How Academic Medicine and the VA Are Being Influenced by Changes in Health-Care Delivery*

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In the wake of events transforming key aspects of the health-care system, it is important to examine the causes and effects of the factors that have led to the status quo. In considering the occurrences of recent years, it is apparent that the systemic changes are even more drastic than ever considered. This is somewhat surprising given the failure of the Clinton health-care plan to be enacted. Instead, other factors have come into play making the current changes much more dynamic and less predictable as to their outcome. These forces have come from multiple areas but are largely economically driven and are an attempt to stop the unsustainable increase in the percentage of the gross national product being spent for health care. These “market” forces have led to the following two trends in our national health care system. Along with governmental budget cuts, these trends are having enormous impact on both academic medicine and the VA.

1. To Ambulatory Care From Hospital Care: As a result of rising hospital costs, increasing use of technology outside the hospital, managed care, and the implementation of state level health-care reform, the role of hospitals is changing. The bottom line is that there will be fewer hospitals in the future. As Joseph Califano said: “In medical times society built churches, in the 20th century Americans have built hospitals,” leading to the excesses we have today. Between 1980 and today, hospital admissions have declined 11% from 38 million to 33.5 million annually, and nearly 1,000 hospitals have been closed. Today there is approximately 1 hospital bed per 200 persons, and the future will see this ratio decrease to resemble the early 19th century level of 1 bed per 900 persons. Hospital days per annum per 100,000 population have dropped from 450 to 150. Currently, 98% of medical care occurs in clinics. In 1995, 75% of all surgical procedures were performed in the outpatient setting. With the increase in home-based care, hospices, and outpatient surgery, there is a 50% excess of hospital beds in most large urban areas. Teaching hospitals are particularly being compromised.2

2. To Generalists From Subspecialists: Subspecialization gave physicians the luxury of being able to concentrate and focus on a very narrow area of knowledge, but it is now being restricted.3 It was noted that subspecialists were the most expensive clinicians often introducing costly technology before adequate evaluation.4 The number of procedures in a population was not related to the prevalence of disease but to the number of specialists, so the response has been to curtail the number or subspecialists.5 Academics are now expected to train generalists and to fill their heads with enough knowledge so that they can handle most subspecialty problems yet know when to refer.6

Where Does the VA Fit in Future Health Care?
The Current VA

Consider how the VA functions now. It is the umbrella of socialized health care for the indigent and the sickest people in our society. Many of the patients we see are socially isolated and without health-care insurance. Others come to us choosing not to decimate savings earmarked for retirement. Another scenario is a patient entering the VA health-care system because a recent hospitalization has left them without any residual insurance coverage. After a hospitalization in the private sector exceeds the limits of reimbursement from the patient’s insurance, they are excluded from their HMO to get care elsewhere. Suddenly the expensive procedure that seemed so necessary can now be postponed until the patient comes to the VA.

Why Is the VA Trying To Imitate the HMOs?

HMOs would like to cover only relatively well people and let the VA take care of the sickest patients. Should the VA try to match the HMOs with 15-min appointments so we can see more patients or spend the time necessary to deal with the complicated VA patients? How important is it to our patients to keep waiting time to only 10 min so that we meet targeted patient satisfaction goals? While no patient should wait, a patient with a complicated problem cannot be dealt with in an average allotted time slot. Should the VA be “patient-oriented” as now directed by central office or

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direct its limited resources to better care for our patients? While it is hard to be against being "patient-oriented," the directives from VA central office appear more as cosmetic changes designed to win public support rather than to benefit patient care. Do all VA patients need to have a general practitioner while being followed by a specialist just because the HMOs do this? Remember that the HMOs do this to limit access to subspecialty care while our patients are relatively sicker and more complicated than patients in HMOs. Should our patients necessarily have the highest technology and life-prolonging procedures aimed at matching "community-standards of practice," or should they have only proven established technology and quality-of-life enhancing procedures meeting national guideline standards? Should the VA compete with the private sector to win more patients in the capitulation war or concentrate on the needs of our current clients? These are difficult questions that will take time and study to begin to answer. Needless to say, the sickest patients will continue to utilize the VA so that our cost efficacy will never equal that required in managed care. Also, patients with chronic problems are the least satisfied with their health care as compared to patients with illnesses that can be treated successfully so the patients in the VA will always be less satisfied with their care.7

The VA Missions

The missions of the VA include medical care, medical education, research, and a contingency backup for national emergencies.5 Liabilities include limited resources, an ill-defined job, a difficult patient population, a cumbersome administrative structure, and the fact that the VA is based in its 172 hospitals while the rest of health care has become centered in outpatient care. While the new vision for the VA certainly will not improve the resources or the patient population problems, there are already hopeful changes in job focus and the administrative structure. The changes implemented by the new national VA Medical Director are commendable, and it is a shame that "politics" limit his plans to close unneeded or inefficient facilities to become more cost-effective. However, while favorable changes are occurring, much of the focus and direction is being left up to local directors. These directors are under enormous pressure to control costs and often find the academic affiliations an encumbrance rather than an enhancement. One point of view is that the VA would not be worth saving if it were not for the VA-University alliance which has saved it from the mediocrity usually associated with socialized governmental medicine. For these reasons, it is critical at this time for the academic-VA alliance to develop a strategic plan for the future. VA academicians are struggling with where to make their allegiances, with the VA or their university.9 These are difficult times, and such struggles will only make them harder.

Where Is the Local VA Strategic Plan?

The failure of the VAs to develop a sound strategic plan locally is not surprising because of the hierarchical tradition of VA management which does not breed innovative leadership. With the emergence of the 21 national Veteran's Integrated Service Networks (VISNs), local directors are worried that some of their technical programs will be centralized to avoid duplication, so they are urging their staff to do more procedures. This is at a time when the rest of the health-care community is trying to limit procedures. Another misdirected policy is the development of satellite clinics. While the goal is to increase the capitated population, no one has used available VA population data to develop a capitation model. There is no idea how many physicians are needed to care for how many veteran outpatients and how many procedures and hospitalizations will be generated at outreach clinics. With shrinking resources, local managers are thinking that more patients mean more resources, but instead, these satellites are going to be a drain of personnel, equipment, and resources that could further handicap the parent site's care of their patients. Often without a plan, decisions are made according to hidden agendas which protect self interests (ie, save one's own department rather than consider the entire academic program). To quote Senator Alan K. Simpson, Chair of the Senate Committee on Veteran's Affairs: "Expanding new outpatient services to additional veterans would consume resources likely to become available only through an offsetting reduction in inpatient care for other veterans."10 Competition with the private sector with outreach clinics does not make as much sense as contracting out for services or making private practitioners part-time VA employees and allowing them to see VA patients in their offices.

Lack of a Comprehensive Strategy

The failure to put in place a total strategy to solve a problem is destined to end in poor results. Take for instance the effort to minimize patient waiting time in a clinic. Many of us explain to patients waiting, why we are behind, apologize, and ask if anyone has a pressing time conflict. Almost routinely someone will say, “Doc, I got all day, take somebody ahead of me.” Now you cannot even allow that to happen since waiting times will average high. While most of our waiting times drop however, we note our patients standing literally for hours to be checked out of the clinic. When this was noted to the clinic supervisor, it was explained that physicians are paid so much more than clinic clerks that
they should never be the source of the wait. The real issue is that the medical center does not have a comprehensive strategy. VA clinics usually are overbooked because we are all accustomed to a relatively high “no show” rate as compared to paying clients, so that waits can become long when most patients appear. This could be avoided easily by calling patients to remind them to come to their appointments or to confirm that they will not make them. An organized approach at the medical center to triage patients via telephone is the solution. Also, if patients bore part of the expense of their care, they would be more likely to keep appointments. Locally, each VA should develop a strategy in conjunction with its affiliated university—not just develop satellite clinics, make efforts to increase patient satisfaction, or hire generalists because HMOs are doing it.

**VA and the University**

The VA-university alliance that has been so beneficial to both parties is now in great jeopardy as both sides struggle in these difficult times. Since downsizing and avoidance of duplication of services are priorities, whenever possible, affiliated VAs should contract out services to their university. Does it make sense to have affiliated hospitals a short distance apart both with cardiac surgery programs?

Many affiliated VAs have hired nonacademic general practitioners to provide primary care, or hired general medicine academics and given them excessive clinical responsibilities. This policy is the case particularly at distant satellites. These physicians dilute the resources of the VA medical center and make it a weak academic sister to the university. Other medical organizations are retraining subspecialists to be generalists because this is the most logical and cost effective way of supporting both worlds. We must foster another generation of academics and not put talented physicians into early retirement. However, the idea that once you become a professor the system owes you a salary must also be removed. Serving in academia is a privilege rather than an entitlement. Another waste of resources is not to use senior academics in administrative positions. Insecure managers are more comfortable with noncredentialed junior “administrative specialist” physicians.

**What’s a VA-Academician To Do?**

We are urged to adapt to change, but we must have a voice in deciding if all these changes are for the good. Certainly these changes driven by market forces are not for the good of the health-care profession, but of greater concern, they are not good for patients. Perhaps this generation of physicians lost its moral compass, and health care will only be turned around by the next generation. Surprisingly, in spite of all the problems, medical school recruitment is at an all time high resulting in very high acceptance standards. While all these changes swirl around us, it is noteworthy that physicians have been very passive. Professional organizations move to protect themselves, yet most physicians sit on the sidelines not even knowing what team to root for or why. There is the opportunity for positive change and improvements in these times. The issue is, will we shape the future for our patients who count on the VA-University alliance, or will this alliance be shaped by financial and political agendas that do not make the quality of patient care a priority?

Most academic subspecialists are making changes. We are more involved in teaching medical students and house staff; we tutor clinical medicine courses for medical students; we attend general medicine clinic and round on the internal medicine service; and we provide “curbside” consultations to our generalist colleagues whenever requested. In other than the service area, our group has developed expert systems to help the generalist in cardiology; we have organized broad-based cardiology symposia and have coauthored a text of cardiology for the ambulatory care practitioner. Our cardiology service has improved the ECG service by reporting ECGs and other tests the day they are performed and keeping the waiting time for exercise tests to less than a week and by testing patients with chest pain straight from the emergency room. We have tried to make the ECG service more responsive to our colleagues, have tried to train generalists in cardiology, have considered cost-efficacy in practice, and have tried to be better generalists. These efforts still leave us wondering what else can we do more than try to respond in our own practice and teaching? How can academic physicians affect positively the changes going on around us?

**The New For-Profit/Capitation Paradigm Will Not Work!**

One scenario is that health care will not be acceptable to society when run as a for-profit business. Even more likely, the profits will soon dry up and health care will be given back to physicians to manage. The profit business motive will not persist because no one will take care of the sick and those without insurance. Though the traditional fee-for-service paradigm where the physician applied usual, reasonable, and customary (URC) charges was partially responsible for the progressive increase in health-care costs, it was more likely to apply health-care resources to patient care than the capitation model. The capitation approach to reimbursement functions by motivating the physician to provide less care for patients. The VA’s patients will not be absorbed by HMOs and our population may...
decline but not disappear. Eventually a single payer system will evolve that will include the VA as one of its arms.14 We hope that the VA will not destroy itself in the process of competing with a for-profit medicine system that will not survive. The inability of the VA to change quickly could certainly leave it out of synchrony with the scenarios proposed.

**The Future of the VA**

More basic to the issues of the future are the answers to the following: Which veterans will receive care? What kinds of care will be provided? How will that care be provided? Are these questions going to be decided for us or with our help? And more critically, how can the good parts of the VA-University alliance be maintained? Though the experts are uncertain regarding the future of health care and now estimate at least 5 years of chaos, there is enough data for a strategy to be developed. Though there will be less veterans to need care as World War II veterans move on into eternity, the worst possible scenario for them would be to have a VA-"post office" type of health-care system. Perhaps the VA administrative and nonmedical services are too cumbersome to allow an evolution to a new VA, and it is better to let the VA be phased out. But there is too much committed in the VA and too much potential to allow this to happen. It is time for university medical centers to bid for the role of taking care of our veterans and work towards a new and grander VA-university alliance. The "for-profit" private sector would not fulfill America's responsibility to those who have served our nation.

**Conclusions**

After considering the forces at work that are dictating changes in our health-care system and the unremitting economic pressures, it is difficult to be optimistic regarding the future viability of traditional academia. Perhaps we are going through a unique evolutionary downsizing in response to excessive sub-specialization. We are left with the feeling that we would have evolved a better solution for our patients had physicians been more proactive. However, forward-thinking organizations like the American College of Physicians and Surgeons supported a single payer system only to face the wrath of their constituency. Without direction for all these changes, market forces will prevail until public outcry forces political action.15 While times of change are also times of opportunity, physicians and academics appear paralyzed and unaware of the opportunity to help the VA and themselves at this critical time.

Only consultation with our four favorite physicians allows an optimistic closure: Dr. Welby (of TV fame) assures us that physicians will not lose their human touch even when limited to a 15-min appointment schedule; Dr. McCoy ("Bones" of "Star Trek") says that technology will never be employed in the future before proper evaluation; Dr. Who (the noble "Time Lord" of BBC) will see that justice is served to the poor and uninsured; and Dr. Seuss will continue to inspire us with his writing (You're Only Old Once: A Manual for Obsolete Children) to help the elderly remain functional for as long as possible and then allow them to die with dignity. If only these four formed the missing national health-care board, then all of the above changes could occur without the current chaos and confusion.

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