

Academic Affairs

Another Perfect Storm



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In *The Perfect Storm*, Sebastian Junger described the ultimate effects of the catastrophic combination of North Atlantic storms. His recounting the storms' effect on the lives of the crew aboard the *Andrea Gail*, is similar to what we in the academic medical centers are sensing, as a combination of potentially catastrophic events are brewing in the academic health care waters. What are these events? How can we prevent the floundering of our academic medical centers?

STORM # 1: MEDICARE LEGISLATION

The 2002 Congress failed to enact Medicare legislation that would alter the current provider payment schedules. In effect, this means the Center for Medicare and Medicaid Services' CMS prior miscalculations of the Medicare payment schedule for physicians, hospitals, and health plans will maintain an improper fee schedule. Not only were the 2002 schedules too low, they are being lowered further in 2003. The House of Representatives actually passed legislation before the Fall elections that would have created a "payback" primarily to physicians, hospitals and health plans. However, the Senate was unable to act, partly because of mixed messages received from the White House. As a result of this action

(or inaction), the paybacks will not occur and the reimbursement rates have been lowered further (e.g., the physician reimbursement averages 15%). This has occurred despite almost heroic efforts by professional organizations and health care political action groups. As a result of this, payments for services provided to the Medicare population are inadequate and will severely affect the ability of providers to maintain fiscal health while caring for this population.

STORM # 2: THE 80 HOUR WORK WEEK FOR HOUSE STAFF

We certainly recognize the priority to provide a healthy learning environment, while organizing and providing quality, safe health care for our patients. However, the rigid regulations that have been enacted by the ACGME (The Accreditation Council for Graduate Medical Education) will certainly challenge us to be able to continue to provide quality training in the environment described above. It is recognized that house staff need to be viewed as students, not low cost (sometimes slave-like) laborers. The new work guidelines that go into effect July 1st that limit the number of hours the house staff can work in a week, as well as in successive days, are necessitating a total change in the organization of post-doctoral training. There will no doubt be additional expenses borne by the academic medical centers to achieve these goals. It also will limit the contact hours house staff will have with patients. This will interfere with the continuity of patient care, as well as the exposure of house staff to the learning environment, particularly for surgical house staff who need to have a great deal of hands-on experience.

STORM # 3: MALPRACTICE CRISIS

Fortunately, our institution resides in a state where significant tort reform was enacted years ago. This definitely places us in a better category than the majority of the United States, including our colleagues close by in the State of Mississippi. Even so, our malpractice rates will be rising approximately 20% in 2003. This increase is not only for our staff physicians, but our physician trainees as well. This is additional expense that will not assure the improvement of quality care. It will not improve the access to care. It is the result of a failure to improve a medical/legal system.

STORM # 4: REDUCED INDIRECT MEDICAL EDUCATION PAYMENTS

Along with the miscalculations by CMS in regards to Medicare reimbursement, the Balanced Budget Act of 1996 in combination with subsequent legislation has put into place a continued roll back of Indirect Medical Education payments to academic medical centers. This is a 16% decrease, which for our institution is about \$2 million. These payments are intended to cover the extra costs that academic medical centers incur by their very existence. That is, the fact that by having training programs and cutting edge technology, it is well recognized that the sicker more complicated patients go to these institutions. Additionally, in order to provide a training environment, the academic medical centers will incur additional costs compared to nonacademic provider organizations. Although many academic medical centers, including our own, have made great strides in reducing cost over the last decades, the increasing cost of technology and the ever increasing acuity of patients still means that the cost of care of these types of patients frequently exceeds the DRG payment scheme. As a result, at a time when the legitimate cost for acutely ill patients is increasing, another form of reimbursement is decreasing.

STORM #5 THE UNINSURED

By the best estimates, approximately 41 million are uninsured people in the United States. These are individuals with absolutely no health care coverage. This is greater than the entire combined populations of Canada and Australia. By all estimates, this number will continue to grow. Where do these patients receive their health care? They frequently receive care on an acute basis in the emergency rooms primarily in academic medical centers that are more likely to be located in an urban environment. It is not unusual for the larger academic medical centers to provide upwards of \$100 million of uncompensated medical care.

CONCLUSION

These storms are on our radar screens. We have a rough idea of where they are headed. How can we avoid them or diminish the effects of the storms that we will not be able to avoid? The effects of these storms will be caused by the diminishing reimbursement in the light of increasing costs. This is our “Perfect Storm.”

It is imperative that we become efficient organizations. We need to have defined strategic plans and the discipline to set priorities. No longer can we be all things to all of our constituents. The priorities must reflect who we are and what our goals are. We need to establish clarity of direction. As academic medical centers we must be able to maintain those qualities that separate us from the community hospitals. We need to provide quality health care in an environment of education and intellectual pursuit (research).

We must continue to educate the public and the payors to the value of academic medical centers both for the current and future health care. We must continue to improve efficiencies so that the costs are not exaggerated and that we do not use the excuse “we are academic medical centers” to rationalize higher costs.

We must work with our local and national governmental representatives in order that they maintain this priority in perspective. We cannot allow the high quality health care and academic activities of our academic medical centers to be “legislated away.”

We have quite a challenge ahead of us, but fortunately we are not on the *Andrea Gail*. ❁