Prologue: Academic health centers reflect the vast financial and human resources that America now invests in its system of medical care delivery. Such centers, which operate a medical school and, in addition, at least one other health professional school, receive substantial funding from public sources, particularly research monies from the National Institutes of Health. In recent years, the stewards of these centers have found their traditional sources of funding squeezed because policymakers are riveted on the notion that medical costs must be moderated. In this essay, Eli Ginsberg, director of the Conservation of Human Resources at Columbia University and a longtime participant in the health policy sphere, sets out the evolution and current troubled state of the academic health center. Ginsberg, the author of countless books and an economics professor who has served in one capacity or another all presidents from Franklin D. Roosevelt to Jimmy Carter, has long been one of the nation’s most active analysts on manpower issues, both within and outside of health care. As chairman of presidential commissions on manpower issues from 1962 to 1981, Ginsberg focused attention on the application of human resources to some of society’s most vexing problems. In the health sphere, Ginsberg was the first national figure to question the notion that the United States faced a physician shortage. In a controversial letter published in The New England Journal of Medicine in January 1960 entitled “A Cautionary View of Medical Care,” Ginsberg said that increasing the supply of physicians would not automatically achieve the policy goals of improved health or better distribution of doctors.
A paradox looms on the health care horizon. Here and abroad it is agreed that American medicine has attained its position of world preeminence through the achievements of the academic health center (AHC). Yet increasingly the warning is raised that in our zeal to constrain the outlays for health care, we will erode the financial base which has enabled the AHCs to flourish.

There is no singular definition of the characteristics of an AHC and therefore no agreement on the number of institutions that are properly designated as AHCs. For the purpose of this analysis I have identified the forty or so major institutions that comprise, in addition to a medical school, at least one other health professional school (dentistry, nursing, veterinary medicine, and allied health) and that collectively received about 75 percent of the external grants and contracts for biomedical research awarded by the National Institutes of Health (NIH). These research funds amounted in 1984 to approximately $1.2 billion.

The leading AHCs perform several distinct functions: they run a medical school and at least one other health professional school; they conduct in their principal teaching hospital and in affiliated hospitals a broad spectrum of residency programs and provide advanced training for a large number of fellows; and they perform a considerable volume of basic research and clinical research in the medical school, the principal teaching hospital, and other affiliated hospitals.

Their third mission, in addition to education and research, is caring for patients, particularly inpatients but also outpatients, in their principal affiliate. Many provide professional services for patients in public hospitals as well.

From time to time, some of the AHCs have undertaken demonstration projects aimed at improving the delivery of health care services to designated population groups and have organized and run a health maintenance organization (HMO). But up till now such nontraditional efforts in health care delivery have been the exception rather than the rule. Each leg of the metaphoric three-legged stool that describes the functional triad of an AHC—education, research, and patient care—is said to be strengthened by, and dependent upon, its interaction with the other two.

There is a growing unease among the medical leadership that this unique American institution, largely the creation of the post-World War II decades, may be at risk. Those speaking for the AHCs have called attention to a number of early warning signs. Some of the more important of these are: (1) the leveling off of federal support in real dollars for biomedical research; (2) the elimination of most federal support for medical and other health professional education; (3) the Medi-Cal reforms in 1983 which eliminated on the basis of competitive bidding certain AHCs from serving as authorized providers for Medicaid patients; (4) the entrance of various AHCs into contractual relations with for-profit hospital chains
for the purchase, management, or joint operation of their major teaching affiliate in an effort to strengthen access to capital and to improve their revenue position; (5) the year-long moratorium imposed in 1983 by the state of New York on all capital expenditures including several large projects of the principal AHCs in New York City for which approval was pending; (6) the development of preferred provider organizations (PPOs), some of which explicitly discriminate against higher-cost AHC hospitals; (7) selected state cutbacks in budgetary support for undergraduate and graduate medical education (GME); and (8) diverse regulatory changes by various states that restrict the freedom of Medicaid patients to select their own providers with an aim of directing these patients to low-cost facilities.

The foregoing fade into insignificance when placed alongside a number of prospective changes that are moving to the top of the health policy agenda in Washington. These include: the recommendation of the Advisory Council for Social Security that Medicare stop reimbursing for GME by 1986; the congressional directive to the Secretary of the Department of Health and Human Services to develop alternatives to the currently in force “pass through” of educational costs under diagnosis-related groups (DRGs) for teaching hospitals; and early action by Congress to strengthen the Medicare Trust Fund which will include efforts to reduce inpatient use and total outlays.

While prospective changes in Medicare will have the greatest immediate impact on the financial position of the AHCs, employer and union-sponsored insurance plans are also being altered. During the last several years there has been considerable restructuring of benefits aimed at encouraging employees to use less expensive providers, and employers have resorted to financial incentives and penalties to influence employee choices. Such efforts are likely to intensify in an atmosphere in which the federal government sets the pace in the search for cost constraints.

The predicament in which the leading AHCs find themselves today and the challenges that they will confront tomorrow can best be understood by briefly reviewing the ways in which the era of easy money altered their basic structure and functioning during the third of a century following World War II.

The AHC had its origins at the end of the nineteenth century and the beginning of the twentieth. A number of medical schools, primarily on the East Coast-Harvard, Yale, Columbia, University of Pennsylvania, Johns Hopkins- were then the nation’s leaders in medical education, research, and patient care. Medical education centered on undergraduates; research was a minor undertaking financed mostly by modest grants from foundations and performed on a part-time basis by busy clinicians, and even the most sophisticated patient care was severely constrained by what medical knowledge and technique could deliver.
The immediate post-World War II years saw the onset of revolutionary changes on each of these fronts which can be captured most concisely by reformulating the law of the distinguished business historian, Alfred Chandler, “structure follows function,” to read “structure follows finances.” It is important to note how new sources of funding affected the mission, organization, and values of the AHCs.

As part of their modernization program for the medical system of the Veterans Administration in 1945-46, Generals Bradley and Hawley sought and obtained the cooperation of the deans of the medical schools who, responding to the new source of financing for residency training, agreed to provide professional services for the VA hospitals.

In 1950, the nation’s total expenditure for medical research amounted to only $160 million, and foundations were still the major contributors. But shortly thereafter, the reorganized and expanded National Institutes of Health became a major conduit for new funding for biomedical research, and most of their grants went to the medical schools that were beginning to be transformed into AHCs. Since medical school finances were severely restricted, the ability of the deans to funnel reimbursement for the indirect costs of research into their educational programs proved helpful. This enabled them to expand the number of full-time faculty and to reduce their reliance on volunteer staff.

The rapid extension of hospital insurance with its charge or cost reimbursement for patient care services introduced an important new flow of funds into the major teaching hospitals. The willingness of third-party payers to reimburse for the direct and indirect costs of expanding residency and fellowship programs provided the financial wherewithal to support the restructuring of medical education which lengthened the physician’s period of preparation from five to eight or ten years or more. Although reimbursement for patient services was the major source of new dollars for GME, the NIH also made important contributions through training grants, fellowships, and career development awards.

In the immediate post-World War II years, the states were slow to expand their role in financing medical education, but by the mid-1950s several had taken the plunge and more followed with the result that a large new stream of money for both capital and operating purposes became available. This included state support for the construction of teaching hospitals and for new and expanded facilities for medical research.

In 1963, the federal government moved to allocate substantial sums directly to medical schools initially for construction and later for operating needs, an effort that reached its zenith with the health manpower training legislation of 1971 which authorized capitation for medical and other health professions students.

These multiple streams of new money from the VA, the NIH, insurance, the states, and direct support for medical schools from the federal gov-
ernment, were augmented by the passage of Medicare and Medicaid in 1965. By providing liberal reimbursement for inpatient and, to a lesser degree, ambulatory care for the elderly and the poor, they were a source of additional funding for the support of residents and the physicians who supervised their training. Since many AHCs, especially those located in the inner city, had long offered a considerable amount of free and below cost care to the elderly and the poor, the fact that henceforth these patients would no longer be a financial drain but rather a financial asset significantly improved their financial position. For many AHCs money no longer was a scarce resource; space yes, but not money.

The Concomitants Of Affluence

A number of major transformations accompanied the cascade of funds into the leading AHCs. The AHC was almost totally removed from university control once it became a contributor to rather than a beneficiary of central budgeting. The system of external financing for research reduced the authority of the dean to a point where he was beholden to his principal investigators rather than they to him. The heads of the major departments of the medical school, who in most instances were also the directors of the corresponding services in the principal teaching affiliate, became all-powerful barons by virtue of their control over research funding, residency slots, fellowships, training funds, and hospital beds. Each had his own kingdom. Prestige and future careers were determined by the esteem of colleagues in the U.S. and abroad. In addition, the NIH reliance on peer review for grant determination transformed the principal investigator from a professor with collegial values and institutional allegiance into an academic entrepreneur who was in a position to bargain with different schools and often went with the highest bidder.

There was an explosive growth in the number of full-time faculty during the period of expanded funding (1950-75). Deans and departmental chairmen recognized that if able investigators were recruited to the staff, they could finance themselves and also make a contribution to the budget of the department, the medical school, and even the university. This faculty expansion occurred in both the basic sciences and the clinical departments. In many institutions, top administration of the university and of the medical school were willing to offer tenured appointments on “soft money,” that is, to professors who financed themselves with grant support.

The critical role of research and research funding in the new value structure of professors profoundly affected their function as educators. Teaching responsibilities, surely at the undergraduate level, were regarded as a deflection from more important activities. Physicians for the Twenty-First Century, the newly released report of the Association of American
Medical Colleges (AAMC) Panel on the General Professional Education of the Physician, chaired by Steven Muller, president of the Johns Hopkins University, is the most recent indictment of the neglect of their educational mission by the medical schools. It is only a slight exaggeration to state that the single significant innovation in undergraduate medical education dates from the mid-1950s when Case Western Reserve set about restructuring its curriculum.

The evolution of GME was even stranger. It came under the professional dominance of the several specialty societies and the residency review committees, with the teaching hospital playing a significant role as financier and employer of residents. Not to overstate the case, it should be noted that the senior medical school professors, in their roles as directors of hospital departments, were important participants. The expanded spectrum of residency programs in the largest AHCs, frequently more than twenty, and the concomitant growth in the total number of residents, in some cases as many as 1,000, brought with it important consequences for hospital operations, financing, and patient care.

Regarding residency training, the dominant view is that its proliferation was broadly beneficial: the presence of residents provided the hospital with full-time house staff, raised the level of clinical acumen by having novitiates challenge their elders, and it encouraged a more “scientific” approach to both diagnosis and therapy. The negatives are usually ignored or minimized: unnecessary testing and procedures, extended patient stays, increased hospital expenditures.

The universality of residency training for graduates of U.S. medical schools as well as expanded opportunities for many foreign medical school graduates to receive similar training had significant effects for the treatment of poor and indigent patients in public hospitals. This occurred initially in the VA hospitals and later in many municipal, county, and state hospitals that looked to the AHCs for professional support. Before World War II, many of these hospitals depended on salaried staff supplemented by volunteer physicians, but in more recent decades most patient care services have been provided by residents under the supervision of attending specialists.

In the decades of new, increased funding for the AHCs, there was relatively little pressure on university, medical school, or hospital trustees to consider joint planning and improved governance. The several bodies had enough to do just to stay on top of their respective responsibilities and concentrated on responding to the expanding opportunities. The ever larger flow of funds enabled each of the key administrative officials to set and maintain a fast pace on a steeply graded trajectory. If one or another source of anticipated funding fell through, there was always another to draw on. As businessmen know so well, a sustained period of expansion is the best short-term device for papering over difficult
Challenge And Response

The high point in the financing of the AHCs came in the early 1970s. Even though NIH funding had leveled off, Medicare and Medicaid reimbursement plus direct federal support for medical education and teaching hospitals’ recourse to the private capital markets for construction funds kept the money sluices open. The reduction and subsequent elimination of federal support for medical education in the late 1970s was the first serious setback since there was no alternative funding source. That, however, is not altogether true. Many AHCs, especially those under private auspices, decided to raise medical school tuition and to establish or expand physician practice plans which produced revenue to cover the salaries of many of the full-time staff and contributed to departmental and medical school budgets.

Almost without notice, practice plan income has within the last decade come to represent the single largest source of funding available to private medical schools (about one-third), amounting at the extreme to $50 or $60 million a year. The typical situation finds a large medical school with a great many different plans, each departmentally based and operated, with considerable hassle as to the amounts that are skimmed off to support the less affluent basic science departments.

Still more recently, a few of the most distinguished AHCs have been able to attract large sums from major domestic or foreign corporations to undertake research in designated areas. The contractual arrangements vary, but most donors are given the first opportunity to exploit findings that may result in proprietary products.

Although the last decade has not been easy for the AHCs, they have all come through, some in better, some in worse condition. But the next decade—1985-1995—will really put them to the test. The conventional wisdom is that third-party payers will recognize that the costs of medical education must be covered in one fashion or another; that the major teaching hospitals need a reimbursement system which reflects the higher intensity of care that they provide for many patients; that the care of the indigent must be paid for; and that the nation must continue to support biomedical research at an appropriate level. Under such conditions the AHCs should be able to survive without serious scarring. For the reasons that are elaborated below, I believe that such an assessment is unduly optimistic and that the AHCs are much more vulnerable than is assumed.

Medical education. One of the potent factors contributing to the heavy flow of funds into AHCs in the 1950-1975 period was the widespread belief that the country needed more and better trained physicians. Today the dominant view is quite different. More often we hear that the

problems.\textsuperscript{14}
nation may face an oversupply of physicians and that excessive numbers of specialists and subspecialists swell the total costs of the health care system. Duke and the University of Pennsylvania have indicated that they will cut back on their undergraduate enrollments, and the political leadership in several Midwestern states is discussing a staged cutback of 20 percent over the next few years in their schools.

There are also stirrings on the GME front. An increasing number of specialty societies are taking another look at their numbers and several residency review committees have increased their requirements with an aim of improving quality, a move antecedent to reducing their future membership.

The shift in the national mood is best exemplified by the fact that the AHCs which originally resisted pressures by the states and the federal government to expand their medical school capacity are now blamed for the oversupply of physicians.

It is difficult to forecast at the beginning of 1985, five years after publication of the Graduate Medical Education National Advisory Committee (GMENAC) Report, whether and how quickly the new atmosphere will lead to actions that will effect significant reductions in undergraduate and graduate medical education. As yet, there is no consensus—and none may emerge—about desirable or necessary measures.

On the other hand, the odds are strong that third-party payers will seek to eliminate the costs of GME from reimbursement for patient care services. In the process of developing alternative financing, the scale and length of residency and fellowship support will be reduced, probably not to one year, the drastic suggestion of the Inspector General of HHS, but more likely to three years, as proposed by Robert Petersdorf of the University of California (San Diego).

The AHCs may also find that the federal government will seek to cut back on residency support in the hospitals of the Veterans Administration and that some of their other public hospital affiliates may decide to rely less on residents and more on salaried staff to treat their patients now that the easing of the physician supply facilitates their recruitment.

As states examine ways to control their health care outlays they may follow an early lead by California that reduced (modestly) its budgeted residency slots on the ground that the state had no need to increase its future supply of physicians. A gubernatorial commission has recently been appointed by New York State to review the scale and scope of residency training within its jurisdiction. New York City, which has approximately 2.5 percent of the nation’s population, trains about 12 percent of the nation’s residents, many of whom relocate to other states to practice.

**Medical research.** During the period of liberal financing for biomedical research, many of the AHCs vastly increased their medical school faculty both in the basic sciences and in the clinical departments. When the
research dollars, in real terms, began to level off and some of the researchers were no longer able to attract new grants to cover their salaries and expenses, a considerable number were shifted to the hospital budget or were subsidized from practice plan revenues. The outlook for the continuation of hospital support is jeopardized by the shift to DRGs, and it is becoming increasingly clear that a medical school that relies heavily on practice plan income will soon find that many of its faculty are so busy practicing that they have little time for research and less for students. Paradoxically, such a medical school will, after a detour of several decades, return close to its starting point when it relied primarily on volunteer physicians for clinical teaching.

Possibly the most serious consequence of the radical shift from a period of easy money to an increasingly constrained budgetary environment is the reduced scope of many AHCs to provide opportunities for young researchers to gain a foothold on the academic ladder that would enable the more talented to attain a tenured position later. Since they have a large complement of tenured faculty with an average age of less than fifty, few AHCs are able to make more than an occasional tenured track appointment. Nothing is more threatening to the continuing vitality of the AHCs than their present and prospective faculty resources, with large numbers past their productive peak and limited opportunities to appoint younger men and women.

The major teaching hospital. As noted earlier, the teaching hospital played a critical role in helping the AHC achieve its position of prominence. It was the site where the AHC demonstrated its capacity to deliver the best of inpatient care. With its large number of residents and fellows it became an important educational resource, perhaps more important than the medical school itself, which concentrated on undergraduates. As the “cash cow,” the teaching hospital was in a good position to make the heavy investments required to keep the AHC at the cutting edge of diagnosis and therapy, and, as we have seen, it also contributed to the salaries of many of the AHCs’ teaching and research staff.

There are several reasons that the teaching hospital may no longer be able to maintain this supportive role, the most important being the changed reimbursement climate, the shift away from inpatient care, and the need for organizational initiatives to protect and enlarge its market share.

Let us briefly inspect each in turn. The DRG system will surely not be the last word in hospital reimbursement, but it speaks to the sea change that has occurred. Third-party payers are determined to moderate their outlays for hospital care and to avoid having to pay providers whatever they demand. The large teaching hospitals will almost surely convince third-party payers that they are entitled to a higher reimbursement rate because of the intensity of treatment that they provide. But this adjust-
ment will be far short of the much higher reimbursement rate that they have long received for all their patients. Moreover, hospitals will no longer be free to cross subsidize, surely not to the same extent as in the past when they loaded their uncovered costs onto self-pay and insured patients. The odds are strong, even overwhelming, that the major teaching hospitals will not continue to enjoy the substantial differential in reimbursement rates that has prevailed between them and community hospitals over the past several decades. They will be under increasing pressure to become price competitive.

Some time must pass before we can be sure, but the trends suggest that the United States has passed the peak in days of hospitalization and that the future, despite a larger and older population, will see a decline, possibly even a steep decline. Numerous explanations are given: the pressures that the DRGs are exerting on hospitals and physicians to reduce length-of-stay; the recent growth of HMOs whose members have a much lower rate of hospital admission; the shift to ambulatory treatment facilities (surgi-center, physicians’ offices, and other sites); monetary and other incentives that employers are using to discourage unnecessary hospitalization; and, most importantly, technological advances that underlie many of the above. Improvements in imaging and in anesthesiology surely have contributed greatly to the recent trend towards ambulatory surgery which is still far from leveling off.21

The major teaching hospitals of the AHCs face a further challenge. For many years they were recognized and sought out by the affluent in search of superior medical treatment. In the intervening decades two important developments occurred: many of the affluent moved to the suburbs and many of the young specialists whom the AHCs had trained established a practice there. In the presence of good hospital and staff support, these suburban specialists found that they had only rarely to refer a patient to the AHC. Most patients could be treated effectively in their community hospital. The combination of these two trends—reduced hospital days and fewer referrals—is likely over time to leave many large teaching hospitals with surplus beds.

If the foregoing scenario of tightened reimbursement, declining hospital use, and fewer referrals proves correct, the major teaching hospitals will be under increasing pressure to restructure themselves to assure their future. They will need to work out new arrangements with physicians, hospitals, clinics, and prepaid group practices to provide a flow of patients adequate in numbers and clinical mix to fill their beds. That will not be easy to accomplish given the preferences and predilections of the medical school faculty whose aims and goals are only partially congruent with the optimal operation of the hospital. The much touted synergism of the past may turn into a serious encumbrance.

There is little that is upbeat in the foregoing summary overview: a
shrinking educational enterprise; declining reimbursement for GME; level financing for medical research; a top-heavy tenured faculty with few openings for younger people; a teaching hospital that faces a declining demand for inpatient care; and a more competitive environment.

But all is not bleak; far from it. The large teaching hospitals in states with waivers are not doing poorly. In a few states that have adopted “all-payer systems” the AHCs are able to continue to treat a considerable number of indigent patients without risking insolvency. In some areas (Boston and New York City among others) the AHCs continue to attract a large number of patients who will pay a premium for the quality of care that the AHCs are singularly able to provide.

Different AHCs, depending on their circumstances and profit margins, have begun to reposition themselves. Some universities are reorganizing their principal teaching hospital as a separate corporation so that they will be buffered from the uncertainties of the hospital environment. Some teaching hospitals are working out new arrangements with their attending staff. Still others are entering into alliances with potential competitors or developing relationships with HMOs and PPOs which will provide a more certain stream of patients, many of whom will require tertiary care. The innovations are many and diverse, and more are surely developing.

Directions For Restructuring The AHCs

We are now in a better position to suggest a range of possible actions that the AHCs could engage in, individually and collectively, to contribute to the advance of medical knowledge and medical practice in the difficult decade ahead. The challenges that they will face include intensified efforts by government and insurance to slow their outlays for health care; a more competitive environment among health care deliverers with AHCs confronted by price-cutting for the first time; a growing conviction among many sectors of the public that the nation has moved from a shortage to a surplus of physicians with consequent implications for the financing of medical education; and a diffuse unease among the public about many dimensions of the health care system, from the perception of excessive earnings by certain groups of specialists to questions about the utility of high-tech interventions to prolong the lives of patients who have little prospect of regaining functionality.

There are clearly alternative policy approaches that the AHCs might adopt to meet these challenges. The following recommendations are grouped under four headings: medical education and research; the delivery of health care; governance; and public opinion. In the interest of brevity, the directions for action that the AHCs might consider are presented without the supporting facts and figures.
Medical education and research. Medical educators should take the initiative and seek to persuade state legislatures and the federal government that it makes sense to cut back moderately on undergraduate enrollments, but only if the inflow of foreign trained graduates is effectively controlled. Further, if such action is decided upon, it would be preferable for state legislators not to reduce the financing of medical schools during the interval when they are downscaling. In states with multiple schools, it would be preferable to merge or close one or more of the weaker schools rather than impose an across-the-board reduction for all schools. In the face of likely reductions in federal funding for student aid, private schools with higher tuition must redouble their efforts to secure additional grant and loan funds so that they do not find themselves in the undesirable position of admitting only applicants from affluent families.

Strategy with respect to faculty should emphasize reductions in total numbers, early retirement of tenured professors, assurance of a reasonable number of tenure-track openings for talented young academicians, and the recognition that there are distinct limits to dependence upon practice plan income for covering salaries because of inevitable conflicts between the practice time required to produce such income and the time required for teaching and research. Also, despite the many difficulties that confront medical school administrators and faculty, the challenges for educational reform set out in the Muller report need to be addressed.

It is likely that Congress will explore, and probably act on, the recommendation of the Advisory Council on Social Security to alter the basis of payment for the direct (and indirect) costs of graduate medical education. The AHCs should develop one or more proposals that, if adopted, would provide GME with independent funding, proposals that will appeal not only to Congress but also to other third-party payers. Such proposals should recognize that Congress and other third-party payers will not be inclined to earmark funds equal in amount to those currently flowing into GME, but there is surely room for compromise. The total funds for GME probably amount to no more than 1 or 2 percent of health care outlays.

The principal source of funds for medical research has been the National Institutes of Health. In 1984, Congress increased their appropriation to over $5 billion, approximately $575 million above the administration’s recommendation. However, in light of the deepening difficulties facing the federal budget it is unlikely that the AHCs can anticipate any better than level funding in the years ahead. With major teaching hospitals facing a more uncertain financial future, there will be less opportunity for hospitals to contribute to the support of researchers who fail to obtain external grants. The AHCs face the unpropitious outlook of no significant new sources of funding for medical research.

The most important challenge to the AHCs on the research front is the
need to ensure that they have openings for talented young academicians to pursue a research career, and that the best of them have the opportunity to attain a tenured position. A stagnant level of funding makes it difficult, but not impossible, to create a reasonable number of such positions, but only if the AHCs adopt appointment, tenure, and retirement policies consistent with this critical goal.

The delivery of health care. The current provisions by Medicare under its DRG reimbursement system to take account of the higher intensity of care that AHCs provide for many patients are almost certain to be revised shortly. It is critically important for the AHCs to assure that the new system continues to reflect their higher costs, including those incurred by virtue of their designation as the sole regional providers for selected expensive services, such as treating burn victims and caring for high risk neonates. The AHCs face the similar task of convincing state governments and insurance carriers that they are entitled to reimbursement for the above average costs of high intensity care.

AHCs must also seek to convince third-party payers that it would be adverse public policy if they were forced, because of lack of adequate reimbursement, to deny treatment to large numbers of the indigent who have traditionally depended upon them for medical care. Public hospitals are seldom in a position to admit and treat effectively a much enlarged flow of these patients. Several states have implemented “all-payer systems” which seek to distribute the costs of charity care among all hospitals in proportion to their volume of indigent patients. This approach, or variants having the same objective, should be further explored and refined.

PPOs and other innovative financing and delivery systems are being introduced with the aim of controlling health care costs. AHCs must be on the alert to avoid being excluded by the marketers of such plans simply because of their higher costs. As noted earlier, a partial explanation for these costs is the fact that they provide services not available in other hospitals. AHCs must convince state officials that they should be given the opportunity to compete fairly with lower cost providers.25

The principal teaching affiliate of many AHCs will probably face in the near or middle term a significant downscaling of its inpatient capacity as the result of several mutually reinforcing trends: major pressure from DRGs to reduce the average length-of-stay; an accelerated shift to ambulatory surgery; the growth of HMOs with their much lower frequency of hospital admissions; and fewer referrals because of the redistribution of specialists to the suburbs and beyond.26

The prospective reversal of the earlier trend toward the expansion of inpatient care in favor of ambulatory services presents a major challenge to the AHCs whose teaching and clinical research as well as patient care are focused almost exclusively on inpatients. The AHCs are not well
positioned to shift their focus, and they face the added challenge that up till now the financing of GME has been predicated on reimbursement for inpatients. Nevertheless, it is unlikely that the AHCs will be able to evade the need to reposition themselves since the propulsion to ambulatory care will be irresistible.

Governance. We have noted that in the long period of easy money relatively little attention was paid to improving the governance and management of AHCs. Now that money has become much tighter this characteristically loose governance represents a major problem for many AHCs. Some universities have moved to sell or contract, usually with a for-profit enterprise, for the management of their principal affiliated hospital in order to protect themselves from the threat of large operating deficits. In other cases, their motivation has been to obtain needed capital for modernization or expansion. If large teaching hospitals should experience serious balance sheet difficulties in the years ahead—a distinct possibility in light of the decline in patient days and greater price competition—more universities will explore alternatives to their present arrangements.

We noted earlier that in the years of open-handed funding for medical research and GME, power shifted from the deans to departmental chairmen and principal investigators. It will not be easy for medical schools to reverse this trend, but if they are to respond to the many critical needs that have been identified, from reforming the curriculum to implementing constructive personnel policies that will assure a vital faculty, a strengthening of the central medical school administration is essential.

The symbiosis of the medical school and its primary clinical affiliate, which has been a major source of strength during the long era of prosperity, may turn into a hindrance, if not a fatal liability, for the hospital in the years ahead. The hospital must move aggressively to work out a great many new linkages with a variety of providers-physician groups, HMOs, freestanding clinics, satellites, PPOs, and others to assure itself of the numbers and types of patients that can make optimal use of its sophisticated services. It is far from clear that the medical school faculty is the most suitable, much less the only, party to such restructuring. The years ahead will see innovation and possibly quite radical changes in the relationships between many medical school faculties and their major teaching affiliate.

Two major initiatives for new and, in many instances, looser relations between medical schools and their principal affiliates will be the need of the teaching hospitals to protect and improve their referral streams and the medical school faculty’s preoccupation with other activities. In the tussle between hospital survival and medical school control, it is likely that the former will move to expand its degrees of freedom to respond to the changing market, and the medical school faculty will probably have
to acquiesce.

Public opinion. In a democracy such as ours, public opinion has a critical influence on the actions of decisionmakers in the governmental, non-profit, and profit-seeking arenas. The golden age of the AHCs (1950-75) owed a great deal to the strong support of the American people for all aspects of the medical enterprise—education, research, and patient care. While public opinion is still broadly supportive of the AHCs, this favorable climate can no longer be taken for granted. The AHCs have the need for improved public information efforts to gain and maintain support for their critical missions.

The following are some of the axes along which information efforts might be directed. First, the American people have been led to believe that there are almost no limits to what modern medicine can accomplish. The AHCs have surely contributed to this view of medical omnipotence, and as a result many citizens expect physicians to be victorious in most encounters with the threat of death. A more realistic set of public expectations about the capacity of modern medicine would protect the AHCs from overreaction to disappointments. Second, total medical research funding, from all sources, amounts to something over $10 billion or approximately 2.5 percent of all health care outlays. Although 1984 was a good year for congressional appropriations for medical research, the future may not be so supportive. The AHCs should make more of an effort to inform the public about the potentialities and limitations of medical research in the short, medium, and long run. Exaggerated claims, such as winning the war on cancer, must be avoided. But reasonable claims that justify enlarged funding should be presented in a way that would commend them to a mature electorate.

The medical leadership of the AHCs also has a responsibility to help the public understand the relationships between medicine and health, between providers and consumers, and the obligation of the individual citizen to protect and maintain his or her health. Admittedly, these educational challenges are often viewed as diversionary by busy academicians and researchers, but they must recognize that no profession and no institution can look to a secure future without the support of an informed, understanding public. That is the lesson of the past and the injunction for the future.

A Concluding Note

Conventional wisdom views the AHC as a modern, uniquely American institution, and so it is. But it would be a mistake to conclude that its uniqueness assures its continuing survival and vitality. Half a century ago in a short essay on “The Decline of Antiquity” I noted that the decline of the civilizations of Greece and later of Rome resulted from the fact that
both the Athenian and the Roman military governments were ultimately unable to extract from the conquered nations the resources needed for the support of its top-heavy superstructure.\textsuperscript{28}

In my most recent book, written with George Vojta, one chapter deals with large nonprofit organizations, which include the AHCS.\textsuperscript{29} The theme of the work is that in periods of rapid and prolonged expansion, the large corporation accumulates a “cushion.” Growth, however, simultaneously produces a more complex organizational structure and a decision-making mechanism that is slow to react. As a consequence, highly successful corporations find it increasingly difficult to respond to complex changes in their environment, and thus lose their edge and initiative and begin to decline.

The AHC is similarly characterized by a complex structure and a slow-responding decision mechanism. In the changing environment ahead its future appears troubled because of uncertainty that it will be able to use its resources, human and physical, in new ways to assure continuing productivity in an era of constrained funding.

NOTES

17. For example, pathology increased its training period to five years and pediatrics requires a minimum of four residents per year for program accreditation.
26. W. B. Schwartz et al., The Changing Geographic Distribution of Board-Certified Physicians (Santa Monica, Calif.: Rand, 1980).
29. Ginzberg and Vojta, Beyond Human Scale: The Large Corporation at Risk.