



American Society of
Anesthesiologists™

Central Line

Episode Number 28

Episode Title: Inside the Monitor – The Curious Economist

Recorded: November 2020

(SOUNDBITE OF MUSIC)

VOICEOVER:

Welcome to ASA's Central Line, the official podcast of the American Society of Anesthesiologists, edited by Dr. Adam Striker.

DR. ADAM STRIKER:

Welcome to another episode of Central Line. I'm your host and editor Adam Striker. Today we're talking with Tom Miller, PhD MBA who is going to be the columnist in a new column appearing in The ASA Monitor called Curious Economist, which will discuss the economics of healthcare, frequently with a focus on perioperative medicine and anesthesia. And Dr. Miller is currently the Director of Analytics and Research Services for the ASA. Dr. Miller thanks for joining us. Welcome to the show.

DR. TOM MILLER:

Thank you. Thank you for having me.

DR. STRIKER:

Let's start off with the column, just introduce a little bit so, um, our listeners can, uh, know what to expect when it appears in The Monitor.

DR. MILLER:

So the column will focus on, as you said, topics of economics. Um, I've been given the ability to talk about a little bit more, so I might get into some healthcare finance cuz healthcare finance and economics are pretty related. Um, we'll talk about topics, I think, that are relevant to, um, anesthesiologists in general and as I recognize that most anesthesiologists don't deal with economics and economic theory on a daily basis, we'll touch into some of that the basics of economics cuz I think it's really at the heart of medicine and at the heart of uh, where the country is headed and where some of the, the medical care field is headed and some of the healthcare industry itself is headed.

DR. STRIKER:

Great, why don't you tell us a little bit about your background and how you got tapped to be the columnist.

DR. MILLER:

Sure, um, it certainly was a bit of a circuitous route. Um, I have a BS in computer science and applied mathematics and the year I graduated was the year that, uh, Apple came out with its first PC, so my degree was not quite applicable anymore. Um, I have an MBA in finance in corporate accounting, and, um, that's really when I got my MBA at University of Rochester, when I got into, um, looking at economic models and realizing how, how, strong they were they were in predicting behavior, certainly economic models don't, aren't the only things that predict behavior, but they had a consistent track record of doing a pretty good job. I became a VP in a small healthcare management consulting firm, um, primarily financial and strategic planning. We sold the firm and I had a bright idea of getting a PhD in health services research with a focus on health economics primarily to strengthen my, um, analytics skills.

I've taught healthcare finance and economics, at Providence College and then at Texas A&M University, and, where I've also worked part-time at Scott & White Health System in Texas. I was recruited by the ASA in 2012 and I spent two years in the DC office. Now I'm basing the Schaumburg office. Um, so my eight years at the ASA gave me a lot of exposure to, um, what folks were thinking about, what folks were doing. Um, I of course contributed to The Monitor on and off, but I hadn't had anything consistent. I'm a huge Steve Schafer fan, and so, um, I asked, or offered, to contribute and, uh, I was attracted to this regular feature idea because I, it really helps me keep involved and current on topics I think that are important, and then it really helps, I think, bridge the gap between some of the healthcare issues and some of the more finance and economic issues that folks are, are dealing with. So, I'm, I'm very pleased to be able to do this. I appreciate the opportunity, and I look forward to the columns.

DR. STRIKER:

Excellent. Well, let's start off with talking about what issues, uh, you're going to start with, or what you think are most important to tackle right off the bat.

DR. MILLER:

Sure, the, the initial column is on the demand for medical care services. It's sort of when you take health economics in, uh, school sort of the first thing out of the bag is why is there demand for health services? So we start with that. Um, I'm also going to talk a lot about costs, and healthcare costs, cuz I think it's one of the most misunderstood concepts in healthcare and we use cost in so many different ways and it's not very well-defined.

Um, I've heard several ASA leadership or people at conferences use the phrase "the answer is money, now what's the question?" So I know people are very aware that economics plays a huge roll, so I am going to really kind of keep it always with an economic focus, but some things that are more controversial than others.

Um, so we'll try to keep it on the key principles and focus on issues that would be most interesting. I'll do a few updates on anesthesia workforce because I'm also the Director of the Center for Anesthesia Workforce Studies at the ASA. Um, I think the economics of quality and the economics of value is also a great topic that we're going to try to address.

Um, I won't talk about details on payment issues but we will talk about payment issues, especially the relationship between payment, um, for physician services and then compensation of a particular physician, or, or clinician. I'll talk about consolidation and mergers in, in anesthesia, the big groups and, and what's going on there and, um, we'll try to get specific within each of these major topics. Um, and then I'm going to, every month, ask for feedback from the membership, from those that are reading the column, to, you know this just send me an email shoot me an email let me know what they'd like to hear about.

DR. STRIKER:

I know there's a lot of physicians out there who have a strong interest in the healthcare economics and finances of what affects them on, at a more local level, but just take a minute to give your opinion on the importance of physicians understanding at least understanding at least a cursory amount of economics, uh, as it pertains to what they're doing every day.

DR. MILLER:

Sure, it, it is important and, and obviously, um, the workers, the clinicians, the people that are on the front lines, anyone, you know in a, in a position, um, what hits them every day is sort of their, basically their compensation. What do they do to earn money, what do they do to have a nice work environment? What do they do to have good

benefits and things like that? Um, and some of the more global things of what's going on around them or above them? What is the, what is their group practice doing? What is their health system doing? What are their hospitals doing? What's the government doing? Um, all these kind of higher-level macroeconomic issues I think are somewhat, not things that you think about on a daily basis, so, um, I'm very interested in market economics, both local market economics as well as regional market ec, economics and sort of, um, the interplay of the different organizations and, and, and sort of the games that are being played out there in terms of people trying to negotiate and, and get within, within different positions of power within a marketplace, whether it's payers, or hospitals and health systems or the government or, or providers.

So I think it's, it's, getting a recognition of the bigger picture is also helpful. By then, even within the hospital and understanding hospital costs in the hospital mentality from a CFO perspective. Like I said, a lot of my background is working with, uh, the CFO's of hospitals and doing some planning with them, and their perspective. I think most physicians kind of get their perspective but, there are some things though, that they may not meet with a CFO every day, and there are some things we'll be talking about there. Um, so I think it's extremely important to go, get out, outside your comfort zone and to try to understand sort of, what would you do on the other side of the fence? I actually have always been a proponent. I would love to see physicians be CEOs and CFO's of hospitals, at least for a year or two. I think they have a good brain set and sort of way they look at things but I also think they do, uh they'd learn a lot and, uh, it would really help. And so I, I really appreciate ASA's push on physician leadership. I think that's a great thing.

DR STRIKER:

Well, let's talk a little bit about specifics. Let's talk about the payment for healthcare services provided by anesthesiologists and physician compensation. What is the, the difference there?

DR. MILLER:

Great question, great issue. Um, I see people of all levels of quote "expertise" that kind of don't clarify it enough, I think for the audience, or somehow get it confused. But for some physicians it's almost the same thing. These are, um, in the business, you talk about we eat what we kill. Um, very private, productive-oriented, the more services I do the more, um, my compensation it is. It's a direct relationship, um, a kind of, uh, productive mentality and so that's, you know, that's still out there. Um, it has slowed down and we see these other models being developed, but that's still there.

So, for some physicians, there's very little difference between, um, how the government and other payers pay for their services and then what sort of is there take home pay, if you will. But on the other side of the spectrum, you may have physicians that perhaps work for, uh, Mayo Clinic or, um, Kaiser, where they are mostly salaried and so they're, they're sort of compensation, their fringe benefits, their offices that they work in, the professional environment, some of the things that they get to do in terms of conferences and stuff like that, and their take-home pay may not all be that directly related to what they did to a particular patient on a particular day and how many times they did that procedure. So, um, it varies throughout the country, regardless of size of the practice or location of the practice, and but they are very two distinct things. Um, and when, when the government or other folks put in incentives for people either to do more or to do better, um, that may or may not go to the bottom line of an individual clinician. And so we need to take those things into account when we, when we talk about incentives and talk about how folks may react to the different economic structures. Both are very, very important to understand, both are very complicated, and both are very different.

DR. STRIKER:

Well, as far as anesthesiology, do you see that disparity increasing over time? Or if it already has, where the revenue that anesthesiologists bring may not the match the compensation, and that it...

DR. MILLER:

It, it def, yes, I think it definitely has increased over time, I mean, it's to some extent it's always been the case. There's been the case to a large extent when it comes to academic medical centers, and academic practices, where they might be salaried, um, they may get additional stipends from requirements of the hospitals to do special things. Um, in some of the larger groups, we see that, um, as you get more and more groups, um, because again, we want the physicians to do more than just the individual productivity of how many patients that they serve, but there's leadership, there's being a good citizen within the health system, um, there's, there's working on quality initiatives, maybe there's some community service. There a lot of other things that, um, in an organization that has many clinicians might want their clinicians to be doing, and so they can't tie everything to a productivity basis, cuz they want them to do many things that may not be productivity based, but that certainly add value to the organization and certainly add value to patient care and patient safety.

So it's been around in the academic centers for a long time. Um, more and more, you'll, you'll see it in groups, um, and, and as we talk about value value-based purchasing and the MIPS Value Pathways that Medicare's going to, and all these things where, you

know, or, or, for years, we've been quote "moving away" from paying for volume and moving toward paying for value, which is a lot easier said than done, because at the end of the day you still need to be very productive, very efficient, and do things the right way. But there's a lot of layers of quality and leadership and other things that are being put on top of this where it's not just about, um, productivity.

So I think we are moving more and more, as more hospitals and health systems employ employee physicians, as some of the larger groups get much, much larger and have their own infrastructures and things that they have to do besides just daily clinical work. Um, and some of the demands of the payers, so we definitely are moving more and more toward, um, somewhat of a, of a separation between compensation and, income, and payment for services but at the end of the day those two things have to reconcile and balance out. No organization can, can compensate to a greater extent than they, than they get paid and last very long. But there's always a relationship, but yes it's, I think it is, slowly but surely, um, drifting apart, but it will never go away there will always be cases where being productive and efficient and doing, um, more cases will, will be of value.

DR. STRIKER:

Is it as simple to say that the reason for smaller independent groups going by the wayside, if you will, the private groups becoming larger and larger, or physicians, or specifically anesthesiologists, but physicians in general, being employed by the hospital as you, as you mentioned? Is it simplest to say that it's because of the amount of administrative work that just makes it impossible to compete? Or is it this disparity with reimbursement for services that makes it additionally difficult to compete for smaller independent groups as opposed to joining larger, uh, larger groups or just being employed by the institutions themselves?

DR. MILLER:

Yeah, so I think it, I think it is all of the above. I mean there's always been the concept of economies of scale, there's also diseconomies of scale. When I was in the consulting business we were told that we were, very reasonably, small, you know 25 consultants and we were told that, oh no, its, you know, you're going to be taken over by the, the very large mega-consultant groups in the world and there's no role for the smaller organizations anymore. Well in something like a law firm or consulting, some of that may be true but allow that isn't true and I think in, um, healthcare and anesthesiology you know, the burdens of administrative burden, quality reporting burden, um, the electronic medical records, the infrastructure that's needed, the organizational human resource structure that's needed, there's a lot of things to say yes, you know, a, a two-

to five-person shop has a very, um, difficult time doing that. Just negotiating with the different payers out there, and working through some of the, the legal things that need to be done. Um, size does help from that perspective, maybe so most of the folks can focus on the clinical side of the business and not have to worry about the administrative side and the regulatory side, which is getting more and more complex, and more and more burdensome financially. So that's definitely the case.

It's also the case though, that from the perspective of hospitals and health systems, um, employing physicians, and this has always been the case, back in the big trend, back in the 90s as well as now, is that there's a feeling that they would have more control, if you will, about, um, what they, um, have those providers do, um, that they're more dedicated to the particular health system or the particular hospital, which usually isn't as big an issue for anesthesiologists is it would be maybe for a surgeon or primary care physician where those aren't really hospital based, per se.

So, um, it's all of the above. I think it is getting more and more difficulty. We've been tracking consolidations and affiliations for the last now, now I think, uh, ten years and, and it certainly has increased. It's slowed down in the last two years because frankly that you know the top eight or nine groups or, you know, represent twenty percent of anesthesiologists out there. So we're, we're getting so much saturated there's still a lot of activity but it's, it's definitely been something that on the side of the people that are getting these, into these big groups they feel that the big groups have a better ability from a perspective of negotiating or from showing value and reporting quality and doing the kind of things you need to do, and from the individual smaller group they may feel like they may not have a, have a choice that they, they can't compete with these larger groups. So, um, it's, it varies across the country. I think it's fascinating what's going on. But, yeah, we'll continue to see it, but it definitely has slowed down quite a bit.

DR STRIKER:

In addition to a couple of issues we've already talked about, let's broaden it out just a little bit. What are some other issues you feel are most important to highlight in the current healthcare climate?

DR. MILLER:

Well, I, I think obviously for anesthesiologists unfortunately one of the biggest issues is the Medicare payment disparity with what makes sense from a marketing perspective. What I think, um, folks associated with the ASA refer to as either the 33% problem which is now more like a 28% problem that is that the Medicare payment for anesthesia services is, you know, less than a third of what the market market-based payment rate

is. And so I think that's obviously is a huge problem, it will always be a huge problem. I don't think any individual physician or even a reasonable sized group can help tackle that. I think that's one of the strengths of the ASA as an organization like the ASA can really help, um, advocate on the behalf of the physicians on that side.

COVID was a big thing. Everyone I know is tired of talking about COVID, so I won't talk about it much, but it was an economic shock. I mean, it was an experiment for economists it was called an economic shock. It was an experiment to see what would happen, both short term and long term, and so I think that was an interesting experiment. I hope that we learn from it for the next time around. Um, the alignment of the physicians, which you just talked about and the hospitals' consolidation, that's a huge thing.

The other thing I think is really interesting, um, again because it's not my area of expertise is sort of the, the new technologies - artificial intelligence, augmented intelligence, machine learning, and how that's going to impact the demand for services and anesthesia professionals. I mean, today we could actually fly most commercial airlines jet routes without a pilot. Not too much of that is happening because I don't personally want to go on a airplane without a pilot, but we could actually do that. And so there's a whole concern of will the new technology, is that something that's going to make things better for everyone? Does it, to any extent impact the demand for the professionals that used to be performing these tasks? And so I think, uh, the new technologies coming out, in terms of um, closed loop systems on the anesthesia side in terms of artificial intelligence and being able to, to, to predict what's going to happen to a patients and adjust medications instantly, um, how does that impact anesthesiologists? Does it make them more valuable, less valuable? And there are arguments of both sides. I kind of lean toward more valuable. It's just a different, you know, stepping up the game in terms of the, um, expertise that the anesthesiologists will be dealing with. Um, let them do their job with um, probably even with less of a concern for safety, which is, you know, such a safe thing right now. But, um, so I think technology is a big thing.

Of course, leadership, leadership, leadership. I, I think the number one way for any physician, much less an anesthesiologist to show value is to really, um, get involved in, um, health system leadership where the leadership of the organization know what you are.

DR. STRIKER:

Well, let's broaden out just a bit again, cuz I do want to talk about the direction that anesthesiology is heading as a specialty. But before that, just wanted to take a little

detour and talk about how the economics of healthcare in general is unique, as opposed to say paying for consumer goods. What are, what are the key differences that everyone needs to understand?

DR. MILLER:

So even back a long time ago I was getting my, um, degree, um, you always heard, oh, healthcare is different. You can't treat it like a normal economic good. What are you doing trying to study healthcare economics? It doesn't make sense because it's so different. Um, and healthcare is very different. It is very unique. But there are many, many economic principles, both micro and macro, that still apply well enough in healthcare. Um, you know, the government payer causes a problem. The discussions among everyone, academics and whatnot, about is healthcare a right, or is healthcare a privilege, those discussions still, you know, they still take effect, and they still imply certain things in terms of how the, um, industry sort of works.

One of the big questions is, is healthcare a normal good in economic terms? And a normal good in economic terms means that the more money a person makes, the more money a country makes, the more money you will spend on a particular good or service. Um, and in fact, if you look at the empirical evidence that is in fact the case, that people that have more money tend to spend more money on healthcare. Um, and that may not be the right thing that happens, it may not be the thing that you personally think is, is correct or how, how things should be, but to the extent that healthcare is a normal good, um, there are a lot of health economic principles that can be applied.

So it is very different though. We have these, we have markets where we have, um, a very tight concentration of payers; Medicare, Medicaid, maybe Blue Cross, maybe United, maybe one other commercial insurance. And we have markets where we have a very high concentration of health systems and providers. And whenever you have a concentration of either the buyers of the services, the payers, or the producers of the services, the hospitals, the health systems, and the physicians, you have some interesting dynamics going on from an economic perspective. They are interesting, they are somewhat different, but they are actually from a pure economic perspective, they're not as different as one might think. We have seen evidence in, um, both on the hospital side and clinician side that concentration of, of either side does influence the ability to negotiate when it comes to, comes to contracts.

Um, so it is different, um, I would say the one thing that strikes me as a person that's different is that except for perhaps obstetrics and having a baby, one does not really purchase medical care for the joy of that experience, for the joy of the medical care. It, in economics, we call it a drive demand, um, so it's a demand for good health, our, it's

our demand for a long life that really drives our demand for medical care. We don't go seek medical care because it's a fun thing to go visit the hospital or it's a fun thing to go visit a physician. We do that simply because we want to stay healthy, we want to have a long life, be with our family, etc, etc. And so except for the having a baby, I don't think it's a very joyful experience to go to a hospital. Um, it's a great experience when you leave the hospital and you're feeling much better than you did entering it. But, so it's very different in that way.

The government regulations are huge and a burden. I don't know if there any more so than banking or some of the other industries, but they certainly feel like it to me, um, knowing what I know. Um, and the other thing is demand, like most other things, is a function of population. It's a population driven business and so you are going to expect to see very different things happening in rural communities vs. urban communities. And to the extent that, that we want to provide access to care for everyone, no matter where they live I think there is particular challenges just cuz of the expense and the infrastructure and things that are needed whether you're a ten-bed hospital or thousand-bed hospital. So, so there's several unique things. I think there's still a lot of commonalities with other industries that makes it, um, worthy to study from an economic perspective. But they're definitely are unique things with healthcare.

DR. STRIKER:

Well, let's circle back now to anesthesiology. What are your thoughts about, uh, the direction of anesthesiology as a specialty, as to where it's heading?

DR. MILLER:

So, I cannot speak to the clinical side, since I am a PhD and not an MD, but, um, I certainly, um, in my eight years of being at the ASA, and my 20-plus years before that and, and doing consulting, um, I really do love the ability to work with the physicians, attend conferences, um, be involved in their committees to learn as much as I can, so I, I really like that, um, and what I've learned I think, um, one thing about anesthesiology versus other specialties is anesthesiology is so unique in that it's such a broad scope of types of payment, patients. I mean, I think that's why the perioperative surgical home and concepts like that are so popular, because literally almost all the operative or procedural type patients the anesthesiologist are involved in, so it's not the knees, it's just not the heart. Certainly, there are specialties within the anesthesia that just do, um, you know, cardiac or just do neuroscience or things like that. But, but in general, the, the expertise of the anesthesiology across the broad spectrum is very, um, impressive.

And so to some extent there's, there's market forces out there that that's making it more and more specialized and there's also market forces out there that are, um, making it less specialized. I think the leadership, the increased role of anesthesiology in terms of leadership, the coordination of care, things like the perioperative surgical home are just very important, um, and I think that's sort of unique to anesthesiology. When I see things like hip and knee surgery is becoming basically all outpatient I think that, um, and all the non-operating room anesthesia that goes on, I think one of the things that is a challenge for some groups is to, to be able to provide services in all these different locations, and adapting models of care to make that work.

I think the other thing, and the biggest thing that's a challenge from an economic perspective is that in general, anesthesiologists don't bring patients to the hospital. The demand for anesthesiologist except for the pain medicine folks reflects the demand for, of course, surgery and procedural care. And so, you know, there's a, you see some in the literature or not so much the literature but the popular press, where people refer to anesthesia professionals as sort of ancillary or workforce, where in fact, um, their role is what they do to me is, is, is so essential and so important, that that it's anything but ancillary. And so I think the direction that the anesthesiology is heading is it's got to continue to really elevate the recognition of this incredible expertise that you all have and the skills as, as we move toward this.

As an outsider, I think it's, it's, it's so important, and, and I've preached to all my friends and family about the importance of physician anesthesiology involvement, um, and the importance of what that does when you, when you have a procedure or surgery. And so to me it's communication of this. I think the, you know, the, the value proposition is the name of the game. When we work with surgeons, when, when y'all work with, uh, proceduralists, when we move towards, sort of, the new economic models of paying for, uh, kind of this team work and we're going to move away from just looking at every single specialty and all these different outcome measures, and say what we want is a good healthy happy patient on the other side of the experience and all the people involved in that care, which anesthesiology use a huge part, contributes to that. And so again we're going to be moving toward that more and more as we are this episode of care and we want to make sure that everyone underneath that episode that's involved, and there are many people involved, or part of this puzzle, and I think anesthesiology has to further step up to the plate and take a leadership role on that. Um, the technology you all work, as, as I said is going to be a big thing in terms of demand and what's going on.

As a specialty I think it's, you know, we've had three or four years of record-setting residency program enrollment, and sort of, the demand for anesthesiology continues on that residency level, so, um, and certainly the demand on the um, on the side of the, as

the uh, population ages and the surgical volume continues to increase. So, I, I see it continuing to grow, uh, becoming different, um, but fortunately some things at a local level may change very quickly, but fortunately on a global level sometimes some of these changes are actually slower than we might first think, and so we have some time, I think the anesthesiologists, um, as a specialty, have a good amount of time to adjust adapt and continue to be really, um, successful.

DR. STRIKER:

I know the ASA has made some, recently, some strong efforts to, uh, help communicate the message out to the public and, and healthcare leaders, the value that physician anesthesiologists do bring and the importance of having physicians involved in anesthesia care. From your perspective, do you feel that that message needs to be delivered, um, in stronger terms to healthcare executives or in a different way to healthcare executives, or in other words, where we always recognize the public may or may not know who is, uh, delivering their care in any number of specialties, but particularly in the field of anesthesia, but um, in terms of healthcare executives, do you feel that they, they require perhaps a, a different level engagement to demonstrate that value or the, that understanding of, of who we are and it's not necessarily just an ancillary workforce?

DR. MILLER:

Right, and I think that's a great question and I think one of the things from the twenty years of working as a consultant to the, to the hospital administration folks and now as I work with the anesthesiologists, yes, I think that to me is a key, and, and I don't know if this is uh, popular or not so popular review, but I think both elevating the, the knowledge to the, um, executives and, and leadership within healthcare within the hospitals is hugely important and I also think, um improving their relationships with the colleagues on the other side of the table, the surgeons, the proceduralists, um, is also extremely important.

And I, and I had the opportunity to shadow several practices when I first started with the ASA and I still do, and in some organizations, you know, it's just amazing what wonderful teamwork and great relationships there are. In other organizations it's uh, it's, you know, not quite as strong, um, and I certainly think success will be to those that, um, are involved around the table, um, whether it's a, a quality committee or an operations committee or even you know I always would tell folks when, when on the consulting side, I would say, you know, hey physicians, you know, take your CFO to lunch. Try to understand what they heck they're doing and when they do the cost accounting and things like that. Take your strategic planner to lunch, take your VP to

lunch, get involved in at any level. I think that really, really does help. I think some of the strongest hospital and health system organizations I've worked with in the past, they've had physicians on the board and very strong physicians, very involved physicians, that were still involved clinically but they were also on the board of the facility and that, they just brought such a great perspective. So, um, yes, I think that's extremely important. I think working with hospitals, health system leadership, um, it's just going to be critical for all physicians, but especially for anesthesiologists.

DR. STRIKER:

You know, you mentioned already, everybody's probably tired of talking about COVID, but I would be remiss if we didn't ask just a little bit about how the financial impact that COVID-19 has had on the anesthesia community, in terms of financial issues.

DR. MILLER:

So, so the simple answer is, it's bad. Not to be, um, um, you know, cavalier about it, but, but it is bad, and so we've been tracking it. There's been several surveys, and you've seen some of the results, where it ranges from, you know, across the board. In some markets, they've felt very little pain, and in other markets there was, um, either permanent or part time furloughs, um, certainly reductions in pay and benefits, always, um, where COVID is being seen, um, we've seen reductions in utilization and so, from an economic perspective, um, unless you're in some sort of a group, you know salary con, contract, and even that's not safe, whenever there's a reduction in services, like I said, because long term it's gotta reconcile. There's gotta be some sort of reduction in, in workforce and in pay. So, we have seen that. I think the good news is it wasn't, it hasn't yet been, I know we're in our second or third surge, so let's cross our fingers, but it hasn't yet been as, as horrible as one might think. And now, you get a hundred phone calls from people that are in marketplaces where they've been devastated. So it's, it's just going to, when it impacts demand, it's going to impact your financials, and so I can't specifically address how that's happening, but it was a clearly, an economic shock and it's an economic shock that, that hopefully we're going to learn from.

And as we've seen the survey results and stuff we do see some very permanent layoffs and permanent reductions in, in recruiting and things like that, um, and on the flipside we've seen some things where they, it was temporary, which is still bad, and then we saw a couple interesting responses from surveys where, um, during this time, um, some organizations that again, maybe this the benefit of maybe being larger or having something natural reserves, actually went out and recruited additional anesthesiologists, and, and residents that were the quote "cream of the crop" right out of school, um, because not too many people were recruiting during this time and so they took

advantage of that in anticipation that the demands and the surgeries would get back to normal and then they would have a, a you know a staff that they really, um, really wanted, and at a reasonable price, if you will. So, it, it's obviously. any kind of a shock like this is bad, economically. Unable to predict it, I have, I've seen a lot of models, it's just hard, it's just a matter of what's happened in the local and regional marketplace. So yeah, it's a tough, it's one of those things that I don't think I could ever answer and get it right across the country since it varies so much.

DR. STRIKER:

Sure, certainly. Well, it's certainly a complicated issue, and I know we're all going to be watching this closely over the coming months here. What should anesthesiologists consider from a financial standpoint to prepare themselves for the future in general? What, uh, advice would you give our listeners?

DR. MILLER:

OK, so here's another place where despite my love for health economics and corporate finance, my personal financial advice is, is really not my thing and I'm not very good at it. But, here's what is always seems to be the case where I see people that have, um, seemed to be successful in upswings and downswings, and that, that is really to always plan, plan, plan. Um, I think no matter how small or large a group you're in, um, to have regular meetings with your peers or colleagues or if you're in a large group with the leadership to, to really articulate folks assumptions about the future, assumptions about what demand's going to look like, assumptions about risk factors. Revisit these things and plan again.

Um, you know, always ask the question, did we demonstrate value? Is it going to be hard for people to say, eh, we don't really need you as much anymore, or need you anymore, um, you are so now part of the organization, so important to the organization, so important to the success of the organization, that, um, you're, you're part of it and, and you're going to be pretty strong financially. So getting involved, staying on top of the trends, things I've said before, staying aware, I think being strategic thinkers which again is probably easier said than done.

Um, so I, you know, the professionals in anesthesiology, we're going to continue the trend toward larger groups, um, but I don't think for any minute really the small and medium-sized practices are going to go away forever. Um, nor should they, cuz there will always be, um, a niche for the small to medium group practice, so I think that's good. But to prepare for the future I think it is, the answer is in the question, which is prepare. Think about all the possibilities, plan and just and, work with it.

So I think involvement in organizations like the ASA State Society, subspecialty societies, if you're a cardiovascular, um, anesthesiologist, um, involvement in those and some of the planning that these organizations do cuz they talk about these, um, external opportunities, external threats, um, you know is a physician your own organization's internal strengths and weaknesses, but you get a really good perspective of some of these macroeconomic things that are impacting you. It's really getting involved with some of these other societies. Um, so preparing is just being, is just being knowledgeable. You know, just learning more and continuing to be knowledgeable. But I am a horrible personal financial advisor, so I won't give any stock tips.

DR. STRIKER:

Well, yeah, all right. Well, yeah, maybe later. We'll talk offline. Um, how do you anticipate that the economy of healthcare in general will, will change moving forward?

DR. MILLER:

Yeah, what, what are we now? I think we're think we're one out of six, or, or, or between one out of six and one out of five and a half people are involved in the, uh, healthcare economy, um, and that continues to grow, and so this is not a small thing this is huge, uh, and we know that. Um, we have the baby boomers, now, you know, me at age 65 I think I'm a lot different than my father was at age, age 65 who already had two open heart surgeries. Um, I'm by no way an, an athlete, but I do, you know, I watch what I eat, do, do the exercise and stuff so I think, um, that although the baby boomers are here and I think we're in the middle of the baby boomers turning 65, um, that will increase their demand for services, it won't be quite as catastrophic as I think, um, we once predicted, and only because I think you know the, the people of age 65 to 75, um, are not all the frail and elderly. We still have a lot active people and that's good.

But we will all die of something. Um, we're going to have some great advances in medicine and technology that will, um, make us live longer but we're all going to die of something. So I think it's going to be a strong economy it's going change in terms of the types of things we care about. Um, you know, the bigger, probably going to get bigger. Kaiser is what? I think Kaiser, in terms of revenues, they're probably the somewhere between the 60th and 70th largest country in the world if they were a country, um, so healthcare in America is big. Um, it will continue. I don't see demand decreasing. I do see hopefully things moving more toward outpatient, more toward the home. I do see things hopefully moving, um, more patient-friendly. We've been talking about it for 20 years but you know, yeah, I have my little fitness watch and I do this, I do that, I have a, I take my blood pressure but I'm still not really integrated. Um, I still have to make appointments to get my lab tests and see my doctor and things like this. So I think we're

going to hopefully we we'll move more toward um, making it on the front end easier to folks to use but there's no way the demand's going to decrease.

Um, we have, in addition of the population growth we still have a lot of bad behaviors and risky activities we have to overcome so, um, I think it's a strong economy. I mean, I tell all of our kids and grandkids that, uh, you know healthcare IT is probably where to go because healthcare is going to be around a long time and the economy is going to be strong. And then the information and technology demands of healthcare is going to be strong and, and going. Um, that is if they don't want to become physicians, which, of course, they all should be.

DR. STRIKER:

That's a large part of the American economy but how does this compare to other countries in the world, not necessarily an exhaustive list, but just in general, that proportion of an economy?

DR. MILLER:

Oh, it's the highest, right? Oh, we're the highest, and I, I apologize that I don't have them off the top of my head, but we'll always see the same statistics which I'm a little tired of, and that is we know where we're eighteen, eighteen percent of the GDP, but we have some of the highest mortality rates. Well, there's many different sizes that story and this isn't the place to address it, but I'm, I'm very high on American healthcare. I mean, my mother used to tell me, you know, if you have your health you have everything. Nothing's more important than your health. And as much as we complain and, some people, um, are disheartened by the fact that we spend you know eighteen percent of the GDP on healthcare, I'm going, well, you know, maybe we should spend fifty percent on it if health is so important, that's the most important thing in the world. So it's a, it's a political question, it's a religious question, it's a economic question, it's a personal question, and it's, that's why healthcare is so interesting. It just touches everything, um, both science and religion and politics and your own personal feelings. Um, but yeah, we definitely spend the most money and there are many, many outcomes where we don't do well at.

But we have a very different um, population than many countries. Um, we have a different approach and, and it still the fact, and I've heard it the other day, that, um, from a population perspective, it may not make sense to do a particular test because it's only going to help out one out of a million times. But if you're an individual and your daughter or son needs a particular test, that even though it may only help, um one out of a million times, you kind of want that tests to be done. And from a macroeconomic, you know,

global kind of position, you don't, that's not a good idea if, if the government or the taxes or the taxpayers are paying for it. But from an individual perspective that still might be something from a personal preference, so that's where we get into this battle of population health, individual health, um, the, the right to be able to buy whatever you want.

Um, quick story, my father-in-law actually walked into more than one facility. He wanted a PET scan of his brain because he had just seen something on 60 Minutes where they looked at PET scans of brains are they could tell something about the personality. And he said I'll, I'll pay cash for it. But of course, they, they wouldn't do that because there's no medical necessity for it but I just thought it was hilarious to hear the story cuz he was quite a character that he wanted to pay for a PET scan, scan on his brain so he could see what type of, uh, what type of issues he might have.

Um, but it's a, it's a touch point, but yeah, we spend more money than any other country, we don't do very well on some of these important, um, national, um, outcome indicators but I'm kind of, when I need my heart surgery, hopefully, I don't, but when I do my hips and knees I have a few hospital systems I know I'll stick to in the United States before I travel to some other country.

DR STRIKER:

Well, if nothing else it certainly underscores the complexity of dealing with healthcare economics and less of how, how you measure it.

Um, well finally, what ways can the anesthesia community work with other specialties to become more economically sound or efficient?

DR. MILLER:

Well, I think there's a couple things. Um, first of all, we tend not to do things until we really have to do things, that's our, that's our nature. I mean if you look at, um, even after a major, um, heart event the number of people that change their smoking habit, their drinking habit, their exercising habit, was actually pretty small but that's the only time they really change it. Something had to happen for them to change it. Is there something that's happening now or going to happen in the economy that will make it necessary for, um, the anesthesia community to work with other specialties? Um, to some extent, absolutely, right?

The whole payment issue and paying for an episode of care, paying to keep people well, paying to have good outcomes, it's a team effort. It's, uh, everyday

anesthesiologists are working with surgeons and other proceduralists, the people in the OR, um, people on the floor, so it's, it's definitely, there's, you know, there's already good relationships I'm sure between individuals, between surgeons, you know, orthopods and anesthesiologists, cardiovascular surgeons and anesthesiologists. There's also great relationships, there's always great relationship there. Then the question becomes how do we make this where we're actually improving our economic basis and becoming more efficient? And that really, to some extent, and many people will disagree with me, but just seeing what I've seen in terms of consolidation and different organizations getting together, that really has to happen at an organizational level. Um, we can be nice to each, other work with each other, etc, etc. But to impact the bottom line, well, we have to be in a single economic unit of some sort, whether that's a single specialty group practice, a multi-specialty group practice, everyone employed by the hospital or whatever. That would be the real way to do it.

Contractually, you can make contracts that work almost as well as an, a single economic unit, but it's a lot more challenging to do that. So, there are reasons that I think some, I've heard some federal folks, they like things like the big groups like Kaiser because it's an integrated system, or Geisinger, I don't want to pick on Kaiser. Just there are a lot of integrated health systems that people really like that model because you are in one big family and so, um, if the organization does well, you can theoretically do well. If the organization doesn't do well, you, you may not do well, so there's a there's a common incentive. Um, that's a very tough one cuz you, you're clashing culture with uh, economics and culture won't, you know, is, is always, tends to be a little bit more influential, if you will.

So, um, definitely we have incentives, through the MIPS Value Pathways to work with other specialties, and we're, we're actually, um, doing that now within the ASA. We're reaching out to these other specialties and talking about them. I think it actually, the anesthesiologists are taking lead on that in some cases, so we have incentives to work with other specialties.

Um, for purposes of quality reporting, for purposes of payment from folks like Medicare, um, but for other purposes of being, you know, um, um, a more efficient lean, mean, you know, economic machine, if you will, that takes a while. But that's why we have some, some large, larger groups. That's why we have people contracting specifically with one or more organizations. Um, so it's, it's, um, it's definitely the incentive is there, but you know, not everyone likes that model. So I, yeah, I think there are many ways I think we're going, we're moving toward that. Um, it's always a good idea. I mean I can't imagine for anesthesiologists any one more important that you want to have like you than the, than the surgeons, probably. But, again, I'm not an anesthesiologist so I may get some hate mail on that. Um, but we definitely have the, we definitely have the

incentives to work with other specialties. Um, we have so much, the anesthesiologists, y'all have so much to offer them and, and so I think that's definitely the way we're going to head. It's just not, it's just not as fast as some people might expect.

DR. STRIKER:

And, and I think anesthesiologists by nature, we work with so many specialties, so many other, um, so many medical problems across the spectrum and so I, I actually think that it's in and of itself, is not a seamless, um, transition in terms of demonstrating value or working for more economic efficiencies because that's something we do every day. We're involved with so many different fields. That's just the nature of, the nature of what we do, right? You know, getting along with all these specialties and working with so many. So, yeah, I think that will be a pretty, pretty seamless transition for, for anesthesiologists, if it needs to come to it from an economic perspective.

DR. MILLER:

And I certainly think that, and there's two sides of the economics, the revenue side and the cost side, and I definitely think on the revenue side, um, you know we're basically there, and we're moving more toward that and like you said you're, you're so well positioned on the revenue side, contracting side, things like that.

On the expense side, um, when we start sharing infrastructure and different things like that, it's a little bit more challenging. Right now, the, the biggest expense on the anesthesia side is, is really the, the personnel. But as we get more and more integrated with systems and things like that, that's, that will be where some of the challenge is. But I agree completely on the, on the revenue contracting side, we're, we're well positioned and we're going to continue I think to improve there.

DR. STRIKER:

Excellent. Well thank you so much for all your time, Dr. Miller, and for joining us on the podcast and, um, really this is been, uh, really insightful and a valuable discussion.

DR. MILLER:

Well I appreciate it, and I'd love for people to send emails and, uh, let me know what they'd like to see some of the columns to be, to be about in the future.

DR. STRIKER:

Well, we're certainly looking forward to The Curious Economist, coming soon to the ASA Monitor, so thanks!

DR. MILLER:

Have a good day!

DR. STRIKER:

This is Adam Striker, thanking everyone for tuning into this episode of ASA's Central Line. Please tune in again next time. Thanks. Take care.

(MUSIC)

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