Integrating Academic and Private Practices

Challenges and Opportunities

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KEYWORDS

- Academic medical center • Merger • Consolidation • Organizational culture
- Academic anesthesiology • Private practice anesthesiology
- Future models of anesthesia

KEY POINTS

- Academic medical centers' model of high-acuity, high-cost care with clinical revenues cross-subsidizing research and education is at risk in the current landscape of health care reform.
- Consolidation of academic and community medical centers through mergers or partnerships provides one mechanism to diversify, increase regional presence, and achieve economies of scale.
- Culture clash between organizations is a major but often ignored factor in failure to achieve a merger's full potential and may even contribute to complete dissolution.
- A merger of academic and private practice anesthesiology groups can benefit both, but cultural differences are likely to play a major role in successful consolidation.

INTRODUCTION

Health care, like any industry, is not immune to market pressures. As payment models and care delivery systems are increasingly pushed toward improving efficiency and value, providers and hospitals must respond, and academic medical centers (AMCs) are no exception. AMCs have historically been relatively protected from competitive forces owing to their large size, reputation, and multiple revenue sources. In the current landscape, however, even these ivory towers have been impacted by the forces affecting the market as a whole. One avenue that some centers are pursuing to enhance their competitive advantage is through mergers or partnerships with community health systems.

Conflicts of Interest: None.

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DIFFERENTIATING THE ACADEMIC MEDICAL CENTERS

AMCs are defined by their tripartite mission of patient care, research, and education (Fig. 1). The interplay of research, education, and advanced care improves each mission separately and collectively. They are typically affiliated with a medical school as well as other health care professional schools, laboratory facilities, and programs for research from bench to bedside, large faculty practice groups, and residency training programs. They tend to enjoy strong name recognition and reputation, and are known for pioneering advancements in medical care. Although only 6% of the nation's hospitals are AMCs, they provide 20% of the hospital care in the country and receive more than 40% of patients who are transferred from community hospitals for higher level of care.[1] Compared with community hospitals, AMCs tend to care for high-risk, higher complexity patients, and provide a highly disproportionate share of intensive and specialized services, including 50% of solid organ transplants, 61% of level 1 regional trauma centers, 62% of pediatric intensive care units, and 75% of burn care units.[1] Besides the differences in the patient care, there are other significant differences in local practices and culture between the AMCs and private practices (Box 1).

Traditional Academic Medical Center Revenue Streams

AMCs have traditionally benefited from a combination of revenue streams. The bulk of this comes from payment for clinical services, including Medicare, Medicaid, and private insurance reimbursements, copayments, and self-payments, and comprises 85% of annual revenues. Research grants and contracts account for 12% of AMCs revenue, with federal funding the largest source, followed by industry and nonprofit foundations. The remaining 3% of AMC revenue comes from tuition, gifts, and endowments.[2] AMCs receive nearly $10 billion in annual funding from Medicare for direct and indirect graduate medical education, as well as $3.9 billion from Medicaid and $1.4 from the Veteran's health Adminitration.[3] Revenues are then distributed across the 3 missions, resulting in cross-funding of research and education from clinical revenues (Fig. 2).

Financial Implications

Providing high-acuity, highly specialized care while cross-subsidizing research and educational missions drives the cost structure of AMCs higher than that of non-AMCs. Other factors, including greater investment in clinical information technology

Fig. 1. Academic medicine: missions.