Improving Physician Productivity and Efficiency: United States

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Prologue

Taking on the subject of physician productivity and efficiency, without any credentials in health economics, is a risky proposition. Readers will find no equations representing production functions or similar constructs to illustrate my points. From an economist's perspective, this paper may approach productivity and efficiency too colloquially. That said, I think it is important to consider what these terms mean in the day-to-day practice of medicine, from a provider, patient, and societal perspective. Improving them sounds simple: just align the incentives in such a way to make it happen. In practice, this is more easily said than done!

Introduction

From almost any perspective, there exists today a great interest in improving productivity and efficiency in health care. From a policy perspective, some are interested due to their beliefs that our nation faces an impending shortage of physicians, particularly in primary care. Others are interested in identifying ways to improve efficiency due to the unsustainable growth in health care costs in America. Still others promote a shift from the physician-dominated practice of medicine, and see productivity and efficiency as central to the rationale for such a change.

Patients want to ensure appropriate access to health care that is, at the same time, affordable. The problem in the U.S. is that expectations for "appropriate access" are often "I should get what I want when I want it," and a system built up around that level of demand, and the reality that visits beget visits and tests beget tests, contributes to the high costs of health care in our country. The word "rationing" sends shivers up the spines of most politicians and health planners in the U.S. Yet, we have reached what many believe is a breaking point in the U.S., wherein threats to the longterm viability of Medicare (our national public healthcare program serving the elderly) are very real. An estimated 62% of all bankruptcies declared in the U.S. are caused an inability to pay medical costs. In 3 of 4 of these medical bankruptcies, the individual had health insurance.[cite Himmelstein 2009 AJM] U.S. businesses have become less price competitive due in part to the rising insurance premiums they offer as a benefit to their workers. Our spiraling healthcare costs have caught up with us, and are pulling us down.

Thus, it is news to no one that the United States is no exemplar of healthcare efficiency. The so-called "cottage industry" of U.S. healthcare, with its separation of hospitals and physicians and others as distinct and independent healthcare businesses, coupled with the massive increase in subspecialty-oriented care, has led to a fragmentation of services and a general predisposition to inefficiency. Increasingly, there are efforts to overcome these inefficiencies through system

redesign, due to a growing awareness of the unsustainable growth in healthcare costs.

Its extravagant per capita spending on health services in absolute terms (over $2.5 trillion in 2009) and as a proportion of the country's Gross Domestic Policy (now roughly 17-18% of GDP and growing) places the U.S. at the top of expenditures throughout the OECD countries. While costs head toward the stratosphere, health outcomes in the U.S. have not been equally impressive. We have a multi-tiered system of insurance that provides inequitable access to care, often leaving those with the greatest needs least able to obtain services (this is not likely to change significantly as a result of health care reform). Among OECD countries, the U.S. is below average for both life expectancy and infant mortality and ranks last in both categories among attendees at the IMWC Conference.

Given its capitalist underpinnings, one might presume that healthcare systems in the United States would have a high incentive to maximize productivity. Indeed, if one measures productivity by revenue generation, then the U.S. healthcare system has been vastly productive. Healthcare systems, medical practices, and providers have developed structures and services that maximize revenue for a given labor input. On the other hand, if the product of health care is actually improved health, evidence suggests that the U.S. healthcare system has reached the "flat of the curve" where vast investments in labor input and related resources lead to marginal gains in population health.

Productivity and efficiency defined

Productivity is a measure of a physician's output, the amount of "goods and services" they produce. Up for debate, and somewhat variable by one's perspective, is what should be considered the "goods and services" of a physician. Is it the number of patients seen? The total revenue generated? A healthy patient panel? Each of these reflects productivity from certain vantage points.

From my perspective as an individual physician, productivity is enhanced when I see more patients and/or provide more services per day, week, or year. Among other things, enhanced