

Examining the Global Landscape of Academic Health Centers: Future Directions for AAHCI

By Sarita Verma, MD, LLB

“Due to the global nature of health, economic, and population concerns, there is now a critical junction of need and opportunity for academic health centers to work in partnership worldwide, and, in doing so, be among the critical forces shaping the 21st century.”

S. Wartman, AAHC President and CEO



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The global academic healthcare community is becoming more and more interconnected with much to learn from and offer to each other. As science, education, health care, and the economy continue to evolve, health professions schools and their affiliated teaching hospitals and health systems are increasingly realizing the need to better align their functions within the structure known as the academic health center. Recognizing the need for academic health centers worldwide to be represented on a global level and to mobilize in partnership, the Association of Academic Health Centers (AAHC) created an international subsidiary in 2008: the **Association of Academic Health Centers International (AAHCI)**.¹

This issue brief describes the history and evolution of AAHCI. Additionally, it provides the results of an environmental scan of the present status of the organization, and concludes with recommendations for the future gathered from a survey and structured interviews and summarized from the report of the visiting scholar at AAHCI in January-March 2012.

AAHCI: MEMBERSHIP AND FOUNDATION

Membership in AAHCI is offered to academic institutions that educate health professionals, conduct biomedical and clinical research, and deliver comprehensive patient care, all with the goal of advancing and applying knowledge to improve health and well-being. Four core principles are the main requirements for membership in AAHCI:

- **Alignment** — A commitment to achieve alignment between patient care, health professions education, and research. The ultimate goal is to attain a virtuous cycle whereby each component enhances the others.
- **Community Engagement** — A commitment

to judge institutional performance based on the health and well-being of the community it serves. This implies a close working relationship with the community that is mutually beneficial.

- **Economic Development** — A commitment to support and participate visibly in the economic and infrastructure development of the region. This includes job growth, capital development, support services, and other effects on the knowledge economy.
- **Collaboration** — A commitment to develop collaborative relationships with other academic health centers around the world to expand best practices and programs geared towards the improvement of health and well-being worldwide.

Since its founding, AAHCI has focused on working with members to facilitate international collaboration and the development of organizational and management expertise to enhance the performance of academic health centers globally. AAHCI's first steps emphasized providing the means for academic health center leaders worldwide to gather together, sharing best practices and discussions on a variety of mutual issues often unique to academic health centers yet vital to enhancing health and well-being in their communities and globally.

Building upon the success and momentum generated from meetings in Asia and Europe, as well as from the International Forums held in Washington, DC, AAHCI convened an International Working Group to address the successful development and sustainability of the academic health center. Participants representing Europe, Asia, Latin America, North America, and Australia discussed the primary issues facing their institutions and common challenges facing academic health centers worldwide. Academic health centers are increasingly advancing in, or working towards, establishing an effective global presence. The Working Group identified key issue areas, such as human resources, regulatory restraints, financial restrictions, security, and management structures for future collaborative meetings.

Since 2008, AAHCI has held a highly successful annual International Forum focused on significant themes including: Building Academic Health Center Infrastructure Worldwide; The New Global Economy: Models, Missions, Risks, and Rewards; Strengthening the Academic Health Center Advantage; Collaborative Partnerships to Enhance Education, Science, and Population Health; and Advancing Clinical Translational Research.

As well, several regional meetings have been held and have been highly applauded for their synergy and networking opportunities. Thus far, regional meetings in Brazil, Australia, Singapore, and Amsterdam have been very well attended and upcoming meetings in China and Qatar are planned for 2012-13. The regional meetings have proven to be valuable in their influence and outreach to local and national governments; have created venues for sharing cases, models, and best practices; and have developed new partnerships between academic health center leaders to explore collaborative projects.

DEFINING PRIORITIES AND FUTURE DIRECTION

At the January 2012 meeting of AAHC's Board of Directors, a discussion document to guide the debate about AAHC's priorities and future directions was distributed. AAHCI figured prominently in this document and in the Board's deliberations. The document recommended that AAHC "develop a strategy for the future relationship between AAHC and AAHCI." The recommendation was accompanied by the commentary: "In considering the long-term future, a discussion about the appropriate relationships between AAHC and AAHCI in an ever-globalizing world is important." This issue was also discussed at the March 2012 AAHCI International Forum.

It was determined that a survey of current AAHCI membership and targeted stakeholders should be conducted in conjunction with a literary review to provide an overview of the current membership in AAHCI; to engage the current membership in dialogue about

the governance, organizational structure, and communication processes of AAHCI; and to make recommendations about how AAHCI can meet membership needs.

Despite time constraints and some logistic challenges, a literature review, member participation in the survey and follow-up interviews, and in-depth discussions with knowledgeable stakeholders provided insights for the future direction of AAHCI.

Summary Literature Overview of Academic Health Centers

A full scientific literature review was not possible within the time constraints; however, there is unequivocal agreement that academic health centers are charged with delivering a tripartite mission of clinical service, teaching, and research with the overriding purpose of improving the health and health care of their local communities and society as a whole. These centers have, over the past two decades, faced an increasingly competitive environment that has stretched private-public partnerships and demanded social accountability.

Academic health centers face many challenges, including expansion of education from urban to more 'distributed' and community-based sites, emerging models of inter-professional learning and collaborative care, more ambulatory patient care, and curricular renewal and calls for invigoration for the future of health professions education. They also face demands for a return on investment in research, an attrition of research funding, and a sophisticated consumer oriented population that wishes to see the translation of discovery from bench to bedside. Emerging scholarship and opinion emphasize the role of academic health centers in knowledge dissemination and knowledge application.² Governments increasingly see knowledge as the key indicator of modernization and wealth creation. Thus, as major employers and contributors to the economic growth and prosperity of their communities, academic health centers are being examined globally for the academic/health interface and its impact on population health. A major theme is the emerging desire for meaningful and transparent

measures of academic health center performance as well as benchmarks for social responsibility and global impact.

AAHCI Membership Survey: Project Overview

The *Association of Academic Health Centers International Membership Survey* was designed to collect basic information about member institutions based outside the United States. The primary representative from each AAHCI member institution was invited to participate in the survey and responses were collected over a four-week period. The survey consisted of three parts:

- Section One covered member institutions demographics;
- Section Two concerned member institution goals and priorities; and
- Section Three related to expected benefits of AAHCI membership.

Members participated in the survey with a response rate of 50% (16 out of 32) with 14 responses fully completed. All members who were surveyed were also invited to participate in follow-up interviews. A key factor was interviewee availability during the time frame of the project. Follow-up interviews were then conducted with available survey respondents, as well as a small group of individuals invited to participate as key informants because they were viewed as having a particularly important perspective on the future of AAHCI.

The Institutional Structure of Academic Health Centers

This is the first survey of the AAHCI membership. The diversity of types and models of academic health centers among respondents was remarkable. Although 100% of the respondents included a

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School of Medicine, more than 60% also included Schools of Nursing and of Graduate Studies. More than 50% included Schools of Public Health. AAHCI members are large Centers with an average of 30% having a range of 100-500 paid full-time (FT) and 100-500 paid part-time (PT) faculty. Approximately a quarter of respondent academic health centers have more than 5000 paid FT faculty. Almost 70 percent graduate between 100-500 MD/equivalent students per year and an equal range of non-MD and doctoral students per year. More than 70% of the respondent academic health centers have between 1000-5000 beds in their hospitals.

The assortment of academic health center models comes as no surprise with 40% being separated between the academic and the hospital/health system; 33% as a hybrid (that is integrated for some functions and separate for others) and only 26% are integrated with the academic and health/hospital system under common ownership, governance, or control. Funding sources are equally split among respondents with half being supported more than 25% by government and only 3/16 being supported almost entirely by government. Almost half (42%) rely on a quarter of their support from non-government funding such as tuition and philanthropy. Only one respondent indicated that their enterprise received 75-100% of the transfer of revenues from the hospital/health system. Most (n=6) relied on the revenues from that source for 0-25% of their funding.

A third (35%) of respondents are directly responsible to a government ministry (or ministries) whereas 64% indicated they are directly accountable to a non-government Board or non-government body. More than 50% of the respondent academic health centers are considered to be “public institutions” — owned, chartered, or established by government; 28% are entirely “private” — not owned, operated, or chartered by

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government; and a small number are “hybrid”, a combination of public and private. More than 80% of the respondent academic health centers serve a predominantly urban population, although 53% also serve patients who travel to them to receive care from a designated center of excellence or from a national referral program.

Strategic Priorities and Partnerships

The survey included an assessment of academic health center strategic priorities and 13 respondents summarized their institution’s goals. The most frequently cited strategic priorities were: quality care, excellence in education, translational research, and fulfilling a social/academic mission.

A majority of respondents already have extensive international partnerships, although there was no common geographic area of regional focus, with most partnerships centered on: research collaboration with multi-center clinical trials; global health partnerships for student and faculty exchanges; health and human resources, especially physician and nursing training capacity; advanced graduate and doctoral education programs; and infrastructure support and development.

AAHCI Purpose: Advancing a Common Vision and Serving Members

More than 90% of the respondents indicated that the highest value services that AAHCI could provide to them would be in collecting and disseminating information (communication of best practices) and in facilitating partnerships among academic health centers. A large majority, 76.9%, felt convening global and regional meetings were worthy and 38.5% indicated that advocacy for government policy change/reform would be valuable.

All of the respondents (n=16) indicated that the highest priority for AAHCI should be given to the development of benchmarks, metrics, and performance indicators. More than 90% indicated priority for dissemination of best practices of academic health center education, research, and clinical functions; and more than 70% indicated that the development of population health metrics would be valued.

Finally, the responses on AAHCI governance and structure were not conclusive. Although more

than 50% (8/16) favored a 'hybrid' of regional and centralized governance, the rest were equally split between a sole regional structure and a fully centralized one.

Member Interviews Highlight Common Themes

Seven in-depth interviews of academic health center leaders were conducted by AAHCI, of which four were with AAHCI members. The interviews provided a second stream of information and used purposeful sampling across multiple viewpoints (US, Canada, Middle East, UK, Asia). All interviewees had a high level and sophisticated knowledge about academic health centers and current issues. The interviews revealed some mutual opinions and interests regarding the future course for AAHCI.

Joining AAHCI

Interviewees expressed an increasing interest in an international organization that is dedicated to the unique issues of academic health centers and their tripartite mission.

Meetings for “networking” and or just getting together are of limited interest unless they offer a unique topic or learning or partnership building opportunity.

AAHCI's Value Proposition

The consensus opinion is that the value proposition for AAHCI would vary amongst countries and systems at differing levels of evolution and maturity of academic health centers. For those in the early phases of contemplation to become an academic health center, the appeal would be sharing evidence of the added value of academic health centers, as well as AAHCI's advocacy in making the case for adoption of any model of integrated health care.

The evolution of health services in some countries has resulted in health care being organized around functions. In other countries, health care is characterized by multiple practitioners and complex organizational structures that focus around the needs of professional groups and not around the needs of patients. Some member academic health

centers have developed as a consequence of the recognition that there has to be a better way of organizing care.

Members of AAHCI countries span the spectrum of those who have already taken the principles of integrated care and applied them to their own health reforms as a potential solution; those who are partially integrated and function as a “confederacy” and those who are poised to start the conversation about integration but require evidence and support. In all of these situations, AAHCI and AAHC can act as a change agent, a catalyst, and a platform for international collaboration.

One example of the success of the value proposition mentioned by almost all interviewees was the facilitation of the establishment of the academic health center model in Singapore and the positive impact of the presence and assistance of AAHC in the conversation.

For more mature academic health center systems, the value proposition would be sharing evidence and convening key discussions about academic health center finances and the web of cross-subsidization that occurs at these institutions. Importantly, many interviewees felt that there would be great value with individual studies.

Of interest were case studies that allow for mutual problem-solving and a congregation of like-minded collaborators on how leaders manage the proliferation of managed care and health care reform initiatives, the attrition of research funding, how these threats are affecting their mission-related activities, and how they are responding to and managing these threats.

All the interviewees mentioned that a common goal for AAHCI would be establishing metrics.

Of value are metrics for performance based on strategic priorities especially in Global Health (determinants of health and chronic disease management), Impact on Population Health, and Innovation in Translational Research.

Key areas of priority for AAHCI to develop in the next 3-5 years were as follows (in no particular order):

- Key performance indicators developed from metrics that assess return on investment by government and private investors, using outputs beyond research (e.g., impact on the community the academic health center serves);
- Mentorship for new senior leaders; focused discussion forums that address stages of academic health center development at advanced, middle, and early/formative levels;
- Documentation, sharing of cases, and scholarship on the purpose and direction of academic health centers: what is the best evidence of models that are in use now;
- Collaboration on innovation and best use of the knowledge economy;
- Enhanced Services — annual assembly of all members and improved communication with members;
- Advocacy with public and private funders about the delivery of the tripartite mission, especially on sustained research funding; and
- Discussions about health human resources and the global migration of the workforce.

AAHCI Governance and Structure

This is an evolving area. As one interviewee put it, there is a tension that can best be described as being a debate between “*organizational control and organizational altruism*.” All interviewees agreed that a new role for AAHCI is needed as it relates to AAHC. However, there is no clear consensus about the best model for the relationship. There is an emerging view that AAHCI member issues, albeit similar, are unique from those of AAHC. One interviewee noted that, “*as the AAHCI membership has grown, a critical mass believe there will be a need for a concrete international level organization to address ‘global’ academic health center issues.*” The interviews complemented the survey data confirming that members of AAHCI feel ready to move beyond their role as a subsidiary to a more complementary status. Based on these sources three types of structure models were suggested:

Sole Member Model

The first model could be readily implemented. It would involve an acknowledgement of AAHCI with a member representative appointed to the AAHC Board.

Executive Advisory Committee Model

This alternative model entails an Executive or Advisory Committee of representatives (volunteer, selected, elected, or invited) who would advise the AAHC Board, the AAHC office, and the CEO about planning for annual and regional meetings, membership and fees, and establishing and setting up of a separate AAHCI governance.

The Committee would be charged to engage all members of AAHCI and those of AAHC who wish to participate in a transitional planning phase over a 2-3 year period to strategically plan for AAHCI and create a structure looking towards the collective future of academic health centers internationally. Representation for the Executive Committee would be regional.

International Office Model

This model proposes one or more international offices outside of Washington and based in partner countries, fully supported by AAHCI fees and the host countries.

AAHCI NEXT STEPS: RECOMMENDATIONS

Outcomes from a review of the literature, the historical context, survey results, and in-depth interviews, have produced five recommendations to consider in determining AAHCI’s future course in structure, governance, and activities.

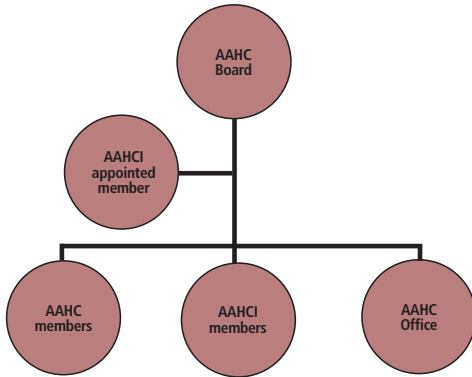
Recommendation # 1

Deliver a comprehensive and reliable communications program that engages AAHCI members, providing a forum for ongoing sharing of interests and projects, and facilitating partnerships. This should use multiple formats, including social media, and be a web-based or a portal-based system.

Recommendation # 2

Convene a roundtable discussion with members of AAHC and AAHCI about the future directions and structure of AAHCI and its relationship with AAHC. In the interim, have a transitional process that would facilitate AAHCI membership in dialogue with the AAHC Board — perhaps

Three types of structure models were suggested.



Sole Member Model



Executive Advisory Committee Model



International Office Model

with a nominated member and/or an advisory committee.

Recommendation # 3

Enhance the secretariat of AAHCI for the sustainable and enhanced recruitment and retention of members, as well as the creation of a business plan for an improved fee schedule and member offerings to meet their unique needs. Conduct an annual needs assessment that would guide regional meetings and the annual International Forum.

Recommendation # 4

Create other mechanisms for member engagement, such as Working Groups. A Working Group that builds on the existing AAHC work on key performance indicators relevant to the international members would be welcomed. Establish Working Groups that measure the impact of research of academic health centers, and on evidence based practices/exemplars of academic health centers. Finally, establish a Working Group on the Social Responsibility of Academic Health Centers based on the World Health Organization (WHO) recommendations.³

Recommendation # 5

Create a network of partnerships building on AAHC and AAHCI databases that link two to three partners across research, education, or clinical projects as demonstration models

for successful collaboration. There are many emerging partnerships but this is not happening in any coordinated way and opportunities may be lost for synergy and winning combinations. Some partnerships can be between those at the same level of evolution whereas others could match emerging academic health centers with more sophisticated ones, and each group would benefit from creative combinations to further the internationalization of the academic health center agenda. Combinations could include North-South academic health centers, regional collaborations, or academic health centers aligned along clinical and research domains.

CONCLUSION

Developing a comprehensive, focused, and widely accepted strategic plan for AAHC's international arm, the world's only coordinating body for academic health centers, is a complex, multi-stakeholder, multidisciplinary challenge. Academic health centers everywhere struggle to deliver a program that is aligned with their mission. They are impeded by many forces, including resource constraints and misaligned missions across their research, teaching, and clinical pillars. The members of AAHCI are not immune; indeed, their size and scope pose several challenges that others do not face. Furthermore, global, national, and local health contexts present additional factors that must be considered when planning the next

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steps, such as addressing inequities in access to health care, tackling unmet health human resources, and measuring the economic value of biomedical research, teaching, and clinical practice.

This report suggests that AAHCI needs an innovative structure. The survey and the interviews indicate that the best outcome would be for AAHCI leaders and the AAHC Board to engage in a two-way dialogue about the future governance of and strategic planning for their relationship. At present, AAHCI is a complex, large and geographically dispersed, and highly diverse group of members with incomparable academic programs, faculty research interests, and variable collaborations with affiliated institutions. Coordination and strategic alignment at multiple levels (inter-departmental, intra-university, cross-institution, and geographically focused) would assist members with an efficient use of limited resources, and optimize the synergies that can exist across AAHCI's broad network. This report concludes that AAHCI membership is now ready to enter into a disciplined, collaborative planning process with AAHC.

Endnotes

¹ Wartman SA, Hillhouse EW, Gunning-Schepers L, Wong JEL. 2009. An International Association of Academic Health Centers. *The Lancet* 2009; 374:1402-1403

² The Commonwealth Fund Task Force on Academic Health Centers. July 2000. *Health Care at the Cutting Edge: The Role of Academic Health Centers in the Provision of Specialty Care*. The Commonwealth Fund: New York, NY. http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2000/Jul/Health%20Care%20at%20the%20Cutting%20Edge%20The%20Role%20of%20Academic%20Health%20Centers%20in%20the%20Provision%20of%20Specialty%20C/blumenthal_edge_390%20pdf.pdf; Academic Health Sciences Centres – National Task Force. May 2010. *Three Missions...One Future - Optimizing the Performance of Canada's Academic Health Sciences Centres*. AHSC-CSSU: Ottawa, Ontario. <http://www.ahsc-ntf.org/?reports>; Board on Health Care Services, Institute of Medicine. 2004. *Academic Health Centers: Leading Change in the 21st Century*. National Academies Press: Washington, DC. http://www.nap.edu/openbook.php?record_id=10734&page=110

³ World Health Organization. 2000. *Towards Unity for Health: Challenges and opportunities for partnership in health development*. Document WHO/EIP/OSD/2000.9. Geneva.

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