Future of the US Healthcare System and the Effects on the Practice of Hand Surgery

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Abstract The multitier healthcare system of the USA has several major flaws. High costs and uncertain quality of care indicate that this system is no longer practical. Several improvement initiatives, such as the Oregon Health Plan, Leapfrog, Lean Manufacturing, and Pay-for-Performance have been implemented into the current system. All of these quality improvement models are being experimented in a limited fashion and do not address the biggest problem in the US healthcare, inequality of care. There is now increasing support for a universal health coverage model as an ethically sound and just way to decrease health disparities in the USA. The current quality initiatives as well as an adoption of universal coverage appear to be the best way to improve quality of care, reduce cost, and increase equality in healthcare. These initiatives may have considerable effects on the practice of hand surgery in the near future, and thus, it is important for the field of hand surgery to become more engaged in advocacy and public policy arena. The purpose of this paper is to examine the current problems in the US healthcare system and to evaluate potential solutions that will enhance quality while simultaneously curbing the unchecked increase in healthcare expenditure.

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Healthcare costs have been increasing at a rate of 15% per year in the USA over the past several years and have now exceeded \$2.25 trillion in 2007. Current estimates put US healthcare spending at approximately 16% of the gross domestic product (GDP), and spending is expected to continue its upward trend to reach 19.5% of the GDP by 2017 [1]. Germany, which spent 10.7% of its GDP on healthcare in 2005, is the next highest spending country [2]; however, it still spends substantially less than the USA in healthcare expenditure (Fig. 1). Despite this enormous financial outlay for healthcare, the USA was ranked 37th in health service performance and 72nd in overall quality of health [3]. The USA's low standing is largely a result of an inequality of its healthcare distribution, with approximately 16% of the population, or 47 million people, uninsured at sometime in 2006 [4]. Additionally, millions more are considerably underinsured, which may cause them to forgo important medical procedures or medications due to high premiums. Among those surveyed in the USA, 37% reported that they had skipped medications, avoided seeing a doctor when sick, or abstained from other recommended care wholly due to expensive medical costs [5]. A study done by the Kaiser foundation showed that there has been a consistent growth in health insurance premiums from 2000 to 2006, which has resulted in its increase of nearly 85% within those 6 years. This inflation in premiums is quite substantial when compared to the 20% increase in workers' earnings [6].

The continued increase in healthcare premiums is a source of concern for the nation, which desires to curb costs but at the same time provide affordable quality care for the American people. A recent poll conducted by the New York

Figure 1 Health spending in 4 countries, 2007. Note that the USA is over 5 percentage points higher than the next on the list, Germany. (modified from source oecd.org, accessed July 14, 2008 & from source [54]).

Times/CBS News found that 81% of Americans polled were dissatisfied with the cost of healthcare; 36% said that “Our healthcare system has so much wrong with it that we need to completely rebuild it”; 95% said that it is a serious problem that many Americans do not have health insurance [7]. Due to this discontent, healthcare reform was indeed one of the major issues in the 2008 election. Because hand surgery can help provide solutions to our national healthcare woes, which include the lack of emergency department coverage of hand trauma in many regions of the countries, an understanding of the current healthcare debate will be crucial to hand surgery’s contribution in resolving the difficulties faced by many Americans whose lifestyle is deleteriously affected by increasing healthcare costs. There is a great interest among hand surgery leadership for a national advocacy initiative to be sure hand surgery is adequately represented in the national dialogues on healthcare reform. A recent advocacy survey of American hand surgeons found that 62% of hand surgeon respondents felt that the area hand surgery societies should be focusing its advocacy efforts on is legislative advocacy at the federal level [8].

Although hand surgeons make up only a small proportion of physicians, hand surgeons are still an integral part of the medical community. Members of hand surgery societies, such as the American Association of Hand Surgeons, met at the American Medical Association (AMA) meetings to discuss topics of interest to hand surgeons. They also collectively monitor and participate in numerous caucuses, including orthopedics, plastic surgery, and surgery caucuses, as well as specialty and service society groups, which together represent roughly 40% of AMA members. While working together with these other groups, the hand surgery specialty could have a large voice if members actively

participate in current and future discussions to preserve the interests of hand surgeons and their patients [9].

The focus of this paper is to lay a foundation of past, current, and future healthcare policy discussions. To achieve this aim, we will discuss the history of the US healthcare system, the changes in healthcare environment that have led to the current fragmented US healthcare delivery system, as well as current and future plans for healthcare transformations and how it may pertain to hand surgeons in America.

History of Healthcare in the USA

The US healthcare system has justifiably been coined an “accidental” system. “If we had to do it again,” says Princeton health economist Uwe Reinhardt, “no policy analyst would recommend this model.” [10]. Following Franklin D. Roosevelt’s election in 1932, his decision to reject universal healthcare in favor of passing a bill for Social Security was one of the historic events that led to the emergence of our current system of insurance. Roosevelt’s decision led to an increasing need for protection against the growing costs of illness, which led to the proliferation of private insurance companies to fill this gap. Blue Cross, the first private insurance company, was originally founded as a nonprofit agency, but commercial insurers followed after, recognizing a way to make money through the population’s need for coverage [10]. In 1948, Harry S. Truman advocated again for a national healthcare system, and there was a 75% public support margin. However, the American Medical Association ignited a concerted effort to block the plan, calling it “socialist” and “un-American,” and the bill was never passed [11].

The US healthcare system worked well in its earliest stages; however, by the 1960s, healthcare costs had doubled, the percentage of people covered by their employers decreased, and many people began to find it difficult to pay for health insurance [12]. The system was failing and the government began to look for ways to revise it, but throughout the next three decades, the cost of healthcare continued to rise (Fig. 2).

Problems Contributing to the Rising Costs in the US Healthcare System

Liability and Malpractice

Why have healthcare costs risen so dramatically over the past few decades? Many point fingers at costly malpractice suits and expensive liability insurance as major contributors. According to insurers, recent hikes in premiums are

Figure 2 Rise in patient cost sharing from 1977 to 1998 (modified from source [12]).

directly due to payout increases for successful malpractice plaintiffs [13]. Thus, America has been dubbed as a “nation of litigators,” and with Americans spending proportionately far more per person on the costs of litigation than any other country in the world, it is easy to see how this expression came to be. The US Department of Health and Human Services expressed that this excessive litigation, “Is a threat to healthcare quality for all Americans.” [14]. Largely, due to the excess of lawsuits against doctors and hospitals, “defensive medicine,” a costly use of unnecessary medical treatments, has been implemented by many doctors in order to avoid litigation.

Defensive medicine is a damaging and costly practice that has evolved out of the medical malpractice system in the USA. A survey conducted by the US Department of Health and Human Services found that over 76% of doctors are concerned that malpractice litigation has damaged their ability to provide quality care to patients [14]. Costs are raised and quality of care is jeopardized when doctors order unnecessary tests or procedures and avoid certain risky procedures because of concern of malpractice suits [15]. Every test, procedure, and treatment poses a certain risk, and performing these tests takes away funds that could be better used [14]. A study conducted in 2002 found that 79% of doctors said they ordered more tests than they deemed medically appropriate, and 41% said that they had prescribed more medications than they would have without the fear of legal action [14].

Litigation for malpractice suits is increasing at a rapid rate, causing an increase in malpractice insurance for physicians. A questionnaire given to board certified hand surgeons found that about 46% of hand surgeon respondents paid \$25,000 to \$50,000 for malpractice insurance in 2004 and about 16% paid \$50,001 to \$70,000 [16]. According to a questionnaire that was distributed to hand surgeons, over 92% of respondents felt that advocacy issues regarding

malpractice reform were either important or extremely important (Fig. 3). These high fees are causing many groups of surgeons and physicians to limit their practices by either avoiding patients with health conditions that would increase the perceived risk of litigation or forcing them to move to states with alternative legal systems in which insurance can be acquired at a more affordable price [14].

One way to combat the growing cost of malpractice insurance and the increasing litigation against physicians is through reform laws. These state tort reform laws are an effective way to decrease the cost and frequency of malpractice claims. In addition, tort reform laws also lower premiums and eventually reduce the practice of defensive medicine [17, 18]. These laws directly limit payments in medical malpractice cases by enacting certain caps on damages for pain and suffering, known as noneconomic damage caps [17]. Noneconomic damage caps help the states by slowing the growth in malpractice premiums and claims payments. For example, the average premium rates between 2001 and 2002 rose 10% in those states that had adopted reform laws compared to 29% in states with more limited reforms [19]. It has been found that laws directly limiting malpractice awards produced notable cutbacks in the cost of treating patients with no noticeable decline in health outcomes [20]. Additionally, it has been shown that limiting malpractice payments lowered the state healthcare expenditure between 3% and 4% [19].

Administration Costs of Healthcare

Administration costs to run the US system are the most rapidly increasing component of out national healthcare expenditures [21]. From 2000 to 2005, the number of people with private insurance fell 1%, juxtaposed to a 32% rise in employment at health insurance companies during

Hand surgeons' assessment on advocacy issues: Malpractice Reform

Figure 3 Results from a 2008 advocacy survey distributed to hand surgeons rating the importance of various advocacy issues found that a large majority of hand surgeons felt that malpractice reform was an important advocacy issue (modified from source [8]).

that same time [22]. The large amount of manpower “required” for private insurance administration is increasing the cost of healthcare. Private insurance companies’ administrative costs are above 12.8% of their total expense, whereas Medicare’s administrative costs are approximately 3% [23].

In order to cut administration costs, substantial changes to our fragmented and complex system of insurance will most likely have to occur. One way to cut administration costs, as proposed by the AMA, is through market reforms [24]. These insurance market regulations would include a guaranteed insurance renewal, as well as a modified community rating in which premium rates will only be affected by age and gender [24]. According to the AMA, these regulations would encourage people to stay with the same insurers for a longer time, leading to lower administration and premium costs [25]. A more drastic approach to reduce costs would be to switch from a pluralistic, privatized insurance system to a single payer system. In a single payer system, the payment for doctors, hospitals, and other providers of healthcare come from a single fund that is generally tax-funded [24]. In contrast to a single payer system, a pluralistic financing system has to pay to bill patients, advertise, collect on outstanding debts, determine coverage restriction and patient eligibility, all the while trying to maximize profits, and pay large executive salaries [24]. Administration cost differences in these two systems are illustrated by comparing the administration costs in Canada and the USA. Administration costs totaled \$307 per capita in the single payer system of Canada, compared to \$1,059 per capita in the USA [4] (Table 1). In theory, a single payer system would control costs by shrinking administration costs and profits that are associated with private health care firms, thus reducing overall medical care costs [26].

Table 1 Costs of healthcare administration in the USA and Canada, 1999.

Cost category	Spending per capita (US\$)	
	USA	Canada
Insurance overhead	259	47
Employee’s cost to manage health benefits	57	8
Hospital administration	315	103
Nursing home administration	62	29
Administration cost of practitioners	324	107
Healthcare administration	42	13
Total	1,059	307

Source [4]

Costs of Technology

Although numerous factors contribute to the rising costs of healthcare, there has been widespread agreement among policymakers that the manufacturing and use of new healthcare technologies (e.g., drugs, medical equipment and devices, etc.) continues to be a major contributor to the rising costs of care in the USA [27]. In 2005, the USA spent \$111 billion on health research, with the largest shares going toward the pharmaceutical industry (\$35 billion), the biotechnology industry (\$16 billion), and medical technology industry (\$10 billion) [28].

Costly advances in medical technology are not necessarily “bad” for the USA. Many advances help fuel our economy’s business growth [29] and create better quality and care for patients, even when cost is taken into account. However, new technologies are often introduced into the marketplace with little evidence about their effectiveness in comparison to already existing devices or procedures [29–31]. It has been noted that efforts in technology assessment are poorly funded and fragmented, with little cooperation or discussion between public and private sector groups to address the implications for quality of care and resource distribution [30]. This is a particular problem in orthopedic and hand surgery, because widespread adoption of the newest and most costly implants, such as plates, screws, and joint replacement implants, result in a substantial increase in overall cost associated with these procedures [31].

In order to help reduce the costs associated with technology advancements, hand surgeons and medical device companies will need to work collaboratively to look at where deficiencies in technologies exist and aim at producing new technologies that improve quality of life and functional outcomes [31]. Changes in the US healthcare policy aimed at compelling clinicians and medical device manufacturers to obtain better evidence related to the use and production of new technologies may help reduce the costs related to technology advancements [31–33].

Pharmaceutical products are also defined as “medical technology” [27] and contribute to the rising costs of healthcare. Studies have documented substantial variation in pharmaceutical prices among countries, with the USA tending to have higher prices than others nations [34]. Nations that are effective in pressuring manufacturers to reduce their prices are the ones that will pay the lowest prices. In the UK, there is an all-or-nothing deal: access to the national market at a practical price or no access at all. This pressures pharmaceutical companies to provide reasonable prices. In the USA, strategies to control drug prices must be implemented by a large number of private and public health plans, which make price control difficult [34],

and leads to a large spending differential. For example, mean monthly spending for prescription and over-the-counter medications ranged from \$8 in the UK to \$114 in the USA [35]. There has been a great deal of resistance from the medical technology industry for major overhaul reforms because their ability to set fees will be markedly curtailed under this system.

Quality Improvement Initiatives

Many strategies have been devised to help curb nationwide costs of healthcare. The quality initiatives discussed in this paper were selected because they are key initiatives proposed by the government and major payers [36–41]. They have been discussed in major publications and represent the major initiatives that are present today. Although many of these strategies, in theory, aim to reduce healthcare costs while simultaneously improving quality of care, many fall short of meeting the needs of all parties involved.

Oregon Health Plan

In 1989, the state of Oregon launched a series of reforms to expand Medicaid to a higher percentage of the population. The Oregon Health Plan (OHP) intended to make healthcare more affordable by offering a more basic, limited health plan. They planned to reach this goal through the use of a prioritized list that ranked medical conditions by seriousness and treatments based on the clinical effectiveness and the overall benefit to the patient [36]. A line would literally be drawn down the list, and all services above the line would be covered and those below would not be. Every 2 years, the Oregon state legislatures were to meet to decide the monetary amount that was to be allotted for the healthcare plan.

The incipient performance of the OHP was relatively positive. From 1993 to 1998, the OHP extended Medicaid to nearly 100,000 new recipients per month, thus reducing Oregon's uninsured from 18% in 1992 to 11% in 1998 [37]. However, no new funds were appropriated for the OHP coverage, so the state had to reduce the services of the already existing enrollees in order to expand their coverage to more uninsured people. Due to the lack of funding, premiums and copayments rapidly increased while services and treatments steadily decreased. A high unemployment rate (7.4%) in 2001–2003 reduced state revenues and further decreased funding to the OHP. By the year 2006, the OHP not only covered fewer services than traditional Medicare but also fewer people [37].

Pay-for-Performance

Another method that has recently been implemented into many medical institutions is the pay-for-performance model. This model awards providers (i.e., hospitals, medical groups, and/or physicians depending on the program) that score high in quality care with monetary bonuses and penalizes low-scoring providers by deducting a portion of their reimbursement [38].

Although this model was met with initial enthusiasm, the pay-for-performance model has been the subject of substantial criticism. Opponents for this program argue that although it was originally designed to improve quality of care, providers that cater mainly to underserved and low-income populations (i.e., safety-net hospitals) may be at risk of adversely affecting their finances and reputations, which in turn would cause a decrease in quality of care because these hospitals may not be able to afford to make suggested improvements. Pay-for-performance program may result in exacerbating disparities in the healthcare system, where rich providers become richer and poor providers become poorer. A recent study conducted by Werner et al. [39] sought to examine the disparities in quality of care between safety-net and nonsafety-net hospitals using data that included almost all US hospitals and to determine how the pay-for-performance system affects the performance of hospitals that serve a substantial percentage of Medicaid patients [39]. This study found that from the time pay-for-performance program was initiated in 2004 until the final data collection in 2006, hospitals with low percentages of Medicaid patients improved their performance significantly more than those with a high percentage of Medicaid patients. They also found that over time, safety-net hospitals had a lower probability of high performance status and would be more likely to incur financial penalties [39].

It is expected that all specialties will be judged on some form of quality improvement programs, particularly pay-for-performance programs; however, high quality research regarding pay-for-performance program is scarce in the field of hand surgery. Future efforts should involve collaboration among the medical community to ensure that pay-for-performance programs are implemented safely and effectively into the field of hand surgery.

Current Quality Improvement Initiatives

Leapfrog

In November 2000, a group composed of 160 private and public sector employers bought benefits for more than 34

million Americans, forming the Leapfrog (LF) initiative [40]. Their main goal was to identify practices, or leaps, that when implemented would theoretically result in healthcare that was of better quality and more cost-efficient. Some of the leaps that they wanted to introduce in the area of patient safety included computerized physician order entry, ICU physician staffing, and a program that referred patients to hospitals based on volume threshold and process standards [42]. As the initiative grew, LF launched its regional rollout effort in 2001, in which healthcare purchasers worked together regionally to encourage hospital survey responses and improvements. One of the key objectives of this effort was to encourage hospitals to publicly report progress on patient safety goals. Monetary rewards were given based on quality and efficiency. The program rewarded both excellence and improvement on evidence-based measures [43].

LF has made notable progress since its foundation in 2000. Before LF was initiated, the release of performance measures to the public was controversial and highly debated; however, now, public release of information is almost universally accepted [40]. This is beneficial because some quality experts believe that this act of publicly releasing data alone may increase quality [44]. Another quality improvement LF implemented into the healthcare industry was computerized physician order entry system (CPOE), which was originally slow to rise, but has increasingly become more prevalent.

Computerized Physician Order Entry

CPOE is a quality improvement concept that has recently emerged into the mainstream. The central idea underlying CPOE is that once patients' charts and orders are computerized, human error will be considerably reduced. To err is human, but in a hospital environment, even minor errors can result in major damages. A recent study indicated that at least 44,000 people, to as many as 98,000 people, die each year from preventable medical errors [45]. Reducing these errors would result in lower costs, better quality of care, lower mortality, and diminished rates of injury. A study conducted by Bates et al. [41] showed that after implementing CPOE, the rate of nonintercepted serious medical errors fell by 55%. Another study examining CPOE showed that the use of computerized orders was connected to a 66% overall decline in total prescribing orders in adults.

The CPOE model clearly has many benefits, but there are some drawbacks associated with this model as well. One major issue is the initial cost associated with CPOE. CPOE is expensive to implement due to technical costs, costs of process redesign, and cost of implementation and

support. However, CPOE has also been shown to be very cost effective over time, in addition to increasing quality of care [46]. Bates et al. estimated that the costs for implementing and maintaining the CPOE system at their hospital would result in a net savings between \$5 and \$10 million per year [41].

NSQIP

In the past, researchers have generally focused on outcomes in the surgical disciplines. These outcomes are oftentimes costly to assess and may be elusive for certain procedures and conditions. As a result, some programs are being initiated to improve surgical outcomes measures. One such program is the Veterans Administration (VA) National Surgical Quality Improvement Program (NSQIP). This program was created to help automate, facilitate, and standardize data on surgical morbidity and mortality. The NSQIP's philosophy is not to single out underperforming surgeons or programs but rather provide high quality, reliable data to improve the overall performance of the VA hospital system [47]. NSQIP supplies continuous feedback regarding major operations in nine surgical specialties. This feedback involves both rankings and outcomes to allow individual VA hospitals to monitor its own quality [47]. The main outcomes measured by NSQIP are the 30-day morbidity and mortality [48]. The NSQIP has proved effective in improving performance on surgical outcome measures, with approximately a 30% decrease in 30-day mortality in the Department of Veterans Affairs [47]. The NSQIP provides medical centers with reliable data and confidence to make necessary changes in intensive quality improvement efforts [47].

Although this model seems promising, there are some drawbacks. One potential problem is that this type of model can be expensive and complicated to setup. There needs to be an infrastructure in place for data collection that may be difficult and costly to implement. Also, every site needs to have at least one data abstractor and high-level officials need to meet regularly to discuss improvements and results, which may be expensive and cumbersome to coordinate.

The future of hand surgery in the ever-changing landscape of healthcare reform has not been adequately researched. Several surgical societies are participating in the quality improvement movement; however, current surgical quality programs, such as the NSQIP, give little helpful feedback to hand surgeons. These programs mainly measure mortality and morbidity, and because the mortality rate in hand surgery is low, these outcome measures do little to affect the practice of hand surgery. Therefore, the pursuit of quality measurements specific to hand surgery is of the utmost importance.

Future of the US Healthcare

With so much media attention on the current distress of our system, many quality initiatives have formed in order to make a more cost-effective and safer clinical setting. These quality improvements are important; however, most do not address the biggest problem in America's healthcare system, the immense inequality of care in our current system. In fact, the USA is the only industrialized country in the world that does not assure healthcare for all of its citizens [49]. As a result, approximately 16% of Americans did not have insurance in 2006, and millions more were significantly underinsured [50]. Former Surgeon General C. Everett Koop stated in a recent interview that, "As an American, we do not have the right to healthcare granted by the Constitution or Bill of Rights, but I do believe that we have the moral right to care." [51]. Hand surgeons also seem to agree that the lack of access to care for everyone is a problem. A recent survey distributed to hand surgeons found that 448 out of 637 hand surgeons felt that advocating access to care for patients is an important issue (Fig. 4). A nation with as much wealth as the USA should be able to provide all of its citizens with sufficient health care.

Policymakers have proposed several different ways to extend health coverage for all Americans. One way would be through incremental expansion of existing public sector programs [24]. This strategy would extend Medicaid, Medicare, and/or State Children's Health Insurance Program

until universal coverage is achieved. In principle, only a few expansions would be needed to achieve universal coverage [24]. After this is achieved, there are a couple possible scenarios for the future. In the first, the private insurance industry would be demoted and eventually removed, allowing public programs to expand and merge, effectively creating a single payer system in which the government is responsible for healthcare distribution [24]. In a single payer system, everyone would have the same healthcare benefits and services and someone could not pay for extra insurance. The second scenario would involve keeping the private insurance companies partially in place and allowing people the option to purchase private insurance on top of the universal, public insurance [24]. This situation would create a two-tier system, which would allow people to purchase services beyond the first tier. The existence of the upper tier would be conditional on the existence and maintenance of a first-tier core benefits package that guarantees adequate care for all Americans [52].

However, when evaluating the results of the Oregon Health Plan, it is obvious that trying to provide healthcare insurance for everyone can be a challenging financial undertaking. In order to create a sustainable program of universal coverage, there would have to be trade-offs between funding for healthcare and funding for education, homeland security, defense, and food and housing assistance [52]. Other changes to reduce healthcare spending will also be necessary. A reduction in unnecessary medical procedures and tests will help reduce the cost of healthcare [15]. In order to realize this, state tort reform laws that cap malpractice litigations should be implemented in all states [19]. Additionally, quality improvement programs should be continuously tested and implemented into healthcare systems. Programs and technology that do not show evidence of quality improvement need to be considered carefully.

Implications for Hand Surgery

The practice of hand surgery will be affected if the USA enacts many of the current healthcare reform proposals. If the USA tries to expand coverage to all of its citizens by rationing services, considerable changes in the types of patients and procedures performed may result. For example, when Oregon attempted to expand coverage to all its residents with the OHP, several procedures involving hand surgery fell below the line on the priority list. The current list [53] has a funding level that covers services appearing on lines numbered 1–503 out of the 680 lines. Treatments for disorders that hand surgeons may encounter, such as circumscribed scleroderma (line 525), synovitis and tenosynovitis (542), keloid scars (623), and ganglion cysts

Hand surgeons' assesment on the importance of advocacy issues:

Figure 4 Results from a 2008 survey distributed to hand surgeons rating the importance of various advocacy issues found that the majority of hand surgeon respondents felt that access to care for patients was an important advocacy issue (modified from source [8]).

(614), all fell below the coverage line. However, diagnoses that are fairly commonplace for hand surgeons to treat, such as crush injuries to extremities (143), open fractures and dislocation of extremity (144), trauma amputation of the arm/hand/thumb/finger (166), closed fractures of extremities (379), rheumatoid arthritis needing arthroplasty or reconstruction (381), malunion and nonunion fractures (461), osteoarthritis and allied disorders (481), and brachial plexus lesions (484) were covered.

Because the majority of hand surgery is nonemergent, if the USA eventually moved to a single payer system, it is conceivable that surgical scheduling would be shifted greatly with longer wait times for hand surgery patients. In Canada and the UK, wait times for elective surgery are significantly longer than wait times in the USA, with 14% of patients seeking elective surgery in Canada and 15% of patients in the UK waiting over 6 months for surgery [54]. However, data are limited that indicate whether long wait times deter patients from choosing elective surgery, but the British Society for Surgery of the Hand annual report states that between 1990 and 2000, referrals for elective hand surgery increased by 36% [55].

Our current healthcare system is straining the practice of hand surgery. Many traumatic hand injuries enter the hospital through the emergency room (ER); however, there has been a decline in specialists covering surgical emergency care and, in particular, in plastic and orthopedic surgery. The forces that contribute to this decline are shortages in the surgical workforce, physician reimbursement decline, increasing fears of malpractice litigation, a growing uninsured population, and an increase in emergency room patients [56]. The Institute of Medicine and the American College of Surgeons have both expressed deep concern for these undesired shortages in surgical emergency care, specifically the shortage of hand surgeons willing to take on hand trauma patients [57, 58]. The decreasing number of surgeons, together with the increasing amount of uninsured patients using the ER, has caused a decline in facility collection rate, and although it is still financially beneficial for a hospital to care for patients with traumatic hand injuries, this status is increasingly strained [56].

Hand surgery is in a unique position to participate in the various quality initiatives being proposed because of the rich and productive interest in measuring outcomes, and these experiences can be most helpful in constructing meaningful quality measures that are pertinent to this specialty [32]. The quality movement is real and with the potential move toward universal coverage in the US healthcare, various programs will be implemented to track performances of various specialties. The participation of hand surgery with national surgical organizations will assure that the position of hand surgery in the national

healthcare debate can be heard in an effort to provide constructive input to improve the care for patients with hand conditions. Participating in the national debate will assure that hand surgery will be “at the table” when these quality initiatives are implemented to assure the merits used for measurements are scientifically sound. It is an opportunity that should not be ignored.

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