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EDITORIAL

Continuous Innovation in Health

Mergers, takeovers, networks, spin-offs—the language of industrial America now applies to America's academic health centers. Driven by changes in the organization and financing of health care, these institutions seek to reduce excess capacity (such as hospital beds), achieve economies of scale, and rationalize the distribution of costly services. The intent is often to create organizations of physicians and facilities so large they cannot be ignored by purchasers of health care. This new reality is accompanied by decreases in net revenues from patient care to faculties and hospitals, a portion of which supports research and education. In 1994, the Association of American Medical Colleges conservatively estimated that over $800 million of clinical income was used annually to support research at academic health centers. I suspect that other, less obvious, subsidies make the actual figure as much as three times greater. Although significant amounts of net revenues from patient care are used for research conducted in clinical departments, some are used for recruiting, equipping, and supporting faculty and graduate students in basic science departments.

The changes now occurring offer important opportunities and pose serious risks to the health science enterprise. Consolidations of research infrastructure, which reduce administrative costs and enhance possibilities for sharing of expensive research facilities and equipment and for collaboration among investigators, could be beneficial. However, such changes require early participation in the planning process by scientists in the consolidating institutions. There is a real risk that research and research training programs that were previously funded separately at consolidating institutions would be arbitrarily forced to merge, although this may not always be best for these programs.

The biggest threat to research arises from the decreased stream of clinical monies that previously—directly and indirectly—supported the research effort. Accurate data about the actual amounts involved are critically important for guiding policy-makers and must be gathered by institutions. Some form of all-payers assessment on health care premiums is a logical way to compensate for these losses. Such an assessment ought to support clinical investigation rather than health science research in general. Clinical research is easily identifiable by patients, purchasers, insurers, and providers as a central component of the care health centers provide. In contrast, support of fundamental science is largely viewed as the responsibility of government, and purchasers resist the notion that fundamental science should be financed by both tax and clinical dollars. A clear separation of the use of health care dollars to support clinical research would emphasize Congress's continued responsibility for the National Institutes of Health (NIH) budget for fundamental science. Otherwise, there is a high probability that, over time, the rate of increase in tax dollars for science would decrease while reliance on monies from health care premiums would increase.

Approximately 30 percent of the NIH budget is currently expended for clinical research. Supporting this portion of the NIH budget with an assessment on health care premiums, while maintaining overall support for NIH, could substantially increase the tax dollars available for fundamental science. Peer-reviewed allocation of these monies through NIH will not only ensure a high-quality merit review process but will assure managed care purchasers that referral of patients to projects funded by these mechanisms is appropriate.

A 1 percent all-payers assessment to support clinical research might be expected to yield $4 billion to $6 billion in the current trillion-dollar health care budget, depending on the portions assessed. If it were implemented in steps of 0.25 percent per year over a 4-year period, the impact on payers' budgetary plans would be minimal and, if applied to all payers, would not provide any unfair advantage in a cost-competitive environment. An all-payers assessment for support of graduate medical education also has been proposed. However, the rationale and management of a research assessment should be considered separately. A clear commitment by the health care industry to directly support innovation to continuously improve the services it delivers is not only appropriate but essential.

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