



# The price of certainty: is reliable access the key to containing costs?

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If you are anything like us, car maintenance is a world that is difficult to navigate. Our relatives, friends and user manuals tell us to get the oil changed every 3–5 thousand miles, and we do our best to listen in order to have our vehicles safely operate as long as possible. However, about once every 6–12 months, a check engine light comes on. The light could be as simple as we forgot to get our oil changed, or as serious as a blown piston. When that light turns on, there is a difficult decision to make. Do we seek maintenance at the dealership where the vehicle may still be under warranty knowing they can handle any problem which has arisen but will inevitably be more expensive if not covered, or do we take it to a local service station where service will be cheaper, but they may or may not be able to handle the issue and we end up going to the dealership anyway? Either way, we know we need to be at work tomorrow.

Unlike vehicle maintenance, access to acute healthcare does not feel like it should be monetized, which makes it a highly controversial issue. In this issue of CJEM, Orkin et al. [1] and Marx et al. [2] do a nice job providing and highlighting evidence on the cost implications of receiving care for low acuity ambulatory conditions in the emergency department (ED) versus the outpatient setting.

Orkin et al. systematically review the literature on the cost of low acuity care in the ED compared to the outpatient setting. The authors point out that though there appears to be consensus that emergency department care is more expensive than urgent care or primary care, the published literature is actually quite sparse and should be interpreted with caution. The authors found only one study that met SIGN methodology checklist standards for health economics studies [3] that focused on the cost of care. They also

appropriately point out that most literature reports charges, which are not necessarily a reliable marker for cost. The authors define cost as expenses incurred by a medical facility (during a patient encounter) which can include material goods, staffing and leasing.

Marx et al. provide new evidence on health care costs through a two-center study of one ED and one Urgent Care clinic in Canada. The authors conducted a retrospective analysis of the costs of healthcare delivery for a grouping of respiratory diagnoses (URI, Pneumonia, COPD and Asthma). They use a previously described Time Driven Acuity Based Costing method (TDABC) analysis tool [4] to quantify costs over the continuum of the acute illness. Not surprisingly, the costs of care for patients who initially presented to an ED were higher than those who presented to an Urgent Care, though interestingly the bounce back rate was higher in the initial ED population. We would also be remiss if we did not highlight the inverse relationship between the provision of antibiotic prescriptions and bounce back rates.

It is undeniable that the cost of healthcare is increasing at an unsustainable pace. Facility fees for emergency department visits for commercially insured patients in the U.S. have potentially increased as much as 531% between 2004 and 2021 [5]. While this reflects charges and not costs, it is also an indicator in the U.S. that the economic pressures from a privatized, insurance-based payment system are likely driving the maximization of revenue from commercial payors to subsidize others who do not cover the total cost of healthcare delivery.

While Orkin et al. provide an excellent review of the lack of available literature on the costs of non-acute ambulatory care by setting, we must respectfully suggest that Marx et al.'s use of the TDABC supports the common sense understanding that the high overhead, highly regulated, resource-intensive emergency department setting will have a higher unit price than a more streamlined, resource-lean ambulatory outpatient setting such as urgent or primary care.

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It is our opinion that the overall cost of care for these patients is the result of the larger issue of access. Patients are going to seek care in the setting in which they know they will be able to receive adequate care in a time-frame that fits their lives. Policies such as the Emergency Medical Treatment and Labor Act (EMTALA) in the U.S. ensure that patients have 24-h access to care regardless of insurance status or ability to pay. However, EMTALA only covers Emergency Departments which are highly regulated, expensive to staff 24 h a day, 365 days a year, and require substantial diagnostic and referral resources compared to other ambulatory settings, leading to higher associated costs to cover per visit. Primary Care providers may have wait times of several days to months for appointments or only accept certain insurance coverage plans. Urgent Care clinics may have substantial up-front fees for patients who are under or uninsured and provide services during limited hours.

Therefore, patients with uncertainty around access to care and the scope of services potentially required to meet their healthcare needs will continue to gravitate towards certainty of timely care in emergency departments, which will contribute to higher charges to compensate. Without a single payor system or universal access to healthcare regardless of setting, it will be difficult to influence patients' decisions on where to obtain care for their low acuity conditions.

In other words, until we know we can go to our local service station without adding additional cost or being told to go to the dealership anyway, we will be taking our cars to the dealership to make sure we are on time for our shift tomorrow.

**Data availability** Data sharing is not applicable to this editorial and no data were created nor analyzed.

## Declarations

**Conflict of interest** The authors have no conflicts of interest to disclose.

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