AHSCs: An Indispensable Partner for Governments

COMMENTARY

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ABSTRACT

A closer relationship between Academic Health Sciences Centres and governments will benefit the overall agenda of health system reform, contribute to the focus and immediacy of the future vision of AHSCs and give governments a deep pool of expertise from which to draw in facing significant policy challenges. Jointly established priorities in health between federal, provincial and territorial governments correspond closely to the interests and expertise of AHSCs. A mutual commitment to evidence as the basis for making decisions in health policy, in education, and in patient care, will find expression in closer interaction between these two institutions.

JEFFREY C. LOZON AND ROBERT M. FOX have provided a timely portrait of a health institution that plays a critical role in the Canadian health system. My own commentary will endorse their call for a more vibrant relationship between AHSCs and governments, as the latter work together to renew healthcare. As it is increasingly clear that issues facing the health system are interconnected, so too it

*The views in this paper are not the views of Health Canada.

should be apparent that the agenda of the system's key players should be complementary. When Canada's First Ministers met in September 2000 to discuss healthcare, they emerged with an agreed plan of action, whose significance for renewal of our health system has been underappreciated. A review of this agenda should quickly persuade the reader of its relevance for the mission of academic health sciences centres.

Central to a modern vision of the AHSC in health renewal is an understanding of the trinity of roles now performed by these institutions: patient care, teaching and research. These roles interlock, and are uniquely brought together by the AHSC. It is striking how many of the issues that preoccupy governments (and others) as they formulate health policy relate to these roles, but more important, to the nexus between them: the joining of the clinic and the "classroom" with a commitment to academic inquiry tests innovation in a real-world setting while shaping the skills and outlook of tomorrow's health professionals. Such issues include health human resource planning; fostering multidisciplinary approaches to training for primary healthcare; patient safety and quality of care; adoption of health information technology and management by the health system; performance measurement; and evaluation and adoption of health technology. In short, for these and many other thorny issues facing us, the AHSC is uniquely placed to produce, provide and use the evidence needed for sound decision-making.

It is worth noting that in recent years, the characteristic segmentation of aspects of the health system has been shown to impede progress, and that integration across these domains can only improve results and promote efficiency. This notion underlies the federal government's approach in creating the Canadian Institutes of Health Research, combining as they do the domains of biomedical, clinical, health services and population research. Similarly, governments have identified key areas where collaboration can advance renewal of the health system. Given the gains to be made through this integrative approach, it is puzzling and unfortunate that AHSCs, with their history of blending clinical, teaching and research roles, have not been better recognized as central players in health policy.

Think of the challenge of improved management of pharmaceuticals. This is high on the priority list of all governments, who have committed themselves to intergovernmental collaboration in more efficient and evidence-based review of drugs, including their safety and cost-effectiveness. The goal is to improve utilization of drugs for the benefit of patients and the system overall. Incorporation of AHSCs into this enterprise could provide an integrated setting for achieving the evaluation of best clinical practice, improved patient outcomes and teaching the next generation of practitioners. And, as suggested by the authors, there is scope for adding to the richness of the AHSC enterprise itself by more explicitly engaging other health disciplines, pharmacy being the most obvious.

Or take primary care. While the modern teaching hospital symbolizes the pinnacle of specialized care in the public mind, the AHSC can play a key role in the adjustment of the primary care system to new models of integration of professions

and types of optimal care. (Primary care reform in this context means both optimal "first contact" of patients with the healthcare system, and a more integrated health system across the continuum of care.) AHSCs have already been in the forefront of innovation in physician remuneration, as the authors explain. The journey of reform that still lies ahead should continue to draw on the mission of the AHSC in order to advance such additional key components of primary care as multidisciplinary collaboration in providing service, information management systems to enable patient-centred tools such as the electronic health record, and applications for telehealth services (thereby addressing some of the needs of Canadians in remote locations).

There is another dimension to the AHSC in relation to primary care: as the interface between primary and secondary services, these institutions have an as-yet-not-fully-utilized role in coordinating services of disease prevention and chronic disease management. Indeed, the AHSC can be a vital planning partner in establishing integrated services in a variety of settings, according to patient needs. The patient care and education missions in particular are relevant to the goal of linking acute and continuing care, but research and evaluation are important too. The vision of health services centred on patient needs, in the form of home care, palliative care, or social services support, cannot be achieved if these services are divorced from acute care. Through engagement in planning for health services beyond the borders of the teaching hospital, the AHSC can make an enormous contribution to the improvement of primary care.

Similarly through the education mission, multidisciplinary cooperation in the delivery of health services can best be achieved in the long run by cooperation across disciplines in the early days of training, and right through to practice. Is it reasonable to expect the health professions to cooperate optimally in primary care, if this goal has not shaped the training experience?

Another priority established by governments is patient safety, recently the focus of this journal (HealthcarePapers Vol. 2, No. 1, 2001). Several themes emerge from the papers in that issue and substantial international work, all of which are relevant to the threefold mission of the AHSC. These include professional development and continuing medical education that gives pride of place to patient safety, the importance of data within the healthcare setting (both to avoid error and support performance measurement), getting governance right (in terms of mechanisms and culture) and the joining of professional and institutional responsibility.

As a final example of the synergy that ought to occur between AHSCs and the health agenda of governments, one can turn to public health. Just as the clue to the Sherlock Holmes mystery was "the dog that *didn't* bark in the night," the contribution made to the health status of individuals and populations by public health infrastructure and interventions is enormous, if not immediately recognized and valued. Facing significant public health challenges in an ever-shrinking and interactive world, governments will need to rely increasingly on AHSCs. When events occur that require acute care, the institutions of the AHSC are in place.

Moreover, these centres contain the backbone of a laboratory infrastructure (always in need of maintenance and upgrading) that is essential in the diagnosis and identification of pathogens and agents causing illness; they house poison control centres, and link to food safety and animal health networks. In short, many AHSCs are vital resources that provide response capability and link to national surveillance networks, enabling the system as a whole to detect outbreaks of illness, assess trends and deliver highly sensitive laboratory analysis upon which the public health system is profoundly dependent.

It should also go without saying that the human resources that will carry forward the public health system into a challenging future are trained in the AHSC. Among the many tasks confronting decision-makers dealing with health human resources is to make adequate provision for the public health workforce of the future. AHSCs play these roles in public health, but it is not always evident that they themselves recognize it, or are recognized for it. Making more explicit the AHSC-government synergy in public health would make the system more seamless and thereby improve its performance, for the public's benefit.

The intricate and nuanced make-up of academic health sciences centres is reflected as well in the delicate interplay of roles and responsibilities in health of federal and provincial-territorial governments in the Canadian system. Lozon and Fox suggest that AHSCs are national resources. Even this is not simple. The national dimension of the AHSCs is truer in reference to the research and educational missions, less so to the patient care mission (although the need for mobility of patients requiring highly specialized care across jurisdictions is not unheard of!). If health research is international in its very nature, how can it not be national in the Canadian context? Similarly, health human resources are highly mobile, within and outside Canada, during and after training. These are national realities that speak to the broader sharing of knowledge, data and human resources. AHSCs, therefore, must necessarily paint on a large canvas. The shared preoccupations of governments in regard to health are an expression of very broad challenges that necessitate as never before the participation of AHSCs.

Potential for Collaboration

How should this potential for collaboration be exploited? How can the riches of the AHSC be mined more extensively for the benefit of patients and their communities? The first step is a formal recognition of the benefit in a closer relationship between AHSCs and governments as the authors suggest. If either player sees the relationship as one-sided, the game will never start. If neither sees the advantages of mutual support and complementarity, the relationship will never flourish and the advantages of collaboration will not be realized. On the other hand, closer collaboration between AHSCs and governments will be proof of the commitment of each to base patient care and public policy on the sure foundation of evidence.

The second step is the establishment of mechanisms for exchange of information and ideas about opportunity and

need. I offer one small example in the research domain to make the point. The federal-provincial-territorial Advisory Committee on Health Services has a working group on research, which last year published a report, *Listening for Directions*, following a consultation with all Deputy Ministers of Health, outlining their preferences for academic research priorities, based on the policy agenda that confronts them. This process was undertaken in cooperation with the Institute for Health Services and Policy Research, the Canadian Institutes of Health Research, the Canadian Health Services Research Foundation, and the Canadian Institute for Health Information. It is an important process innovation with great potential for linking the policy needs of governments with the intellectual and experiential power of AHSCs. In the short term, this document, representing as it does the preoccupations of health departments, could be used as the basis for establishing research and policy collaborations. In the longer term, AHSCs could be incorporated into the process in a second round.

Third, greater collaboration across disciplines within the AHSC will make the institution far more persuasive and influential in its interactions with governments. If all the relevant disciplines can be incorporated into a common vision for the AHSC, then the prospects for a truly integrated health system will be greatly enhanced and tangible. Governments will respond to such a demonstration of solidarity, recognizing that positions taken and advice offered are less the result of vested interests speaking and more a reflection of rigorous inquiry and frontline experience.

Finally, consistent attention by governments to recent commitments to health research and ongoing performance measurement and reporting should inevitably draw the players together. An appetite for sound information and relevant evidence will be satisfied through proximity to institutions that can supply them! All institutions will have a stake in, and be affected by, high quality performance measurement and reporting of health outcomes.

The challenges facing the health sector are not abating. It can only help to face those challenges together in productive and collaborative relationships.

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