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SHEA News

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Managed Care in Infectious Diseases

At the recent IDSA/ICAAC meeting in San Francisco, California, a symposium by this title attempted to summarize issues presented in more detail at a 2-day conference in Chicago, Illinois, last June. The general overview showed a wide range of penetration of capitated versus traditional fee-for-service payment systems in the United States. In those "markets" that are overwhelmingly prepaid, there are strong financial disincentives to use subspecialty consultants, unless there is demonstrated (and measurable) added value (or decreased costs). Drs. Simmons, Massanari, Weinstein, Parry, and Williams pointed out that some infectious diseases specialists have the opportunity to function in an expanded role in infection control, as well as in a measurement support function, to contribute both directly and indirectly towards cost efficiencies.

An illustration of the legislative reactions that managed-care cost-saving steps have evoked is that Maryland and New Jersey recently have mandated that insurance companies pay for at least 48 hours of care for newborns and their mothers. In late September, Greenwich Hospital in Connecticut announced that it was providing an extra day of hospital care at no cost, even if insurance companies refused reimbursement. According to the *New York Times*, September 29, 1995, . . . "[T]he obstetricians (at Greenwich Hospital) were seeing more of their patients . . . suffering from streptococcal and urinary tract infections, and they felt that these conditions could have been detected and treated with an extra day in the hospital."

One of our opportunities as epidemiologists is to improve on both inpatient and postdischarge nosocomial infection surveillance of these patients. In addition, similar epidemiologic tools need to be applied to address the issues of neonatal jaundice, problems with breast feeding, and other measures of functional status of mothers and their babies discharged at varying intervals. Only if we provide better data can our own hospitals, as well as the insurance companies and the legislators, have a solid scientific basis on which to make their decisions as to the cost effectiveness of the shorter (or longer) hospital stays for the 3.5 million new mother baby pairs that are expected next year (and every year).

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