Message from the Executive Vice President for Medical Affairs

Late in May, the Board of Regents introduced Mary Sue Coleman, Ph.D., as the 13th president of the University of Michigan, effective August 1. She is a leading figure in higher education and an experienced Big Ten president. President-elect Coleman is a scientist who studied the biochemistry of leukemias before moving into full-time administration in 1990 at the University of North Carolina, then the University of New Mexico, and since 1995 the University of Iowa. She is a member of the Institute of Medicine and is knowledgeable about the fine academic medical center at Iowa. She exhibits a great sense of humor and an eagerness to join the U-M. We warmly welcome President-elect Coleman and her husband, Kenneth, to Ann Arbor. My colleagues and I thank Interim President B. Joseph White for very effective leadership of the University and engagement with the Health System during this transition.

Meanwhile, your Medical School and the U-M Health System continue to advance in all dimensions of our responsibilities. We are attracting top students, faculty, and staff; markedly increasing federal and total grant support for research; building a magnificent 470,000-square foot Biomedical Sciences Research Building, as well as underwriting a substantial portion of the University-wide Life Sciences Institute; growing our clinical programs and planning major facility expansions for patient care; improving technology transfer; and moving progressively higher in the national rankings of hospitals, medical schools, and health plans. As described in this issue of *Medicine at Michigan*, we are contributing our share and more to national leadership at NIH and to advocacy for important needs of academic health centers, in the broad public interest.

Nevertheless, there are serious stresses, basically reflecting the chasm between the desires of an aging and growing population for access to high-quality, rapidly-advancing medical care and the willingness of those who pay for most of this care, the employers and taxpayers, to foot the bill. After several years of beating up on "managed care," which was mostly "managed cost," politicians, payers, providers, and consumers are now beginning to realize that wide-open choice for patients and greater discretion for physicians are accompanied by big increases in expenditures. Employers, including the U-M, and governments are anxiously trying to pay this year's double-digit increases in private health care insurance premiums, while all signs point to even larger increases next year. The Medicare experiment with managed care, called Medicare + Choice, is vanishing even while the federal agency proclaims high interest in expanding it. M+Choice offered a (partial) outpatient prescription benefit, while the rest of Medicare does not. M-CARE is one of only three plans in the nation (among a couple dozen which competed) with which the federal Medicare agency agreed to share the difference in reimbursement between fee-for-service payments and the capitated payment under M+Choice. Nevertheless, barring increased reimbursement, M-CARE may have to drop this plan due to continuing under-payment, costing millions of dollars to the Health System, for the actual cost of care for the patients who chose this option.

While the national administration seems unconcerned overall about the reappearance of large federal budget deficits following the big tax act of 2001 and the costs of the open-ended war on terrorism, President Bush has proposed a 5.4 percent reduction in reimbursement rates to physicians and serious cuts in the graduate medical education-based payments to hospitals. Despite payment pressures each year, we continue to achieve positive operating margins through a combination of increased volumes and effective cost containment. And we are investing in patient safety and quality-of-care initiatives.

On the research side, there is a final glorious 15 percent increase in funding for NIH, though a large part of the increment is for bioterrorism-related programs. The NIH budget will have more than doubled from $13 billion to $27 billion per year from fiscal year 1998 to fiscal year 2003. Beginning in 2004, the Bush Administration budget shows two percent per year increases for NIH, a drastic reduction from the current growth rate. We and others will work hard in the Congress to increase NIH funding substantially, confident of broad public support for such investments.

We have had lots of very positive feedback about *Medicine at Michigan*. I thank our editorial staff and all of the members of the UMHS community — including our loyal, keenly interested alumni — for the advances and services that we are able to highlight with this publication. And I wish our recent Medical School and residency graduates satisfying careers in the always-fascinating, still-wonderful world of medicine.

Best wishes to all.

Gilbert S. Omenn, M.D., Ph.D
U-M Executive Vice President for Medical Affairs and
CEO, U-M Health System