

Opinion

The Boomers Are Coming: Will We Be Ready?

After World War II, there was a baby boom in the United States. As those babies reached their prime work years starting in the mid-1980s, we experienced an economic boom. Now those same people are poised to develop medical conditions that will have the effect of a sonic boom on health care delivery systems, including eye care. Consider the numbers. Using 2000 as a base year, there will be 20 percent more people over 65 in 2010, and nearly double the number by 2030, fully 70 million Medicare beneficiaries. That number will be even larger if life expectancy continues to increase. Population-based eye studies such as the Baltimore Eye Survey and the Beaver Dam Eye Study show the eye diseases we deal with most—cataract, glaucoma, macular degeneration, diabetic retinopathy—all become more prevalent exponentially with age.

Now let's look at the supply side. We've had a 15 percent increase in ophthalmologists over the past decade. Our residency programs have had no appreciable increases in graduates, and don't seem likely to churn out more into the future. Currently, there is one ophthalmologist for every 16,000 people, a number that has been remarkably stable for the last 15 years. In that same period, we've become better at treating many diseases, like diabetes and macular degeneration, so those 16,000 people seek eye care in your office more than they used to. As a profession, we've been able to handle

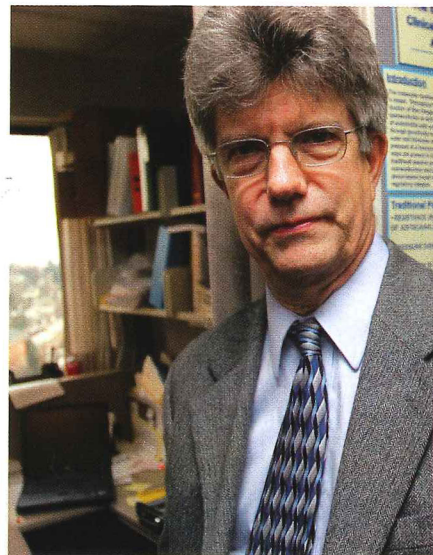
this volume by increasing efficiency.

I can't help recalling eye care workforce debates of the past. Some experts predicted a surplus of ophthalmologists, and others a shortfall. Mostly, it depended on what model of eye care was assumed to be dominant, and the degree to which optometrists provided primary eye care. But when the calculations extend further out, to the boomer years, it's clear that most models predict a shortfall. Recently, the Academy's ad hoc Task Force on Eye Care Delivery reported that there was no basis on which to recommend one ideal model of eye care to the membership. Local issues and practitioner preferences make it impossible to advocate a "one size fits all" practice structure. What the Academy must do, they said, is alert members to the trends and provide them with tools to prepare for the predicted onslaught of patient volume, expecting ophthalmologists to adapt without jeopardizing quality, as they have in the past.

What are the costs of not being ready? Demand will outpace capacity. Persistent unfilled demand leads to unhappy patients and societal and political pressure to increase capacity to meet the demand. Since training more ophthalmologists would take too long, alternative providers would be allowed to fill the void, to the detriment of quality patient care. There is another option. If we ophthalmologists understand the need to increase throughput, we can begin to make changes in our own prac-

tices. Some of us will increase technical staff; others will hire optometrists; still others will institute efficiencies in the processing of patients within the office. Whatever solution is most comfortable, it's important for you to know how your practice measures up against your peers. To this end the Academy will debut a benchmarking database at the AAOE Resource Center (Booth #1431) during the 2006 Joint Meeting in Las Vegas that will, later in 2007, be useful in comparing your office to your peers' practices.

The main thing at this stage is to recognize we have a problem looming in the near future. If we can solve it effectively, this Opinion will be a harbinger of boom rather than doom for eye care.



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