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Administration of Emergency Medicine

THE ECONOMIC ROLE OF THE EMERGENCY DEPARTMENT IN THE HEALTH CARE CONTINUUM: APPLYING MICHAEL PORTER'S FIVE FORCES MODEL TO EMERGENCY MEDICINE

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☐ **Abstract—Emergency Medicine plays a vital role in the health care continuum in the United States. Michael Porters' five forces model of industry analysis provides an insight into the economics of emergency care by showing how the forces of supplier power, buyer power, threat of substitution, barriers to entry, and internal rivalry affect Emergency Medicine. Illustrating these relationships provides a view into the complexities of the emergency care industry and offers opportunities for Emergency Departments, groups of physicians, and the individual emergency physician to maximize the relationship with other market players. © 2006 Elsevier Inc.**

☐ **Keywords— economics; emergency medicine; Porter; industry analysis; competition**

INTRODUCTION

Emergency Departments (ED) play a unique role in the health care system. Unlike any other health care resource, EDs provide continuous access to the health care system for both emergent and urgent medical needs. In addition, the Federal Emergency Medical Treatment and Active Labor Act (EMTALA) requires EDs to provide a medical screening examination to all patients who seek care. A medical screening examination may include expensive diagnostic tests, treatment, and specialty consultation. EMTALA was passed to prevent hospitals from discriminating against indigent or uninsured patients by transferring, discharging, or refusing care (1). Because ED care is the only care that is required by law, it provides an important health safety net for the uninsured and underinsured.

Although the ED plays a critical role in the health care system, it finds itself increasingly challenged in the face of rapid change. For many reasons, EDs have experienced a remarkable rise in patient volume over the last 50 years, with about 108 million visits in the United States in the year 2000, up 14% from 1997. At the same time, health care market forces have forced many EDs to close their doors to patients. Over the period of 1997–2000, the number of EDs in the United States decreased from 4005 to 3934 (2). The uninsured rate in the United States in 2001 was 16.7%, and it is well known that the uninsured, under-insured, and socioeconomically disadvantaged groups are more likely to seek care in EDs (3–5).

Staffing in EDs has shifted considerably, from a single room staffed by interns with no attending coverage, to departments staffed by trained emergency practitioners with access to the state-of-the-art in diagnostics and medical treatments [(6), p. 237]. The expanded role for Emergency Departments (EDs) in the health care system created the need for specialists in Emergency Medicine. The first EM training program was instituted at the University of Cincinnati in 1970 and today there are 132 accredited allopathic training programs and 30 osteopathic programs in the United States.

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At the same time, the economics of medicine and of emergency care have also changed. What was once a cottage industry now claims an ever-increasing portion of the US gross domestic product (GDP). As of 2002, US health care expenditures topped 14% of GDP (7). Due to the prominent role of the health care system in the economy and cost increases, government and market reforms have shifted to reduce provider payments and reorganize the way that care is delivered and reimbursed. Whereas the promise of managed health care has not met expectations, other entities such as physician practice management companies (contract management companies) have emerged in an attempt to centralize the administrative aspects of the health care business.

Now, there are many players in the Emergency Medicine (EM) marketplace, from emergency physicians, nurses and contract management groups (CMG), to pharmaceutical companies, device manufacturers and insurance companies. Comprehending the role of EM in the health care marketplace is difficult due to the complex interactions among many forces. In this respect, using a model can provide insight into the emergency care industry and shed light on the myriad forces affecting Emergency Medicine.

In 1980, Michael Porter introduced a model of competitive strategy to explain an industry's position in a complex strategic environment (8). Porter's five forces model provides one way to present the current position of EM or what will be called the industry for "emergency care" in a macroeconomic context. The five forces presented in this model are the degree of rivalry, the supplier power, the buyer power, barriers to entry, and the threat of substitution (8). Placing the industry of "emergency care" in a framework such as this offers unique insight into the bargaining position that we as emergency physicians have when negotiating with the different market players.

SUPPLIER POWER

The definition of a "supplier" in Emergency Medicine is quite broad: basically, everyone outside the department who supplies products or resources to make an ED function effectively. The power of suppliers is as diverse as the entities themselves, and depending on the organization, suppliers can have substantial power over the ED. Suppliers to the ED include pharmaceutical companies, medical device and medical software companies, consulting physicians, nurses, pre-hospital providers, radiology services and laboratory services.

Pharmaceutical companies have a tremendous amount of influence over organized medicine in general. Pharmaceutical companies often have less interaction with the ED than with other specialties because the medicines prescribed by emergency physicians represent a smaller portion of their total sales than for physicians who prescribe large market-share chronic medicines for conditions like diabetes and heart disease. In turn, they tend to spend considerably less effort marketing to emergency physicians than other specialties. Due to the relatively small market of medicines that are prescribed in EDs in comparison to primary care practices, pharmaceutical companies do not give as much consideration to EDs in determining drug pricing and marketing. Emergency physicians do, however, prescribe some expensive medicines, particularly i.v. antibiotics and cardiovascular medicines. The specific choice of i.v. antibiotic therapy by an emergency physician may not be changed by the hospitalist or inpatient team managing the patient. Despite this, pharmaceutical companies are in a position of power over EDs because, in general, they decide what medicines to develop and distribute and what they want to charge for them. Pharmaceutical companies may also alter the practice of Emergency Medicine by changing the formulary available to the emergency physician. An example of this is the recent country-wide absence of Compazine (prochlorperazine). In addition, because a good portion of emergency care is not reimbursed and pharmaceuticals are expensive, pricing can play a significant role in the bottom line for the ED and the hospital. However, when a drug has an equivalent generic alternative or a less expensive therapy is equally effective, the cost of switching may be minimal.

Medical device and medical software companies have a similar relationship with the ED. However, EDs represent a significant market for companies that produce intubation equipment, monitoring devices, defibrillation equipment, central line kits, and some computer software packages. At large meetings, product salespeople are more than happy to offer demonstrations and in some cases discounts to EDs for purchasing cutting edge devices. Because this is a highly competitive market, in many instances, EDs can influence the innovation and production at device companies. EDs retain the ability to choose among different suppliers for the most cost-effective products.

Specialty physicians serving as ED consultants and physicians who manage/accept care for hospital admissions can also be described as suppliers to the ED. More than any other hospital department, the ED relies on healthy relationships with consultants and admitting physicians to run smoothly and provide appropriate patient care. Access to specialty services may be a scarce commodity in rural and inner-city communities. As a result, many communities have carved out specialty care that has reduced availability to the uninsured. The power balance in the relationship between the ED and consul-

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