MEDICAL EDUCATION

The Impact of the Puerto Rico Health Reform Act on Graduate Medical Education.*

ESTHER A. TORRES, MD, FACP†

In an effort to decrease the rising costs and poor quality of health services and the limited access to medical care, the Clinton Administration spear headed an unsuccessful health reform in 1993. Although this effort failed, the private sector gleefully took up the quest, and the managed care revolution was on. Sweeping California-the state where everything goes-and spreading across the nation, managed care is a health system that emphasizes cost containment by disease prevention and increased primary care, thus attempting to reduce the need and utilization of costly tertiary services. The best known model of managed care has been that of the primary care physician (PCP) acting as a gatekeeper, the person responsible for authorizing and in many cases also subsidizing referrals for specialists, diagnostic and laboratory tests, procedures and even medications. This physician has been suddenly faced with the ethical dilemma of restricting medical services (no longer the patients' advocate) or authorizing them to the extreme of this own demise, either terminated by the managed care organization or his own finances. Excellent clinical judgement, as well as a lot of luck, are required to succeed in this environment. Fortunately, the public has not taken kindly to this, and changes are occurring.

Managed care in the United States has extended beyond the private sector into Medicaid and Medicare. The state and federal governments have discovered that buying health insurance for their patients is easier and less expensive than providing costly services or paying fee for service, and the competition for this new market has also flourished.

In this environment of extreme competition and pure business, we find the Academic Health Centers. These are University-based Health Centers that include a hospital and associated clinics, a medical school and other health professional schools. They come in all sizes and combinations, private and public. The missions of the Academic Health Center include not only the education of physicians to-be and specialists, but also the furthering of scientific knowledge through biomedical research and the offering of clinical services. Traditionally, Academic Health Centers have served a large proportion of the indigent, unisured and disadvantaged population, often suffering from complex diseases, requiring costly special care and lacking a social support system. Many of these health centers are public hospitals, receiving some government support for this mission, and often cross-subsidizing it with income derived from the "private" clinical services. The clinical practice is also increasingly subsidizing the medical school in its missions of education and research, complementing funding from the university and the government for undergraduate and graduate medical education and helping unfunded research.

Overnight, the health services environment has shifted, threatening the livelihood and survival of academic health centers. Government funding has been reduced. The change to managed care in the public and private sectors has shifted patients to less costly and frequently more efficient providers, leaving academic health centers with a decrease in revenues from clinical services as well as an important reduction in the volume of patients needed for teaching. The care of patients has also shifted away from the inpatient to ambulatory services, requiring new physical and human resources not readily available to academic health centers. Efficient communication and information systems, not a characteristic of large institutions, are a requirement of the managed care health system.

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†Director, Department of Medicine, University of Puerto Rico, School of Medicine, San Juan, Puerto Rico.

Address for correspondence: Esther A. Torres, MD, Director Department of Medicine, University of Puerto Rico Medical Sciences Campus, PO Box 36506 San Juan, PR 00936-5067

In order to meet these needs, Academic Health Centers have opted for buying primary practices or affiliating with them, becoming integrated delivery systems, joining or merging with other providers, developing areas of highly specialized multidisciplinary care (like cancer, cardiovascular or women's health centers) with varying success or failure. Medical education, both undergraduate and graduate, has felt the need to adapt its curriculum to these changes in order to prepare the new physicians for success on the environment in which they will practice. The ethical conflicts brought about by the clash between medicine and commerce are deep and unresolved.

What about Puerto Rico? The Puerto Rico Health Care Reform Act was established in 1993 with the purpose of allowing access to private medical services to a population that until then had been cared for by government physicians in public health centers and hospitals. The intent has been to convert the health care system from two tiers (public and private) to one, and to emphasize prevention to reduce costs. Managed care has been the vehicle for these goals. Although implementation has been slower that projected, by 1999 most of the island has been converted to this system; and by 2000, government employees are expected to be offered this option.

Apart from the difficulties in this system encountered by providers as well as patients and the government, we in academic medicine have also been affect. Like the story about the wolf, most of us did not believe it would happen, and were not ready for the changes. The dream of a "bail out" by the state university has died hard. As the government sells off or privatizes its health facilities, some of our training sites are lost or reduced in capacity (like the Mayagüez Medical Center and Caguas Regional Hospital) so our students and residents must be relocated. The care of our patients by private providers has resulted in a dramatic decrease of referrals to our clinics. The required experience in ambulatory and continuity clinics is in jeopardy, admissions to our University Hospital have decreased 20% in the past year. The patients we do receive are very sick and more complex, depriving our students and residents from the experience of everyday medicine. These patients, when discharged, return to their primary physicians, they do not return to our services for follow up and consequently their clinical course and final outcome remains unknown to all those that participated in the management of their malaise.

And what about the finances? It is no secret that the Department of Health has serious budgetary constraints and that the University of Puerto Rico assumes fiscal responsibility for resident and faculty salaries. In this way we acquired the Carolina Area Hospital and hopefully the Puerto Rico Cardiovascular Center will be next. Nevertheless, the decrease in patient volume and the increasing number of complex cases we receive, reduces revenues and raises costs in our hospitals. This creates an unfavorable situation, since the University of Puerto Rico does not receive federal funds for graduate medical education, irrespective of its assumption of many of the costs and support. The source of faculty salaries for clinical care of medically indigent patients, the famous, or more appropriately infamous Account 281, paying way below the lowest rate for services rendered, has also suffered reductions in the past years, making it impossible to replace faculty members that resign or retire.

The government has somehow managed to forget that it was charged with providing the clinical facilities and resources for the education of its healthcare professionals, and has left the University to fend for itself, without even the benefit of a clear public policy regarding this issue. Furthermore, our Academic Health Center faces the challenge to educate its health professionals in serving successfully in this altered medical environment. This need extends from medical students to the residents and even beyond, to other health professionals. It is obvious that new resources are urgently needed for this task.

What then can we expect? Or to paraphrase John Kennedy "What can we do for our University"?. We must accept responsibility; the faculties are the most important resources of Academic Health Centers. We require agile, energetic, effective, and proactive leadership, to exert change from the top. But only we, the faculty, can bring about that change; individual or departmental autonomy is no longer possible, territorial divisions are untenable. Sharing of ideas, resources and efforts, and collaboration across disciplines to achieve successful teamwork are essential. New and previously unthought-of alliances will be necessary. Creative restructuring of services and facilities will be needed to develop their full potential.

The need of more or less physicians, either primary care or specialists, in our island must be assessed in a realistic way. It is the civic duty of our Academic Health Center to address this issue and offer the solutions that are required to survive in this "new" medical environment providing high quality medical services and excellence in medical education. Our undergraduate and graduate curriculums have the moral obligation of preparing our professionals for the world they are going into, while at the same time preserving the strict code of ethics of the patient-physician relationship. We must assure each of these young physicians has the tools to continue on to the career of their choice, whether a primary care physician, a specialist, an educator, a reseacher, or even an administrator. The excellence of all our training programs must be maintained within the context of our needs and

resources. We must not ssettle for less. Again, sharing is imperative, and only the faculty is responsible for this.

Since research is the hallmark of *academia*, we are responsible for being creative in the furthering of this endeavor. This can be accomplished by increasing collaboration with basic scientists, expanding research into the health care and outcomes fields, and sharing resources.

It may not be easy, but it can be done. Rather than allowing change to be forced on us, our willingness to change and to take charge will be our guarantee of success. Let us transmit to our students and residents, whose education we guide, a message not of discouragement or despair, but of strength and hope. Let us join forces and face this challenge with enthusiasm.