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Where Americans Get Acute Care: Increasingly, It's Not At Their Doctor's Office

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ABSTRACT Historically, general practitioners provided first-contact care in the United States. Today, however, only 42 percent of the 354 million annual visits for acute care—treatment for newly arising health problems—are made to patients' personal physicians. The rest are made to emergency departments (28 percent), specialists (20 percent), or outpatient departments (7 percent). Although fewer than 5 percent of doctors are emergency physicians, they handle a quarter of all acute care encounters and more than half of such visits by the uninsured. Health reform provisions in the Patient Protection and Affordable Care Act that advance patient-centered medical homes and accountable care organizations are intended to improve access to acute care. The challenge for reform will be to succeed in the current, complex acute care landscape.

Analysts predict that the Patient Protection and Affordable Care Act will extend coverage to thirty-two million Americans who currently lack health insurance, mainly through health insurance exchanges offering broader access to private insurance products and the expansion of Medicaid. The health reform law will also boost funding for primary care, promote patient-centered medical homes, and encourage the formation of accountable care organizations.¹

Timely access to care is important, especially for those who are acutely ill.² First-contact care (referred to here as acute care) has been a central tenet of primary care.³ But over the past few decades, the focus of primary care has shifted as a result of an aging population, the growing burden of chronic disease, and the challenge of coordinating care across multiple physicians. Low rates of reimbursement have accelerated this trend by forcing many primary care physicians to pack their daily schedules with fifteen-minute office visits, leaving little time for patients with acute health problems.^{4–6}

It is generally acknowledged that the delivery of acute care—treatment for newly arising health problems—has changed dramatically in recent decades. But modern patterns of acute care have not been analyzed. In this paper we combine data from three federal surveys to determine where, when, and why Americans seek treatment for acute health problems. The data reveal that a large and growing share of acute care visits now take place in hospital emergency departments and other non-primary care settings. In fact, fewer than half of acute care visits today are managed by a patient's personal physician. This is the landscape that national health reform aims to alter.

Study Data And Methods

DATA SOURCES Each year, the Ambulatory and Hospital Care Statistics Branch of the National Center for Health Statistics conducts three surveys of ambulatory care delivery in the United States: the National Ambulatory Medical Care Survey (NAMCS) of office visits; the National Hospital Ambulatory Medical Care Survey

(NHAMCS) outpatient department subsample; and the NHAMCS emergency department subsample.⁷ All three are stratified, multistage probability samples of outpatient encounters in the United States. Each assigns a weight to sampled observations to generate nationally representative estimates. We used the statistical package Stata, version 11, survey commands, to account for the complex sampling methodology.

To create samples of sufficient size capable of generating specialty-specific estimates, we aggregated all surveys available for public use from 1997 to the present. However, most of our analyses required the “initial visit” identifier, which limited us to 2001–4, the only years when all three surveys included this item. This restricted time period produced 387,746 records for analysis.

We used the coding conventions of the Ambulatory and Hospital Care Statistics Branch to classify variables. For example, we classified patients with multiple payers according to the following hierarchy: Medicaid/Children’s Health Insurance Program (CHIP), Medicare, private insurance, worker’s compensation, self-pay, no charge, and other. We combined “self-pay” and “no charge” records into a single “no insurance” category. We grouped “worker’s compensation” with “other.”

NAMCS clusters physician specialties into three groups—primary care, medical specialty, and surgical specialty. However, our analysis used four groups: general/family practice, general internal medicine, general pediatrics, and all non-primary care, office-based subspecialties. This enabled us to make comparisons between pediatric and adult-oriented primary care practices, specialist practices, hospital outpatient departments, and hospital emergency departments.

We drew estimates of workforce size from an analysis of the American Medical Association Physician Masterfile published by the Health Resources and Services Administration.⁸

IDENTIFYING ACUTE CARE VISITS If the “major reason for this visit” was “acute” or “chronic disease flare-up” (in NAMCS or in the outpatient department subsample of NHAMCS), or if “episode of care” was “initial” (in NAMCS or either of the two subsamples of NHAMCS), we considered the visit to be for acute care. The combination of variables defining “acute care” was missing in a proportion of records, ranging from 6.2 percent to 8.9 percent by specialty. Missing records were excluded from the analysis.

We assumed that all emergency department visits were acute, although they were not necessarily initial visits for an acute health condition. We also assumed that no emergency medicine

physician served as a patient’s personal physician. Although we would have preferred to include as acute care visits only those that were “self-referred,” we found that the variable specifying referral source was missing among visits to specialists too frequently (15 percent), and we excluded it except where specified.

CHARACTERIZING USE We used the primary reason-for-visit codes on the surveys to identify the ten most common problems managed by each type of practice.⁹ To maintain groups of sufficient size, we collapsed the hierarchically arranged five-digit codes into four digits. We further aggregated four-digit codes related to the upper respiratory and digestive tract into a single category that we called “upper respiratory complaints.” It includes reason-for-visit codes 1440 (cough), 1455 (throat problem), 1355 (earache), 1400 (nasal congestion), 1445 (head cold), and 1410 (sinus problem). We aggregated codes 5205–5230 into another single category called “laceration.”

We coded office and hospital outpatient visits on Saturdays or Sundays as “weekend visits,” along with emergency department visits occurring between midnight Friday and midnight Sunday. Because the surveys do not record time of arrival for visits to physicians’ offices or hospital outpatient departments, we chose an arbitrary threshold range of 8 a.m. to 5 p.m. on weekdays to create an operational definition of “arrival during office hours” for emergency department patients. This definition is inaccurate to the extent that emergency department arrivals during this interval overlap with those that began in the evening hours and that office practices see patients who arrive outside these hours.

LIMITATIONS The surveys consider certain encounters—such as visits to retail clinics, urgent care centers, military facilities, and institutional or industrial clinics—to be beyond their scope. However, the surveys we analyzed do not exclude ambulatory visits by institutionalized and homeless people, migrant workers, and undocumented immigrants. These populations are not captured by population-based household surveys but may be heavy users of ambulatory care. The National Center for Health Statistics, and thus our analysis, does not count physician contacts provided over the telephone or the Internet—a growing form of medical encounter that could displace some traditional ambulatory visits.

Because the surveys are based on visits rather than population, they capture details that household surveys underreport, such as the frequency, dates, and location of encounters; and poorly remembered complaints and interventions. However, visit-based surveys such as the ones

we used tend to oversample patients who are frequent users of health care services. Although some experts believe that emergency departments are being overused, studies show that frequent users of emergency departments are more likely than other patients to have one or more serious chronic illnesses, to have an established primary care provider, and to make frequent office visits as well.¹⁰

Study Results

Between 2001 and 2004, Americans made an average of 1.09 billion outpatient visits per year to physicians. That amounts to a rate of 321 visits per 1,000 people per month. Slightly more than a third of all encounters—354 million per year—were for acute care (Exhibit 1).¹¹

Twenty-two percent of acute care visits were managed by general/family practitioners, 10 percent by general internists, 13 percent by general pediatricians, 20 percent by non-primary care office-based subspecialists, 7 percent by hospital outpatient departments, and 28 percent by hospital emergency departments. When an acute care visit occurred in a primary care practice, the patient saw his or her personal physician 83–90 percent of the time. However, because

most acute care visits took place in non-primary care settings, only 42 percent of all such visits involved a patient's personal physician.¹¹

VISITS BY TYPE OF PRACTICE Exhibit 2 shows the distribution of acuity of visits by detailed specialty subgroups. After emergency departments, general and family practice providers saw the largest number of acute care visits annually. Exhibit 3 shows that although emergency departments handled 11 percent of all ambulatory visits, they accounted for only 4 percent of the physician workforce. In contrast, medical specialists accounted for 60 percent of the workforce but only 43 percent of ambulatory visits. This exhibit also shows the disproportionate share of uninsured patients handled in emergency departments compared to other care sites.

REASONS FOR VISIT Exhibit 4 depicts the ten most frequent acute care problems managed by emergency departments, general or family practices, and non-primary care specialty practices (additional results for other types of practices are available in Appendix Exhibit 4).¹¹ Stomach and abdominal pain, chest pain, and fever dominated the "top 10" list in emergency departments. Cough, throat symptoms, skin rash, and earache were the most frequent acute care problems in general and family practices, with

EXHIBIT 1

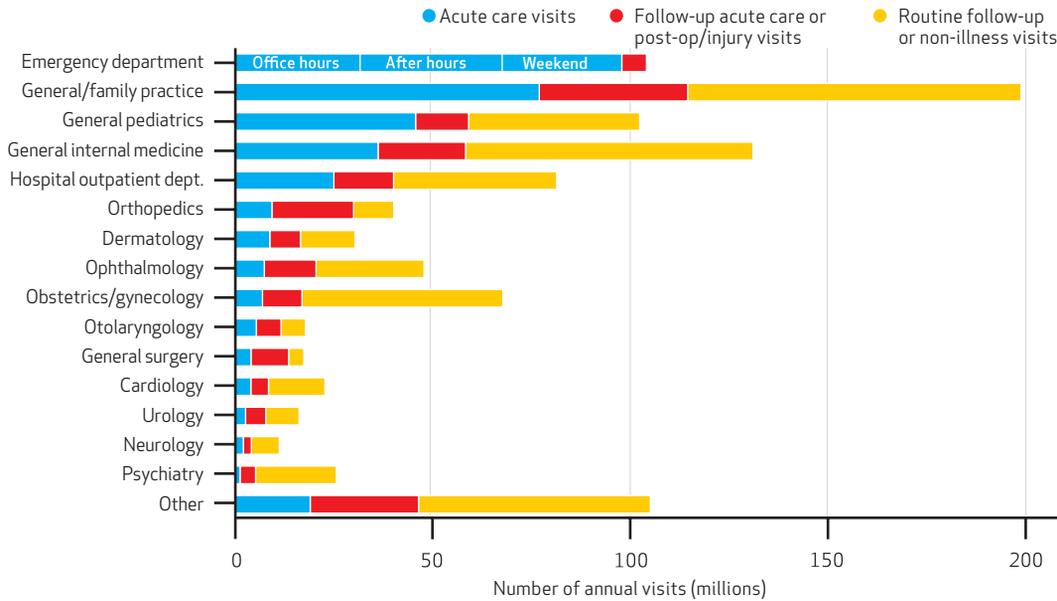
Ambulatory Visits By Setting, Millions Of Visits Annually, 2001–2004

Type of visit/source of payment	Survey						Total ^a
	NHAMCS-ED	NAMCS			NHAMCS-OPD		
	Emergency department	General or family practice	General internal medicine	General pediatrics	All other specialties	Hospital outpatient department	
ALL VISITS							
Total	104.1	198.8	131.1	102.4	402.9	81.4	1,020.7
Routine follow-up or non-illness visits	0.0	84.3	72.7	43.3	221.0	41.3	462.5
Follow-up acute visits or postoperative/injury visits	6.2	37.5	22.1	13.4	110.2	15.1	204.5
Acute care visits	97.9	77.0	36.2	45.7	71.8	25.1	353.7
ACUTE CARE VISITS							
To primary care physician	0.0	62.7	28.4	39.8	6.3	9.7	146.9
EXPECTED SOURCE OF PAYMENT							
Private insurance	37.7	51.0	22.0	32.6	43.8	11.8	198.9
Medicare	14.9	10.2	8.6	0.4	15.9	2.5	52.5
Medicaid/CHIP	20.0	6.9	2.2 ^b	9.9	4.0	6.1	49.1
No insurance	15.4	4.8	1.4 ^b	1.2	3.1	2.7	28.6
Other	4.3	2.0 ^b	1.0 ^b	— ^c	2.8	1.0	11.9

SOURCE Authors' analysis of data from the National Ambulatory Medical Care Survey (NAMCS) and the National Hospital Ambulatory Medical Care Survey (NHAMCS). **NOTES** Exhibit has been abridged because of space constraints. A more complete version of this exhibit, including row and column percentages, is available online as Appendix Exhibit 1 (click the Appendix Exhibits link in the box to the right of the article online). Standard errors are less than 15 percent of the estimate except as noted. NHAMCS-ED is National Hospital Ambulatory Medical Care Survey emergency department subsample. NHAMCS-OPD is National Hospital Ambulatory Medical Care Survey outpatient department subsample. CHIP is Children's Health Insurance Program. ^aTotal excludes records with missing values for acute care status (6.7 percent of the weighted total). ^bStandard error is 15–30 percent of estimate. ^cFigure is not reliable (standard error is greater than 30 percent of estimate).

EXHIBIT 2

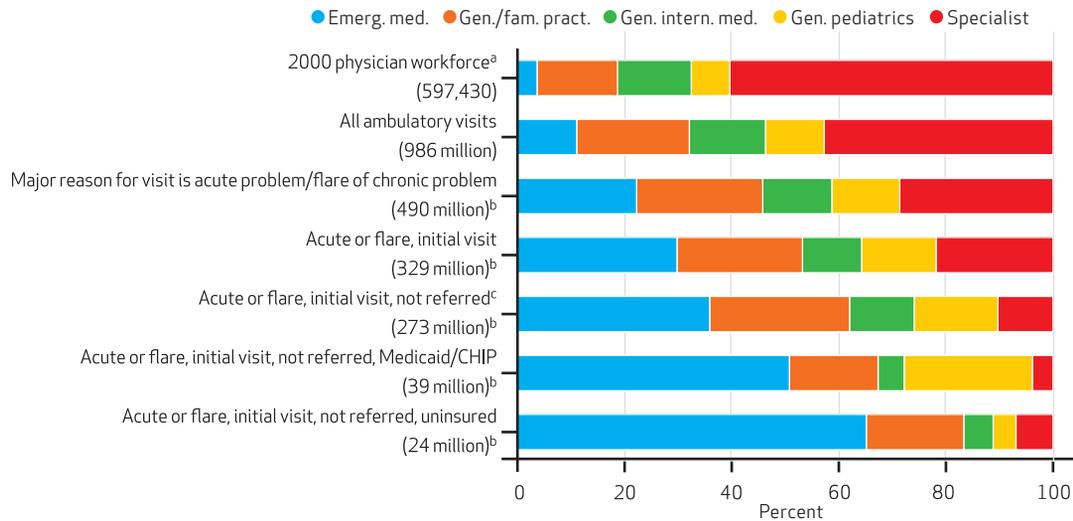
Average Number Of Ambulatory Visits Annually, Millions, By Setting, Sorted By Frequency Of Acute Care Visits, 2001-4



SOURCE Authors' analysis of data from the National Ambulatory Medical Care Survey and the National Hospital Ambulatory Medical Care Survey. **NOTES** All standard errors are less than 15 percent of the estimate. Weekend visits accounted for only 11 percent of hospital outpatient department acute care visits and less than 5 percent of acute care visits to all other sites, so they are not shown.

EXHIBIT 3

Percentage Distribution Of Physician Specialties (2000), Average Annual Visit Frequency, And Other Visit Characteristics, 2001-4



SOURCE Authors' analysis of data from the National Ambulatory Medical Care Survey and the National Hospital Ambulatory Medical Care Survey. **NOTES** Total visit counts are in parentheses. Because physicians in outpatient departments represent a wide range of specialties and are not separately identified in the American Medical Association Physician Masterfile (see Note 8 in text), we excluded outpatient department visits—7 percent of the unweighted total—from the workforce activity comparison that we present here. ^a Includes all clinically active physicians with either M.D. or D.O. degrees (see Note 8 in text). ^b Excludes outpatient department visits. ^c "Referred" status was missing in 15 percent of specialist visits.

EXHIBIT 4

Ten Most Frequent Complaints In Acute Care Visits, By Setting, 2001-4

Setting of care/complaint	Percent (standard error)
Emergency department total	33.6 (0.6)
Stomach and abdominal pain	6.6
Chest pain and related symptoms	5.3
Fever	4.6
Cough	2.9
Headache, pain in head	2.7
Shortness of breath	2.5
Back symptoms	2.4
Vomiting	2.2
Symptoms referable to throat	2.2
Pain, nonspecific	2.1
General/family practice total	37.0 (0.9)
Cough	8.0
Symptoms referable to throat	6.6
Skin rash	3.1
Earache or ear infection	3.1
Head cold, upper respiratory infection	2.9
Stomach and abdominal pain	2.9
Sinus problems	2.7
Nasal congestion	2.6
Back symptoms	2.5
Fever	2.5
Non-primary care specialty total	23.5 (0.7)
Vision dysfunctions	4.0
Knee symptoms	3.4
Stomach and abdominal pain	2.6
Hand and finger symptoms	2.4
Skin rash	2.3
Shoulder symptoms	1.9
Counseling, NOS	1.8
Discoloration or pigmentation	1.7
Abnormal sensations of the eye	1.7
Cough	1.6

SOURCE Authors' analysis of data from the National Ambulatory Medical Care Survey and the National Hospital Ambulatory Medical Care Survey. **NOTES** Subtotals might not add up to totals because of rounding. NOS is not otherwise specified.

EXHIBIT 5

Average Annual Frequency Of Acute Care Visits For Selected Primary Patient Complaints, Millions And Percentage Distribution, By Setting, 2001-4

	Emergency department	General or family practice	General internal medicine	General pediatrics	All other specialties	Hospital outpatient department	Total
All acute care visits	97.9 (27.7%)	77 (21.8%)	36.2 (10.2%)	45.7 (12.9%)	71.8 (20.3%)	25.1 (7.1%)	353.7 (100%)
Upper respiratory complaint ^a	8.1 (12.3%)	20 (30.3%)	8.6 (13%)	18.9 (28.6%)	4.2 (6.4%)	6.2 (9.4%)	66.0 (100%)
Headache	2.7 (34.8%)	1.8 (24.1%)	0.9 (12.1%)	0.8 (10.1%)	0.9 (11.5%)	0.6 (7.4%)	7.6 (100%)
Any injury	35.9 (45.7%)	14 (17.8%)	5.3 (6.7%)	5.2 (6.6%)	13.4 (17%)	4.8 (6.1%)	78.6 (100%)
Abdominal pain	6.5 (48.1%)	2.2 (16.5%)	1.2 (9.1%)	0.9 (7.1%)	1.9 (14%)	0.7 (5.3%)	13.4 (100%)
Dyspnea	4.2 (55.7%)	0.8 (10.7%)	0.5 (6.4%)	0.5 (6.6%)	1.2 (16.5%)	0.3 (4.2%)	7.5 (100%)
Chest pain	5.2 (57.8%)	1.3 (14.8%)	0.8 (8.8%)	— ^b	1.1 (12.7%)	0.4 (4%)	9.0 (100%)
Laceration ^a	4.5 (75.2%)	— ^b	— ^b	— ^b	— ^b	— ^b	6.0 (100%)

SOURCE Authors' analysis of data from the National Ambulatory Medical Care Survey and the National Hospital Ambulatory Medical Care Survey. **NOTE** Subtotals might not add up to totals because of rounding. ^aSee the Study Data and Methods section in text for reason-for-visit code range. ^bFigure not reliable (standard error greater than 30 percent of estimate).

upper respiratory complaints being a major theme among primary care providers generally and in hospital outpatient departments. Non-primary care specialists focused on problems in their respective areas of expertise (dermatologists managed skin problems, ophthalmologists treated eye problems, and so on).

Three-fourths of patients with acute upper respiratory complaints received care in a primary care practice or hospital outpatient department. Conversely, more than half of chest pain patients were treated in an emergency department. Lacerations were almost exclusively treated in emergency departments (Exhibit 5).

TIME AND DAY OF CARE Our analysis showed that more than 95 percent of acute care visits to office-based primary care providers and subspecialists occurred on weekdays, as did 89 percent of acute care visits to hospital outpatient departments. In contrast, two-thirds of acute care visits to emergency departments took place on weekends (30 percent) or on a weekday after office hours (37 percent—see Methods for definition of office hours).

PAYER MIX The payer mix varied by setting. General pediatricians and general or family practitioners saw the highest proportions of privately insured patients. General internists and non-primary care subspecialists were the most likely to treat Medicare beneficiaries. Pediatricians and emergency departments were the most likely to treat Medicaid patients, and hospital outpatient and emergency departments were the most likely to treat uninsured patients.

In fact, although emergency departments managed only 19 percent of acute care visits by privately insured patients—compared to 28 per-

cent of patients overall—more acute care visits by the uninsured took place in emergency departments than all other sites of care combined (Exhibit 3).

Policy Implications

A half-century ago, general practitioners were the main providers of acute care, backed by what were then considered the “specialties” of internal medicine and pediatrics. In their landmark 1961 study, Kerr White and colleagues calculated that adult Americans at the time made 250 “illness visits” per 1,000 adults per month.¹² The study did not explicitly define an *illness visit*, so this total may have included some physical examinations and routine prenatal visits.

Modern primary care differs markedly from primary care in White and colleagues’ era. According to our figures, ambulatory visits have risen to 336 visits per 1,000 adults per month, two-thirds of which are for nonacute care such as prenatal checks, physical exams, management of chronic disease, and specialist consultations. Apparently, primary care physicians provide much less acute care than in the past.

Discussion And Conclusion

TIMELY ACCESS TO CARE One of the biggest barriers to acute care in primary care practice is many office-based practitioners’ busy schedules. This makes “same-day scheduling” and other efforts to ensure access extremely difficult.¹³ Busy schedules also discourage primary care physicians from taking extra time to treat patients with complex undifferentiated complaints; they often opt instead to refer such patients to specialists or emergency departments.^{6,14} Finally, hectic schedules reduce the likelihood that physicians will see additional patients after hours. One survey reported that 87 percent of primary care practitioners in the United Kingdom and 95 percent in the Netherlands manage patients after hours without referring them to emergency departments. In the United States, only 40 percent of primary care practitioners see patients after hours.¹⁵

Ensuring timely access to primary care is a desirable policy goal. Timely access increases a person’s likelihood of seeking primary care, as well as receiving ongoing care from that provider.¹⁶ Unfortunately, Americans’ access to primary care is in decline. A recent Commonwealth Fund study of trends in health care delivery gave the United States low marks for access to care across several dimensions. The study also noted that the percentage of Americans who visited emergency departments with ailments that

could have been treated by regular doctors was more than three times that of people in Germany and the Netherlands, the best-performing countries in the study.¹⁷ In 2009 the Medicare Payment Advisory Commission (MedPAC) reported that 28 percent of Medicare beneficiaries—and a similar percentage of a privately insured control group—had difficulty finding a primary care provider.¹⁸

Many patients have adapted by seeking care elsewhere. Our data indicate that more than half of acute visits today involve a doctor other than the patient’s personal physician. More than a quarter of all acute care visits—including virtually all weekend and “after hours” encounters—occur in hospital emergency departments.

Heavy use of emergency departments for problems that a primary care provider could treat is not desirable from a societal perspective. Too often, emergency care is disconnected from patients’ ongoing health care needs. Lack of shared health information promotes duplicative testing, hinders follow-up, and increases the risk of medical errors. Although emergency department crowding is largely caused by other factors, a packed waiting room complicates efforts to treat every patient in an appropriate time frame.^{19–21}

THE PATIENT-CENTERED MEDICAL HOME During the debate over health reform, supporters argued that the new law would reduce emergency department visits by strengthening primary care and encouraging the development of patient-centered medical homes.²² Many countries belonging to the Organization for Economic Cooperation and Development already provide incentives to their primary care physicians to offer after-hours care and set clear expectations for performance.^{15,23,24} In these countries, general practitioners take turns handling after-hours problems. Some have created cooperatives to offer after-hours care.²⁵ In addition to improving access to primary care, measures such as these enable emergency departments to focus on more serious cases.²⁶

Although provisions of the Patient Protection and Affordable Care Act should prompt a substantial scaling up of the medical home model, it is unlikely that some of the results achieved in other countries will materialize in the short term in the United States. When the Centers for Medicare and Medicaid Services (CMS) first began funding medical home demonstration projects—well before the new health reform law was enacted—it required the projects to adhere to National Committee for Quality Assurance (NCQA) criteria.²⁷ But the committee set a low bar for access, as follows: A grantee only had to have “written standards for patient access and

patient communication” and “data to show it meets its standards for patient access and communication.” Same-day scheduling was encouraged but not required. Medical homes did not have to offer evening or weekend availability, and urgent telephone calls could be returned in whatever time frame a practice deemed appropriate.²⁶

If ensuring timely access was not important to becoming a medical home then, it is unlikely to be important now. Additional incentives may be needed.²⁸

Workforce shortages represent another obstacle to expanding access to primary care. Today’s primary care physicians are hard pressed to meet existing levels of demand, much less the pent-up needs of the estimated thirty-two million Americans who will soon acquire health insurance.

A promising feature of the health reform law is the addition of 15,000 new providers to federally qualified community health centers, which were not separately identified in the ambulatory care surveys until 2006. These centers tend to serve the uninsured and those in Medicare, Medicaid, and CHIP. The expansion of the centers has the potential to reduce low-acuity emergency department visits, given the centers’ explicit mission to manage the care of people with acute medical problems.²⁹

Enhanced rates of reimbursement—another feature of the Affordable Care Act—may also spur some practitioners to expand access and may attract more medical students to primary care. But the pipeline will take years, if not decades, to catch up.

Entrenched practice patterns constitute still another obstacle to access to timely acute care. Many primary care physicians have come to regard unscheduled visits as a time-consuming disruption to their workday.⁶ If a patient has a complicated problem, legal liability is an added concern. It is much easier to refer such patients to a specialist or nearby emergency department.³⁰ Some policy makers believe that primary care must be fundamentally redesigned to overcome these obstacles.³¹ The transformation won’t be easy.

ACCOUNTABLE CARE ORGANIZATIONS The health reform law also seeks to foster accountable care organizations—integrated or virtually integrated delivery systems that will provide care for a defined population in a range of settings, linked by health information technology. In theory, this should improve access to acute care without sacrificing continuity and coordination of care, including follow-up care.³² Properly executed, accountable care organizations will integrate specialist expertise with the continuity

It is not clear how the Affordable Care Act will influence access to acute care in the years to come.

and coordination of primary care.

Skeptics question how quickly accountable care organizations will emerge in many parts of the country. Some doubt whether they will have the desired impact on costs and patient satisfaction.^{33,34} The details of how they will link competing physician practices and hospitals into cooperative networks are still being sorted out.

MARKET-BASED APPROACHES If health reform fails to achieve its promise of expanded access to care, market forces may drive other solutions. Concierge care, in which subscribers pay an annual fee for the services of a physician, is growing in popularity. One of the signature features of concierge practice is access. Not only do concierge physicians accommodate same-day scheduling, but most make house calls.³⁵ Unfortunately, the price of concierge care puts it out of reach for most Americans.

Retail clinics and urgent care centers are other market-based approaches.³⁶ Preliminary evidence suggests that retail clinics can efficiently manage certain commonplace concerns. One study noted that ten clinical problems—including sinusitis and routine immunizations—make up 90 percent of retail clinic visits, 30 percent of pediatric primary care doctor visits, 13 percent of adult primary care doctor visits, and 13 percent of emergency department visits.³⁷

But retail clinics and urgent care centers are not a panacea for access. Despite moves by retail clinic chains such as MinuteClinic to expand heavily into chronic disease care and management, critics assert that the clinics are poorly suited to manage the chronic and acute conditions typically seen in primary care practices, much less in emergency departments.³⁸ Others worry that retail clinics actually increase costs through induced demand.³⁹

Unless they are electronically linked to local hospitals and primary care practices, retail clinics and urgent care centers are likely to further fragment the delivery of health care. And because they treat only paying patients, they could de-

stabilize local health care markets by drawing revenue-generating patients away from private doctors' offices and emergency departments, leaving the uninsured behind.⁴⁰ This could worsen the financial climate for hospitals, much as specialty hospitals have done.⁴¹

Given these conflicting trends, it is not clear how the Affordable Care Act will influence access to acute care in the years to come. If it strengthens primary care, emergency department visits for "primary care treatable" and "primary care preventable" conditions should decline.⁴²⁻⁴⁴ The same effects should be observed if accountable care organizations provide weekend and after-hours care and facilitate short-term follow-up after emergency department visits. When emergency physicians can confidently arrange follow-up care, they feel less compelled to hospitalize medically fragile patients.⁴⁵ These effects, if realized, should translate into lower health care costs.

But if history is any guide, things might not go as planned. If primary care capacity lags behind rising demand, patients will seek care elsewhere. If reimbursement rates are too low to interest

office-based physicians in treating patients with public insurance, such patients may have no choice but to head to the nearest emergency department. Massachusetts offers a cautionary lesson. There, expansion of coverage was not matched by growth in primary care capacity. As a result, visits to emergency departments increased.⁴⁶

CONCLUSION In *Crossing the Quality Chasm*, the Institute of Medicine declared that health care should be "safe, effective, patient-centered, timely, efficient, and equitable."⁴⁷ Considerable attention has been focused on five of these attributes, but the sixth—timeliness—has been given short shrift.¹⁹

Our analysis indicates that Americans make more than 350 million visits to health care providers per year for acute care. Fewer than half involve the patient's personal physician. The Patient Protection and Affordable Care Act includes several provisions intended to expand access to primary care. One way to evaluate whether these provisions succeed is to monitor where, when, and why Americans seek care for acute health problems. It's about time someone did. ■

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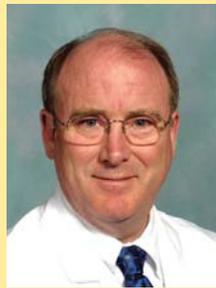
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As physicians, the authors brought direct experience—in many instances, from the emergency department—to their analysis of the changing nature of acute care in the United States. Although the numbers of people who turn to emergency departments for acute care initially surprised them, Pitts said that after twenty-seven years of practice, he has realized that increasingly patients regard hospital emergency and trauma centers “as an acceptable, or even the proper, place to go when you get sick.”

The authors doubt whether the trend will change, and not only because of the shortage of primary care doctors. “I think these modes of practice are here to stay, given the dependence of modern medical decision making on complex diagnostic equipment,” which tends to be found in hospitals, Pitts said.