FUNDAMENTAL STRATEGIES FOR ACADEMIC HEALTH CENTERS

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FINANCING AND FUNDS FLOW

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The business of healthcare is evolving significantly, adding new pressures to the already considerable challenges of managing the flow of funds in academic health science centers to support education, research, and patient care. Many institutions are engaged in deep conversations about these changes. Here, finance expert Ronnie Jowers frames some key questions to help inform those discussions.

1 Make Financial Decisions Based on the Priorities of the Entire Academic Health Center

In any given academic health center, different units—schools, hospitals, divisions, research centers, physician clinical practices, etc.—will have their own priorities for funding, including how to appropriate any income that the unit produces.

Decisions about divvying up finite resources when funds are tight and competition for allocations is fierce are inherently challenging even in prosperous times. Individual unit priorities can conflict with institutional priorities, which can make discussions about allocation of resources politically charged or even acrimonious.

One of the challenges for leaders of academic health centers is to lead and drive productive conversations in this regard. To that end, it is important that decisions get made based on what is best for the academic health center as whole, not just based on who has the loudest voice or most resources in the conversation.

A related strategic concern is how funds flow relates to budgeting at the university level. How does the academic health center support the university? How does the university support the academic health center? This will differ significantly from institution to institution, based on whether the university is public or private and other factors. In some regions, factors such as which government agency provides the bulk of public funding may be critical.

At Emory University, for example, tuition for each school, as well as direct and indirect research dollars, flow directly to the school, hospital, clinic or other operating unit within the academic health center and become revenue for the respective revenue generating unit. But, such funds also have to support the university as a whole and often other units of the academic health center. Emory has a cost allocation system where the academic health center contributes to help pay for everything from campus life to salaries for top leaders. That can be a major expenditure for the academic health center, and it is one for which Emory Health has little control. I have said that the best allocation system is one that everyone dislikes equally.

2 Have Strategic Discussions around Where to Pursue and Accept Funding

A 2014 study for AAHC conducted by John Manning from Vanderbilt, Tony Ferrara from the University of Tennessee, and myself found that for every NIH grant received, the recipient institution had to subsidize 25 to 40 cents for every grant dollar received.

Today, though, as NIH funding gets harder to obtain, that calculus has changed even further as more institutions are looking to foundations for grants.

One may anticipate that as more grants shift away from NIH, indirect recovery costs go down. However, for any institution conducting research, those costs have not disappeared—it's just that the institution is picking up more of them. Consider a hypothetical but concrete comparison: With a given NIH grant, for every dollar of direct support, the institution might get another 55 cents for indirect costs. But, a grant for similar purposes from a foundation might provide just 10 cents in indirect costs support.

3 Minimize Reliance on Tuition

As academic health centers look to enhance revenue streams, one tempting target might be further increases in tuition for students in the medical school and other health professions. However, that is problematic for several reasons.

Estimates vary, but by some measures, medical students in the US finish their studies with nearly US$200,000 in debt. Their colleagues in nursing, pharmacy, and other health professions also graduate with proportionately high debt loads. Apart from those in well-paying specialties, many health professionals, including some physicians, may earn far less than US$200,000 in annual salaries. Many of our students will spend years digging themselves out from the economic disadvantage they incurred through their student debts. Further, academic health centers must be aware of debt loads at competitive academic health centers to ensure that they are not pricing themselves out of the market for the best and brightest students. These issues need more attention from academic health centers.

4 Have Difficult Conversations around Faculty Productivity

It is difficult in academe to talk about faculty productivity, but in the context of funds flow, academic health centers need to find the vocabulary and metrics to have more regular and productive discussions about our expectations for faculty across the health professions, and to include tenure-awarded faculty.

This, of course, is a subset of considerations under the broader umbrella of how well we measure institutional performance overall.

The key point is that fundamental shifts in the factors that drive funds flow mean that we have to reassess all the factors that drive our business results. In that context, the broad issue of faculty productivity warrants deeper attention from academic health centers.

Expectations for faculty in medical schools in the US are generally more well-defined. We might say that if you come in on a research track we expect you to generate 65 percent of your salary off grants. Under today's financial challenges, we may need more conversations about those expectations. Additional discussion and development need even more attention in other schools. In my experience, expectations for faculty in schools of nursing and public health are not as clear as they may be for faculty in medical schools.

KEY CONSIDERATIONS FOR ACADEMIC HEALTH CENTER LEADERS

- What are the strategic priorities for the entire academic health center? How well does the academic health center's strategic plan guide decisions about funds flow at the macro level?
- How can overarching funding priorities for the academic health center mesh with funding priorities for individual units? What priorities cross multiple units? How can funding allocations to units help advance strategic priorities for the academic health center as a whole?
- How can top leadership in the academic health center best follow the allocation of academic health center revenues to the university? How can the academic health center ensure that allocations being charged by the university are fair and equitable?
- Academic health centers, of course, want and need to help support the universities they are part of, but how can top leadership in the academic health center successfully challenge allocation decisions at the university level when such decisions seem to be unfair for the academic health center?
- As part of the pursuit of grants, does your institution look strategically at the long-term implications of subsidization of each of those grants?
- Does your institution have guidelines about thresholds in its blended indirect costs recovery rate for research grants? Might some grants not be worth pursuing because the subsidization factor would be too onerous?
- As it factors the price of tuition and the amount of financial aid it awards, is your academic health center taking concerted steps to control the rise of student debt?
- Might the debt load that your students incur lead potential students to matriculate in schools where student debt tracks lower?
- Does your academic health center provide counseling to help students learn to manage their debt load? Does it help students decide specialties based on factors other than how lucrative they might be?
- Across all of our health professions schools, are we clear about our expectations for how much revenue each faculty member is expected to generate through research awards? Are we clear about how much we will subsidize them to help them reach the goals we set for them?
- Similarly, are we clear about our expectations about what percentage of a faculty member's time should be devoted to clinical work and to education? Are we clear about how much we will pay for special considerations such as administrative oversight of a program? In all our schools, are we clear about the metrics by which we will measure faculty productivity?

Clearly defined funds flow agreements need to be established on a multi-year basis between the hospitals and physician practices regarding their level of support to the medical school. Said multi-year agreements will provide some level of assurance of funds flow to the medical school and will avoid the need to enter into annual, laborious negotiations between the institutions. A key priority that has recently developed, which must be clear in the strategic plan, is the priority to use available funds to acquire additional remote hospitals and/or clinical practices versus using those same funds to continue to strengthen the medical school or other priority aspects of the academic health center.

KEY TAKEAWAYS

The highly cross-subsidized nature of institutional funds flow in academic health centers is being significantly impacted today by a wide range of changes, including healthcare reform at the national level, declining federal support for research, and upheaval in business models for the delivery of care. In light of these challenges, academic health centers need to engage in different conversations about funds flow, including those framed here.

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