Joint Symposium of the Association of Academic Health Centers International, USA (AAHCI) and the Deutsche Hochschulmedizin
Frankfurt, Germany
June 20, 2014

Medical School Economics: Challenges of Financing the Academic Mission

Lilly Marks
Vice President for Health Affairs
University of Colorado
Executive Vice Chancellor
Anschutz Medical Campus
©Lilly Marks 2014
Comparison of Fully Accredited Medical Schools’ Revenues
Total Revenue by Funding Source, FY2012

*Based on Direct Federal Research Grants and Contracts expenditures reported on the AFQ.
Source: LCME I-A, Annual Financial Questionnaire (AFQ)
© Association of American Medical Colleges 2013. All rights reserved.
All Fully Accredited Medical Schools Have Witnessed Prodigious Growth Fueled by Medical Service Income in Millions, FY 1965-FY2012

Source: LCME 1-A Annual Financial Questionnaire (AFQ) @Association of American Medical Colleges 2013. All rights reserved.
Institutional & State Appropriations – Tuition Revenue:

- Underpins core educational mission of School & basic administrative and infrastructure costs.
Institutional & State Appropriation Issues

1. Ongoing state budget deficits have led to reduced state support to medical schools.

2. Faculty under increasing pressure to cover salaries via research and clinical activities and believe they can’t afford teaching and administrative commitments, which aren’t adequately compensated.

3. Inadequate as cross-subsidy for any other missions or gaps in funding.

4. Decreases in state support have led to sharp tuition increases.
TREND IN MEDICAL STUDENT TUITION AND FEES

Source: Association of American Medical Colleges (AAMC)
(1) Starting in 04-05 health insurance fees are excluded if schools indicate that they will waive the fee upon proof of overage.
Institutional & State Appropriation Issues continued:

5. These institutional “hard dollars” are the financial underpinning for academic entitlements (tenure, sabbaticals, guaranteed salaries and protected time, etc.).
Other Revenue

1. Affiliated hospital support (including GME).

2. Gifts/endowment income.

3. Auxiliary income.
Other Revenue Issues:

1. Hospitals facing potential of significant reductions and reimbursements. Future support of academic missions unclear and unstable.

2. Philanthropy subject to economy. Endowment income subject to market.
Research Revenue Issues:

1. NIH growth has flattened post 1999-2003 doubling era making grant awards far more competitive.

2. Even successful research institutions with increasing grant revenue are seeing growing number of faculty lose grants and salary support.

3. NIH $ are restricted (not fungible) so excess $ in one area can’t be shifted to cover deficit in another.
Research Revenue Issues:

4. Current federal deficit and political division in Congress make the foreseeable future for NIH funding worrisome.

5. Significant institutional cost of developing and maintaining research programs.

(protected time, unfunded research, bridge funding, institutional cost sharing, need for research cores including robust bioinformatics, indirect costs gaps).
Research Revenue Issues continued:

6. Are we headed for an era of Research Darwinism?

7. Diversification of research portfolio (industry, foundations, Biotechnology transfer).
Physician Clinical Revenue:

1. For 3 decades, fastest growing, largest, most flexible revenue source in SOM Budget.

2. Now accounts for 55-60% of typical SOM budget.

3. Represents major source of cross-subsidy for other SOM missions and programs.
Clinical Revenue Issues:

1. Successful faculty physicians and teaching hospitals have been able to extract significant above market contract premiums.

2. Growing health care cost crisis, coupled with economic recession, threaten continuation of academic provider reimbursement premiums.

3. Commoditization of health care pricing is underway.

4. Further consolidation of all sectors of healthcare system underway.

5. Can we remain “Switzerland?”
Clinical Revenue Issues continued:

6. To sustain premium pricing, AMC’s must differentiate selves on quality and outcomes and gain greater market leverage.

7. To sustain margins as reimbursement declines, we MUST tackle cost and productivity.

8. Impact on changing physician employment models.

9. Health care reform impact.
Health Care Reform
A Convergence of Economics and Politics

THE ECONOMY:

— US finally emerging from deep and prolonged recession.

— Unemployment remains near 6.5%.

— Federal budget deficit deficit unsustainable.
  • $18 trillion 2014.

— Cost of employee healthcare often cited as the major concern of U.S. employers.
A Convergence of Economics and Politics

continued

POLITICS:

- Anti-tax and push for smaller government.
- On going demands for huge budget cuts.
- Increasing politicization and polarization.
A Tale of Two Bubbles?

Education

Academic Medicine

Health Care

©2013 AAMC. May not be reproduced without permission.
2012 Milliman Medical Index

Healthcare costs for American families in 2012 exceed $20,000 for the first time

Because of the way employer-sponsored health insurance is paid for, many families may not realize the cost of their healthcare for a single year is roughly equivalent to the cost of a basic mid-size sedan.
Political, economic and market forces will profoundly impact Academic Medicine across all our missions.
STAY AWAKE !!
Rebalancing the Enterprise in response to a “New Normal.”
Balancing the Missions

Research
Teaching
Other

Clinical
Balancing the Realities

PRINCIPLE

PRINCIPAL
Intersection of Funding Realities and SOM Policies

• Interconnectivity of missions requires interconnectivity of solutions. Changes may be required in:

• University/school policies
  • Tenure.
  • Appointments and promotions.
  • Specialty tracks.
  • Compensation.
  • Assignable income.
  • Conflicts of interest and commitment.

• School/Department practices:
  • Investment and recruitment decisions.
  • Centralized/decentralized management and decision making.

• Organization and Governance
  • Relationship between School, departments, hospital and practice plan.

• Culture
  • Entitlements.
  • Productivity.
  • Accountability.
“At every crossroad on the path that leads to the future, tradition has placed 10,000 men to guard the past.”

Count Maurice Maeterlinck
Academic Socialism vs. Capitalism
To rob from the rich and give to the poor may be an acceptable application of academic principle.

To rob from the rich and give to the unproductive may be an unwise use of financial principal.
“Eat what you kill.”
Balancing the value system and culture.
Balancing Act

Successful leadership and management of the School of Medicine’s missions and resources is all about balance.

• Principle vs. Principal.
• Academic Socialism vs. Capitalism.
• The benefits vs. evils of taxation.
Balancing Act continued

- Traditional academic department structures vs. service lines, centers and institutes.

- Integration of the clinical enterprise vs. disintegration of the academic enterprise.
Alignment of Stature and Incentives

“I’ve got it, too, Omar... a strange feeling like we’ve just been going in circles.”