A U.S. Perspective on AHSCs: A Future of Increased Diversification

COMMENTARY

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"Hello, old friend – my future is assured!" Albert Alligator
"I'd be happy if my past was assured." Pogo Possum
– Walt Kelly, 1956

ABSTRACT

Academic Health Sciences Centres (AHSCs) have long been viewed much as the historic battleship – possessing great force, power and bulk, but increasingly vulnerable to forays of lighter and more agile competitors. This commentary reviews the efforts of leaders of AHSCs in the United States to reposition their institutions at the centre of integrated delivery systems, partly as a result of greatly increased reliance on clinical revenue to support the historic teaching mission. While Lozon and Fox point to increased involvement of AHSCs in broad regional systems of care financed through a coordinated strategy, integrated systems in the United States may be fragmenting as marketplace-driven financial schemes actually discourage integrated care. From the perspective of organizational theory, the future seems to imply a diversification of organizational forms for the AHSCs in the United States, with a corresponding strategy of lessening reliance on clinical revenues through enhancement of research funding.

IN THEIR SWEEPING and thought-provoking analysis of the condition of the Academic Health Sciences Centre, Jeffrey Lozon and Robert Fox assess the development and prospects of these extraordinarily complex institutions. I will approach my commentary from the perspective of organizational theory, with particular reference to the experience of academic health sciences centres in the United States as a point of comparison to the authors' insights. Much of the development that has taken place in the United States during the last decade and which carries over into the immediate future may be viewed as the unleashing of market forces in healthcare that has shaken the foundations of these powerful organizations. The increasing entanglement of academic medicine with the evolving healthcare delivery and financing systems has caused universities to rethink and in some instances radically alter or abandon traditional relationships formed initially to carry out the academic mission of the university.

What is striking about the authors' view of the development of the academic health sciences centres in Canada is the similarity of the challenges and possible future solutions confronting their American counterparts. At the same time, there are impressive developmental variations between the organizations of the two nations, as Canada has attempted to work within a planned system approach while the United States has emphasized diverse responses to the fluctuations of a market-driven competitive system.

The Challenge of Integrated Delivery Systems

Just as managed care's ascent in the United States created a need for a new vocabulary in the realm of health finance, the recent decade saw similar definitional challenges for academic health sciences centres. Lozon and Fox adopt the traditional position that education is, in the final analysis, the reason for being of the health sciences centre. Yet, they also describe pressure to mesh policy and operational decisions of these entities with broader provincial health networks. They further astutely observe that the prominence of the academic health sciences centre as the hub of a health system around which other actors revolve is no longer assured. This fundamental tension between the educational mission of the academic health sciences centre and the healthcare delivery mission has also been a critical organizational problem for U.S. counterparts as the health system in the United States has embraced a competitive, market-based ethos.

This tension resulted from a very similar set of policy objectives to those that Lozon and Fox identify as ascendant in Canada. The "grand strategy" of the integrated delivery system dominated strategic discussions of the future of the health system in the United States throughout the 1990s. The concept was launched with the laudable objective of reducing system fragmentation through the integration under single leadership of hospitals, physicians and payers (Shortell et al. 1996). In pursuing this primary objective of common action through coordination, proponents of the integrated system approach argued that the community would be the ultimate winner through improvements in population health and reduction in healthcare costs to consumers and employers (Kindig 1997).

This vision for the future of healthcare was given an enormous boost by the much reviled Clinton Health Security plan of 1993–94 (Hacker and Skocpol 1997). The plan, which failed spectacularly in its effort to obtain Congressional approval, featured the establishment of a limited number of competing "accountable health plans" in any given geographic area of the United States. These plans were to provide a full array of services to their participants, which would include persons covered by employer and government sponsored health benefits as well as extending coverage to the uninsured (Sokolov 1995). The federal government would assume the role of financial agent for the plan, though operations would be left up to the individual accountable health plans, thereby insuring competition within an organizationally and economically structured framework.

With the political defeat of the Clinton plan and the retreat of the federal government from wide-ranging health reform, a new model emerged based upon organizing principles of the private market rather than those of government. Large organizations uniting hospitals, physicians and insurers would emerge to manage and deliver healthcare to large populations under at-risk contracts. An organization's ability to compete in such a market required substantial resources financially to sustain the risk of capitated contracts as well as organizationally to provide the full range of essential services. In this widely adopted strategic scenario, the maturation and consolidation of markets would necessitate corresponding consolidation on the part of providers (Coile 1997).

The Ascendance of the Clinical Enterprise

The major strategic question facing academic health sciences centres was one of what, if any, role these organizations would play in the evolving health systems. If the mission of the AHSC was primarily educational, then one might view these organizations as complementing the work of the integrated health system through education of essential professionals. This basic mission, however, was called into question by managed-care executives who saw an incongruity between specialty focused education within the academic institutions and the predominantly primary care needs of the emerging delivery systems (Grumbach 1999).

Furthermore, a fundamental shift in the financing pattern for medical schools (by far the largest of the health science schools by budget) had taken place gradually throughout the 1980s and 1990s. Jones (1997) reports a doubling in the number of faculty in clinical departments in the United States. While faculty growth in the 1960s and 1970s had been associated with increased class sizes and new medical schools, Jones writes that "since 1980, it has been concentrated in the clinical disciplines and largely fueled by the expanded involvement of medical schools in patient care activities" (Jones 1997). It is not unusual to find schools of medicine that rely on clinically generated revenues (the sum of faculty practice professional income and hospital transfer payments) for in excess of 50% of their operating budgets. In turn, tuition income and state support (primarily in the case of public institutions) have declined as a portion of budgetary support (Blumenthal et al. 1999).

The organizational theorist Jeffrey Pfeffer has described various approaches that organizations will adopt in a conceptual scheme known as "resource dependence" theory (Pfeffer and Salancik 1978). Given the very considerable position of the medical school with regard to clinical revenue, the adoption of a budget recipient posture is a frightening one to many academic leaders at the health sciences and university levels. The strategic alternative is to create one's own integrated delivery system operated by the AHSC, for as Pfeffer and Salancik (1978) note: "The most direct method for controlling dependence is to control the source of that dependence. One is not always in a position to achieve control over dependence through acquisition and ownership, however."

In fact, this strategy has held considerable appeal for AHSC leadership in the United States as a way of confronting the problem of vulnerable clinical revenues. This strategy was partly a response to the formation of integrated delivery systems, which deliberately excluded academic providers (hospitals and faculty physicians) from their networks as costly and consumer unfriendly providers of service. These services could be obtained more economically and with superior utilization control from non-academic providers (Culbertson 1997). In addition, the AHSC was perceived as offering services that were once exclusive to the AHSC but were now readily available from community providers, such as cardiac surgery and transplantation (Reuter 1999).

The model of the leader of the academic health sciences centre as head of the clinical enterprise was a powerful model and one that placed considerable power for clinical and academic performance in one office. A prime example was the appointment of Dr. William Kelley as CEO of the University of Pennsylvania Health System in addition to the academic responsibility of Dean of the Medical School (Van der Werf 1999). The organization created in this case functioned "within a self-contained integrated delivery system in which the elements of system finance, hospital/institutional services, professional services, and medical education are delivered under single governance and administration" (Culbertson, Goode and Dickler 1996). Services necessary for the product offerings of the system would be "made" or produced within the system's participants rather than "bought" from outside entities through contract or affiliation.

It is no surprise that a significant number of Deans of Medicine in the United States describe themselves as also serving as CEO of their clinical enterprise. Farrell (1999) reported that 26% of 64 deans surveyed identified themselves as CEO of an integrated structure. The popularity of this model reflects the desire of the academic enterprise to compete in the health delivery marketplace as a self-sufficient and contained system.

Problems in the Marketplace

Just as the pressures of a competitive marketplace are identified with the rise of the integrated delivery system model of organization, there are now clear indications that these same pressures are contributing to its demise. Much to the surprise of earlier observers, capitation and risk-based financing arrangements have failed to dominate the market and are actually in decline as a financing

strategy (Luke and Begun 2001). Equally surprising has been the increase in hospital-physician tension and dissolution of a number of arrangements in which systems had acquired physician practices in order to provide a full range of services (Lesser and Ginsburg 2001).

A dramatic recent example is the public break-up of the Allina Health System of Minneapolis. At the time of its formation, Allina was cited as a national model of integration of hospitals and owned or contracted physician groups with a successful and aggressive insurance product, Medica (Sprenger 1994). Minneapolis was seen as the most fully developed of the competitive markets and a national demonstration of the future of healthcare in the United States in which three dominant competitors would provide one-stop shopping for all services to employers and consumers (Coile 1997).

Regrettably for the proponents of this strategy, employers in Minnesota and the State Attorney-General took a different view of the public interest. Rather than seeing discipline and price control, Attorney General Hatch saw inefficiency, rising costs and restriction of consumer choice (*Minneapolis Star Tribune* 2001). As a result, the system has "dis-integrated" into its former separate entities of the provider organization Allina and the Medica health plan. Each is governed by separate newly created boards of directors approved by the Attorney-General of Minnesota.

Marketplace failure rather than political intervention has been the more common basis for the dismantling of recently formed academic integrated systems. One notable example has been the divestiture of health plan, or insurance, operations by Duke and Emory universities and the sale of these operations to proprietary concerns. The involvement of the academic institution in the world of risk arrangements and concerns that such plans might jeopardize the fiscal well-being of the entire university have caused most AHSCs to stay out of these undertakings in the first place.

What is perhaps more surprising has been the shakiness of efforts to unify the provider components, hospitals and faculty physicians, into a coherent whole. The most prominent recent example is the termination of the merger of the highly prestigious medical centres/ hospitals of the University of California-San Francisco and Stanford University (Commonwealth Fund 2000). Also a casualty of the failed merger was the attempt to integrate the faculty groups of the two institutions at least for contracting purposes.

As difficult as efforts to integrate hospital providers and systems have proven, efforts to unify physicians have been even more troublesome. While noting the successful hospital integration of the Indiana University Medical Centre and Methodist Hospital of Indianapolis into the Clarian Health System, Indiana University President Myles Brand notes that he is unable to identify a comparable example of successful integration of faculty and non-faculty physicians (Brand 1999). Nevertheless, efforts to achieve a successful integration do continue, notably at the University of Wisconsin-Madison.

A Failed Organizational Strategy?

My discussion to this point has been to

identify the organizational response of medical schools and AHSCs in the United States to a marketplace-driven health system. The most visible model of creation of a controlled clinical system that is fully supportive of the academic mission of the university appears to be a much more difficult one to operationalize than it is to conceptualize. It is also important to note that of the 126 schools of medicine in the United States, a considerable number (44) are community-based schools that do not own or operate hospitals. This is one of the few points on which I must take issue with Lozon and Fox, for many medical schools in the United States do not fit the pattern of owned hospitals but rely instead on affiliations with community providers for clinical teaching and practice opportunities.

Lozon and Fox enjoy the advantage of at least a relatively consistent definition of what constitutes an academic health sciences centre. Valberg and colleagues (1994) have defined it as "the association of a faculty of medicine with one or more other health science faculties … with one or more teaching hospitals." What is striking in the U.S. example is the diversity of organizational forms that abound and which span a range of organizational configurations ranging from academic to clinical practice dominance in senior strategic management and governance (Weiner et al. 2001). Weiner and his colleagues observe that, in light of growing financial losses reported by academic centres, "we expect to see growing interest among medical school leaders in alliances, coalitions, and other more loosely structured models for organizing medical school-clinical enterprise relationships" (Weiner et al. 2001). This very diversity of organization that characterizes the U.S. landscape is perhaps the key point of contrast between AHSCs in the United States and Canada.

The Research Mission as a Common Opportunity

As apprehension increases in the United States concerning clinical revenues and the best organizational strategy by which to pursue them, research funds are regarded as a growing source of support. The Clinton and Bush administrations have committed to a doubling of the budget of the National Institutes of Health to $23 billion annually (Commonwealth Fund 2000). In addition, private research funding and industrial partnerships are also seen as added sources of support (Oinonen et al. 2001). In this respect, Lozon and Fox see comparable possibilities for Canadian AHSCs as a means of sustaining the complex missions of these institutions through other than clinical sources.

Masten (1986) commented that "decisions regarding organizational form require choices among various faulty alternatives. The task is therefore to assess the costs and limitations of these alternatives and review their relative merits." My commentary has attempted to examine the future of the academic health sciences centre from the vantage of organizational experiments in the U.S. market-driven system in contrast to the planned approach examined by Lozon and Fox. The similarities of the challenges faced in each system are considerable and should provide opportunities for experiments in organizational adaptation by academic health sciences centres in the future.

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