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Academic Health Centers:
The Making of a Crisis and Potential Remedies
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Academic health centers (AHCs) play a major role in advancing medical progress in the U.S. These institutions educate students, nurses, and allied health personnel who are required for the country’s health system workforce. They provide a training ground for the next generation of physicians who will care for our citizens and the physician–scientists and clinical investigators who will fuel the country’s research enterprise—currently the most productive in the world. From the AHCs’ basic and clinical laboratories come the discoveries that translate into new diagnostic technologies, pharmaceuticals, and devices. New treatment regimens are tested in multicenter clinical trials at many of our AHCs. The economic well-being of the communities in which AHCs reside is dependent on the financial viability of these institutions. Biotechnology companies are spawned from AHCs, contributing to the national economy.

From the 1970s to the early 1990s, AHCs enjoyed almost unlimited resources, and their bottom lines always showed profits. Health care was dominated by a fee-for-service environment that allowed a flow of clinical income in AHCs, yielding overages for departments and the subsidization of medical education and research. More recently, however, there has been a reversal of these good times for academic medicine.

For the past three years, many AHCs have experienced severe financial stresses resulting in falling operating margins or losses that have prompted major cuts in spending and strategies to enhance revenue streams. According to Ralph Muller, chief executive officer of the University of Chicago Hospital and Health System, the average operating margin at the nation’s 125 AHCs fell to 2% at the end of 1999, with 35% of them operating in the red (1). According to Mr. Muller, Moody’s Investors Service downgraded the bonds of AHCs five times more often than it upgraded them. Margins at AHCs are expected to dip below 1% in 2002.

THE BALANCED BUDGET ACT OF 1997: THE CRISIS BEGINS

The major contributing factor to the financial crises at AHCs was congressional passage of the Balanced Budget Act (BBA, the Act) of 1997 (2). According to an in-depth analysis of the BBA as it was originally passed, and projections made by the Association of American Medical Colleges (AAMC), Medicare payments emanating from the Act, compared with estimates of how much Medicare would have paid had the Act not been passed, would result in a cumulative loss of $45.8 million in Medicare support for a typical major teaching hospital by 2002. Furthermore, the AAMC estimated that the cumulative BBA-associated losses for the 265 major teaching hospitals analyzed would be $14.7 billion. These Medicare reductions would lower the median total margin for AAMC members by more than 50% (to 1%) by 2002, and 38% of the 100 major teaching hospitals would face negative total margins (operating losses) over the five-year enactment of the BBA. (The 1997 BBA, as originally passed, would have cut hospital payments by $227 billion between 1998 and 2004, which is almost twice the amount intended [1]).

OTHER FACTORS LEADING TO THE CRISIS

Other factors contributing to the financial crisis in AHCs include:

- Ratcheting down of reimbursements from managed care companies;
- Delays in payments of bills by health maintenance organizations (HMOs), as many of them have experienced their own financial problems; they are not only slow to pay but are also increasingly denying payments for services rendered;
- A marked rise in the costs of drugs and labor; in 1998, prescription drug expenditures increased 15% compared with 5% for physician services and 3% for hospital care;
- Large deficits incurred by primary care physicians or networks whose practices were purchased by AHCs;
- Acquisitions of regional community hospitals to capture market share that subsequently proved to be unprofitable;
- Mergers of major AHCs that actually increased, rather than reduced, total administrative costs;
- An increased number of uninsured patients;
- A disproportionate number of very sick patients who incur high hospital costs;
- An inability to constrain expenditures;
- Ineffective and inefficient governance with excessive administrative costs and failure to reduce overall costs;
- Establishment of university hospital–owned HMOs that
were inappropriately managed and consequently developed large operating deficits; and
- The high cost of new technology (e.g., stents, rotobladers, glycoprotein protein IIb/IIIa platelet antagonists) that is under-reimbursed because of fixed case rates.

**VICTIMS OF THE CRISIS**

Some of our most prestigious academic institutions have experienced major operating losses, and in some cases the results have been graphic. For example, the University of Pennsylvania had $198 million in operating losses in FY 1998, which increased slightly to approximately $200 million in 1999. According to Borzo (1), the University of California–San Francisco (UCSF) lost $50 million in the 10 months after its merger with Stanford University unraveled. Ohio State University lost $35 million in 1999 (1). From 1997 to 1999, Wayne State University lost nearly $200 million (3). University of Connecticut Dean Peter Deckers estimated that its 204-bed teaching hospital lost $16 million in 1999. The University of Texas–Houston Medical Center projected a $20 million loss this year (4).

Even the major teaching hospitals in Boston were not immune to the effects of the BBA and the other variables resulting in a diminishing bottom line. Jeffrey Otten, president of Brigham and Women’s Hospital, was quoted in The New York Times (5), stating, “Most of the hospitals are losing money at a rate between a half-million and a million dollars a week.” Beth Israel–Deaconess Medical Center lost $16 million in just the first three months of 1999, even though most of the hospital beds were filled. This loss prompted the elimination of 80 management positions at that hospital, thinning out the management ranks by 23.5% (6). A subsequent report indicated that the Beth Israel–Deaconess Medical Center planned to reduce its payroll by $20 million, in part by laying off several hundred employees (7). This action was prompted by a $73 million total loss in 1999. The following month, the hospital system laid off more than 100 additional administrators and other staff in an attempt to recover from these fiscal losses (8).

In New York, Medicare cuts were predicted to cost the state’s hospitals $5 billion through 2002, forcing the closure of money-losing departments and whole hospitals (5). According to a report in the Times (9), it was projected that New York Presbyterian Hospital would lose about $320 million, more money than any other American hospital over the course of the BBA. The hospital’s chief executive officer asked every department to cut spending by 5%.

**MEASURES TO CURTAIL FINANCIAL LOSSES**

Layoffs to reduce hospital budgets were not the only measure taken by AHCs to counteract the staggering losses incurred from 1997 to 1999. Cost reductions were instituted in a number of areas. Decreasing the length of hospital stay (LOS) was one of the first actions taken by both AHCs and nonacademic institutions to reduce costs. This effort did improve the financial performance of hospitals. In fact, cutting the LOS was a particularly noteworthy achievement in cardiovascular care, where the LOS for patients undergoing coronary artery bypass surgery fell significantly. The LOS reduction seemed to have reached a plateau in 1999, and now there is evidence that it is increasing slightly. At the University of Virginia Hospital, the LOS bottomed out at 5.2 days last year and is now 5.3 days. Thus, despite the savings experienced by LOS reduction, it alone was not enough to stop the downward spiral in financial performance. Another approach to improving the bottom line was more standardization of care, whereby savings are realized in the purchasing of hospital supplies and commodities. Companies like Novations and Premier have emerged to serve as purchasing agents for a number of hospitals. Bulk purchasing gives them the power to bargain for lower supply costs. Similarly, overseeing drug utilization and contracting with companies that can purchase drugs at lower prices for a consortium of hospitals, rather than individual hospitals, can reduce costs.

Many AHCs signed unfavorable contracts with HMOs that, in some instances, resulted in a loss for every covered patient treated. Evidence suggests that physicians and hospitals are rejecting or deciding not to renew managed care contracts that propose rates considerably below regional market rates and that would result in a loss for each patient served. Some of these contracts have required acceptance of fees considerably below Medicare reimbursement rates for the same services. In a recent publication, the American College of Cardiology (ACC) noted that there are situations in which “walking away from bad business is good business” and managed care contracts should be terminated (10).

Academic health centers are also at an increased risk for adverse selection in a managed care system because, as mentioned previously, academic managed care organizations are selected by a large percentage of the sickest patients (11). Illustrating this likelihood are Tennessee’s academic managed care organizations, which enrolled only 4.5% of the TennCare population in the statewide Medicaid managed care program but cared for 38% of Tennessee’s AIDS patients (11).

Academic health centers are often plagued by inefficient administrative functions, a fact that has prompted some to note that, in the face of such peril, teaching hospitals must run their operations like businesses. “The survival of academic cardiology is dependent on the operation of the entity as a business,” noted Drs. Kenneth Lee Baughman and Michael H. Crawford in 1998, when they co-chaired the ACC’s Thirtieth Bethesda Conference, which brought together cardiologists and others from around the country to examine the future of academic cardiology (12). This observation is true now more than ever. For starters, AHCs must reduce their cost/case ratio without sacrificing quality. They must also establish computerized information systems that enhance efficiency, streamline administrative functions,
and improve oversight in clinical decision making and medical management to reduce excess utilization of expensive technology and costly drugs, which are often used outside of practice guidelines.

In the meantime, AHCs are divesting themselves of poorly performing primary care practices and ancillary hospitals that are losing money. Some AHCs have even sold their university hospitals to for-profit entities. For example, Georgetown University, which lost $57 million in 1997, $62 million in 1998, and $83 million in 1999, sold its hospital to improve its bottom line and save its teaching institution (13). Facing tremendous operating losses, the University of Minnesota sold its hospital to the private Fairview Health Systems (13). In some instances, a sale like this one has a happy ending. Two years after the St. Louis University Hospital was sold to Tenet, the university faculty are providing new services, medical school faculty continue to be the hospital’s sole staff, and the university employs the residents at the hospital (13).

FEDERAL GOVERNMENT PROVIDES SOME RELIEF

In the years after the BBA was passed, the federal government realized that the Act was having far worse effects on AHCs than had been originally assumed. In 1999, as a result of lobbying efforts by the AAMC and the American Hospital Association, Congress passed a bill that provides $7 billion in “give-backs” to hospitals to compensate for the severe Medicare cuts they suffered under the BBA of 1997. The AAMC has estimated that, for the typical teaching hospital, the Balanced Budget Refinement Act (or “give-back” bill) will result in a Medicare payment increase of 6%. This year, the AAMC is fighting to freeze indirect medical education (IME) payments at 6.5% for five years. Without the freeze, IME payments will drop to 6.25% in FY 2001 and to 5.5% in FY 2002. These reductions in IME represent the second largest inpatient payment cut for teaching hospitals ever. A five-year freeze in IME payments would cost the federal government $2.1 billion.

UNDOING FAILED MEASURES

As mentioned, some AHCs merged in hope of saving money. In 1997, Pennsylvania State University and its Milton S. Hershey Medical Center merged with the Geisinger Health System, thus creating an integrated system with $1 billion in net operating revenues. This new system included not only three hospitals and their affiliations but also approximately 1,000 physicians. At the time of the merger, the entities predicted savings of more than $20 million over three years. In 1999, they reversed their prediction and estimated that the new integrated system would lose between $100 and $150 million by 2002. Approximately four months later, Penn State/Hershey and Geisinger dissolved the merger. Stanford University and UCSF also merged to become more efficient, increase their market share, and save money in the process. The merger lost $11 million in the first quarter in the second year, and losses continued at a rate of $1 million per week. To stem the tide, 2,000 of 12,000 staff positions were eliminated. The merger was subsequently dissolved (14).

RESPONSE OF ACADEMIC PHYSICIANS AND THEIR DEPARTMENTS

Faculty members in academic departments and faculty practice plans have also been adversely affected by such financial losses and budget cutbacks. Productivity targets for faculty members have been increased. Dr. Judith Swain, chair of Stanford’s Department of Medicine, reports that relative value units per faculty member in her department increased by 26%. Although one outcome of increased clinical workloads is more clinical revenue, another result is less time for teaching and clinical research. At some AHCs, faculty salaries have increased little or not at all, and, in some instances, salaries have been reduced. This situation can lead to morale problems and loss of faculty members to private practice. To reverse this trend, measures to enhance nonclinical revenues have been instituted. Academic health centers have enjoyed increased research funding from the National Institutes of Health (NIH) and from industry sponsors. Technology transfer and commercialization of intellectual property have resulted in more revenues for faculty members and their research laboratories. Enhanced fundraising activities to augment endowment funds have been successfully implemented in many AHCs. Donations by grateful patients and foundations have supplemented the traditional sources of clinical and grant revenues for AHCs. Cardiology divisions and other areas in departments of medicine have implemented clinical pathways based on practice guidelines to reduce excessive costs, standardize care, and improve the quality of care. Much of today’s technology is expensive, as are many of the new pharmaceuticals. Appropriate use of these costly treatments is mandatory to maintain fiscal accountability.

EMERGING FROM THE CRISIS

Although the future is looking bleak for many AHCs, there is increasing optimism that the financial debacles of the late 1990s will be reversed. Hospital and physician groups are engaged in intense federal lobbying efforts to further correct the draconian cuts in Medicare imposed by the 1997 BBA. It is expected that, when the 107th Congress convenes next year, there will likely be major attempts to enact legislation mandating insurance coverage for many of the 45 million uninsured in the U.S. Among specialty societies, the ACC is positioning itself to become one of the major advocates for universal health coverage. Because AHCs currently provide the largest percentage of uncompensated care, increased revenues should be seen when a greater number of Americans have insurance coverage. The passion of College members for this issue has fostered the development of a
new position statement of principles on health system reform that will serve as the basis for its advocacy efforts. The ACC’s Immediate Past President, Arthur Garson, Jr., MD, MPH, made this the subject of his Presidential Plenary Address at the Annual Scientific Session in March of this year (15). In its pursuit of health system reform, the College recognizes the need to increase academic cardiology’s research capabilities as a means to enhance the quality of care.

In the meantime, a national effort has been launched to double the NIH’s support of medical research. Increases of $2 billion and $2.3 billion in the NIH budget were provided in the past two years (16). The NIH continues to increase its funding for basic and clinical research. This will provide greater salary support for investigators who compete successfully for federal grant awards.

The population of seniors in this country is growing, and the amount of cardiovascular care needed will increase in tandem. If AHCs, like private institutions, remain at the cutting edge of the specialty and cardiovascular care becomes more cost effective, increased clinical revenue from Medicare patients should be garnered. This would be predicated, however, on attaining fair reimbursement from the Health Care Financing Administration for cardiovascular care rendered to the growing Medicare population and on implementing an effective prescription drug benefits program. The ACC is leading a coalition of more than 40 medical and specialty groups to halt additional cuts to physician payments through the Medicare fee schedule. In addition, the College supports reducing the cost barriers to outpatient prescription drugs, but without jeopardizing the viability of the Medicare program and beneficiary access to quality cardiovascular care.

Faculty at our AHCs must sustain their tripartite mission of clinical care, teaching, and research, which is vital for the optimal treatment of patients in this country. We in the U.S. are blessed with outstanding medical care and a research establishment that has as its goal the discovery of new ways to prevent, diagnose, treat, and cure disease. It is our AHCs that educate the basic researchers and train the clinician–scientists who will be making the discoveries of the future that will improve medical care the world over. We must support their quest to succeed in their mission in this twenty-first century.

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