

AHSCs: The Movement from Brokers of Scarce Resources to Victims of the Changing Environment of Healthcare Delivery



COMMENTARY

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ABSTRACT

Academic health sciences centres in both the United States and Canada, once major “brokers” of medical and biomedical knowledge and other scarce resources, are frequently depicted as “victims” of the environments in which they exist. While the national and local environments in which these organizations exist differ substantially, the integrity of AHSCs in both nations is threatened by a variety of emergent and continuing externalities. It is important that AHSCs develop a sufficient vision and market to be self-determining and successful in countering pressures that challenge their teaching, research and service activities. Leadership in both Canada and the United States must become much more skilled in strategic management to achieve this goal.

Background

With over 100 academic health sciences centres (AHSCs) spread over a very diverse set of states, academic health centres in the United States, as in Canada, are incredibly difficult to typify. As described below, these organizations, once valued as repositories for information, complex and unique services and manpower supply, can no longer be depicted as the U.S. brokers of scarce resources or uncontested aspirants to achieving designation as centres of excellence for very complex care.

Over the years, many writers on U.S. academic health centres have scrutinized the directions AHSCs have taken in our rapidly changing and sometimes turbulent health environment. In both the United States and Canada, critiques of AHSCs have focused on the imbalances associated with the teaching, research, and service missions of the AHSC. While many have decried the organizational design of the AHSC, few have carefully thought through the options and opportunities that AHSCs have in the changing world of medicine.

Grounded in the very important observations by Lozon and Fox in their lead paper on the Canadian AHSC environment, this commentary presents a brief overview of my observations of events leading to the state of U.S. AHSCs at the turn of the century. This is followed by a set of observations that challenge the possibility for U.S. and Canadian AHSCs emerging as organizations in command of their strategic futures.

Academic Health Sciences Centres in the United States

It is important to begin by stating that in

a nation with over 42 million uninsured individuals, academic health centres serve as a principal part of the U. S. “safety net.” This is an enormous constraint on the ability of AHSCs to balance their mission of teaching, research and service – and presents a constraint that is not fully shared with Canadian counterparts. But it is a constraint in the United States that is shared by AHSCs with their non-AHSC counterparts.

AHSCs have been seen as targets for tactically engaging federal and state policies pertaining to balancing the physician specialty mix. Changing financial incentives associated with funding for the care of the poor and uncertain manpower policy contribute to an environment where many AHSCs have come to see themselves as experiencing a loss of self-determination. While many AHSCs were shielded from aspects of regulated environments (for example, AHSCs in New York were buffered from the problems associated with the initial implementation of a reimbursement system employing DRGs), AHSCs do not enjoy a “favoured nation” position in the U.S. population of healthcare delivery system organizations. In contracting for services, the aggressive U.S. insurance industry, characterized by managed care, has frequently failed to differentiate the range and quality of services provided by AHSCs from their non-AHSC counterparts.

Certainly there has been innovation in AHSC organization in the United States. There have been mergers and consolidations as well as the transfer of university hospitals to investor-owned and other forms of management schemes. Yet, in the competitive environment of the United States the strategic management

of academic health sciences centres has proven to be a very difficult task – with AHSCs taking on, in many environments, a “victim-like” status.

Over a decade ago my extensive interviews with AHSC leadership revealed a diminished AHSC influence throughout the medical communities in which they were located. AHSCs were described by their leadership as having experienced loss of control in areas as diverse as access to labour, patients (especially paying patients), continuing education revenues and specialty/knowledge brokerage. In the United States, there continues to be a narrowing of the distance between the AHSC and community partners and competitors. This is characterized by a levelling of technologies throughout urban hospitals as well as in hospitals at the fringe of urban areas that compete with AHSCs for the valued referral of patients seeking specialty care. As residency programs have been resized and extended into the broader community, the ability of AHSCs to have a strategic advantage by virtue of their role relating to the distribution of such resources is diminished.

Elsewhere, I have documented a theme (although unarticulated) of loss of AHSC self-determination (Schneller 2001). This theme is dominant in the analysis by Ginzberg (2000) and his associates who write about the several decades’ long dominant influence of social policy on the AHSC’s engagement with its mission. Principal deterministic events include the infusion of Medicare and Medicaid dollars in the mid-1960s, changing immigration laws regarding international medical graduates, the influence of charitable foundation dollars to shape AHSC behaviour, and the managed-care revolution.

Ludmerer (1999) has chronicled the substantial influence of managed care on AHSCs as multifaceted service and educational organizations unable to navigate in an environment where patient revenue generation leads to the “erosion of the clinical learning environment, the diminishing of faculty scholarship, and the reemergence of a proprietary system of medical schools.”

The AHSC’s role in research and development leading to determination and coordination of services and standard-setting is much reduced in the face of the environment of managed care. Enlightened managed-care organizations have launched their own research organizations to scrutinize best practice and outcomes, establish their own benchmarks, and frequently restrict the distribution of their findings, which they see as part of their competitive advantage. Many of these companies are investor-owned and frequently unwilling, in an environment where they desire to retain competitive advantage, to share their findings with other community providers. The consequence of this is substantial – reducing the ability of AHSCs to meet expectations of the clinical community who must achieve the goals of the insurers, the organizations in which care is provided, and the patients. The demand for better outcomes is as likely to come from major purchasers who have come together to influence the system (e.g., the Leapfrog Group) as it is from the initiatives of the AHSCs. U.S. AHSCs also continue to compete with non-AHSCs for public and private research dollars and frequently find themselves disadvantaged as a result of their having to comply with a variety of restrictions associated with their not-

for-profit status and reliance on government subsidy. Clinical trials are increasingly conducted through community-based non-AHSC organizations, and an industry that includes institutional review boards, servicing the broader research enterprise, has emerged.

AHSC hospitals, once the centrepiece of the AHSC configuration, are now recognized as being substantial cost centres that are difficult to manage. Both public and private sector AHSCs have unbundled the hospital component and, in many cases, brought in outside management companies or become part of the investor-owned infrastructure. These organizations have been especially disadvantaged by the movement of procedures from inpatient to outpatient and have experienced significant difficulty in resizing their capacity. U.S. AHSCs have been unevenly successful in becoming local, regional, national and even international referral centres. The causes for failures are not clear – but, it is certain that in many instances management has not been equipped to meet challenges associated with migrating excellence in patient skills into new clinical and business environments.

Over a decade ago, I argued (Schneller 1987) that AHSCs, which had once been seen as an instrument for social and professional change in the United States, needed to re-establish their role in brokering health manpower and knowledge throughout the system. At that time I believed that there was still an essential monopoly of professional knowledge residing in the AHSC coffers and that in many cases these organizations had a unique advantage. Recently, I have argued that in a clinical environment that

requires rapid organizational realignment and opportunities for renewal, AHSCs have failed to define, refine and understand their central competencies (Schneller 2001: 171). Once the principal producers, warehouses and brokers of knowledge for a society that was not connected to the modern communications tools of the 21st century, many AHSCs are now not leading their non-teaching counterparts. Characterized by patient populations of great clinical severity, they increasingly lack the knowledge and delivery platform to prepare the cadres of practitioners who will be necessary to manage a population characterized by chronic illness and in need of prevention, and they have been criticized by provider organizations for not adequately preparing graduates to meet the needs of the full range of community practice settings.

U.S. and Canadian Convergences and Dissimilarities

I agree with Lozon and Fox that it is an important time to assess how AHSCs will reassert their value in the new era of healthcare. There is, I believe, good reason to continue to link analysis of the AHSC to its broad (i.e., not uniquely physician) faculty.

Under pressure of shrinking margins and demands that U.S. faculty spend substantial time in the clinic than in their research, there is a growing chance that the AHSC will look even more and more like its community hospital counterparts. Growth in NIH budgets in the United States may counter this trend. Canada, without doubt, has a unique opportunity to reconfigure its research enterprise around the infusion of new research

dollars into the system.

U.S. community hospitals and integrated delivery systems have increased their levels of complexity and incorporated a wide range of technologies into their operating structure. In this environment, AHSCs experience differential success in sustaining their reputations as referral centres at the local, regional, national and even international levels.

Readers of the Lozon and Fox paper who have knowledge of the U.S. system will be convinced that Canadian AHSCs, like their U.S. counterparts, are indeed threatened – but less by marketplace demands than by clarity of purpose. In both the United States and Canada it has been argued that the medical school/hospital axis shapes the face of the AHSC. Lozon and Fox argue for a definition of AHSCs that is more multidisciplinary. But such a definition cannot emerge unless there is a more focused effort to redefine the role of the AHSC in the Canadian system. I would contend that the task focus on AHSCs provides too narrow a definition. The failure may not be, as Lozon and Fox contend, the AHSC's inability to illuminate the underlying tensions among the three AHSC missions of care, education and residency, but because it provides no clear vision for neutralizing the tensions.

I contend that in the United States the plight of AHSCs has been overly focused on their failure to command scarce resources rather than on their inability to articulate a clear vision and mission to guide and deal with change and emergent issues. Indeed, having witnessed other industries in the United States and abroad, one might argue that the AHSCs have actually been very slow

to change – but have expended great efforts around a set of persistent stressors regarding patient income, research and the teaching mission.

Lozon and Fox argue that the AHSC is a victim (in many ways similar to their U.S. counterparts) of reduced dollar resources, increased accountability and cyclical trends in health manpower policy. One might wonder why AHSCs have been so ineffective in becoming the repository of knowledge regarding the appropriate mixes of manpower and, therein, gaining the “policy edge.”

Lozon and Fox are correct that the relationship between the university as the degree-granting entity and the AHSC operates successfully because “the caregiving organization is willing to accept the higher costs and is committed to the same educational mission.” While this may serve as a rationalization for the continued linkage of the AHSC and its educational partners, AHSCs in both Canada and the United States must be the leaders in the design and development of new practice models that will be accepted in their communities.

In Canada, as in the United States, the AHSC is challenged by the development of regionalized integrated systems. AHSCs may indeed be the losers if they are rolled into a larger network of regionalized healthcare services in Canada. Yet their failure to understand the importance of working in harmony with others may mean that they are not just subordinated to primary care and home health service organizations, but that they are subordinated to aggressive community hospitals who have access to technologies that mirror the AHSC. It is not clear that government entities in the United States

or Canada are prepared to offer AHSCs “favoured nation status.” By working in collaboration with government, AHSCs would almost certainly become even more dependent on external definitions of the AHSC project – which in the long run would not solve AHSC problems.

Lozon and Fox argue, on the one hand, that the AHSC could be charged with the responsibility to lead health services integration, planning, information and technological standardization on an integrated basis. They also argue, however, that in the face of system change, “the AHSC must be seen as a participant and a stakeholder but probably not the generator of new models of delivery or funding.” I would suggest that neither Canadian nor U.S. society can have it both ways. AHSCs must assume a new 21st-century leadership role.

Conclusion

While the concept “victim” is usually reserved for individuals caught up in actions beyond their control, one can easily read the literature on academic health centres in the United States and Canada as histories of organizations that are relatively powerless to set their own direction, overwhelmed by policies over which they have little control. Such histories also depict organizations stunted in their attempts to change by having internalized an ideology of self-defeat and impotency. U.S. writers on academic health sciences centres, while not clearly articulating their bias, have viewed these organizations through “an analytic lens associated with the population ecology” perspective (Shortell and Kaluzny 1994; Hannon and Freeman 1984). In this scheme, AHSCs are characterized as

hampered in their ability to affect their own destiny. This perspective sees external environmental pressures as the principal forces for organizational progress and envisions managerial efforts as having little real influence on the organization’s long-range structure, functioning and even survival. In such settings, managers “tinker at the margins,” as a sector moves ahead in its contemporary time and space. The population ecology lens frequently denies the ability of leadership to actually set new courses and to assure that organizations can make a purposive difference. It would be, I believe, unfortunate for AHSCs to assume such a stance.

“Managing Academic Health Centres: Meeting the Challenges of the New Health Care World” (Commonwealth Fund 2000) helps to focus the discussion of AHSCs much more on the strategic and managerial issues pertaining to their survival and redefinition. It is pointed out that “the most important capability for the future success of AHSCs and their mission-related activities is the development of the capacity for innovation: skilled, creative leadership; adaptive and flexible governance; improved information systems to support decision-making; and an appropriate balance of centralization and decentralization within the unique structure of the university-affiliated clinical enterprise.” Achieving this will not be easy, requiring that these organizations “become much more self-critical and open than they have been in the past.”

This is a time to engage in a variety of strategic management exercises for AHSCs, including strategic thinking and the development of scenarios that provide tactical advantages. Such scenarios must be attentive to changes and opportunities

associated with changing local and regional markets, globalization of healthcare services, the adoption of business models used in other complex industries and the emergent field of knowledge management. Failure by AHSCs to become the centres for knowledge management in this century will lead to a continuing diminishment of their capacity to claims of excellence in medical markets in both the United States and Canada.

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