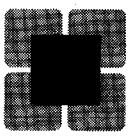

IMPACT OF THE HEALTH CARE MARKETPLACE ON TERTIARY CARE INSTITUTIONS

■ *To the Editor:* While Congress was involved in proposal-bashing during the much-ballyhooed health care reform, private market forces acted on their own to transform the system. Stimulus was provided by payers and employers in an attempt to reduce the cost of health care and its impact on their balance sheets. Indeed, market competition exposed vast differences in charges for similar services that did not reflect any demonstrable differences in patient outcomes. During the past 2 years, the majority of privately insured Americans joined managed care plans, and for-profit health maintenance organizations (HMOs) grew rapidly. In 1991, 47% of insured patients were under managed care; in 1994, 65% were.

Physicians accepted these phenomena (though reluctantly, and partly out of fear of losing control of their patients); 75% of them signed contracts covering at least some of their patients, agreed to cut fees, and even accepted supervision and oversight of their medical decisions. These changes, of course, have not at all affected the millions of uninsured or inadequately insured Americans. Instead, the competition has centered around insured patients who, in the words of Uwe Reinhardt, are "money-generating biological structures."

The changes in the health care landscape have caused the ground under academic (tertiary care) centers to shift. In addition to providing health care that utilizes advanced technology, these centers emphasize education and research, all of which increase the cost of care. Struggling to cope with the new environment, these institutions face payers that refuse to pay higher charges, faculties that guard their professional and departmental independence (or at least their version of it), and the reality that high-tech services cannot sustain a large hospital. They do have some competive advantages: the perception of high-quality care, typically high-quality faculty, and the facilities and staff to manage rare diseases.

Several high-profile institutions were unable to deal with these changes at first. Boston's Massachusetts General Hospital was excluded by the "Blues" from contracted care in its new "HMO Blue" plan, which controls 240 000 insured persons. Then, later on, it was excluded by the Harvard Community Health Plan, which chose to make its tertiary care arrangement with Boston's Children's Hospital. Since then, Massachusetts General Hospital has responded by contracting with its physicians to accept market charges. It has also announced a merger with Brigham and Women's Hospital, a combination that should be a dominant force in Boston's inpatient market. As another example, the University of Minnesota Hospital recently announced that it would join a system headed by Minnesota Blue Cross and Blue Shield, the largest insurer in the state. The University of California-Los Angeles Medical Center reduced its staff by 800 and has begun an ambitious program to reduce its 1996 budget by $100 million. It continues to hold an important tertiary care contract with Kaiser Permanente, which covers 14% of Los Angeles' insured population.

There are no simple answers to how tertiary care-academic medical centers should respond to change. However, the consensus favors providing total care rather than single units of service. Developing a strong primary care base to protect patient referrals is mandatory. Steps need to be taken to win over the faculty, end department-by-department rates and billing, and develop outcome data documenting higher quality. Hospitals must continue to downsize, and teaching institutions, as part of their tertiary care focus, should protect research and teaching and may need to subsidize this with patient care dollars.

The Cleveland Clinic Foundation (CCF) has the advantage of having a unified, physician-run administration for both its hospital and its clinics. We are now taking the necessary steps to extend our primary care base through strategically placed satellites and arrangements with other group practices and solo practitioners. This, coupled with our current network of hospitals, should enable the CCF to continue to serve its patient base.

MUZAFFAR AHMAD, MD
Chairman, Division of Medicine
The Cleveland Clinic Foundation

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