Heart Hospitals: Are They the Next Wave?

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The concept of regionalizing and centralizing cardiac care has existed for a long time. In our own medical school and hospital, such a concept was formally put on paper and submitted several years ago to the medical school hierarchy for review. Although everyone was quite enthusiastic about the possibilities this would provide, there were major concerns about its effect on the traditional medical school structure. Our institute would have involved adult and pediatric cardiologists, cardiac surgeons, radiologists, anesthesiologists, etc. However, the appropriate department chairmen were very concerned about the fiscal impact it would have on them, and the worry that other groups might wish to do the same thing (gastroenterology, hematology, oncology, etc.). Ultimately the concept was killed, and there were sentiments expressed such as: “Since we are a medical school we need a broad equity of departments and divisions. Since teaching is our major mission, we only need a certain number of patients for teaching and there is no need to try and increase our volume in any given area which would create a lopsided balance of power.” Because of such sentiments, we probably will never have a separate clinical cardiovascular institute. Other institutions, including private hospitals, have made much more progress with this concept, which is already a reality in many large centers. In a medical environment today where the bottom line is king, this regionalization of services appears to make more fiscal sense.

In this environment, it is no surprise that the concept of separate heart hospitals has emerged and may be thriving. I recently attended a meeting of cardiologists in the East Bay area near San Francisco where a cardiovascular consulting services company made a presentation about the virtues of possibly building a new heart hospital to cover the cardiovascular needs of a geographic area where several hospitals currently provide such services. There were seven local hospitals in that geographic area which had a combined annual rate of almost 6,000 catheterizations, 2,500 percutaneous coronary interventions and 1,100 cardiac operations. Based on the heart hospitals which have been built around the country there is a general blueprint of what it should contain. Six acres of land are required to build a two-story 90,000 square foot building with appropriate parking. There would be about 45 to 60 beds, 2 to 4 cath labs and 2 to 4 operating rooms. Physician investors would be asked to invest $25,000 to $200,000 each. Deep pocket investors and loans would make up the rest.

The proposed benefits of such a concept are physician control, improved income, no competition for resources and a focus on better quality of cardiac care. Other touted benefits were consolidation of existing cardiac programs, reduction of health care costs and improved patient convenience and satisfaction. The problems are self-evident, namely trying to remove business from existing hospitals and practice and referral groups. The local politics of such a proposal could be fierce. As the group reviewed those hospitals which have been built, it appears that the successful ones have not been in major metropolitan areas (coastal) but have worked to a variable extent when built inland in areas where the competition is less and there may be a need. It did not seem likely to me that such a venture would succeed in close proximity to UCSF, Stanford and all of the other major medical centers in the East Bay area. There are two apparently successful examples in central California and several other examples scattered around the country.

There were a lot of questions asked at the meeting. It was clear that not all cardiologists were interested in the proposal. A potential problem of collegiality was also present, and it was clear that the hospitals involved would fight a fierce battle to retain their cardiac services. In the end, there would be cardiac specialists inside and others would be left outside. It also wasn’t clear if such a hospital was the best place to invest one’s personal money. In sum, it wasn’t clear to me that the East Bay area was ready for such a hospital. Nevertheless, this proposal raises some very interesting issues. As reimbursement continues to dry up, it does make a lot of sense to consider regionalization of services. This is in place in many localities already. It is apparent to the casual observer that there are major duplications of cardiac services in selected geographic areas. A move toward regionalization even in these areas may become a survival mode in the future. In that sense, therefore, the local heart hospital may play a role. The tenuous financial health of academic medical centers will force them to be de facto regional heart hospitals, or to consider building one. It may be that economic forces like this will require restructuring of the traditional medical school departments and divisions. Although this has occurred already in several places around the country, based on financial pressures it is likely to increase.

My own reaction to the above is mixed. I am empathetic with the concept because of the functionality of such an arrangement. At the same time, it is troublesome to see the
bottom line once again as the major motivation for this new wave. Since financial considerations are likely to play the major role in the future of American medicine, it may well be that the building of heart hospitals is the wave of the future. Another alternative would be the restructuring of medical schools to accomplish the same goals. At the moment we are very inefficient in the provision of medical care, in part because of our other missions of teaching and research. Maybe both options are necessary as we strive to survive.

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