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Editorial Opinion

The shrinking role of academic health centers in health care reform

One striking thing absent from the debate on health care reform is the role of academic health centers in this discussion. This is surprising, or is it, as one considers the role of the academic health center and the goals of health care reform.

The need for health care reform

I admit my list may be incomplete and my understanding of health care reform may be flawed, but I believe the need for health care reform is based on the following issues.

Universal coverage

We should attempt to achieve universal coverage regardless of socioeconomic status.

Controlling costs or at least decreasing the rate of health care cost growth

Can growth cost control be achieved in a country where we perceive that everything bigger is better and therefore more expensive and more technically advanced but not necessarily better? It is not clear to me how we can achieve this goal.

Improved quality of care

An important constituent of health care reform is increasing the quality of care and changing the perception that the health care system as it currently exists is substantially and disproportionally expensive yet does not always deliver first-class care.

Decrease the disparity of health care based on economic circumstances

Although many academic medical centers have become the place where indigent individuals go for care of last resort, this inevitability was not welcomed. However, academic centers do see the potential use of these patients in the education of future medical practitioners.

Improved outcomes

Health care has become excessively expensive, however, more expensive health care does not necessarily result in better outcomes.

Improve communications among the various services in academic health care

Assuming electronic forms of records improve communication, although this is by no means assured, it would be helpful if academic health centers as well as large and small hospitals had electronic records that could talk to one another. It generally is assumed that electronic records save money; I am not certain this is the case. Recent data appear to come to the same conclusion. Furthermore, correcting electronic records is difficult and one wonders whether the corrections are actually made. The electronic transmission of patient history and laboratory values overall works pretty well; however, it is extraordinarily difficult to download radiology text and figures and potentially very expensive in the instances in which it can virtually destroy and disable computers.

Allegedly, $30 billion has been set aside for electronic medical records; however, nowhere in the specifications for electronic medical records has it been stipulated that electronic medical record formats must be universally compatible. This is an egregious oversight. At the present time, every hospital and health-related system adopts whatever

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format that suits their purpose and budget and often one cannot obtain the necessary information because of transmission and compatibility issues.

Employer-funded health care

Health care reform has not dealt appropriately with the question consistently raised by companies, "Why should health care be paid by employers?" A point made by various large companies is that there is no intrinsic reason why this should be a benefit. This is a valid question. Employer-sponsored coverage came about by accident after World War II with the return of 28 million service men and women and the elimination of war-related jobs. At that time, everyone wanted a car. To meet consumer demand for new cars the automobile industry needed to attract workers in an economy abundant with available jobs. President Truman placed a freeze on wages, which prevented automakers from attracting employees with higher wages. Automobile manufacturers came up with a plan to attract potential employees by offering health care benefits as an employment incentive. At the present time, most companies do not see this as essential to recruit employees, and most companies do not philosophically believe this is their responsibility.

Despite the 26% increase in family premiums over the past decade, separate surveys by McKinsey & Company and the National Business Group on Health predict that over the next 5 years, 40 million employees may lose their employment-sponsored health insurance. The same surveys report that these companies will be offering high-deductible insurance; 45% are offering a high deductible as well as standard insurance and 20% are offering only high-deductible insurance.[1–3] In the Midwest, the average deductible is currently $2,800 per individual and $6,800 per family, and it is increasing rapidly.

Advanced payment for surgical procedures

A new aspect of surgery has crept in whereby patients are forced to pay up to 30% upfront in cash. Many families do not have the wherewithal to find the money to pay for the surgery to begin with and so usurious companies have sprung up offering to lend the money and, as such, demand 10% a month interest if one pays off what has been advanced. To me this represents a breakdown of our social contract. Physicians should not have any ownership or involvement in such vicious practices.

Loss of coverage

The number of patients without insurance will increase dramatically. When employees lose their health insurance they will have to pay cash. The costs of fairly straightforward surgeries in large hospitals will bankrupt patients and their families. For example, although the actual cost of a laparoscopic cholecystectomy is between $1,500 and $3,500 (depending on how you calculate it), many large hospitals charge patients without insurance $19,000. Medical bills are the largest source of bankruptcy for families, especially middle-class families; this will not improve and blame will be placed on physicians.

Health insurance savings

The physician should be the patient's advocate. Unfortunately, we cannot provide 100% patient advocacy because we find ourselves at the mercy of 2 forces: the hospitals where we work and health insurance companies. Both of these entities have profited dramatically and are paying exorbitant salaries to executives. Hospitals pay excessive salaries to administrators and insurance companies also compensate their executives exorbitantly. Salaries of $10 million paid to administrators managing small groups of 5 hospitals is not unusual, and salaries of health insurance executives seems to start in the range of $10 million and goes up from there. I believe it is wrong to make massive amounts of money based on the ills of others, but this appears to be the current trend. One Chief Executive Officer, a physician of a major health insurance company, amassed a $2 billion fortune while in office. Most of these profits were the result of the increased value of the stock granted. Eventually, it was determined that the stock options were postdated and the CEO returned $600 million.

Approximately 18 months ago at a White House meeting, insurance companies promised savings of $2 trillion over the next decade. To those individuals who have worked with them and the physicians who deal with them on a daily basis, this remarkable offer left most of us incredulous. Not for long. The next week these same insurance companies revised their estimate downward between $1.1 and $1.7 trillion. I doubt even this estimate has any relationship to reality as to what they actually intend to do.

Academic health centers are not concerned with most of the earlier-referenced issues

There are a few exceptions, such as controlling the rate of growth of health care costs. Although they give lip-service to universal coverage, they devote little time and effort to its study, or improving the quality of health care.

Another exception is the absence of any significant role of academic medical centers in discussions concerning health care reform. One would think that given the self-proclaimed importance of academic health centers in the training of health care professionals and the care of patients, the academic health centers would be in the thick of the discussion concerning health care reform and patient advocacy. Unless I am missing something, their silence is deafening, but there are some notable exceptions. Occasionally, one hears of an initiative, usually funded by a wealthy and grateful patient, for the improvement of patient care. The institution may attach the name of the donor to a new

program for the improvement of patient care, but it is usually in the guise of some form of outcomes research.

Why? Research in an academic medical center is the coin of the realm. When members of the Association of American Medical Colleges and the Council of Deans meet, research ranking of the academic health centers is paramount. Research ranking in the form of money received is tangible or at least can be measured; patient care is more difficult to measure. However, the most successful academic health centers are those that are profitable and attract patients at the same time, such as the Mayo Clinic, which may not accept insurance payments for their care. Others such as the Cleveland Clinic, Johns Hopkins, and Massachusetts General Hospital accept insurance and collect philanthropic donations from wealthy patients and make up the rest for their growth and funding of new research from large endowments.

These institutions are the exceptions rather than the rule. The emphasis on research is paramount and the means to attain this goal occupies the thought process of deans and hospital administrators.

The emphasis on research has profound implications. National Institutes of Health (NIH) grants and grants from other entities are grants in aid. A grant in aid means that the grant is not expected to cover the entire cost of the research; theoretically, the institution must come up with the difference between the money received from the NIH and the actual cost of the research. NIH grants only partially support the investigators as evidenced by the cap on salaries that may be assigned to investigators receiving an NIH grant. There is also a great deal of expenditure on the part of academic medical centers to recruit and support investigators who are believed to be more likely to succeed and subsequently to establish well-known research programs. Research programs are rarely fully funded, at least at the outset, and therefore initial funding of these individuals is required, perhaps partially for the entirety of their careers. Many of these research programs may have some tenuous relationship with human disease but it is usually very basic science-oriented. Thus, we have a series of incubators for investigators who are thought to have the talent to establish their own research programs but whose relevance to human disease is often somewhat distant. Their basic science may be excellent science, but whether or not it ever results in the improvement of patient disease is tenuous in most cases.

To a considerable extent these incubation periods are funded by clinical practice in the academic institution. The funding of these incubators significantly and negatively affects the other needs of the academic medical centers, such as (1) single-occupancy, commodious, and attractive patient rooms and (2) adequate operating rooms. This necessitates a program to reduce surgical site infections and, for example, perform all the suggestions recently published by Alexander et al in a recent *Annals of Surgery* review[4]: "unnecessary surgical site infection is probably the most expensive hospital expenditure and the principal expensive complication in most surgical procedures." Operating rooms that are sterilized appropriately and with all the necessary initiatives to reduce surgical site infections are vital. In addition, if the institution is performing complicated tertiary and even quaternary surgery, adequate-sized operating rooms with sufficient equipment are important for positive surgical outcomes. Maintaining operating suites is expensive and if the bulk of surplus hospital funds are being spent on supporting promising investigators, it is often the Department of Surgery and all the other Divisions of Surgery that are forced to perform these procedures in inadequate operating rooms.

Another need that goes unaddressed when the atmosphere for expenditures becomes guarded, are adequate call rooms, libraries and teaching facilities for the care and education of residents.

Patient care. Patients believe that the academic medical center is the best equipped with cutting-edge equipment as well as being staffed by the best doctors. The reality is that the equipment in most academic medical centers is reasonable but not outstanding and they do not keep up with the cutting-edge equipment that large private hospitals may have. Patients believe that the best physicians are at the academic medical centers and that they will be cared for by those physicians. This may or may not be the case depending on the various systems for patient care in certain departments in these centers**.**

Who in academic medical centers actually sees patients? One would hope that in these centers, which patients come to for what they perceive to be the best care, the best and most experienced physicians will care for patients. This is usually not the case initially. The teaching model is that the least experienced (the third-year medical student) sees the patient initially and provides the most contact with the patient. Unfortunately, gone are the Saturday morning teaching rounds where such giants as George Thorne (Chief of Medicine) and Francis D. Moore (the iconic Chair of Surgery) at the Peter Brent Brigham and Women's showed their formidable clinical skills to the entire medical school class.

After an extensive history is taken by the medical student the patient then is seen by the intern or resident, or perhaps a fellow in that particular specialty (who writes another, often verbose, history), and eventually the patient will see the attending physician. In most academic medical centers the attending physician is primarily a researcher performing their 1 out of 12 month service. You will have a difficult time convincing me that a clinician who spends only 1 month a year in close contact with patients has retained the necessary clinical skills to provide excellent patient care. Instead, the attending primarily cares for the patient by obtaining multiple consults.

Most busy surgeons in academic medical centers have read many records but I am not convinced that having the history repeated from the one originally obtained by the medical student actually yields a more intelligent history or

a history that is more focused on the patient's actual disease. Also, at morning report the Chair (or whoever is presiding) reviews the report but may not see or examine the patient.

To be fair, there are many priorities other than patient care such as research, multiple divisions, and other responsibilities that ultimately interfere with the focus on patient care.

Graduate Medical Education supplementation. I have heard a number of senior surgical colleagues calling for the restoration of Graduate Medical Education (GME) funding, and reverse what the national administration really intends to do, which is to cut GME dollars in academic medical centers. It is true that GME supports some of the surgical residents and interns but the lion's share of GME goes to support the salaries of the enormous numbers of nonsurgical residents and fellows, ACGME and non-ACGME approved. Taking a contrarian view, I do not think that senior surgeons in this country should defend by word or deed full GME funding to academic medical centers. Part of what we are supposed to do is promote good patient care, but most often the surgical department is the primary patient advocate. Having junior staff keep the patient away from a highly skilled attending is not in the best interest of the patient. Obviously, someone in the national administration has broken the code and feels likewise. The surgical community should not defend the $9 billion that currently is expended, which in my view does not really result in excellent patient care, which should be and is the primary goal of an academic medical center.

Conclusions

The academic medical center is not central in the debate concerning health care reform but rather appears to be peripheral to the stated goals of the community at large, including this national executive branch, industry, and those insurance companies interested in improving the care of the population as a whole. Whether we like it or not, most academic health centers pay lip-service to improving patient care but it nonetheless is not a principal concern as they are currently structured. They are structured to promote research. The public is somewhat enamored by the concept of research but what really concerns them is excellent care. Yes, it is true that it would be nice if the enormous amount of money, perhaps as much as $83 billion, expended in the United States in medically related research yielded breakthroughs and wondrous results in the care of patients; however, this probably is not often the case. My own prejudice is that the $83 billion expended actually buys very little in the form of direct and enhanced patient care. It is true that some of the genetic research has on occasion been instrumental in improving patient care such as the discovery of the breast cancer gene and the proliferation of anticancer drugs yielding longer survival, but the latter is funded largely by industry. I wonder how an audit of such a large expenditure on research would fair. My opinion is that a look at that expenditure would result in a response such as, "is this all we've got?" As a surgeon I am certain I would be shouted down in any meeting in which I presented this particular point of view but $83 billion is a lot of money. Although the academic medical center advertises that they are a 3-legged stool—patient care, research, and teaching—patient care is the short leg of the tripartite stool. It does not appear to be a priority of most academic health centers in this country and therefore the participation of these health centers and those institutions that represent them in this debate seem to be conspicuous by its absence. This is particularly unfortunate because decisions will be made in this debate that will determine the course of health care in this country for some time.

The purpose of this article has been to clarify some little publicized practices and let surgical leadership of all such groups know better where they stand, and should stand, on these issues.

Exceptional patient care is front and center; what we as surgeons are about and we should take advantage of it.

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