Academic health centres: what is the agenda for research?

A new construct has entered the realm of health services policy and planning in the United Kingdom. The latest approach to health care delivery in the nation's capital city introduces 'academic health sciences centres' as a component of future services. These are defined as 'corporate entities with integrated governance and leadership structures that have assumed the role of strategically and operationally managing both health care and relevant academic resources'. Their role is to bring together 'world-class research, teaching and patient care'.[1] From an international perspective, it is remarkable that it has taken this construct so long to find its place in mainstream health care policy in the UK. Academic health centres (AHCs), to adopt the most widely used label, have long played an important role in North American policy and academic discourse.[2–4] Less well-documented in English, but closer to home, The Netherlands has experimented with a range of models across its eight academic medical centres. The UK's neglect of the topic has perhaps been because of the desire for uniformity of organizational structures within the public sector and because the relationship between universities and the NHS has functioned reasonably well.

Defining academic health centres

Academic health centres can be defined either by their organizational form or by their mission, although both approaches present difficulties. Historically, AHCs were defined as a distinct form of partnership between a medical school and a teaching hospital. In the USA, and in some European countries, the university often established and owned the hospital so as to ensure access to patients for research and educational purposes. The reality of the modern AHC is rather more complex, not least in the USA where it has reached its most elaborated form including a range of clinical partners, not all necessarily under common ownership, as well as other schools of professional training. The AHC will also usually incorporate a faculty practice plan, the vehicle through which academic doctors are employed. Faced with this complexity, a recent committee of the Institute of Medicine decided to view the AHC 'not as a single institution but as a constellation of functions and organisations committed to improving the health of patients and populations through their roles in research, education and patient care'.[2] As a result, most AHCs would now be better described as academic health systems.

Ownership is equally complex. In less than half of AHCs in the USA there is common ownership of the medical school and clinical facilities, and of these around 60% are publicly owned.[5] The remainder function through a range of mechanisms for affiliation. Structures of ownership and governance are so varied that US commentators have constructed elaborate typologies of AHCs in an attempt to discern order among the chaos.[6]

What all AHCs have in common is their commitment to a tripartite mission of clinical care, education and research. Each partner pursues this mission from a distinct position: universities are more focused on education and research, health care providers on clinical service. In publicly funded services, institutional accountability both to ministries for education and health can be divisive.[7] But both partners must attend to all three strands of the mission to maintain the scale, range and intensity of activities that distinguishes AHC partners from other organizations in their respective sectors. Operational interdependency for all three strands of the mission ties universities and health services together in a complex relationship that requires frequent re-negotiation. Definitions based on mission are also problematical because the profile of activities is highly variable between AHCs, on both sides of the Atlantic.[8,9]

Academic health centres in the United Kingdom

The arrival of the AHC concept in British health care policy may point to issues that are of relevance internationally. Imperial College, London, which is among the world's most highly rated universities for biomedicine, has created the UK's first centre, involving a merger with two teaching hospitals. The new organization promises not only excellence in health care but also the promotion and support of research that aims to increase the competitiveness of the national economy.[10–12]

Biomedical research at the highest level now involves global competition, with funding increasingly concentrated in a premier league of universities. The Department of Health in England has recognized this by focusing NHS research funding in a small number of Biomedical Research Centres, for which a university hospital is the lead partner. Designation of such entities as academic health centres (or systems) is seen as a logical development for any government that aspires to a leading international position in biomedical research. The danger for health care is that a university's priorities dominate and diverge from those of the health care sector and of the public. Also, the establishment of AHCs should not be at the cost of undermining less research intensive universities and hospitals

which have important roles in providing clinical services and education as well as making a significant contribution to regional economies. The challenge is to develop policies that sustain a diverse portfolio.

Need for research on Academic Health Centres

Although there is a common element to many of the concerns of AHC leaders internationally, it should not be assumed that solutions from one country can be readily imported to another.[13] More research is needed outside North America to address a range of issues: investigation of the structure and governance of AHCs; more detailed studies of the mechanisms through which AHCs integrate clinical and academic management and balance the tripartite mission; studies of the importance of culture, personal relationships and leadership in maintaining successful partnerships; employment arrangements and career incentives for academic doctors and the implications of this for the tripartite mission; and the impact of academic programmes on the quality of clinical care.

More widely, there is a theme of social mission running through US writing on AHCs, which talks about the social contract between AHCs and society, and the AHC role in compensating for market failure.[14,15] In the European context, this is more likely to be expressed as a concern to understand the societal impact of AHCs.[9] More research in this area would inform policy for both health improvement and wider socioeconomic goals. Policy-making should recognize the value of diversity in governance arrangements and the need to balance the three strands of the mission of AHCs, creating different types of AHCs that are integrated within national health care systems.

Conclusion

To paraphrase the final report of the Commonwealth Fund Task Force (and with apologies to Voltaire), if Academic Health Centres did not exist it would probably be necessary to invent them.[3] No other model has yet been found to deliver the excellence in advanced clinical care, education of health care professionals and globally competitive biomedical research to which policy-makers aspire. Yet those involved in the management of these institutions often feel that policy-makers pay insufficient attention to the unique challenges they face. This is an aspect of health care delivery for which there is a substantial need for research and in which Europe has lagged behind North America.

Stephen Davies
Director NIHR Service Delivery and Organisation R & D Programme London School of Hygiene and Tropical Medicine 99 Gower Street, London WC1E 6AA
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