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THE IMPACT OF CHANGES IN FEDERAL POLICY ON ACADEMIC HEALTH CENTERS

by Ruth S. Hanft

Prologue:
Academic health centers have evolved and grown over the last two decades, a period when the federal health largesse reached its full flower. Now these institutions are facing an uncertain future as government support for their multiple missions declines and as concern continues to mount over the high cost of medical care. An academic health center is an institution with a medical school, a primary teaching hospital, and one or more additional health profession education programs, such as a school of nursing, dentistry or allied health. To document the realities that these institutions face, The Commonwealth Fund sponsored a study by Ruth S. Hanft to trace the flow of federal funds to academic health centers from 1963 to 1981 and to look at the impact of changes in federal policy on six academic health centers. No policy analyst was better suited for the task than Hanft, a respected health economist and former deputy assistant secretary of the Department of Health and Human Services during the Carter administration. Hanft is a dogged researcher, has a reputation for intellectual honesty, and was director of two major studies undertaken by the Institute of Medicine: The Cost of Education in the Health Professions and Medicare and Medicaid Reimbursement Policies. Hanft recognizes the pressures that are impinging upon academic health centers. She believes these centers must now begin to evaluate what they want their futures to hold because, having grown like topsy, many are in disarray, lacking control and direction. Perhaps not every center can continue to include a major tertiary hospital. Hanft’s article will stimulate a great deal of thinking as academic health centers look toward their future.
The academic health center as an organizational entity developed during the last twenty years in response to a perceived need on the part of universities and health professions schools to coordinate and share multiple activities, facilities, and sources of financing for health professions education, research, and patient care. Recent changes in federal policy related to the multiple missions of these institutions will affect not only the education programs of individual health professions, but clinical research and patient care services nationally.

For almost twenty years the resources available to academic health centers rose steadily and, during certain periods, at very rapid rates. There is little question that financing and the sources of financing have had a major impact on the size and the nature of programs and that the availability of financing influences the behavior of institutions, their faculty, and education programs. One only need look at the responses of medical and other health professions schools to the surge in research financing, the decision to use the schools, mainly the medical school, as a base for biomedical research, and the influence of this trend on health professions education. The influence of the availability of patient care revenue stimulated by the Medicare and Medicaid programs strongly affected graduate medical education, the size and mix of clinical faculty, and clinical education.

The Commonwealth Fund sponsored a study to trace the flow of federal funds to the academic health centers from 1963 to 1981 and to look at the impact of changes in federal policy on six academic health centers. The analysis of historic trends indicated that although the seeds of the current policies germinated in the mid- to late seventies, in research, education, and patient care, 1981 may well be regarded as the end of an era and a watershed for academic health centers and their teaching hospitals.

Recent events presage:

- A potential decline of 30 percent in the real dollar value of biomedical research funding in the next three years;
- Accelerating financial difficulties for primary teaching hospitals who serve large low-income and Medicare populations, which will affect education, patient care, and clinical research programs;
- Leveling and decline of state funding for health professions education in all fields;
- Reductions in support of residency programs;
- Increasing difficulty in supporting current student/faculty ratios as biomedical research grants, appropriations, and patient care revenues level off or are reduced.

While the financial future appears bleak, hard times often present opportunities to reconsider policies that have become common wisdom or "mystiques," and that have guided the programs and strategies in the past. The discussion that follows is divided into sections on the history of
federal policy and financing; findings related to medical schools; findings related to teaching hospitals; and policy issues that should be addressed by the institutions and the public.

**Historical Perspective**

Unlike the education of health professions in most nations, national government support in the United States for this purpose developed very late. Direct support for health professional education has been provided only for a brief period of time (twenty years). Historically, most support has come indirectly through programs of biomedical research and patient care. Viewed in an even broader historical context, even indirect support from the federal government itself is a relatively recent phenomenon dating from the late 1930s. Until recently, the rationale provided for federal participation has centered on the need to develop biomedical knowledge and to provide for the care of specific federal beneficiaries.

From early times until well into the first third of this century, the federal view of governmental involvement in the area of health care was limited to "public health" concerns related to communicable disease and the care of special beneficiaries—military veterans, merchant seamen, and Indians. There were also a small number of scattered medical research programs related primarily to special problems of federal beneficiaries and communicable diseases, for example, yellow fever. Until World War II, research, education, and patient care were private (nonprofit and philanthropic), state, and local concerns. Educational oversight was controlled by the health professions, enhanced by state activities through private commissions and processes of accreditation of education programs, state licensure processes, and private nonprofit health facilities, such as the hospitals which sponsored schools of nursing and programs for the training of technicians and residents. States, through their university systems, historically provided support for health professions schools.

The concept of health professional education in the United States is predicated (to a greater or lesser extent depending on the specific profession) on multiple activities of didactic instruction, research, and patient care. Support for research and patient care activities plays an integral role in the support of health professional education, as does support received from state appropriations and tuition.

**Biomedical Research**

While the Ransdell Bill was enacted in 1930, creating the National Institutes of Health (NIH), followed in 1937 by the establishment of the National Cancer Institute, funding for biomedical research did not increase substantially until World War II, when biomedical research activi-
ties began to be funded through the Office of Scientific Research and Development. In 1944, amendments to the Public Health Service Act, granting NIH the authority to conduct an extensive research program, mark the beginning of the large federal investment in and commitment to biomedical research.

Initially, research grants were investigator initiated and flowed directly to the individual researchers at the academic institutions. Although various forms of institutional support have followed (basic research support grants and centers grants), individual grants still predominate today. The flow of research grants to individual investigators has had arguable consequences for the ability of institutions to balance their programs, provide stability, and manage multiple interdependent programs. Biomedical research grants from the National Institutes of Health, and later from other agencies of the federal government including the Department of Defense, Energy, Veterans Administration, National Aeronautics and Space Administration (NASA), and the National Science Foundation have been directed particularly to researchers in the schools of medicine and in the graduate departments of universities. A relatively smaller number of grants flow to other health professions schools, hospitals, and a few “independent” research centers. Unlike many European countries, however, where there are separate research institutes, the preponderance of biomedical research in the United States takes place in health professions schools and in their affiliates.

By way of historical comparison, in fiscal year 1941, only six of the seventy-one, four-year medical schools received income from the federal government. In 1948, all but two of these schools received NIH grants. The proportion of medical school income from federal research grants grew from 11 percent in 1947 to 29 percent in 1969. By 1980, income from other resources was growing rapidly and federal biomedical research income as a proportion of the total was less than 18 percent, although in absolute terms the federal investment has grown. In the eighteen years from 1963 to 1981, the expenditures to academic health centers grew from $294 million in fiscal year 1963 to $2.0 billion in fiscal year 1981.

While biomedical research funds are granted primarily for the conduct of biomedical research, these funds have also enabled medical schools to expand the size and expertise of their faculty. Research funds have supported research assistants, graduate students, and fellows, and have thereby led indirectly to the further development of technology, specialist training, and the consequent specialization in the delivery of medical care in the United States. The combination of an increasing reliance on federal support for research and the opposition by the American Medical Association, primarily to direct federal involvement in the support of education, led to the domination of biomedical research and research-oriented faculty in medical education over a twenty-year period.
In the late 1950s and early 1960s, there was a growing public demand for health care services stimulated by a growth in health insurance and a public perception of a shortage of health professionals, particularly in the fields of medicine, dentistry, and nursing. Efforts to provide hospital insurance for the elderly and the increased federal involvement in the care of the indigent elderly through the Kerr-Mills Act helped to stimulate public and congressional fears that the increased demand for services could not be met due to a shortage of health professionals. Although some private and public commission reports urged federal support for health professions education, organized medicine stood firm in opposition to such support until the early 1960s. In 1963, at the onset of the Great Society programs, the Health Professionals Education Assistance Act was passed (P.L.88-129). The act provided for matching grants to assist in the construction of teaching facilities for schools of medicine, dentistry, osteopathy, public health, optometry, pharmacy, podiatry, and nursing. In addition, grants could be made to school loan funds for loans up to $2,000 per academic year for students of medicine, osteopathy, and dentistry. Encouraged by increased fears of shortages, the act was the start of a stream of legislation enlarging the federal commitment to health professional education. In 1965, the same year that Medicare and Medicaid were enacted, the 1965 Health Professions Education Assistance amendments and related legislation offered grants to those health professionals schools (five different professions) that would agree to increase enrollments. In addition, federal incentives were made available to schools that increased enrollments in 1968 (P.L. 90-490). The 1971 Comprehensive Health Manpower Training Act (P.L. 92-157) and Nurse Training Act (P.L. 92-158) provided a new departure in the type of support to health professions schools. It authorized annual operating grants to schools based on the number of students enrolled in health professional programs—capitation grants.

Almost as soon as the ink was dry on the 1971 legislation, voices questioning the alleged shortages of health professionals began to be heard in increasing numbers, and pressures to reduce the capitation levels mounted. Although the manpower legislation continued to require the expansion of enrollment until 1980, emphasis during this later period was focused on issues of geographic and specialty distribution rather than on actual numbers. Beginning in 1974, arguments over the need for appropriations for capitation developed into a battle between the executive branch of government and Congress, with the latter supporting continued funding and being clearly in a position of strength. The executive branch was concerned with a potential surplus of personnel, while Congress was concerned with geographic shortages of personnel. By 1978, however, the
battle shifted in favor of the executive branch as capitation grants for veterinary medicine, optometry, podiatry, and pharmacy were reduced. In the fiscal year 1980, the capitation support level was reduced to less than one-half the 1972 amount and in fiscal year 1982, it was completely eliminated.

Overlapping these new developments were changes in the support from the Veterans Administration (VA) and the Department of Defense (DOD) including: Veterans Administration support to increase enrollment and improve the quality of instruction in existing medical schools; the development of new Veterans Administration medical schools; and the creation of a federal medical school to train physicians for the uniformed services. The Veterans Administration began to develop affiliations with medical schools in 1946 under legislation whose goal was the improvement of the quality of care in VA hospitals and clinics. Medical school faculty and residents have been supported through these arrangements since that time. Despite the direct educational support provided from the Veterans Administration and the programs funded under the health manpower legislation, biomedical research and patient care dollars continued to provide higher proportions of financial support to institutions during this period than did federal education support programs (direct federal support for medical school education averaged approximately 5-10 percent of total revenues). On the other hand, in recent years, state governments appropriations for education exceeded 20 percent of total revenues for all medical schools and provided an even higher proportion of the total revenues for schools in the other health professions.

**Patient Care**

In the United States, patient care activities are an integral part of the educational process in all fields of health professions education. Prior to the growth and development of private insurance, Medicare, and Medicaid, clinical instruction was supported primarily through small stipends from the hospitals for support of residents and interns. Full-time clinical faculty were supported by tuition and state and county appropriations to state university and county hospitals, and volunteer and part-time faculty found their support through private practice earnings. Most joint patient care/instructional activities were focused on "charity" patients during this time. Patient care activity in the university setting was enhanced by federal Hill-Burton construction and loan payments which enabled university health science schools to construct their own hospital facilities and to modernize their existing facilities.

With the advent of Medicare and Medicaid and the rapid growth of third-party payments through private insurance, new sources of funding became available for support of clinical training. This support took two
forms: support of trainees and supervisory physicians in hospitals, and support for patient care services to individuals newly covered by public or private insurance. The new sources of revenue also enabled teaching hospitals to expand their residency programs and allowed them to keep pace with the expansion of undergraduate medical school programs.

The hospital reimbursement formulas of Medicare and Medicaid included the cost of stipends for interns and residents, supervision costs (faculty salaries) for the training of graduate students, undergraduate students, technicians, and others. This new source of revenue enabled hospitals and academic health centers to raise the stipends of interns and residents to a living wage, increase full-time clinical faculties, and reduce their reliance on part-time and volunteer faculty. Teaching physicians who heretofore provided individual patient care service without reimbursement for charity patients, or free care, were now able to bill fees for these services. Many medical schools and their individual departments and divisions developed or expanded “practice plans” for collection and disbursement of these fees. The plans served to augment faculty salaries and fringe benefits and to provide resources for educational enrichment such as equipment and curriculum development. This source of income to the schools has grown rapidly since the early 1970s. With the increased flow of third-party payments, however, issues relating to both geographic location and the type of health care specialty began to arise. Specifically, reimbursement from third-party payers for inpatient services is nearly 100 percent. In contrast, reimbursement for outpatient services from third parties is usually structured to include deductibles and coinsurance and does not cover preventive services. Furthermore, the payment of fees on a usual, customary, and reasonable basis provides for the reimbursement for surgery and procedure-oriented specialists at a higher level (based on time and experience) than primary care nonprocedural activities.

The development of practice plans and the revenues they generate reflect these patterns, with departments of surgery, radiology, pathology, and others earning more money to augment faculty salaries and enrich education programs than departments of family practice, psychiatry, and pediatrics. Practice plan revenues generally flow to the faculty and to their department in the school, with some allocation, albeit small, to the dean for general support of the school.

Since 1972 when the rising costs of medical care emerged as a major national concern, various attempts to control costs have affected the support of teaching hospitals and patient care revenue for teaching physicians. Most notable are state rate regulations for hospitals; Section 223 limits on Medicare “reasonable costs” for routine services in hospitals; reimbursement below cost for outpatient services in some state Medicaid programs; reductions in Medicaid eligibility; limits on hospital stays and outpatient services; and attempts to modify reimbursement for teaching physicians.
Recent actions of the administration and Congress which will have further impact on patient care activities include reductions in federal Medicaid payments; an extension of limits on hospital costs to include ancillary services, and target limits on increases in hospital payments; reductions in payment for physicians' services in outpatient departments of hospitals and changes in payment for hospital-based physicians.

Changes In Academic Health Education Support

In terms of revenues flowing to academic health centers, the period from 1965 to the late seventies can be characterized as expansive for all three missions of the centers. Research funding reached its zenith in the mid-seventies. Direct support for education began in the 1960s and peaked in 1977, declining substantially from that time forward. Patient care funding continued to grow steadily despite the efforts to constrain the increases under various cost-containment proposals. These increases were due to growth of the population covered by Medicare and Medicaid, rises in prices, and coverage of new groups in the population. The continued increased flow of patient care funds during this period also is in part attributable to the ability of some institutions to shift costs from Medicare and Medicaid to private payers (including private health insurance), the increase in the number of organized medical practice plans, and generally improved billing and collection procedures. While the study did not address the issue of state funding to these institutions, state contributions also increased steadily during the period from 1960 to 1980. This increased support was evident in state actions to increase enrollment, to develop new programs and new schools, and to expand state-owned clinical facilities. The funding from federal and state research, education, and patient care programs and the growth of private insurance had the combined effect of spurring a vast increase in the number of health professions students and faculty in all fields, and stimulating a large increase in new teaching institutions (for example, a growth from eighty-eight medical schools, including two-year programs, in 1960, to the 126 medical schools operating today).

Historically, hospitals have served as teaching settings for a number of occupations: nursing, pharmacy, dentistry, allied health, graduate medical education, and postgraduate education. Over the past fifteen or more years, as medical and other health professions education programs have expanded, the number of teaching hospitals and their relationship with health professions schools have been changing. Closer relationships now exist between teaching hospitals and their affiliated medical, dental, and pharmacy schools, with greater responsibility lying with the school for inhospital education.
The positive effects of investments made in health professions education are numerous. Earlier perceived shortages in medicine, dentistry, and pharmacy have been replaced by newly-perceived surpluses. Geographic distribution of health professionals has improved substantially even in less affluent rural areas. This improved distribution includes specialists as well as primary care practitioners. Access to care for the poor, the elderly, and minority groups have improved substantially as has the nation’s general health status. Critics cite a number of negative effects resulting from these developments. For example, the number of specialities and the length of training have substantially increased (particularly in the fields of medicine and allied health), and even more significantly, the cost of training (not the cost to the student) has risen at a pace substantially above the general inflation rate. The balance struck between primary care and specialist care (such as surgery and medical subspecialities) is considered skewed toward high technology and higher costs with consequent inflationary impacts.

Impact Of Changes In Federal Policy: An Overview

It takes several years before changes in policy ripple through large, complex organizations. The trends highlighted here should therefore be regarded as preliminary. Many of the trends are also the result of policy changes that began in the late 1970s. Trends that are emerging include:

- Many states are faced with severe fiscal problems as a result of federal cutbacks and from revenues lost due to the economic recession. Program cuts in higher education in general are occurring, and Medicaid and other health services programs are being reduced.
- Changes in federal policy are affecting all parts of academic health centers. The most serious effects have occurred in the teaching hospitals which provide large amounts of service to the indigent and medically indigent. The teaching hospitals are in the most vulnerable position of all components of the academic health centers and, by all indications, the problems facing these hospitals will increase rapidly during the next few years.

The medical schools are the least affected to date since their sources of financing are the most diverse and changes in patient care payments and biomedical research will not begin to be fully felt until fiscal year 1983. The current relative stability of these schools is probably a temporary phenomenon. By fiscal 1983 they will be affected by:

- The fiscal problem of the teaching hospitals, specifically rising deficits and an increase in low-income and no-pay patients;
- Cuts in Medicare and Medicaid payments to teaching hospitals and teaching physicians;
- Substantial cuts in the real dollar value of funding for biomedical research;
- Reduction in the real dollar, or even in the actual, amount of state appropriations.

Medical Schools: Study Findings

There is no strong trend toward major reductions in medical school enrollments. A few state schools have made reductions this fall. However, a number of new schools have not yet reached their full enrollment goals. While a number of deans are discussing potential future reductions, the trends to date have shown no aggregate decrease. The size of the residency programs is being reduced (not yet substantially) in some institutions, particularly those affiliated with county and some Veterans Administration hospitals. Administrators of other hospitals, including university hospitals and affiliated nonprofit voluntary hospitals, are contemplating reductions in the number of residents they will support. There is a strong probability that the number of available residency positions will be reduced faster than enrollment in M.D. programs. This factor, combined with an unknown number of U.S. citizens studying medicine abroad who will seek residency positions, may result in a serious shortage in the number of available residency positions in the near future, unless there is a rapid concomitant reduction in medical school enrollment. There also is a strong possibility of a reduction in graduate student (Ph.D) enrollment due to fewer graduate student loans and reduced biomedical research grants which also support graduate student research assistants. The schools with large graduate programs will also be most immediately affected by proposals to reduce indirect costs.

The number of basic science and clinical science faculty has increased rapidly in the last ten years—at a faster rate than medical school enrollment and residency program size. With erosion of biomedical research and patient care support, maintaining current student-to-faculty ratios will become increasingly difficult. Tenure considerations will be major impediments to reduction in faculty members, particularly in the basic sciences. If Congress limits biomedical research support to the 1982 levels, this will mean a real cut in support of 8-10 percent per year beyond the current direct 4 percent reduction, or a real cut of 30 percent by 1985. With a reduction in biomedical research funding, medical schools will have to reconsider the role of biomedical research in medical education, the size of basic science faculty needed for such education, and the organization of basic science instruction on academic health center campuses. With cuts in growth and cuts in current levels in patient care financing programs for hospital and physicians' services, medical schools will have to reexamine the size and activities of clinical faculty and residents. There
will be increased resistance by teaching hospitals to the support of education and clinical research activities, resulting in increased tension among faculty regarding the relative importance of the missions of education, research, and patient care.

Organized outpatient care arrangements which are separate from the hospital setting (multispecialty groups) are being established and faculty efforts are being directed at attracting new patients with private health insurance. In some instances, these groups will serve all patients including indigents. In others, where county hospitals serve indigents and medically indigent patients, these new settings will mainly serve patients with private insurance.

Medical schools have grown in number, enrollment, faculty, complexity, and costs of education. Sometimes the growth appears random, with levels of activities in biomedical research and patient care that seem far larger than are necessary for the education of undergraduate and graduate medical students.

The financing of the research and patient care missions are such that "mini-entrepreneurships" exist within the institutions, providing little leverage for planning and implementation of education policies and programs. Research funds flow to the investigator, program projects, or interdisciplinary centers. Patient care revenues flow mainly to individual departments through practice plans, with some departments well funded from patient practice and others, particularly primary care departments, funded at distressingly lesser levels. There appears to be little long-range planning and coordination of financing at many institutions.

Medical Schools: Policy Issues

The expansion of sources and levels of financing during the past two decades enabled these institutions to grow rapidly and expand enrollment, faculty, and programs in all missions of the institution. The sources of financing clearly influenced the education process, specialty distribution, the extent of research activities in the institution, the delivery of patient care, and costs of education, research, and care. The resources are now shrinking and there is a potential that unplanned changes will be made in institutions without consideration of the long-term implications for the productivity and quality of education, research, and patient care activities. Some of the policy issues that need to be raised are as follows.

• Universities, medical schools, states, and the federal government need to reconsider the role and influence of large biomedical research and patient care activities on medical schools and the education of physicians. Among the considerations are the development of university-wide, rather than school specific, research institutes combining research interest across compatible scientific fields, a concept which may be more appropriate
for the rest of this century. Some universities have a centralized academic health center or university basic science departments which provide didactic instruction across a number of fields. Other institutions should look at these models and the effects on the faculty size, productivity, and quality of teaching.

- This may be a time to reconsider the role of major biomedical research programs as a desirable function of all medical schools. There are some schools today that conduct relatively small amounts of research. They concentrate on the production of physicians for community practice. There are no definitive studies which indicate that students graduating from these schools perform less well as clinicians, yet there is a strong belief among many educators that research activity is essential to excellence. Is it necessary for all medical schools to aspire to be research institutions or might the academic medical community stress the value of both practice orientation and research orientation, with individual institutions and states deciding which direction to emphasize? Reducing the number of schools and faculty competing for biomedical research funds could concentrate research excellence, maintain interdisciplinary research bases, and enhance research productivity.

- For years, the influence of the tertiary care hospital as a training site for medical education has been criticized as encouraging the creation of an imbalance between primary care and specialist training. The practice plans and reimbursement structure reinforce the specialty and tertiary care influences. Furthermore, the hospitals closely tied to universities often cannot operate efficiently because of the mixed missions of the university and university policy constraints and the demands by faculty on the hospital. Universities need to consider whether they should operate hospitals or develop new types of arrangements for undergraduate and graduate medical education. They need to explore, if they are to continue to operate these hospitals, governance structures that inhibit efficient management. With the reduction in residencies and the continued flow of M.D. graduates, it may be a time to consider a reevaluation of training sites, a return to a new type of preceptorship, different training for primary care physicians, and much smaller groups of physicians trained in certain specialties.

In reality, the medical education community has been evolving toward two or three types of medical schools: community-based schools, and the more traditional model, some with large biomedical research programs, and others with modes and programs. Yet, over time, the peer pressure and reward systems in academic medicine are such that these community-oriented schools seek to emulate the research and tertiary care orientation of the more traditional schools.
**Teaching Hospitals: Study Findings**

The external and internal pressures which are negatively affecting the financial position and missions of the teaching hospitals are increasing rapidly. Reductions in public funding for the care of the indigent, medically indigent, and Medicare patients affect many of these hospitals disproportionately. The increase in competition in providing secondary and tertiary care is affecting the ability of these hospitals to maintain and increase payments from patients with private third-party coverage. Community hospitals are "dumping" Medicaid and medically needy patients, particularly in states with limits on hospital duration. Unless case mix and severity indices can be refined to show the reasons for differences in cost between teaching and community hospitals, and unless public and private programs are willing to pay for these differences and for the costs of educating health professionals, teaching hospitals will experience growing deficits and declines in admissions, affecting the availability of care for low-income people and clinical training for health professional students.

Teaching hospitals are reviewing their commitments to support the education of students in dentistry, pharmacy, and medicine, in terms of the number of residency positions and the level of faculty support for supervision of residents and other students. Support has already been cut in dentistry and pharmacy and in some medical residency programs. Teaching hospitals, including state university hospitals, are attempting to restrict the proportion of nonpaying patients admitted to their facilities and are exploring ways to increase the number of patients with private insurance.

Access to care for low-income groups is being reduced and once again there is a trend toward two-class medicine. Symptoms of this development include the closing of outpatient departments, construction of medical school outpatient office buildings separated from the hospitals, limits on hospital admissions, and growing pressures on county hospitals to serve additional nonpay or low-pay patients.

Internal factors are also affecting these institutions. They include conflicts between the education and patient care missions of the teaching hospital and governance structures which inhibit business-oriented management. There are a number of problems related to hospital ownership that directly affect the ability of some institutions to operate efficiently and maintain sufficient flexibility to accommodate change. State university and county hospitals often are bound by centralized state and county personnel and purchasing practices which are inhibiting to a hospital or “business operation.” These constraints place state university and county hospitals in a poor competitive position in relation to nonprofit and proprietary hospitals. A number of teaching hospitals are undergoing organizational and administrative changes to improve management. They are
exploring changes in their organizational and governance arrangements with university systems and state government in order to increase flexibility in procurement, personnel practices, and patient care policies. The study confirmed that the current major financing problems of academic health centers are those of the teaching hospitals, particularly hospitals that serve large numbers of low-income people and university-owned institutions.

Academic health centers cannot solve the problem of lack of financing for low-income groups; nor can the teaching hospitals be expected to provide a disproportionate part of the subsidy for care of these populations. One of the most distressing findings of this study is the identification of the trend toward limiting access to some hospitals for the poor and near-poor.

Teaching Hospitals: Policy Issues

Some of the problems of these hospitals, particularly the university hospitals, are related to factors within the control of the academic health center or the parent university system. There are a number of issues cited in the report that need to be addressed urgently by academic health centers. The costs of education will have to be identified and some agreement reached on "appropriate" costs and who shall finance them. Since most tertiary care institutions are also teaching hospitals, the costs of "tertiary" services also need to be identified: cost per diagnosis, severity indices, and case mix measures must become more sophisticated. Some hospitals have inadequate data and systems to identify case mix. Cross subsidies and average costs will probably be a concept of the past. Governance in some hospitals inhibits good management. Teaching hospitals will no longer be able to survive by passing excess costs that are incurred by personnel, tenure, procurement, and other practices related to governance to third parties, patients, and state appropriations. Clearer and better definitions of mission and responsibilities are needed. This includes such factors as:

- Articulation and knowledge of clinical research activities in the hospital that are not funded as research; (The practice of taking that extra test or x-ray because a clinician or resident is conducting research will need to be modified or financed by revenues other than patient care revenues.)
- Responsibilities of the hospital to provide office space, technicians, nurses for clinicians’ practice and research, and decisions regarding who pays for such overhead costs;
- Decision making on new services, equipment, and staffing;
- Peer and cost review of patient care services ordered and provided by clinicians and residents;
Demands by all of the professional schools for the hospital as a training site and demands from the education section for recruitment of staff with certain credentials, without consideration of the cost or efficiency implications.

### Academic Health Center Administration

The role of academic health center (AHC) administrators varies widely. Some have a strong central role in developing and implementing policy and budget related to educational and clinical programs, as well as in the day-to-day administration of a campus. In other cases, the AHC administrator acts primarily in an advisory capacity to university administrators. The chief administrative officer of the academic health center has little direct control over the flow of revenues to the health professions school, particularly in medicine. Research funds generally flow to the investigator, program project, or center. Practice plan dollars flow to faculty, departments, or divisions, with small amounts earmarked for deans. State appropriations often are set on a per student basis and flow from the state to the university. Tuition usually flows to the university. Hence it is difficult for the chief administrative officer to make major resource allocation decisions.

One of the rationales for the development of academic health centers has been to encourage interdisciplinary activity among the health professions schools and to achieve economies by the sharing of clinical and research resources. There is only modest evidence that such sharing has occurred. With shrinking resources, there is an opportunity for chief administrative officers and deans to explore the benefits and economies that could be achieved through consolidation of duplicative activities and greater interdisciplinary activity of faculty and students among the health professions.

A growing source of tension on university campuses is the fiscal problems of the university hospitals. Unless changes are made in the way some of these hospitals are required to manage their affairs to meet their multiple missions, the financial difficulties will increase. Administrators need to focus on the following issues:

- Personnel and procurement policies, lines of authority and responsibility, planning processes for decisions on services, education, and research programs;
- University hospital responsibility for undergraduate education, graduate medical education, and biomedical research in relation to service needs;
- Responsibility for care of the indigent and medically indigent.

In troubled times, strong leadership is usually a key to successful survival. Many of the trends and issues raised in the study require solutions that
cut across many parts of the academic health center and require more centralized policy and planning direction, and decisions to affirm or redefine the missions of the institutions. The latter issue, that of mission, in many institutions requires direct policy clarification on the part of state government and university administration. Indirect influence will continue to buffet these institutions in federal biomedical research policy, and patient care payment policies of public and private third parties.

NOTES:
2. Ibid.