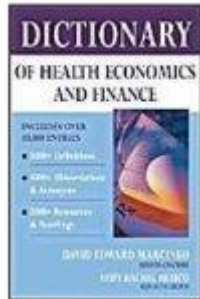


Thomas E. Getzen PhD



Why the Dictionary of Healthcare Economics and Finance?

Every business and healthcare administration student I've ever taught over the last three decades has struggled to decipher the alphabet soup of medical economics (i.e., OPHCOO, ALOS, DRG, RBRVS, behavioral health, acuity, etc), while those coming from clinical medicine struggled to internalize the lingo of finance (i.e., call premium, cost benefit ratios, IGARCH, AACPD, IBNR ABCM, internal rate of return, accounts receivable days outstanding, etc.).

Until we have a common language however, medical and business professionals cannot possess a shared vision, nor can we communicate successfully to create healthcare entities that provide quality care to patients and reasonable profits to medical practitioners.

Of course, no single tool can meet all needs and there are many fine books on healthcare economics and finance, along with a legion of consulting firms, management associations and university programs.

Yet, to effectively use these resources, one needs to have the right words, and to use seemingly everyday terms in a way that economists and healthcare financial experts speak.

Unfortunately, healthcare service costs continued to rise more rapidly than wages during the last decade, and consumed an ever-larger share of Gross Domestic Product (GDP), creating hardships for both employers and employees.

For example, health spending accounted for 15.3 percent of the nation's economy or \$2.05 trillion in 2006, averaging \$6,175 for every American. Health insurance premiums rose 8.8% to more than \$14,500 for family coverage, and by 2013, the US government forecasts health spending will reach 18.4 percent of gross domestic product.

It is no wonder that controlling costs is the top concern of fringe benefit specialists, according to Deloitte Consulting and the International Society of Certified Employee Benefit Specialists.

More than one-third of the rise was due to a 13.6% increase in outpatient spending. Higher utilization rates accounted for 43% of the increase, fueled by increased demand, more intense medical treatment and defensive medicine, according to PricewaterhouseCooper.

And, let us not forget that one in seven Americans lack health insurance; that's 46 million people or 15.7 percent.

At the same time, medical professionals struggled to maintain adequate income levels. While some specialties flourished, others like primary care barely moved forward, not even incrementally keeping up with inflation.

In the words of Atul Gawande, MD, a surgical resident at Brigham and Women's Hospital in Boston, and one of the best young medical writers in America, "Doctors quickly learn that how much they make has little to do with how good they are. It largely depends on how they handle the business side of their practice".

Increasing, some physicians have become more aggressive in seeking out business opportunities. For example, Neurosurgeon Larry Teuber MD, built a specialty hospital in Rapid City SD, and earned \$9 million dollars in a single year. Investors also became wealthy, and the hospital where he previously practiced and some former colleagues were not so fortunate or happy; even suggesting that he stepped "over the line."

While it is difficult to fully understand a complex situation from a brief overview, it is vital for medical professionals to have definitions that clarify "the line," and for businesses to define the forces and implicit understandings that underlie medical ethics.

Alas, the *Dictionary of Healthcare Economics and Finance* cannot solve these problems, just as the rule-of-law cannot answer the question of whether or not Dr. Teuber did "the right thing."

What the *Dictionary* can do however, is set the context, and clarify the terms of debate. Consumers also need to know what these terms and conditions mean. If this was not evident until now, passage of Medicare Part D has made it painfully obvious that clarity is needed, and that continuing education in the economic and financial terminology of healthcare is a lifetime task.

Once drug co-payments, corridor deductibles and exclusions are mastered, one can begin to sort out the limits on long-term care insurance, homecare and hospice benefits, and the ever-changing levels of hospital and physician reimbursement dictated by SGA (sustainable growth adjustments) ... and there is still much more to study and learn. It takes knowledge to practice medicine and to earn capital, assume risk and invest in emerging healthcare entities.

And, none of us can escape the responsibility of knowing what the terms of engagement are. In times of great flux, such as the revolution in reimbursement and payment systems occurring today, codified information protects us all.

The *Dictionary of Healthcare Economics and Finance* provides that protection by bringing stability to the nomenclature of healthcare fiscal and economic concerns.

With 10,000 definitions, acronyms, illustrations, cliometric equations and industry notables, the *Dictionary* is an authoritative and comprehensive guide to better healthcare administration transactions.

Dr. David Edward Marcinko MBA, Academic Provost for the Institute of Medical Business Advisors, Inc, and a Certified Medical Planner© should be complimented for conceiving and completing this ambitious project.

The *Dictionary of Healthcare Economics and Finance* spells out the terms of reference and the principle players in the contemporaneous healthcare industrial complex. Having such a compendium readily at hand and sharing it with others, is a way for patients, accountants, financial planners and insurance agents, medical practitioners, nurse managers and healthcare executives to improve economic efficiency and clinical quality.

Of course, it may even help restore fiscal enterprise-wide sanity, as well.

Simply put, my suggestion is to refer to the *Dictionary of Healthcare Economics and Finance* frequently, and “reap”.

1. The New Yorker, April 4, p.47, 2005.
2. Wall St. Journal, Aug 2, 2005.
3. Reuters, Jan 31, 2006.
4. Modern Healthcare Jan 31, 2006.

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