingale and Clara Barton in the mid-19th century, to the benefactors who established charitable hospitals in the various American colonies during the 18th century and the hospital services of various religious orders of Medieval Europe.

  In the late 19th century and early 20th century, however, advances in medical science generated new curative treatments that superseded the need for palliative care, such as rest in tuberculosis wards. In addition to revenue from private clients, increased taxpayer financing of care for the indigent poor, such as that provided through the Medicaid program and public hospitals and clinics, replaced much of the private charitable funding of medical care for the poor. A large portion of the remaining charity care in the health system is now delivered to uninsured patients who present to hospital emergency departments, with the balance delivered largely through nonprofit primary care clinics or in-kind care from private providers.
- **Revenue raiser.** Ever since their inception in the early 20th century, hospital EDs have also served as a major entry point or "sales channel" for paying patients needing acute care treatments. Hospitals really have only two sources of patients: those who are brought in or sent in by physicians and those who bring themselves or are brought by ambulance to the emergency department. Forty-three percent of all hospital admissions originate in the ED.[9]

The interplay of these three, very diverse roles and missions underlies much of the current crisis in emergency medicine. Despite the increased use of hospitals by affluent and middle-class patients that began nearly a century ago and the consequent changes in hospital financing, the traditional idea that hospitals have a charitable mission has persisted.

Beginning in the 1960s, the cultural norm of hospital EDs' social responsibility was progressively formalized in both state and federal law, culminating in enactment of the Emergency Medical Treatment and Active Labor Act (EMTALA) in 1986. The EMTALA legislation mandates that all patients pre-

7. John C. Moorhead *et al.*, "A Study of the Workforce in Emergency Medicine: 1999," *Annals of Emergency Medicine*, Vol. 40, No. 1 (July 2002), pp. 3–15, at *http://download.journals.elsevierhealth.com/pdfs/journals/0196-0644/PIIS019606440200001X.pdf* (June 20, 2007).
8. American Medical Association, *Physician Characteristics and Distribution in the US: 2004 Edition* (Chicago: American Medical Association Press, 2004).
9. Chaya T. Merrill and Anne Elixhauser, Ph.D., "Hospitalization in the United States," U.S. Department of Health and Human Services, Agency for Health Care Research and Quality *Fact Book* No. 6, June 2005, at *www.ahrq.gov/data/hcup/factbk6/factbk6.pdf* (May 10, 2007).

senting to emergency departments must be evaluated and stabilized, regardless of their ability to pay.[10] This has codified an ethical or social responsibility on the part of medical professionals in American hospitals into a legal obligation to provide medical care, establishing for all practical purposes a legal right to medical care for all Americans.

At the same time, however, emergency departments continue to be the entry point for over 40 percent of hospital admissions. This incentive motivates hospitals to get as many patients as possible through their doors to avoid losing market share to their competition. Consequently, hospital officials feel increasingly pressured to expand their own ED capacity rather than have paying patients cared for in a different venue.

Because of the legal force of EMTALA, expanding the ED also means implicitly expanding the hospital's role as the principal provider of charity care in the community, despite the fact that the ED is an inappropriate place in which to care for many of those patients. This, in turn, has led hospitals during the past two decades to pressure federal, state, and local governments into providing direct taxpayer subsidies to offset the substantial cost of the "free care" that governments expect them to provide.

Politically, this pressure has been successful. It has turned EMTALA's direct mandate on hospitals into an indirect mandate on all American taxpayers.

Caught between the hospital's need for paying patients and state and federal lawmakers' requirements to provide charity care, American emergency departments are increasingly shortchanging their third role of emergency response. Too often, when an emergency does occur, the ED is already full and simply cannot handle it. Because hospitals and their EDs try to be all things to all patients, they consequently fail to provide safe, effective, patient-centered, timely, efficient, and equitable care to many.[11] ED overcrowding, patient boarding, ambulance diversions, and growing workforce problems will not be solved without a fundamental change in the financing and delivery of emergency medical care.

Why the Emergency Medicine Crisis Is Deepening

The perceived need for hospitals to funnel as many patients as possible through their EDs comes at a very high price: Misusing the ED to provide primary medical care is more costly than providing the same care in a physician's office, and primary medical care received through the ED is of poorer quality. In addition, using the ED for non-emergent patient care contributes to ED overcrowding, patient boarding, ambulance diversion, and delayed ambulance response times on a daily basis. It also limits the system's ability to prepare for and respond to a major medical disaster, such as a flu pandemic or terrorist attack.

Meanwhile, finding specialists who are willing or able to provide on-call coverage has become increasingly difficult, largely because of unresolved medical liability and regulation issues and the large amount of emergency care that is uncompensated or undercompensated.

Overcrowding. From 1994 through 2004, the number of ED visits increased by 18 percent, rising from 93.4 million visits to 110.2 million visits annually. This increase was spread across all age groups and represents an average increase of more than 1.5 million visits per year and 38.2 visits per 100 people in the nation.

Conventional health care financing in both the public and the private sectors has aggravated this problem. Mainly in response to rising costs of care and lower reimbursements by managed care and other payers, including Medicare and Medicaid, America experienced a net loss of 703 hospitals, 198,000 hospital beds, and 425 EDs during roughly the same period.[12] The evidence indicates that hospital restructuring in response to financial pressures has been a major contributor to ED overcrowding.[13] (See Chart 1.)

10. 42 U.S. Code § 1395dd.

11. These are the six quality aims defined in Institute of Medicine, Committee on Quality of Health Care in America, *Crossing the Quality Chasm: A New Health System for the Future* (Washington, D.C.: National Academies Press, 2001).

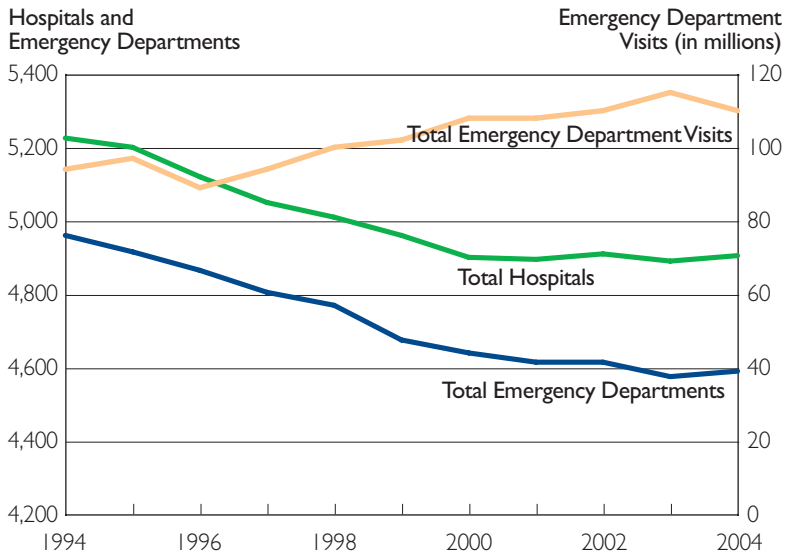
12. Lewin Group analysis of AHA annual statistics, 1991–2004.

Many reasons have been given for the increased demand on EDs, including an increase in the number of the uninsured. The U.S. Census Bureau estimates that approximately 46.6 million people have no insurance coverage, and further research indicates that many of them are individuals and families who had coverage but, because their employer-based health insurance was not portable, became uninsured when they changed jobs.

Because uninsured patients are more likely to lack access to regular primary care and preventive services, they tend to interact with the health care system when they are sicker, and these encounters often take place in the ED. However, the uninsured are not the only or even the largest source of the increased ED demand. The number of ED visits by publicly and privately insured patients has also increased, while the *proportion* of ED patients without a third-party source of payment has remained stable over the past several years.[14]

Chart 1 B 2092

Trends in Emergency Care, 1994–2004



Sources: American Hospital Association, *TrendWatch Chartbook 2006: Trends Affecting Hospitals and Health Systems*, April 2006, p. 2-2, Table 2.1, and p. 3-4, Table 3.3, at *www.aha.org/aha/research-and-trends/health-and-hospital-trends/2006.html* (January 25, 2007), and Linda F. McCaig and Eric W. Nawar, "National Hospital Ambulatory Medical Care Survey: 2004 Emergency Department Summary," Centers for Disease Control and Prevention, National Center for Health Statistics *Advance Data from Vital Health Statistics* No. 372, June 23, 2006, at *www.cdc.gov/nchs/data/ad/ad372.pdf* (January 25, 2007).

The Medicaid Mess. In 2004, the rate of ED visits for those without insurance was 44.6 per 100 persons, compared to 47.1 per 100 persons for those covered by Medicare and 20.3 per 100 persons for those with private insurance. In contrast, the ED visit rates for Medicaid and SCHIP patients was 80.3 per 100 persons—four times the rate for the privately insured and nearly twice the rate for the uninsured and Medicare recipients. (See Chart 2.)

Patterns vary from state to state. In Maryland, from 2003 to 2005, Medicare and Medicaid patients accounted for 36.1 percent of emergency room visits, while self-paying patients, including the uninsured, accounted for 18.8 percent and patients with HMO coverage accounted for 16.3 percent.[15] Self-paying and Medicaid patients make up the largest proportion of Maryland patients seeking non-emergent care in Maryland emergency rooms.

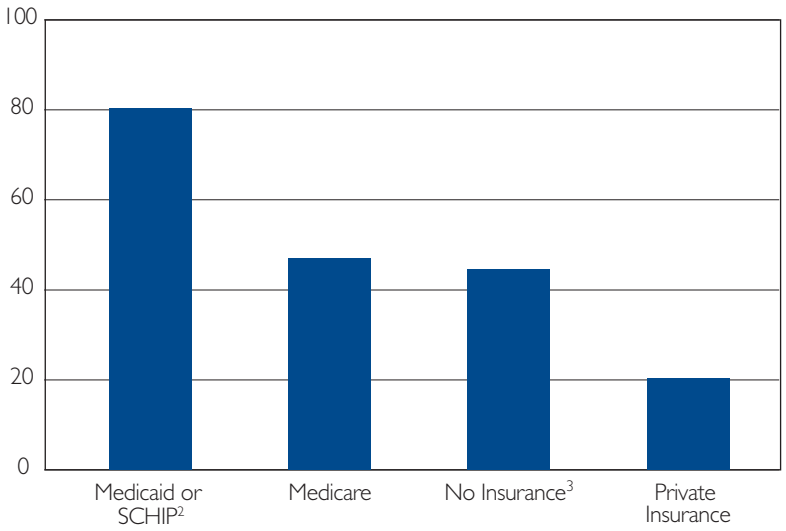
Patients come to EDs with a wide spectrum of ailments. Abdominal pain, chest pain, fever, and back symptoms are the leading patient complaints and account for nearly one-fifth of all visits. Injury-related visits account for an estimated 41.4 million each year, or 14.4 visits per 100 persons.

13. Michael J. Schull, John-Paul Szalai, Brian Schwartz, and Donald A. Redelmeier, "Emergency Department Overcrowding Following Systematic Hospital Restructuring: Trends at Twenty Hospitals over Ten Years," *Academic Emergency Medicine*, Vol. 8, No. 11 (November 2001), pp. 1037–1043.
14. Lewin Group, "Emergency Department Overload: A Growing Crisis," April 2002, p. 19, at *www.aha.org/aha/content/2002/pdf/EdoCrisisSlides.pdf* (May 10, 2007).
15. Maryland Health Care Commission, "Use of Maryland Hospital Emergency Departments," p. 21.

However, a substantial part of ED demand comes from patients who could be cared for elsewhere. According to the National Hospital Ambulatory Medical Care Survey (NHAMCS), less than half of emergency department visits (47 percent) in 2004 were classified as either emergent (12.9 percent) or urgent (37.8 percent). This was true for all insurance groups with the exception of Medicare patients (about 57 percent of Medicare visits were emergent or urgent).[16] Moreover, visits classified as semi-urgent, non-urgent, or "unknown triage" accounted for all of the overall emergency department visit increase across all insurance groups between 1996–1997 and 2000–2001.[17]

Chart 2 B 2092

Emergency Department Visits in 2004 by Payer Group



[1] The denominator for each rate is the population total for each type of insurance as reported in the 2004 National Health Interview Survey.
[2] State Children's Health Insurance Program.
[3] Includes self-pay, no charge, and charity.

Note: A non-urgent or semi-urgent visit is one in which the patient does not require attention immediately, but needs care within two to 24 hours.

Source: Ann S. O'Malley, Anneliese M. Gerland, Hoangmai H. Pham, and Robert A. Berenson, "Rising Pressures: Hospital Emergency Departments as Barometers of the Health Care System," Center for Studying Health System Change *Issue Brief* No. 101, November 2005, p. 2, at *www.hschange.com/CONTENT/799/799.pdf* (January 25, 2007).

Other possible causes of the rise in ED demand are capacity constraints experienced by office-based physicians, a loosening of managed-care restrictions, difficulty scheduling appointments with private physicians, and very low Medicaid reimbursement rates that lead primary care physicians to refuse Medicaid patients.[18] More generally, increasing numbers of physicians report having inadequate time to spend with their patients, and some are closing their practices to new patients because of increasing time constraints.[19] Physicians may be responding to an increasing workload by referring patients to EDs with greater frequency, and declines in risk contracting and capitation mean that they no longer have financial disincentives to do so.[20]

16. Linda F. McCaig and Eric W. Nawar, "National Hospital Ambulatory Medical Care Survey: 2004 Emergency Department Summary," Centers for Disease Control and Prevention *Advance Data from Vital and Health Statistics* No. 372, June 23, 2006, at *www.cdc.gov/nchs/data/ad/ad372.pdf* (May 10, 2007).
17. The National Hospital Ambulatory Medical Care Survey uses the following system to classify the immediacy of the patient's condition as perceived by the person doing the initial evaluation: "emergent" (should be seen in less than 15 minutes); "urgent" (should be seen in 15–60 minutes); "semi-urgent" (should be seen in 61–120 minutes); "non-urgent" (should be seen in 121 minutes to 24 hours); and "unknown" (includes visits in which no triage was done or recorded or the patient was dead on arrival).
18. Bradley C. Strunk and Peter J. Cunningham, "Treading Water: Americans' Access to Needed Medical Care, 1997–2001," Center for Studying Health System Change *Tracking Report* No. 1, March 2002, at *www.hschange.org/CONTENT/421* (May 10, 2007).
19. Sally Trude, "So Much to Do, So Little Time: Physician Capacity Constraints," Center for Studying Health System Change *Tracking Report* No. 8, May 2003, at *www.hschange.org/CONTENT/556* (May 10, 2007).

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In some cases, increased utilization may be associated with physicians practicing defensive medicine by sending potentially risky patients to EDs instead of providing care in their offices.[21] With extended hours and no appointment necessary, emergency departments are also more convenient than scheduled office visits as a source of primary care. For Medicaid and uninsured patients, EDs are often one of the few remaining primary care options.

Waste and Inefficiency. Estimating the excess health care spending attributable to providing nonemergent care in the ED is difficult, largely because of disagreement among patients, physicians, and payers about the "prudent definition" of an emergent condition.[22] Even within the medical profession there is disagreement on this issue.[23]

The data suggest that, in contrast to patients who go to a private physician's office or primary care clinic, ED patients receive a higher intensity of service, and EDs charge an estimated two to five times more than a private office would charge to treat minor problems. In 2004, diagnostic and screening services were provided in 89.9 percent of ED visits, imaging studies were ordered in 43.7 percent, procedures were performed or ordered in 47.7 percent, and medications were prescribed in 78.4 percent. Approximately 13 percent of ED visits resulted in a hospital admission. Statistically, the average patient spends 3.3 hours in the ED, of which 47.4 minutes are spent waiting to see a physician.[24]

By comparison, patients seen in a physician's office in 2004 received diagnostic or screening services 85.9 percent of the time, although most of these services were low-intensity (50.5 percent were general medical exams). Imaging studies were ordered in 10.0 percent of visits, and procedures were ordered or performed in 7.7 percent. Counseling and preventive care, which is rarely provided in the ED setting, were provided in a physician's office in a significant proportion of visits (37.6 percent).[25] These cost differences are very significant because about 43 percent of ED patients could be cared for safely in a less expensive setting if one were available.[26]

Patient Boarding. The problem of ED overcrowding has multiple ripple effects. For example, it forces hospitals to engage in the practice of patient boarding—holding admitted patients, including intensive care patients, in the ED until a bed becomes available. Boarding contributes to overcrowding because the utilization of equipment and staff by admitted patients impedes the ED's ability to treat additional patients, thereby causing longer waits to see a physician. It also further limits the system's ability to meet periodic surges in demand or respond to a disaster.

20. Linda R. Brewster, Liza Rudell, and Cara S. Lesser, "Emergency Room Diversions: A Symptom of Hospitals Under Stress," Center for Studying Health System Change *Issue Brief* No. 38, May 2001, at *www.hschange.org/CONTENT/312* (May 10, 2007).
21. Robert A. Berenson, Sylvia Kuo, and Jessica H. May, "Medical Malpractice Liability Crisis Meets Markets: Stress in Unexpected Places," Center for Studying Health System Change *Issue Brief* No. 68, September 2003, at *www.hschange.org/CONTENT/605* (May 10, 2007).
22. Nurit Guttman, Deena R. Zimmerman, and Myra Schaub Nelson, "The Many Faces of Access: Reasons for Medically Non-Urgent Emergency Department Visits," *Journal of Health Politics, Policy and Law*, Vol. 28, No. 6 (December 2003), pp. 1089–1120.
23. Gail M. O'Brien, M.D., Marc J. Shapiro, M.D., Mark J. Fagan, M.D., Robert W. Woolard, M.D., Patricia S. O'Sullivan, Ed.D., and Michael D. Stein, M.D., "Do Internists and Emergency Physicians Agree on the Appropriateness of Emergency Department Visits," *Journal of General Internal Medicine*, Vol. 12, Issue 3 (March 1997), pp. 188–191, at *www.blackwell-synergy.com/doi/pdf/10.1046/j.1525-1497.1997.012003188.x* (May 10, 2007).
24. McCaig and Nawar, "National Hospital Ambulatory Medical Care Survey."
25. Esther Hing, Donald K. Cherry, and David A. Woodwell, "National Ambulatory Medical Care Survey: 2004 Summary," Centers for Disease Control and Prevention, *Advance Data from Vital and Health Statistics* No. 374, June 23, 2006, at *www.cdc.gov/nchs/data/ad/ad374.pdf* (May 10, 2007).
26. U.S. General Accounting Office, *Emergency Departments: Unevenly Affected by Growth and Change in Patient Use*, GAO/HRD–93–4, January 1993, at *http://archive.gao.gov/d36t11/148331.pdf* (May 10, 2007).

According to a 2003 survey by the American College of Emergency Physicians (ACEP), boarding of admitted patients in the emergency department is a major problem. More than half of respondents (60 percent) said that their EDs board patients every day or several days per week. The majority (62 percent) said that an average of one to five patients are boarded at any given time, and more than 64 percent said that these patients wait four hours to 12 hours for inpatient beds to become available. During times of high volume, boarding patients for up to 48 hours or more is not unusual. Admitted ED patients are not simply waiting for a bed. They often require monitoring, procedures for stabilization, and initiation of critical care therapies. In addition, a majority (80 percent) of emergency physicians consider patient boarding to have a moderately to severely negative impact on patient safety.[27]

Ambulance Diversion. For a hospital's ED to be at or over capacity not only creates a backup in the hospital ED, but also can have a major ripple effect on every member of the community served by a hospital by forcing the hospital to divert ambulances away from its overcrowded ED. Annually, more than 16 million ED patients arrive by ambulance (15.1 percent of ED visits). In 2003, U.S. hospitals diverted approximately 500,000 ambulances—an average of one per minute. Because overcrowding is rarely limited to a single hospital, the ripple effect can cause surrounding emergency departments to divert ambulances as well, in effect creating a "rolling blackout" of emergency care.

A 2005 American Hospital Association (AHA) survey found that 40 percent of all hospitals, including 70 percent of urban hospitals and 74 percent of teaching hospitals, reported being "on diversion" for some period of time during the previous year. Nearly one in six urban hospitals reported being on diversion more than 20 percent of the time. Although a direct link between ambulance diversion and increased morbidity and mortality has not been studied in detail, hospitals that spend greater than 20 percent of their time on diversion status subject their patients to longer wait times for evaluation and treatment, and there is a good correlation between delay in treatment and adverse outcomes.[28]

Insufficient Inpatient Capacity. Insufficient hospital inpatient capacity is an underappreciated cause of ED overcrowding and may be more important than the overall increase in ED visits and the use of the ED as a source of primary care. It is the unnoticed villain in the emergency medical care drama. According to a 2005 AHA survey of hospital leaders, a lack of critical care beds or general acute care beds accounted for 57 percent of the time that hospital EDs spent on ambulance diversion.[29] Hospitals depend on the ED for a significant part of their business, yet through the ED, hospitals are also federally mandated to provide uncompensated care.

Lack of inpatient capacity is often merely a reflection of any hospital's natural preference for compensated care. For example, inpatient beds are often held open for elective surgery, even if other patients are boarded in the ED. The hospital knows the elective surgery patient's ability to pay and the ability of any patient being boarded in the ED to pay, whereas the payment status of the next patient to come to the ED is an unknown. Thus, the hospital has a financial incentive to hold a bed open for the elective (paying) patient to use the next day, board the stabilized (paying) patient in the ED until an acute care bed is available, and divert the patient coming by ambulance (whose payment status is uncertain) to another hospital.

Furthermore, these incentives and rational responses are identical regardless of whether a hospital is organized as a for-profit or nonprofit entity.

27. News release, "Eighty Percent of Emergency Physicians Surveyed Say Emergency Departments Lack Surge Capacity," American College of Emergency Physicians, October 13, 2003, at *www.acep.org/webportal/Newsroom/NR/general/2003/EightyPercentofEmergencyPhysiciansSurveyedSayEmergencyDepartmentsLackSurgeCapacity.htm* (May 10, 2007).
28. Lewin Group, *TrendWatch Chartbook 2005: Trends Affecting Hospitals and Health Systems*, American Hospital Association, May 2005.
29. American Hospital Association, "The State of America's Hospitals—Taking the Pulse: Findings from the 2006 AHA Survey of Hospital Leaders," at *www.aha.org/aha/content/2006/PowerPoint/StateHospitalsChartPack2006.PPT* (May 10, 2007).

Indeed, a nonprofit hospital that disregarded the payment status of its patients would go broke as fast as or even faster than a for-profit hospital.

Additionally, both EDs and hospitals are subject to large and sudden fluctuations in capacity that make management of these poorly aligned incentives more difficult. For example, on one day, an ED may face a capacity three to five times what it was 24 hours earlier, and general acute care bed occupancy can range from 50 percent to well over 100 percent in a three-day period.[30]

Frustrated Doctors and Overworked Nurses. The issues that are associated with overcrowding not only affect the ED workforce, in terms of increased stress and staff shortages, but also contribute to the current shortage of physicians who are willing or able to provide specialist on-call emergency and trauma care services. In a 2004 survey conducted by the ACEP, 65.9 percent of emergency department directors reported a problem with inadequate on-call specialist coverage, with uncompensated care reported as the most common reason, followed by liability concerns, hospital competition, changes in practice patterns, loss to limited-specialty hospitals and Ambulatory Surgery Centers (ASCs), and EMTALA regulations.[31]

Traditionally, physicians entering practice viewed ED call as a source of new patients, and to build their practice, specialists were willing to provide on-call services in exchange for hospital admitting privileges. Often saddled with sizeable debt from student loans, most new physicians now prefer the security afforded by larger well-established groups to the financial vagaries and lifestyle restrictions of solo practice. This makes ED-call responsibilities more of a burden than an opportunity. The trend toward outpatient treatment, including the growth of limited-service or specialty hospitals, also allows specialists to avoid the need for staff privileges at a general acute care hospital, and many hospitals continue the policy of allowing older staff members to opt out of ED call after a certain number of years (usually 15–20), further reducing the number of available specialists.

Financial pressures have also significantly affected both emergency room physicians and specialists who provide on-call services. Physicians provide nearly 20 percent of all uncompensated care received by the uninsured, and much of that care is provided through ED responsibilities. Although the *proportion* of uninsured patients coming to the ED has not grown, the total number of ED visits by uninsured patients has increased, and while hospitals are subsidized to greater or lesser degrees for uncompensated care, physicians are not.[32] Because Medicaid reimburses at very low rates and reimbursement rates from all sources are on the decline, physicians find cross-subsidizing uncompensated or undercompensated care even more difficult.

Another problem is a nationwide nursing shortage that adds to the ED workforce issues and has a negative impact on inpatient capacity. Because of the intensity of emergency care and the deteriorating work environment, EDs are particularly vulnerable to the nursing shortage. As in other areas of the hospital, inappropriate nursing levels in the emergency room result in an inappropriate level of care for patients.[33]

Medical Liability. Although a number of states have made positive reforms in their medical liability laws in recent years,[34] liability concerns still

30. Lewin Group, "Hospital Capacity and Emergency Department Diversion: Four Community Case Studies—AHA Survey Results," American Hospital Association, April 2004, at *www.aha.org/aha/content/2004/PowerPoint/EDDiversionSurvey040421.ppt* (May 11, 2007).
31. American College of Emergency Physicians, "On-Call Specialist Coverage in U.S. Emergency Departments: ACEP Survey of Emergency Department Directors," September 2004, at *www.acep.org/webportal/Newsroom/NR/general/2006/050206.htm* (May 11, 2007).
32. Jack Hadley and John Holahan, "Who Pays and How Much? The Cost of Caring for the Uninsured," Urban Institute, February 2003, at *www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14319* (May 11, 2007). See also news release, "Nation's Emergency Physicians Provide the Highest Percentages of Charity Care," American College of Emergency Physicians, April 27, 2006, at *www.acep.org/webportal/Newsroom/NR/general/2006/032706.htm* (May 11, 2007).

clearly discourage physicians from taking ED call for several reasons. First, regardless of whether or not ED patients are more likely to sue, insurance premiums are significantly higher for physicians who take emergency call. Some specialties are disproportionately affected by the link between their emergency services and their malpractice exposure. For example, in a 2004 survey conducted by the American Association of Neurological Surgeons, 46 percent of neurosurgeons reported limiting the amount or type of emergency services that they provide. Of those who had limited their services, 87 percent cited liability concerns as a reason.[35]

The Emergency Medical Treatment and Active Labor Act is an unfunded federal mandate that requires that all patients presenting to the ED be evaluated and stabilized regardless of ability to pay. As a classic example of the law of unintended consequences, the legislation itself contributes to the reluctance of doctors to provide on-call services, adversely affecting the group of patients that the law was meant to protect.

According to the American Medical Association's 2001 Patient Care Physician Survey (PCPS), more than 30 percent of physicians provide care covered by EMTALA in a typical week of practice, with emergency medicine physicians providing an average of 22.9 hours and surgeons providing 9.7 hours per week. Of self-employed physicians, 42 percent reported that a significant portion of their bad debt was attributable to EMTALA-related services, accounting for 13.7 percent of all bad debts—an estimated $12,300 per provider for a total of $4.2 billion annually.[36]

Although physicians have traditionally provided some medical services without compensation, the reason behind this behavior is complex and cannot be fully explained by purely economic models that discount charitable, ethical, or professional motivations. However, it seems clear that many physicians not only are less willing or able to provide free care, but also attach more utility to quality of life, thereby increasing the opportunity costs of spending nights and weekends caring for emergency patients.

In the past several years, often following prolonged and contentious negotiations with medical staff, at least one-third of hospitals, through fee schedules, stipends, or malpractice premium support, have begun to compensate physicians for at least some of the on-call services that they provide. In some cases, the high cost of compensating certain specialties, such as neurosurgery, makes this an unrealistic long-term option.[37]

Seven Steps to Resuscitate a Critically Ill Emergency System

The good news is that the public has become increasingly aware of the crisis in the nation's emergency medical care system and that the majority of Americans favor legislation to address the problem. Specifically:

- 62 percent of Americans favor legal protection for physicians who care for uninsured patients in the emergency room, similar to the protections given to physicians who treat patients in community health centers;
- 71 percent favor providing additional funding to hospitals to alleviate the problem of patient boarding; and
- 62 percent favor recognizing emergency care as an essential public service and would support

33. Jack Needleman, Ph.D., Peter Buerhaus, Ph.D., Soeren Mattke, M.D., Maureen Stewart, and Katya Zelevinsky, "Nurse-Staffing Levels and the Quality of Care in Hospitals," *New England Journal of Medicine*, Vol. 346, No. 22 (May 30, 2002), pp. 1715–1722.
34. For a detailed discussion of options that are available to state lawmakers to help them address medical liability problems, see Randolph W. Pate, J.D., and Derek Hunter, "Code Blue: The Case for Serious State Medicaid Liability Reform," Heritage Foundation *Backgrounder* No. 1908, January 17, 2006, at *www.heritage.org/Research/HealthCare/upload/93759_1.pdf*.
35. Alex B. Valadka, M.D., "The ER—Who Is Answering Call?" *American Association of Neurological Surgeons Bulletin*, Vol. 13, No. 4 (Winter 2004), pp. 7–12.
36. Carol K. Kane, Ph.D., "The Impact of EMTALA on Physician Practices," American Medical Association *Physician Marketplace Report*, February 2003, at *www.ama-assn.org/ama1/pub/upload/mm/363/pmr2003-02.pdf* (May 11, 2007).
37. American Hospital Association, "The State of America's Hospitals."

increasing physician and hospital Medicare payments by at least 10 percent to help to pay for emergency medical services.[38]

Simply throwing more taxpayer money at the problem will not solve the crisis in emergency medicine. The emergency medical care system needs a fundamental restructuring that will allow it to perform its primary function—the evaluation and treatment of patients with true emergencies. The way to start the process of reform is therefore by disentangling this essential function of the hospital emergency department from its two other current, conflicting roles: principal charity care provider and major hospital revenue channel.

The following seven steps, if properly implemented, can accomplish this goal.

STEP #1: Rapidly expand private health coverage to include the uninsured.

The first step in reforming the emergency medical system is to reduce its inappropriate use by patients who could safely be seen elsewhere. For example, growing numbers of uninsured Americans frequently lack regular primary care, and the ED often fills the gap. Covering the uninsured for non-emergent care—if done correctly—is an essential element of emergency medical reform and would certainly help to reduce the strain on the system. Patients would then be more likely to receive regular care (including preventive services), have less need for the ED, and avoid costly hospital admissions.

The data indicate that simply moving the uninsured into public programs such as Medicaid and SCHIP might not solve the ED demand crisis and could even exacerbate the problem. According to a recent National Hospital Ambulatory Medical Care Survey, patients with Medicaid as the expected source of payment used hospital emergency departments in 2004 at nearly twice the rate of the uninsured and at four times the rate of the privately insured. Moreover, more ED visits by Medicaid and SCHIP patients (35.7 percent) were classified as non-urgent or semi-urgent than were visits by self-paying patients (23.7 percent).[39]

The number of Medicaid-eligible patients who initially present to the emergency department as uninsured and are eventually converted to Medicaid is unknown, but it is not likely to be large enough to have any significant effect on the data reported in the NHAMCS study.[40] However, a major cause of these disparities is probably the lack of a sufficient number of primary care doctors available to Medicaid patients. This is likely a natural response to Medicaid's very low physician reimbursement rates in many states.

Thus, the most effective way to reduce inappropriate ED utilization is to institute sound "premium support" programs that would enable Medicaid patients to purchase quality private health insurance coverage with better access to care. The right policy is to integrate the working uninsured population and non-disabled Medicaid and SCHIP beneficiaries into a reformed private health insurance market.

At the state level, legislators could also create premium support programs for private health insurance for low-income individuals and families and combine this with a new statewide market in which employers could make defined contributions to their employees' health insurance through a health insurance exchange, securing portability and personal ownership of health coverage.[41] This would not only eliminate gaps in health care coverage, but also ensure continuity of care.

Beyond Medicaid changes and state market reforms, Congress could enact a universal tax deduction for health insurance, as recommended by President George W. Bush, which would allow individuals and families to purchase personal and portable health insurance.[42] For lower-income per-

38. News release, "Majority of Americans Support Legislation to Strengthen Emergency Medicine System, New Poll Finds," American College of Emergency Physicians, May 22, 2006, at *www.acep.org/webportal/Newsroom/NR/general/2006/052206.htm* (May 11, 2007).

39. McCaig and Nawar, "National Hospital Ambulatory Medical Care Survey."

40. Personal communication with several hospitals reveals that even Medicaid-eligible patients will have their expected source of payment listed as "no insurance" and that the process of converting the patient to Medicaid is lengthy, often taking more than 12 months.

sons, Congress could also enact a generous individual health care tax credit program, particularly for those who do not and cannot get health insurance through the workplace. Such a program, with a family tax credit of up to $4,000 annually, is embodied in the Tax Equity and Affordability Act (S. 397 and H.R. 914), sponsored by Senator Mel Martinez (R–FL) and Representative Paul Ryan (R–WI).[43]

Private health plans possess the right set of economic incentives to coordinate patient care in ways that reduce costs and improve outcomes, including limiting patient ED use to true emergency situations.

STEP #2: Focus on public safety as a key policy objective in the delivery of emergency medical care services.

When a patient presents to an emergency department in shock from a stomach ulcer with massive bleeding, the patient has not had time to choose the ED. When informed that surgery is needed, the patient is taken to the operating room as quickly as possible and is usually operated on by the surgeon who happens to be on call. The highest possible level of services needs to be maintained and made available to all patients in these specialized situations. This is a matter of public safety.

Meanwhile, the cost burdens of free riders continue to distort the markets, stimulating increased political pressure for even more government intervention in the operation of what is left of free-market forces in the health system. Under the current conditions of emergency medicine, in some cases the delivery of a particular emergency service is simply not worth the cost of providing it. This is already happening with ED on-call coverage in certain specialties, such as neurosurgery, obstetrics, and orthopedics.

These problems highlight the need for state officials to overhaul the laws and regulations that govern both hospital planning and the provision of emergency medical services, balancing the role of government regulation and private-sector competition. In the process, state officials must see that government regulation is tailored to ensure that proper economic incentives are in place for doctors and hospitals and other medical specialists engaged in the delivery of emergency care.

To improve public safety, state officials should also let contracts to private-sector organizations similar to contract management groups (CMGs), which would compete for these publicly funded contracts on a state basis or on a regional (interstate or multistate) basis to coordinate, oversee, and provide emergency services. This could prove valuable in meeting the geographically broad challenge of natural disasters, pandemics, or terrorist attacks. The CMG would contract with state officials for the provision of all emergency medical care services appropriate to the local medical demographics, including 9/11 services, pre-hospital triage and transport, emergency care provided at all levels of emergency facilities, and in-hospital treatment related to the emergency condition.

STEP #3: States should separate laws that govern emergency medical planning from laws that govern hospital planning.

While relieving hospital EDs of most of their current social safety net responsibilities will help to alleviate overcrowding, it addresses only half of the problem. The other half is the problem of hospital planning. Most often, this involves some sort of state regulation or hospital decisions that are heavily influenced by the actions of state or local government officials.

41. For an in-depth discussion of how this could be done, see Edmund F. Haislmaier and Nina Owcharenko, "The Massachusetts Approach: A New Way to Restructure State Health Insurance Markets and Public Programs," *Health Affairs*, Vol. 25, No. 6 (November/December 2006), pp. 1580–1590. See also Robert E. Moffit, Ph.D., "The Rationale for a Statewide Health Insurance Exchange," Heritage Foundation *WebMemo* No. 1230, October 5, 2006, at *www.heritage.org/research/healthcare/upload/wm_1230.pdf*.
42. For a description of this change in tax policy, see Stuart M. Butler, Ph.D., and Nina Owcharenko, "Making Health Care Affordable: Bush's Bold Health Tax Reform Plan," Heritage Foundation *WebMemo* No. 1316, January 22, 2007, at *www.heritage.org/Research/HealthCare/upload/wm_1316.pdf*.
43. For an account of the legislation, see Nina Owcharenko, "The Tax Equity and Affordability Act: A Solution for the Uninsured," Heritage Foundation *Backgrounder* No. 1963, August 30, 2006, at *www.heritage.org/research/healthcare/upload/bg_1963.pdf*.

This entire process needs to be reviewed and reconsidered. In many states, hospital planning and construction are undertaken in accordance with state laws and regulations, including certificate of need (CON) laws. These are equivalent to state government permits that regulate the construction of medical facilities, including hospitals and emergency rooms, on the basis of perceived or officially projected need.[44] While many state officials insist on retaining these rules, a special federal task force from the Department of Justice and the Federal Trade Commission recently concluded that CON laws are unsuccessful in containing costs and pose "serious anti-competitive risks."[45] Beyond wrestling with the traditional CON process, hospital officials are often conflicted between their expectations of the ED as a revenue channel and the community's need for adequate, reliable, and coordinated emergency medical services.

Emergency planning is not the same as conventional hospital planning. Even with more appropriate use of primary care and preventive services, some patients will need emergency care. State officials will need to separate the availability of emergency care from more elective health care services. The size, scope, distribution, and level of sophistication of emergency medical services should match the needs of each particular community.

Two sets of data are needed: the number and type of emergency facilities currently available and the number and type that are most appropriate to the specific community. Too often, one hospital ED is at or over capacity when a nearby facility can handle additional patients. The flow of patients from the busy hospital will not occur until the hospital begins to divert ambulances from its ED or patients tire of waiting to be seen.

Historically, hospital-based emergency medical capabilities in most states have been built around the distribution of facilities as determined by hospital choices. This should be reversed.

Rational state and local decision making combined with the proper market incentives would significantly change the flow of patients. A given community could have a number of emergency services with varying capabilities, based on the needs of that community, analogous to how trauma center needs have been determined in some states. Some facilities would be able to handle the most complex cases, with immediate intensive care and operative services available if needed. At the other end of the spectrum would be facilities with limited diagnostic and therapeutic capabilities.

The number and type of facilities serving a population should depend on the emergency medical demographics of the area being served. These demographics would include such factors as population density, population age, historical trauma and emergency medicine trends, and disaster preparedness needs. Given the proper information, the prehospital EMS system could direct patients to the facility that is most appropriate, using evidence-based protocols.

With the proper assessment of community needs and an effective communication system, there would be no ED overcrowding, patient boarding, or ambulance diversion. Use of the ED for non-urgent problems could be addressed by a widespread and sustained public education program that explains the changes in the system, showing the adverse affects of inappropriate use of the ED and increasing public awareness of alternative options for non-urgent care. Along with the patient education program, an expanded 911 system could help to direct patients to the most appropriate facility. Private physicians and private patients could interact with the system as needed for off-hours emergency care.

For example, a patient with a life-threatening condition, such as a massive hemorrhage from a gastric ulcer, obviously needs to go to a facility with high-level capabilities. A patient with mild abdominal pain can go to a lower-level facility. If a routine appendicitis is discovered, there is time to send the patient for definitive surgery. As data accumulate, triage decisions can become more precise.

44. The District of Columbia and 36 states have CON laws.

45. U.S. Department of Justice and Federal Trade Commission, *Improving Health Care: A Dose of Competition*, July 2004, at *www.usdoj.gov/atr/public/health_care/204694.pdf* (May 11, 2007).

STEP #4: Free hospitals to specialize in the delivery of medical care.

Restructuring the emergency medical system will also require fundamentally rethinking the place of acute care hospitals in America's health care system. Hospitals should no longer depend on getting as many patients as possible through their EDs to maintain market share. Nor should they face an unfunded mandate to provide a disproportionate share of safety net services.

Instead, hospitals should compete primarily on their ability to provide health care services based on what they do best. Some hospitals would choose to provide "emergency medical treatment," such as treatment for an acute myocardial infarction or surgery for a bleeding gastric ulcer, and would be reimbursed accordingly as agreed in prearranged contracts. Other services would be provided on a more elective basis, and patients, with the proper payment structure, would make decisions based on the value of those services.

In a properly functioning system driven by free-market incentives, hospital services would likely evolve and become more specialized.[46] A growing body of evidence suggests that medical outcomes are improved and costs possibly reduced, especially for complex conditions and complicated procedures, when care is provided at high-volume or specialized centers.[47] This has been demonstrated most clearly by the nationwide trauma system, but it is also true for elective care of adults and children. Specialization of hospital services would evolve because of several factors, including hospital competency, the pressure of market forces, and changing community needs. The further development of specialty hospitals will affect emergency care only if EDs continue as both a needed source of business and an unwanted source of uncompensated safety net care.

STEP #5: Limit federal authority to clearly defined national responsibilities.

States, working with local authorities and first responders, should have the primary responsibility for policies that govern emergency medical decision making. Although the Department of Health and Human Services (HHS) is the logical lead federal agency for the administration and oversight of federally funded emergency medical services, policy planning at the state level is more responsive to regional and local variations.

Ideally, the HHS Secretary should set the basic parameters that need to be met and decide on federal grants to fund appropriate demonstration projects at the state, regional, and local levels, coordinating the department's responsibilities in this area with other federal agencies and departments. One good model for cooperation already exists and could be incorporated directly into a modernized emergency medical system: the Federal Interagency Committee on Emergency Medical Services (FICEMS).

Established in the 1970s, remodeled in the 1980s, and given formal status by the Emergency Medical Services Support Act of 2005,[48] FICEMS focuses on pre-hospital and hospital-based emergency medical care and issues related to homeland security and disaster preparedness. Its leadership rotates among member organizations on an annual basis. Because of its wide representation and input and because of the importance of emergency medical services to other areas, such as disaster preparedness and homeland security, FICEMS, under the leadership of HHS, could define and coordinate emergency medical policy at the federal level.

Consolidation and coordination under HHS as a lead agency needs to be balanced against the risk of disruption that comes with combining diverse agencies with different missions and different orga-

46. For an extensive discussion of this point, see Regina Herzlinger, *Market Driven Health Care: Who Wins, Who Loses in the Transformation of America's Largest Service Industry* (New York: Addison-Wesley Publishing Company, 1997).

47. Bruce E. Hillner, Thomas J. Smith, and Christopher E. Desch, "Hospital and Physician Volume or Specialization and Outcomes in Cancer Treatment: Importance in Quality of Cancer Care," *Journal of Clinical Oncology*, Vol. 18, No. 11 (June 11, 2000), pp. 2327–2340. See also Deborah Schrag, Laura D. Cramer, Peter B. Bach, Alfred M. Cohen, Joan L. Warren, and Colin B. Begg, "Influence of Hospital Procedure Volume on Outcomes for Surgery Following Colon Cancer," *JAMA*, Vol. 284, No. 23 (December 20, 2000), pp. 3028–3035.

48. Public Law 109–59.

nizational cultures. For example, consolidation of programs in the formation of the Department of Homeland Security (DHS) proved to be much more difficult than initially anticipated.[49]

In any case, HHS's leadership role should be limited and clearly defined. For example, HHS could set quality and performance parameters for handling medical emergencies of national or regional import, such as a terrorist attack or a natural disaster, but state and local agencies and providers should decide how best to achieve those parameters, whether through financial incentives, regulatory penalties, or other mechanisms. Allowing flexibility to respond to disparate local and regional needs will be of paramount importance. With the proper incentives, providing emergency care for all patients would be more of an opportunity and less of a burden for doctors and other medical professionals.

STEP #6: Streamline the financing of emergency medical care.

The dominant role of private insurance in reimbursing emergency medical care would continue, unaffected by any change in state or federal laws governing emergency medical care or the separation of emergency medical and routine hospital care.

However, the provision of emergency medical care serves public safety (most clearly in the case of a natural disaster or terrorist attack) and is thus a legitimate focus of public funding. The evolution of trauma centers in some states provides lessons in restructuring the financing of emergency medical care. Although trauma center classification offers prestige to a hospital in that hospitals with a Level I classification are generally considered to be competent institutions, this designation does not directly correlate with financial success. Trauma care can be complicated, is resource-intensive, and often brings with it additional burdens, such as increased costs of liability protection that make providing these services a risky business.[50] Hospitals have been more receptive to trauma center classifications than they would likely be to classification of non-trauma emergency services, at least under the current incentive structure.

Although the uninsured number almost 47 million, reducing the number of uninsured alone would not solve the financial crisis facing the nation's EDs. Socialized medicine would also fail to resolve the difficulty and could import a whole series of other problems.[51] Australia, Canada, and Great Britain, which have single-payer or government-managed health systems, also have serious problems with ED overcrowding.[52]

Flawed Proposals. Some recent proposals to reduce the financial burden of emergency care are seriously flawed. One proposal is to readjust payments to reflect the increased costs of emergency hospital admissions versus elective admissions. However, this would likely create an incentive for devising ways to admit elective cases through the ED, thus worsening the problem of overcrowding.

Another proposal is to assess direct financial rewards or penalties on hospitals based on their performance in terms of ED patient "throughput," reducing or denying payment to hospitals for chronic delays in treatment, ED overcrowding, and ambulance diversion,[53] but this would only increase the strain on already financially strapped hospitals without addressing the underlying problems that contrib-

49. For a more detailed discussion of the concerns of establishing a lead agency, see Institute of Medicine, *Hospital-Based Emergency Care at the Breaking Point* (Washington, D.C.: National Academies Press, 2007), pp. 86–96.
50. Paul A. Taheri, David A. Butz, Charles M. Watts, Louisa C. Griffes, and Lazar J. Greenfield, "Trauma Services: A Profit Center?" *Journal of the American College of Surgeons*, Vol. 188, No. 4 (April 1999), pp. 349–354.
51. For a description of these problems, see Kevin C. Fleming, M.D., "High-Priced Pain: What to Expect from a Single-Payer Health Care System," Heritage Foundation *Backgrounder* No. 1973, September 22, 2006, at *www.heritage.org/research/healthcare/upload/bg_1973.pdf*.
52. Australasian College for Emergency Medicine, "Access Block and Overcrowding in Emergency Department," April 2004, at *www.acem.org.au/media/Access_Block1.pdf* (May 11, 2007), and O. Miro, M. T. Antonio, S. Jimenez, A. De Dios, M. Sanchez, A. Borras, and J. Milla, "Decreased Health Care Quality Associated with Emergency Department Overcrowding," *European Journal of Emergency Medicine*, Vol. 6, No. 2 (June 1999), pp. 105–107.
53. Institute of Medicine, *Hospital-Based Emergency Care*, p. 77.

ute to overcrowding. Many of these problems, such as the aging of the population, the increasing number of uninsured, insufficient Medicaid reimbursement rates, and misaligned economic incentives, are external to the ED and beyond the hospital's control.

Finally, recent congressional proposals to increase reimbursement (and malpractice relief) for providers of emergency medical care through an upward adjustment in the Medicare fee schedule[54] would provide only limited and short-term relief. A more effective solution would disentangle the current incentive structure that weds a hospital to its own institutional emergency services.

Consolidated Funding. In some states, building new emergency facilities or acquiring existing facilities might be necessary. Private contractors, as noted, could secure start-up funding and ongoing funding from state or federal sources. State governments could contribute by designating a portion of state Medicaid funds for emergency care. Other state revenues could supplement the system. For example, Maryland funds a portion of its first-class trauma care system through a user fee on the issuance of state license plates.

Likewise, federal funding of state or regional emergency medical efforts could be reprogrammed from several existing sources. Money is already in the system. Possible funding sources include both a portion of Medicare and federal Medicaid funds to cover eligible patients in these programs and Medicare's disproportionate share of hospital payments that supplement hospitals for care of low-income patients. Another potential source of federal funding, especially during transition in the states, could be grants from the DHS, Centers for Disease Control and Prevention, Health Resources and Services Administration, and National Highway Traffic Safety Administration.

Today, federal funding is heavily distorted. For example, federal spending on bioterrorism and emergency preparedness within HHS increased from $237 million in fiscal year 2000 to $9.6 billion in fiscal year 2006. However, in the same period, Congress eliminated the HHS Trauma–Emergency Medical Services System program. In May 2007, President Bush signed the Trauma Care Systems Planning and Development Act, reauthorizing the program, although the legislation provides only approximately $8 million in annual funding through 2012.[55] In addition, of the 52 Centers for Public Health Preparedness that receive federal funding to address various aspects of bioterrorism, not one federally funded center focuses on issues related to terrorist bombings, the most likely type of attack.[56]

Current funding ignores the crucial role of the emergency medical care system in homeland security and disaster preparedness. Congress needs to redistribute existing funding to strengthen the trauma and emergency care systems and should support research by professional organizations in critical areas, such as evidence-based indicators of emergency medical care system performance and the civilian consequences of a terrorist attack using conventional (non-nuclear, non-biological) weapons.

STEP #7: Intensify efficiency and capacity improvements.

State and local officials are already pursuing a number of sound initiatives, which are in various stages of planning, to cope with the growing problems facing emergency medical care delivery systems in their jurisdictions. They should continue.

Techniques that attempt to relieve ED backup include adjusting daily elective surgery schedules to handle seasonal and even daily variations in ED and inpatient volume; establishing a dedicated person or team that can respond to real-time capacity and demand issues and facilitate inpatient admission and discharge; and using observation units for patients with certain presenting conditions, such as chest pain or congestive heart failure, who may not need hospital admission after diagnostic testing and/or initiation of treatment. Other approaches

54. Access to Emergency Medical Services Act of 2006, S. 2750, 109th Cong., 2nd Sess., and Access to Emergency Medical Services Act of 2005, H.R. 3875, 109th Cong., 1st Sess.

55. Mary Ellen Schneider, "Trauma Law Props Up Ailing Systems" *Surgery News*, June 2007, p. 1.

56. Arthur L. Kellermann, M.D., "Crisis in the Emergency Department," *New England Journal of Medicine*, Vol. 355, No. 13 (September 28, 2006), p. 1302.

streamline patient care in the ED, including "fast track" units for patients with minor ailments, simplified administrative activities such as patient registration, improvements in the triage process, and using information technology to track patients and patient information more efficiently.

Another promising effort is regionalizing emergency care of patients with certain conditions, such as stroke, burns, and cardiac disease. The Maryland EMS and Trauma System is an example of an attempt to regionalize emergency care.[57] Other areas have plans in place that regionalize pre-hospital triage, transportation of patients, and on-call ED coverage by specialists. Many of these efficiency improvements are drawn from innovations in engineering and operations research that have transformed other sectors of the economy, such as banking and the airlines.

These approaches have had some success on an institutional and regional level, but they do not address the underlying incentive structure of the emergency medical care system and are unlikely to provide anything more than local, temporary relief. They are not a substitute for real reform. A more fundamental approach to the incentive structure and the delivery and financing of emergency medicine is needed. Moreover, state officials should review and reform their medical liability laws.

Conclusion

America's emergency room crisis is complex. Hospital EDs are in the increasingly difficult position of fulfilling the conflicting roles of being a major source of hospital business and the main provider of safety net services for the poor and the uninsured. The increase in the demand for both emergency services and charity care coincides with increased pressures to contain costs.

These colliding forces have further distorted incentives for hospital officials who are trying to juggle different roles and responsibilities. Conflicting roles and misaligned incentives not only inhibit the ability of state emergency medical systems to respond to a potential attack, disaster, or pandemic, but also threaten access to high-quality emergency medical care for all patients, regardless of their insurance status.

Reform of the emergency medical system will require fundamentally rethinking the role of the emergency department and its relation to the acute care hospital. There is sound reason for separating these functions, both in law and regulation, while allowing hospitals to specialize and free-standing clinics and urgent care centers to multiply and flourish. Public officials should undertake this separation in the interest of public safety.

Inasmuch as the response to a terrorist attack or natural disaster must involve federal authorities, HHS should play the lead role, but the implementation of appropriate federal guidelines for the delivery of emergency medical care should be left to state policymakers, who should retain the primary role in overseeing initial responders. Meanwhile, public officials at both the federal and state levels should rapidly expand private health insurance coverage to move patients with non-urgent problems out of the emergency room and treat them in more appropriate venues. At the federal level, this would require individual health care tax credits. At the state level, it would involve reform of the state health insurance market to make health insurance more accessible and affordable.

Generally, the failure to address the problem of emergency medical care degrades the quality of care for all Americans. Specifically, it jeopardizes critically ill citizens' access to timely, efficient, and highly competent emergency medical services while compromising the ability of the health care system to respond to disasters.

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57. John R. Wish, Ph.D., William B. Long III, M.D., and Richard F. Edlich, M.D., Ph.D., "Better Trauma Care: How Maryland Does It," *Journal of Long-Term Effects of Medical Implants*, Vol. 15, No. 1 (2005), pp. 79–89.