

# Academic Health Sciences Centres: A View from the Academy



COMMENTARY

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## ABSTRACT

*Academic Health Sciences Centres have provided and continue to provide valuable service to society. However, the lack of a clear mandate, structure, governance and administration results in their full potential not being met. As the Canadian healthcare system undergoes the reform that must occur to make the publicly funded system sustainable into the future, it is essential that AHSCs have clarification of their roles, develop a distinct governance structure and be provided a distinct budget for a set of deliverables within an agreed-upon accountability framework.*

*The paper by Lozon and Fox in this issue outlines the opportunities and challenges for AHSCs as we move forward. This commentary expands on some of these issues from the perspective of the university. At present, both partners at times feel that the other organization makes decisions that have important implications, but without proper consultation or reflection on impact. This is no greater a problem for the healthcare system than for the university and underlines the urgent need for a new definition of this strategic partnership we refer to as the AHSC. Canadian AHSCs have been impacted negatively during the past decade, and particularly so in those provinces that developed regional governance models. To assure that this does not continue to happen, AHSCs must be rede-*

*fined to be both more responsive to societal needs and more recognizable by their stakeholders, not the least of which are the public and governments.*

*The lead paper by Lozon and Fox provides a comprehensive overview of the Academic Health Sciences Centre, its origins, complexity, resilience, costs, value to society and challenges. Although I agree with most of Lozon and Fox's perspectives, in this commentary I will offer an additional viewpoint on a number of issues: the definition and role of the AHSC, relationships within (rather than with) the university, the impact of regionalization on the AHSC, and some thoughts on the future. These comments are primarily from the perspective of the university, although some reference to the healthcare delivery system and the need for fundamental change is also provided.*

## **The Academic Health Sciences Centre**

*The Academic [Health Sciences] Centre is much like a symphony with wind, string and percussion instruments playing together. Each can make music without the others. Each group usually has a leader and a special function. Together, properly conducted, each complements the other. The business of the [health sciences] centres – education, research and patient care – must be conducted in a like manner. (Heyssel 1984)*

Lozon and Fox correctly point out the organizational complexity of the AHSC. They also note that despite the recognition that an AHSC involves more than a faculty of medicine and a teaching hospital, this is the working definition that is most frequently used and the one used as the framework for much of their commentary. Indeed, despite the authors' obvious effort, their comments are largely written from the viewpoint of the teaching hospital rather than that of the AHSC per se; they also provide a more Ontario-centred view than one of the rest of Canada. This is not unexpected, given their experience, the primacy of the healthcare system and the respective size of budgets. However, if AHSCs are to meet the terms of their social contract

(Miles et al. 1993, The Commonwealth Fund 2001), they must be more clearly identifiable as organizational structures not only by the participants, but also by citizens (AAMC 1996) and governments.

Although perhaps an oversimplification, it seems useful to think of the AHSC in terms of more traditional business models. The university (company A) has objectives, in order of priority, in education, research and clinical care – but has an assembly process and distribution network capable of delivering only research and, to an incomplete degree, education. The healthcare system (company B) also has objectives, in order of priority, in clinical care, education and research, but it has complete capability only for healthcare and, to a lesser degree, in research and education. The strategic partnership – the academic health sciences centre – has the capability to produce and distribute the complete product line. This partnership makes “business” sense and would be the model developed in the commercial world, with the founding partners working hard to make the “new” entity successful. The partners in the AHSC, however, seem only partially committed to the combined entity. As Lozon and Fox point out, there is no generally accepted definition or

working model for an AHSC. Thus, the success of Canadian AHSCs remains much too dependent on personalities, careers, control, rewards and recognition. Given the unstable environment in which AHSCs must function, this is not the formula required for success.

Lozon and Fox point out some of the difficulties experienced in trying to make AHSCs work. The healthcare institutions must provide certain expensive services, not because they are necessarily needed for patient care, but because they are essential to the educational programs. Hospitals are dependent on the service delivery from students, graduate clinical trainees and faculty. Yet, the university and other groups determine the numbers of students and residents available and where they will be assigned, potentially causing major problems for the healthcare institutions. Some hospitals most interested in major tertiary or quaternary services must also provide a spectrum of "community" services in order to compete successfully for students and residents. However, viewing these same issues from the perspective of the educational institution makes it apparent why considerable tension exists within AHSCs. Thus, decisions by the healthcare institutions to develop new programs, increase emphasis on an existing program, discontinue an old one or move to programmatic service delivery all have major implications to the university partner. Faculty may need to be recruited or moved to another site while other arrangements must be developed for trainees.

This has been a particular problem in those parts of the country where regionalization has occurred. Some faculty members now spend enormous propor-

tions of their time travelling with their trainees to that location determined to be the most appropriate delivery site for a given service, away from their office, research facilities and colleagues. In those hospitals or regions that have developed programmatic delivery models, there is the potential for major disruption of academic programs. If the university is organized by traditional departments while the healthcare system develops cross-cutting programs, the clinical leader who controls resources may have no relationship to the university and little interest or skill in research or education. In this situation, clinician scientists may be exposed to excessive clinical work in an environment in which the university has little or no control (Smith 1998).

It seems clear that universities must be viewed as more important to the partnership than the provider of students, residents and professors as "helping hands" to the main enterprise of hospitals, that of providing health services. This issue will become even more problematic as the universities increasingly realize that the traditional teaching hospital provides neither the proper classroom for much of health education nor the ideal laboratory for the future health research (ACMC/ACTH 1995). More about this later.

Another issue that continues to challenge the relationship between the partners in the AHSC is that of hospital-based research institutes. As noted by Lozon and Fox, the development of research institutes demonstrates the commitment of hospitals to research and the overall academic mission, and in the ideal world would simply function to increase the overall scholarly potential. Unfortunately, the organization and

governance of research institutes frequently creates yet another focus for strain between the partners. Bernadine Healy, when Director of the National Institutes of Health in the United States, described the formation of research institutes by hospitals as part of a “new paradigm” – a response to not receiving enough attention. Certainly, the development of prominent research initiatives is seen as a means to distinguish the teaching hospital from the community hospital and to increase the profile of the institution within the community. However, this may not be the profile most valued by the community (AAMC 1996). Recently, a major Canadian academic hospital did a survey in its community and found that the extremely high visibility program around which it was planning many of its strategies was not viewed nearly so positively by the citizens, who instead rated access to user-friendly care as more important. Hospital research institutes have created competition with universities for faculty, often being successful perhaps because they can pay higher salaries and “protect” the individual from the responsibilities in teaching and administration expected of colleagues in the academy. However, institute researchers also expect the prestige of a university appointment and covet the protection of academic freedom and tenure status normally available to faculty. This “best of both worlds” desire results in many challenges for administration of both partners. Finally, there is the competition for funding, both from the granting organizations and within the community. Whereas competition is usually desirable, there is a finite pool of resources that calls out for integrated planning and management.

## Relationships within the University

*A University president died and went to hell. When told by the Devil that he would be president of the University of Hell, the president expressed his pleasure. But the Devil said, “Oh, you don’t understand, this University has two medical schools.”*

Health faculties, and particularly faculties of medicine, find themselves in a difficult and not always supportive environment within the greater university. There are many reasons for this, not the least of which is the perception by the rest of the academy that faculties involved in health are favoured for funding. They use the knowledge that funds do flow from government departments of health to support the education mission and at times the research role. They are also aware of the ability of health science researchers to obtain research funds. Indeed, many faculties of medicine in Canada attract 50% or more of the total research funding to their university. What is not widely appreciated within the university is that these sources of funding are associated with both deliverables and costs. The research grant dollars will soon decrease if the Faculty is not able to provide the infrastructure needed to support the research. This seems obvious, but we frequently lose sight of the fact that for each grant received (in the absence of included overhead) there are added expenses to the Faculty. Similarly, if the clinical service expectations of the health-care partner are not being met, funding will not be continued. Within this environment, the faculties of medicine must argue effectively for their budget.

During the 1990s, the global budget to universities was decreased, and in some provinces dramatically so. The response to such restraint tends to be either across-the-board cuts or the removal of some funding from the “fat cats” in order to keep the smaller programs alive. Either of these approaches made it very difficult for the faculties of medicine to maintain their excellence and served to heighten tensions with other faculties. Being part of a university but living on the cusp of the healthcare system creates daily challenges in the management of Faculty affairs. During the 1990s, this tension was increased considerably by the fact that the healthcare system also received budget cuts; the response was to seek non-core (read education and research) areas to reduce or eliminate. Thus, a faculty of medicine inhabits that unenviable position of being a part of one, and a partner of another, large budget centre, but without control or much influence over the decision-making processes in either. The lack of definition of the AHSC and its vague governance amplifies this difficulty (ACMC/ACTH 1995). Whereas these problems are amplified during periods of budget reductions, they exist and plague the organizations even during periods of growth.

### **The Impact of Regionalization**

Perhaps no other trend in healthcare organization has threatened the AHSC more than the regionalization of the 1990s (Smith 1998). From the viewpoint of the academic mission, it would be easy to take the view that if regionalization is the answer, it must have been a dumb question. However, as with many other changes to complex systems, not all of the

outcomes have been bad.

A major reason to regionalize the delivery of healthcare is to achieve decentralization of decision-making (Lomas 1997). However, within a region, and particularly in those large regions associated with an AHSC, there is actually a centralization of decision-making. This has considerable implications to the academic mission. In the more traditional system, a university has affiliation agreements with a number of “teaching” hospitals as well as with other long-term-care and community organizations. Regionalization voided all of these agreements and the considerable opportunities for faculties within a university to negotiate support for academic programs with their various healthcare partners. With regionalization, there is only one healthcare partner in the AHSC, and this partner has a much broader mandate than any of the traditional ones. Deans of medical faculties who had enjoyed seats on the boards of a number of teaching hospitals found themselves excluded from the regional boards (now corrected in most jurisdictions) and continually scrambling to protect valued programs of education and research, but also unique programs of healthcare. Within the broadened mandate of the regional boards, there were variable but significant degrees of restructuring of systems of care delivery. Thus, medical faculties were “forced” to relocate educational programs and even research initiatives because of decisions within the region. This caused major disruption and in some cases the loss of excellent programs that had taken years to develop. In many jurisdictions there were increased expectations for clinical care from the academic physicians

with a subsequent reduction in protected time for education and research (Canadian Medical Forum 1997). Morale within the faculty became extremely low, and good people moved to less stressful environments. It has taken several years for the regional boards to re-identify with the education and research missions, develop meaningful affiliation agreements with universities and, more important, redevelop the trust and working relationships that characterize successful partnerships.

Perhaps one of the most difficult issues is that related to the pursuit of excellence. The regional boards have responsibility for the complete range of health services, with hospital care being only one segment. Moreover, the tertiary/quaternary care portion – usually identified with the AHSC – is an even smaller segment. The boards were challenged with what in reality was a huge merger of many different cultures, and there was a desire to have a system that functioned without favourites. Rightly or wrongly, the major teaching hospitals were viewed as being resource rich and favoured, and the result was a conscious effort to redistribute high-profile programs throughout the region so that there would be one *good* standard of healthcare throughout the region. But the enemy of excellence is “good” and this philosophy (which some would characterize as anti-academic) represented one of the greatest challenges to the maintenance of quality academic programs.

Whereas these bad effects of regionalization have represented an enormous challenge to the AHSC, there have also been real, or at least potential, benefits. First, regionalization abolished or greatly diminished the destructive competition

between teaching hospitals located within the same city. But it also diminished the constructive competition that served to raise the standard of excellence throughout a medical community. Perhaps of greatest potential benefit to the academic mission is the opportunity to have access to community resources both for education and for research. This remains largely an unrealized goal, but one that the AHSC will need to firmly embrace (Smith 1998). Much of what students in the health disciplines need to know can best be taught in community settings rather than the tertiary care hospital. Importantly, many of the major research needs of the system will also use the community as the laboratory. Thus, outcomes research, studies in health economics, health policy research and population health research require information systems and a community linkage. Even as we attempt to utilize the vast information contained in the human genome, we will need community settings. Studies into genes of susceptibility will determine where we focus our prevention strategies, genomic pharmacology will determine who will respond to given medications, and genetic epidemiology will help us understand the reasons for differing prevalence of disease. These new directions do not lessen the importance of more traditional clinical studies to improve the understanding, diagnosis and management of disease, but rather point to the need to have a research base greater than only people admitted to hospitals. Regions with large populations and integrated information systems can provide this opportunity.

The final chapter on the overall impact of regionalization on academic

programs of the AHSC has not been written, but it is my strong sense that the dominant effect has been negative and that it will take years to recover.

### **The Future**

The major themes that need to be addressed to ensure the vitality of the AHSC in the largely restructured Canadian healthcare system have been covered well by Lozon and Fox. A few comments seem appropriate.

The major threat facing the Canadian healthcare system is the knowledge that, at current rates of growth, the publicly funded system is not sustainable. We require some fundamental reform and not mere restructuring as occurred during the 1990s. The recent provincial commissions in Quebec, Saskatchewan and Alberta attest to the urgency of this matter; the work of the Senate Committee chaired by Michael Kirby and the initiation of the Romanow Commission confirm that the federal government is also now deeply concerned. Several things seem clear. First, we must put to rest the concept that there is enough money in the system – we just need greater efficiency. The demands for health services are such that we must identify added (new) sources of revenue or we will continue to limit access and ration resources. Of course, there are some efficiencies to be realized, but many of these require major change to the system and will not be easy. Of obvious importance is the identification of means to create incentives: to the citizens to use the system more wisely, to providers to utilize resources better and to payers and administrators to do what is best in the longer term. One obvious issue is the method of payment for physicians. The

fee-for-service method of payment represents a huge barrier to change in service delivery models, and unless this is satisfactorily resolved little meaningful change will occur. A move to models of multidisciplinary and comprehensive primary care as well as methods of disease management, in addition to the alternative payment systems referred to by Lozon and Fox, will require a longer-term outlook than usually is evident in negotiations between the medical profession and the provincial governments. There is a great need for research into health policy, economics and system innovation; this represents a major opportunity for, and responsibility of, AHSCs (Cohen 1995) that is not currently being adequately embraced.

How can the AHSC be defined and preserved in this ever-changing environment? As noted, governments must recognize the value of AHSCs and agree to help organize and fund them appropriately (ACMC/ACTH 1996). This will require enormous leadership from the AHSCs in a way that is not seen to be self-serving (Cohen 1995). My personal view is that we will only witness the true potential of our AHSCs if we create a quasi-independent governance structure that allows AHSCs to achieve their mandates in education, research and advanced patient care. This will require “teaching” hospitals to become centres of excellence in focused areas, with appropriate funding to succeed without competing with the community hospital for more routine care. But an important part of the healthcare system included in the AHSC will be affiliation with community hospitals, community services and resources for both the education and

research mandates. For all this to happen, it will require the creation of an organization with integrated planning, governance and funding. Perhaps each province should have only one academic health sciences *network* (even if on multiple campuses), with an identified funding envelope outside the hospital/region or the university budgets and with agreed-upon deliverables and accountability structures. This would include the mandate for the *network* to do integrated planning and delivery of programs in education, research and care in a multidisciplinary environment. Perhaps in such a model we would not only get rid of non-productive intraprovincial competition and duplication, but also finally realize the working definition of the AHSC (or network) that represents the breadth of the academy rather than just the medical school and one or more teaching hospitals. Such an organizational model would create the opportunity for equality of partners with joint planning and decision-making within an accountability framework agreed to by all. In this way, during tough economic times, we would not see the major efforts to shift costs between the partners that we have witnessed in the past.

## Conclusion

The AHSC is a construct that has delivered and will continue to deliver much value to society. However, we must do much better at the operationalization of our fuzzy concepts and develop a structure that is transparent, accountable and functional. It must not be all things to all people, but rather an entity with a clearly enunciated mandate, goals and objectives. It must include the hospital with tertiary and quaternary services, but also must

have access to community hospitals and services for both education and research. It would function best with a unique governance structure and funding envelope; it should be created with a view to the reform we must achieve in our healthcare system if it is to be sustainable. Given energy, vision and determination, Canada could create a unique model of academic health sciences centres for the rest of the world.

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