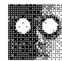
Governments, Policy Directions and the Future of Academic Health Sciences Centres



COMMENTARY

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ABSTRACT

Governments and the policy-making bureaucracy are faced with all of the challenges currently facing academic health sciences centres (AHSC). Traditionally, AHSCs and their faculty partners were key players in the development of policies that defined the directions of the healthcare system. A better understanding of the determinants of health, demands for new community services and an inflexible workforce are forcing governments and policy-makers to re-evaluate the role and responsiveness of AHSCs as directions are set for the system of the future. AHSCs must engage policy-makers if they expect to continue as a major influence in the direction of a Canadian publicly funded health system.

IN THIS EDITION of Healthcare*Papers*, the lead authors have described in detail the evolution and current status of academic health sciences centres (AHSCs) within the Canadian system. They have outlined the pressures on the academic health sciences centres including diminished financial support, increasing demands, new care delivery forms, issues of physician remuneration and new models for research. Governments and their policy-making bureaucracy also face these pressures. The authors have also discussed the lack of coherence between the directions and goals of the academic health sciences centres, their university faculty partners and governments. Most particularly, they highlighted their belief of a

lack of comprehension between governments and academic health sciences centres concerning roles and responsibilities.

However, the issues and challenges raised are not new, but the urgency for dialogue is more acute. Over the last decade, many authors in both the United States and Canada have highlighted challenges or pressures faced by academic healthcare institutions (Barondess 1991; Korn 1996; Naughton and Vana 1994; Theid et al. 1994; Martin 1996; Blumenthal 1997). In 1991, Barondess suggested the reorganization or redirection of the academic health sciences centre was energized to a substantial degree by the widening perception that the agenda of academic health sciences centres and broader society were on increasingly divergent paths. This observation appears to be valid today. The setting of new directions for AHSCs is a challenging task not only for the centres, but also for the governments that are their primary source of operating funds. Most authors writing on the topic of AHSCs would agree that the status quo has not been an option for some time, and if anything, the current pressures to rethink the role and directions of the academic health sciences centre will intensify over the next few years. The most fundamental question, if the status quo is not an option, is then: What is the preferred direction, and how will the journey start? Importantly, the current pressures will force governments to new directions, with or without the participation of AHSCs.

The noted futurist Ian Morrison wrote in his book *The Second Curve* (1996) specifically on the issue of healthcare. He suggested that the systems of the future would be formed as a result of pressures in five major areas. Those included biotechnology, information technology, increased consumer knowledge and choice, the greater emphasis on population health and the role of the previous system. Morrison has also spoken on the concept of first and second order change. A change or improvement that occurs within a system or structure without fundamentally changing either the system or structure is described as first order. The end result is more a reinforcement of the current system than one of fundamental change. Second order change is much more fundamental with significant changes in focus and structure. To date, one could argue that much of the change in the healthcare system has been first order.

More recently, Lomas (2000) raised a new set of issues and challenges for the system, its components and for policy-makers. He noted that "if we are not careful, we may become victims of the lengthy transition process from ideas to policy – implementing policy solutions of the 1980s with only a partial fit for the issues of the 21st century." Additionally, he suggested other areas of action would emerge as issues. These included an explicit clarification of national values, significant reform of workforce education, in-service training and regulation, and lastly, an enhanced role for government regulation of valid health information. Each area is of interest, and these will be integrated by policy-makers as new directions are planned for the healthcare system.

Academic health sciences centres are but one component of the system, albeit an important component. Many jurisdic-

tions have one or more AHSCs within their boundaries while others have none, but all provinces and territories fund and oversee the directions of an entire healthcare system. Within governments, the role of policy-makers is primarily to distil evidence and information about the system, the public's expectations, and to advise governments of opportunities to shape and facilitate the directions for the systems and services including AHSCs. For governments, it is a continuing era of fiscal restraint combined with increasing public knowledge and expectation, not only about acute care delivery services, but more importantly a greater understanding and desire to deal with the determinants of health, particularly at the community level. Moreover, within the resources available to any jurisdiction, policy-makers are becoming increasingly focused on mechanisms to decrease the burden of illness and to support services within the community in an attempt to control the increasing costs of medications, technology and interventions. No one can argue the benefit of improving the general health of the population. Governments must also plan for an increased demand for home and residential support services for an aging population. The public is also expecting an integrated, seamless continuum of care with improved accessibility, particularly for primary care at the community level. To many in the public and those active in community affairs, academic health sciences centres have seemed to become increasingly centres of intensive diagnostic and interventional activities directed at a very small portion of the population. Against this background, policy-makers are challenged to understand where the AHSC with its roles of patient care, teaching and research fits in the system of the future.

There is no doubt that the care provided by the academic health sciences centre is of high quality, but there remain challenges. In an era where the focus is shifting to community-based programs, many regional AHSCs have been slow to respond. Within major metropolitan areas, the provision of services, particularly primary care to high-risk populations such as the homeless, the poor and isolated seniors, remains problematic. The provision of services to rural and remote areas continues to be a question for governments. With respect to the high-end services controlled by AHSCs, equity of access often remains to be resolved in many areas of Canada.

On the education side, the AHSC and its faculty partners are major players in the production of healthcare professionals. The responsiveness of these partners to emerging educational needs for both the current workforce as well as the training for a future, flexible workforce must be improved greatly. In the current environment, with knowledge doubling almost yearly, post-secondary institutions must fast-track new courses and programs. The articulation of secondary training from community colleges to universities is a necessary requirement in stabilizing the workforce and attracting new recruits. Governments, particularly health departments, must be involved in the planning for the current and future workforce. Issues of education funding, standards of service delivery and care, and the health policies primarily rest within the purview of governments. Governments will no longer be comfortable with academic

institutions and professional groups as the sole adjudicators of training and standards for the healthcare workforce.

For academic health sciences centres and their faculty partners, it seems clear that a renewed emphasis or focus on the determinants of health, primary care and a more humanistic approach to dealing with individual patients, families and the general population will be fundamental to future success. Moreover, as communities and the public ask for an integrated, seamless system, academic training centres must become leaders in innovative methods of integrating and teaching team relationships. New, combined approaches to care of patients and families are looked for in both academic health sciences centres and the community at large.

Lastly, the arena of research is a focus of growing concern with policy-makers. There is a significant concern about the open partnerships (Lewis et al. 2001) between AHSCs and technology manufacturers focused on developing diagnostic or therapeutic equipment and modalities that increasingly seem to do little in terms of meeting the needs of the underserviced populations or of improving the overall well-being of the public. Governments are becoming more focused on mechanisms to decrease the burden of illness in the populations they serve, particularly as the population continues to age. To some extent, this focus seems contrary to the mission of AHSCs and generates a tension between the governments and the leaders in the teaching hospitals. The tension will continue to increase in the absence of demonstrated cost-effectiveness or cost-benefit studies for high-cost intervention or treatments. If these concerns are not resolved, governments will be reluctant to increase resources to an AHSC as opposed to dealing with the determinants of health at the community level.

It is unclear why academic health sciences centres and their academic partners have been unable to reach a clear understanding between themselves as to what their roles and direction should be. Both institutions are publicly funded for the most part, and they are committed to serving the best interests of the public. Clearly, one of those interests should be improving the health status of the public, and a second interest should be the production of a skilled, flexible workforce to meet the needs of the healthcare system today and tomorrow. It is vital that academic health sciences centres and universities define new working relationships, including an improved flexibility in terms of new training programs and educational approaches to support the lifelong learning of healthcare teams.

The final point is that academic health sciences centres and their faculty partners must engage policy-makers in a discussion about future directions of the healthcare system. Recently, Pelligrino (1999) discussed the role of the AHSC from an ethical perspective. An important line of exploration was questioning the mutual ethical obligations of society and the AHSC to each other. The authors of the lead paper note their concern about a lack of comprehension between governments and academic health sciences centres around roles and responsibilities. Their concern is well founded, and the urgency for dialogue is most acute. Governments, post-secondary institutions and AHSCs are here to serve the public, first and foremost. The question of

mutual ethical obligations could be a beginning for the thoughtful dialogue about AHSCs and the evolving health-care system of the 21st century.

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Discussion

"Excellent. It is exactly the in-depth discussion that we need more often. The multiplicity of views is very healthy and the willingness among authors to disagree is refreshing. Finally the rebuttal is essential. Very timely to say the least!"

- **Dr. Robert McMurtry,**
GDW Cameron Visiting Chair Health Canada and past Dean of the University of Western Ontario Faculty of Medicine and Dentistry

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