Like the procrustean bed, prospective payment attempts to create averages where they do not exist. The intent of prospective payment legislation has been to reduce the alarming rate of increase in health expenditures. An unfortunate consequence, however, may be a deterioration in tertiary care, academic medicine, graduate medical education, and intensive care medicine.

Without question, any system that works on averages generally produces mediocrity. What happens is that the unique, the innovative, and the avant garde in medicine become stifled and, in their place, the entrepreneurial, manipulated, and the regulated are offered. Although a hospital will try to economize under prospective payment, it can just as likely alter its case mix to maintain profitability so that diagnoses with a favorable payment-to-cost ratio will be encouraged and those with unfavorable payment-to-cost ratio will be shunned.

Realistically, hospitals and their physician staffs may also respond to threats of diagnosis related group (DRG)-induced losses by modifying admission policies to adopt more lucrative (yet clinically acceptable) practice styles, and by adjusting the labelling of cases.1 This will lead to the establishment of specialty centers in unnecessary situations, along with the shunting of patients to a tertiary care center with unfavorable payment-to-cost ratio for the receiving institution. It is critical to find an economic solution that does not conflict with other equally important objectives.

**What are the Problems?**

**Tertiary Care**

Tertiary care is threatened because payment based on a DRG average often incurs a loss for such centers. Whereas the more complicated patient is sent to the tertiary care center for treatment, the average person with pancreatitis or cholelithiasis, for example, is less likely to go to this type of facility. With such a scenario, the tertiary care center may face economic liability because the compensation for complexity is not commensurate with the expenses in the DRG system.

**Academic Medical Center**

American medicine has achieved its position of eminence because of the marked impact of scientific developments and their rapid application to the clinical care of patients. Scientific development and initial testing of technology is dependent on the academic medical center. Testing of technology must continue so that advances found to be meritorious will be used on a wide-scale basis.

**Graduate Medical Education**

A cutback in graduate medical education may appear reasonable in light of the present surplus of physicians. Yet, the quantity and quality of graduate medical education may decrease simultaneously if an across-the-board reduction occurs in funding.

**Intensive Care Medicine**

Tremendous losses have been shown for patients treated in an academic intensive care unit.4 It can be anticipated that such patients will be shifted to tertiary care centers where adequate beds and resources are unavailable to meet the demand.

**Proposed Solutions**

Several alternatives are proposed to deal with the prospective payment issue so that costs can be contained without further dilution in the quality of patient care. Payment should be based on a “severity of illness index” that will gauge the complexity and burden of illness as well as diagnosis.5

Also recommended is the development of “centers of excellence” to test the clinical applicability of medical advances. Certain medical techniques would be concentrated in these designated centers where favorable third party payment could serve as an incentive to maintain and develop specialized techniques. In return, reimbursement would depend upon the center’s assurance and documentation of the following: 1) reasonable expectation of improvement with the specialized technique over the standard therapy, 2) adequate volume to maintain quality, and 3) careful
evaluations comparing the efficacy of new techniques with that of standard therapies. Reliable information regarding the effects of such interventions would then be transmitted to the medical community.

In looking at physician abundance vis-a-vis graduate medical education, I believe that there is an excellent opportunity at present to decrease quantity without simultaneously jeopardizing quality. Why not provide incentives for programs judged to be superior to maintain funding for their training, with funding phased out for mediocre or poor programs? The residency review committee could provide this analysis.

As for intensive care centers, the following suggestions for counteracting current losses are offered:

- Give funding for “severity of illness” in addition to diagnosis.3
- Provide disincentives to discourage intensive care in centers where volume does not assure quality. Emphasize instead an area for stabilization before transfer.
- Provide incentives to test new technology in “centers of excellence” to establish validity and clinical usefulness of new technology.
- Provide incentives to conduct ethical, legal, and economic research on “quality of life” produced by intensive care. Develop guidelines for providing an improved quality of life rather than prolonging the agony of death.

I hope that prospective payment represents act one of a three-act play. In the first act, the advantages and problems emerge; in act two, reactions are evaluated; and in act three, constructive resolution of the problem occurs. Surely, in such an evolutionary system, tertiary care, academic medicine, graduate medical education, and intensive care medicine will not only survive but also improve. Physicians must become proactive regarding these issues to help formulate solutions that do not decrease the quality of medical care.

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REFERENCES

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