Roles of Managers in Academic Health Centers: Strategies for the Managed Care Environment

This article addresses survival strategies of academic health centers (AHCs) in responding to market pressures and government reforms. Using six case studies of AHCs, the study links strategic changes in structure and management to managerial role performance. Utilizing Mintzberg’s classification of work roles, the roles of liaison, monitor, entrepreneur, and resource allocator were found to be used by top-level managers as they implement strategies to enhance the viability of their AHCs. Based on these new roles, the study recommends improving management practices through education and training as well as changing organizational culture to support management decision making and foster the continued growth of managers and their AHCs. Key words: academic health centers, health strategies, managed care, roles of managers

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With the rapid spread of managed care to control rising health care costs, academic health centers’ (AHCs’) unique position in the U.S. health care system as producers of highly trained health care professionals, technological innovations, and advanced patient care is becoming increasingly precarious. Recent political, economic, and environmental changes have undermined AHCs’ ability to maintain their missions and have left them vulnerable to numerous challenges. Government cutbacks in financial support to AHCs means scrambling for new sources of revenue that must be divided into smaller portions towards support for medical research, education, and care to indigent populations. Consequently, the various roles of AHCs make them slow and noncompetitive in a fast-changing managed care environment.

The private market does not recognize the values of the social missions of AHCs, yet these very important societal needs cannot be compromised. In the past, AHCs supported those without insurance through cost shifting. However, this is no longer an option.

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What was once a way to quench the fires of uncompensated care is no longer enough as the fires rage out of control with no relief in sight. AHCs have reached a perilous state. Managed care organizations (MCOs) demand more profits through cost-driven competition. Similarly, government legislates more budgetary reductions. The Balanced Budget Act of 1997 reduced $118.9 billion from hospital support for 1998-2004. Numerous agencies predicted bankruptcies, deficits, layoffs, and mergers as the looming fate of AHCs. The viability of AHCs is at stake when they are hindered by cuts in subsidies while still attempting to compete with MCOs.

Among the various solutions to increase AHC viability, researchers have pointed out a number of strategies including increases in funding support to AHCs, partnering with MCOs, and changing AHC organizational structure and management. It is this last point that becomes the focal point of this article. Existing AHCs’ organizational culture and structure serve as a major impediment in the competitive environment. The traditional structure of AHCs as stand-alone, specialty-driven institutions does not foster collaboration and further hinders entry into the private market. To overcome barriers in organizational culture, leadership is essential to the success of AHCs.

Previous roles of managers are inadequate in the changing environment. In order for AHCs to survive, the solution lies in the understanding of the essential roles that managers must perform. Thus, greater emphasis should be placed on educating managers to develop specific skills required in the evolving managed care environment. Reinhardt notes that leaders of academic medicine have become victims of rapid changes for which no one in society had prepared them. They will continue to be victims until society recognizes that all parties—AHCs, government, and MCOs—must work together to build partnerships to enhance knowledge, skills, and attitudes. Furthermore, effective management should create a clear mission and vision as well as foster cooperation and collaboration.

Many studies have considered the general topic of academic health or medical centers. Some may have addressed these institutions within the managed care context. Although they may mention briefly that management and structure are important to the overall success of AHCs, no literature has been found that makes the critical linkage between managerial roles and their specific uses in the managed care environment, particularly for AHCs. In this article, the linkage is made in order to underline significant strategies that managers can contribute to the survival of AHCs.

OVERVIEW OF AHCs

According to the Association of Academic Health Centers, a national non-profit organization, there are 125 AHCs in the U.S. They consist of institutions that have an allopathic or osteopathic medical school, at least one or more other health professional schools, and an associated teaching clinical enterprise. The following is a discussion of the critical influence of AHCs to the overall health care system, which is pertinent to understanding the rationale for protecting AHCs’ missions.

AHCs play an important role in the health care system. However, recent restructuring of the system, which includes managed care and market competition, has affected greatly AHCs’ mission of training highly qualified physicians and other health professionals,
conducting cutting-edge biomedical research, providing specialized services, and putting technological innovations into medical practice. While AHCs are responsible for the excellent reputations of U.S. medicine, their mission is threatened by the competitive market place as a major paradigm shift changes from the traditional fee-for-service health care delivery system to managed care plans.4-6

The first mission of AHCs is medical education and training. AHCs' educational mission to train physicians and other health professionals is extremely valuable. The number of accredited programs in graduate medical education (GME) increased by 21 percent from 1983 to 1991.1 While AHCs comprise 18 percent of all teaching institutions, they sponsor 59 percent of all GME programs.7 Major concerns for AHCs include training more minority physicians and ensuring that graduates are distributed to serve areas of need. At the same time, another concern is the funding of GME. GME costs include direct costs for training physicians such as salary and fringe benefits. Other costs include clinical expenses, which are often higher for physician trainees than more experienced physicians. Funding is derived from federal and some state governments as well as clinical activities of the AHCs. In terms of the federal government, Medicare is the largest payer of GME at $6.1 billion in 1994.8 The National Institutes of Health (NIH) provide support for research, with the majority of support awarded to AHCs. Clinical activities of the AHC amounted to $850 million to support GME from 1992 to 1993.9 Nevertheless, support for medical education is lacking. Failure to deal with this will threaten the survival of AHCs and ultimately result in their demise. Fein points out that there is a lack of leadership in AHCs that has contributed to the present financial picture.10 Therefore, leaders of AHCs should be held accountable. While it is true that funding cuts have occurred at all levels, leaders tried to secure and retain whatever funding they could get. As a result, their bookkeeping efforts were lax as long as they saw the flow of funds coming in without regard to their sources. They failed to recognize the adverse effects on the AHCs. Consequently, leaders in AHCs did not speak out forcefully for broad based support for education or research.

The second mission of AHCs is research. AHCs are the nation's primary source of new discoveries and innovations. On the plus side, the benefits of research are numerous. Patients can gain access to advanced technologies, new knowledge, and expertise. Industries can partner with AHCs to develop new products. Research also generates additional jobs, thereby stimulating the economy. However, there are several significant pitfalls. Academic research requires enormous investments of money, time, and human capital. Putting forth these resources also leads to substantial risks. Researchers may devote a great deal of time to their projects, yet find themselves lacking federal or industry sponsors. Without research support dollars, their research survival is at stake. On the other hand, researchers who receive funding from industry find themselves amidst the issue of conflict of interest. Especially due to the pressures of the competitive managed care market, shrinking levels of government funding to AHCs may justify researchers' need to look to industries for support. Moses and Martin found that $8 to $10 billion in industry research and development was given to AHCs for biomedical research in 2000.11 However, a study by Andreopoulos et al. suggests that biomedical research with
partnerships between industry and AHCs is motivated more by the pursuit of profit than the search for answers. The study further notes that researchers more likely will pursue projects that lead to additional funding or even commercial spin-offs. Unfortunately, these profit-motivated efforts impede the advancement of knowledge. Academic partnerships with industry undoubtedly will continue to grow given that the managed care market has contributed largely to the plight of AHCs with cost consciousness and reductions in funding. To reduce and avoid risks for researchers, Moses and Martin suggest that remedies should isolate research from economic pressure. Furthermore, AHCs should police themselves. That job ultimately lies in the hands of the top level managers of AHCs.

The third mission of AHCs is to provide patient care. In particular, AHCs serve as safety nets to vulnerable populations, especially for those who are unable to pay. Thus, uncompensated care (care provided to indigent patients), care to Medicaid patients (patients receiving public assistance), and care to those whose costs may exceed payment contribute to rising costs for AHCs. In 1989, AHCs provided 33 percent of all uncompensated care; this increased to 37 percent by 1994. Care provided to Medicaid patients also is increasing because Medicaid often reimburses less than the actual costs of care. Public AHC hospitals provided 20 percent of Medicaid as a percentage of net patient revenue in 1989; this increased to 34 percent by 1994. Private AHCs provided only 10.7 percent of Medicaid as a percentage of net patient revenue in 1989, increasing to 13.7 percent by 1994. During the 5-year period from 1989 to 1994, AHC expenses grew at an average annual rate of 8.1 percent. While expenses have continued to grow, inpatient days have decreased. For the same time period, inpatient admissions declined by 2.6 percent.

Due to the large financial burden brought about by uncompensated care, AHCs have been playing a survival game of cost shifting. Historically, AHCs charge 30–40 percent more than non-academic hospitals to offset the expenses they cannot recoup by caring for the poorest and sickest populations. However, in the competitive managed care marketplace, health maintenance organizations (HMOs) and other MCOs seek to purchase health services at the best possible prices for their members. For this reason, health plans prefer not to contract with AHCs and readily negotiate with lower-priced, nonteaching hospitals. According to Reuter, AHCs lost nearly 20 percent of the HMO market to other hospitals in 1994. In general, HMOs seldom use AHCs for primary care, but most commonly use AHCs for tertiary and quaternary care. Blumenthal and Meyer conducted case studies of several AHCs and found the mix of patients with private insurance is low while the percentage of uninsured is high. In some cases, the percentage of uninsured is higher than the national average of 14.7 percent. Nevertheless, AHCs must compete with managed care plans to survive. Thus, AHCs try to compete with these nonteaching hospitals by attempting to control costs in GME, training, faculty compensation, and encouragement of faculty to seek industrial funding for their research. Unfortunately, these methods only contribute a small portion of total expenditures. Therefore, more comprehensive strategic planning and implementation processes are needed to overhaul AHCs, requiring top-level managers to lead these processes.
A review of the missions of AHCs suggests the following. First, revenues received from research and clinical services are a significant source of funding for mission-related activities. Second, because AHCs rely heavily on government funding for their education, research, and social missions, they are more sensitive to regulations that affect payment changes. Third, costs are higher for AHCs than nonteaching hospitals because they serve higher numbers of uncompensated care populations. Consequently, due to increased costs, AHCs find themselves at a disadvantage and unable to compete in the managed care environment. As a result of these mission-driven changes, AHCs are seeking alternative strategies as they become more prepared to face their challenges.

**STRATEGIES OF AHCS**

Research studies have found several kinds of strategies in response to the challenges illustrated by the competitive managed care environment. Most notably, external and internal strategies have been suggested as ways to facilitate the understanding of market and government changes. In response to the market, external reform strategies advocate the formation of partnerships between MCOs and AHCs. Within the AHC organization, other researchers have discussed strategies such as the creation of advanced information systems, focusing on primary care and examining governance and management structures for change. Specifically, chief executive officers (CEOs) must act as change agents in decision making roles. Rogers et al. and Rabkin agree that administrative decision making will require more rapid and timely decisions in order to react to forces in the managed care environment.6,20

Still others suggest alterations to existing AHC organizational structure. For instance, legal separation of the hospital from the university or the state makes the AHC more responsive to changes. In this case, more authority is kept within the AHC and is hindered less by state regulations. Furthermore, decentralization allows for rapid management decision making. Alexander indicated that CEOs of restructured hospitals have “greater operational flexibility and control.”22 On the other hand, instead of separation, integration combines several advantages, including access to a wide range of specialty services and resources. For the AHC, affiliating with integrated delivery systems means expanding its patient base, accessing large primary care networks, and developing relationships with organizations along the continuum.23 As a result of integration, AHCs can become much more attractive to MCOs. However, Persily and Gottlieb also caution that integration can cause territorial and resistance attitude within the AHC.23 Thus, AHC leaders must communicate trust and a common sense of purpose throughout the institution in order for integration to develop into a successful strategy. Blumenthal and Meyer point out that as AHCs evolve through partnerships, integration, and alliances, they become much more complex, geographically diverse, and ultimately very difficult to manage.15

The need for strategies to enhance revenues in response to government funding cuts is becoming more prevalent. The Balanced Budget Act of 1997 not only reduced funding to AHCs but also sent the message that more accountability of the support dollars is required. Accountability of funding falls into the scope of responsibilities of managers. Without “complex and expensive
management information systems,” there has been no incentive for academic leaders to demand accountability in AHCs.\(^2\) If AHCs are able to identify and reduce areas of waste without compromising on quality, then such reductions in cost will allow AHCs to get more out of their government subsidies.\(^2\) Furthermore, AHCs must be innovative in the development of government oriented strategies. For instance, tying AHCs’ advanced technological and infrastructure advantages with government and public needs is one way to ensure additional funding. Blumenthal and Meyer assert that because AHCs have the capabilities, they must make use of their specialized services and products to focus on governmental health priorities, which may result in additional governmental direct and indirect funding opportunities.\(^2\) In other words, AHCs must capitalize on their missions as they develop survival strategies. Moreover, Pardes recognizes the effects of decreased government funding to AHCs. He recommends that the political agenda should concentrate on making reversals to the Balanced Budget Act of 1997 thereby increasing funding to hospitals.\(^2\) For this to happen, managers at AHCs must take an active role in informing the public and government of the problems facing AHCs. Leaders in AHCs should “share information and analyses with the public.” Problems will not be resolved behind “closed-door meetings.” There must be a willingness to change behavior.\(^1\) At this time, AHCs have come to recognize the extent of their problems. However, resolution will require top leaders to alter their roles and responsibilities to better meet their challenges.

**CASE STUDIES OF AHCs**

In addition to the broad strategies outlined above, several case studies of AHCs were identified. The following cases are discussed for the purpose of underlining the characteristics of AHCs that establish the need for strategic choices to increase the viability of AHCs due to the managed care environment. Meyer and Blumenthal visited the University of Tennessee Health Sciences Center and Meharry Medical College to investigate the effects of TennCare, the state’s Medicaid managed care.\(^2\) They found five challenging areas for these two AHCs due to TennCare: (1) decreased payments for services, (2) decreased volumes of clinical services, (3) decreased market share of the Medicaid population, (4) adverse selection, and (5) loss of graduate medical education payments as well as disproportionate share hospital payments and capital funds. The effects of TennCare were both positive and negative. On the one hand, it enabled more vulnerable populations access to health care. On the other hand, it challenged the traditional missions of AHCs. Specifically, Medicaid patients had the option to seek other MCOs rather than AHCs. As a result, both AHCs experienced decreased patient services. In response to these challenges, both AHCs derived strategies that not only increased patient volume and revenue but also ensured that patient needs were met. Strategies at Meharry included increasing its outpatient services and maintaining its primary care base and developing networks with community health centers. The University of Tennessee’s strategies were to develop its
primary care services through marketing efforts and to create an AHC without walls for rapid decision making.

Saxton et al. addressed the case of Emory University. With the appointment of the new executive vice president for health affairs, an extensive study of Emory was conducted. Findings showed that managed care enrollment was high. Emory’s operations were inefficient, lacked integration, and were deficient in friendly customer service. In response to these problems, integration and administrative consolidation led to the formation of Emory Health Care with seven goals, which emphasize the creation of a management and governance structure reflective of key priorities. The new governance structure enhances management and coordination of Emory’s strategic objectives. Ultimate authority and accountability rest with the executive vice president for health affairs. In addition, a leadership team was created consisting of top executives from Emory hospitals, Emory Clinic, and Wesley Woods Center. Clinical management teams also were created with decision making authority.

Similar to Emory, Oregon Health Sciences University’s (OHSU’s) administration also chose to pursue strategies that enabled it to compete in a very competitive managed care market. The competitive environment was created largely by changes to the Oregon legislature when it established the Oregon HealthPlan in the early 1990s, whereby hospitals that accepted Medicaid patients had to deliver care through managed care plans. Under the Oregon HealthPlan, more patients received coverage, which increased the number of individuals seeking care and in turn increased the number of providers. This also meant additional patients for OHSU. In the area served by OHSU, more than two thirds of the region’s population are enrolled in HMOs and preferred provider organizations (PPOs). Nearly 50 percent of Medicare patients and 75 percent of Medicaid patients are enrolled in MCOs.

Although OHSU has the advantage of being the only AHC in the state, it seeks to gain its competitive edge. Strategies called for structural and management changes. One innovative structural change is the formation of a public corporation. It allows OHSU to maintain its public missions while moving towards more business-like practices. A seven-member board serves as the governing body for the institution and focuses its entire attention on OHSU. This process streamlines the bureaucratic system into a centralized decision making structure.

Another strategy called for management changes, where upper management personnel consist of the vice president for finance and administration, vice president for academic affairs, and provost and director of the healthcare system. Instead of being bogged down by multiple levels of decision making, the merger of various administration positions allows for ease of operations and signifies the AHC’s response to the market with rapid decisions. Other strategies include converting to a 1-year budget cycle for more responsiveness as well as aggressively initiating a marketing campaign of OHSU’s services.

At the University of Illinois at Chicago (UIC), administration developed a strategic plan in 1991 in response to the demands of the health care environment. This was evaluated and revised for the rest of the decade. The goal of the plan was to market the institution to enhance its reputation. UIC sought to become more attractive to MCOs, thus obtaining more contracts, managed care
patients, and referrals. Another initiative was to develop capital resources for improving facilities and programs. The vice chancellor was made responsible for investment funds, which are allocated for strategic development of clinical programs and recruitment of faculty. In other words, all decisions regarding the allocation of funds must be approved by the vice chancellor.

Likewise, at the Medical College of Wisconsin (MCW), administration evaluated the health care environment and determined that managed care is of major concern because it is the cause for the deteriorating referral base. Moreover, competition stems from the other major hospitals in the area and even some from the neighboring state of Minnesota. MCW is committed to ensuring its survival under the evolving market place. After careful monitoring of the environment, MCW sought to combat competitors through the initiation of a strategic plan, which consists of increasing primary care, participating in integrated delivery systems, reducing costs, developing an information system, and preparing to accept risk.

Based on the discussion of these cases, it was shown that AHCs chose a number of strategies to reduce cost and increase services and revenue while preserving their missions. In fact, the development and implementation of these strategies are vital to the survival of AHCs in the changing health care environment (see Table 1). Moreover, AHCs rely on their administration to understand the forces in the market prior to initiating strategies that will enhance their positions.

### ROLES OF MANAGERS IN AHCs

The literature review and especially the case studies depict numerous changes taking place in the health care environment of AHCs. As the managed care environment becomes more complex and competitive, AHC viability requires comprehensive strategic planning for which AHCs must depend on their managers. Throughout the literature on AHCs, what has become obvious is that managers play an important role in AHCs. In particular, they are crucial to the development of strategies. However, what is not apparent from the literature is the exact roles and responsibilities of managers.

Of the numerous approaches to managerial behavior available in the literature, many were found to be too complex. Others assert that managers do not have clearly defined jobs in which activities include a wide variety of contacts. Stewart found differences among managers in the frequency and range of work and type of contacts as well as a general fragmentation of work activities. Mintzberg studied managerial work; his research is of particular interest because he was able to identify distinctive roles of the manager and classify them into 10 work roles. Due to the comprehensiveness of his work, his roles of managers will be used to study the roles of managers in AHCs. The literature supports his classification of work roles. Thus, Mintzberg’s research continues to be recognized as especially significant to the study of managerial work. Moreover, his classification is representative of the activities of the manager. Mintzberg developed a framework of behavioral roles classified into 10 work roles (see Table 2). The interpersonal roles describe the work of the manager as a figurehead, leader, and liaison. In the figurehead role, the manager is responsible for a variety of social and ceremonial activities. As a leader, a manager gives the organization direction and purpose. In the liaison
Table 1. Strategies of AHCs

<table>
<thead>
<tr>
<th>AHC</th>
<th>Strategies</th>
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<tbody>
<tr>
<td>University of Tennessee</td>
<td>• Develop primary care through marketing</td>
</tr>
<tr>
<td></td>
<td>• Create AHC without walls</td>
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<tr>
<td>Meharry Medical College</td>
<td>• Increase outpatient services</td>
</tr>
<tr>
<td></td>
<td>• Maintain primary care</td>
</tr>
<tr>
<td></td>
<td>• Develop networks</td>
</tr>
<tr>
<td>Emory Health Care</td>
<td>• Integrate and consolidate to form Emory Health Care</td>
</tr>
<tr>
<td></td>
<td>• Create management and governance structure and leadership teams with decision making authority</td>
</tr>
<tr>
<td>Oregon Health Sciences University</td>
<td>• Merge administrative positions</td>
</tr>
<tr>
<td></td>
<td>• Streamline decision making</td>
</tr>
<tr>
<td></td>
<td>• Convert to a 1-year budget cycle</td>
</tr>
<tr>
<td>University of Illinois at Chicago</td>
<td>• Market to enhance reputation</td>
</tr>
<tr>
<td></td>
<td>• Attract managed care organizations and patients</td>
</tr>
<tr>
<td></td>
<td>• Develop capital resources</td>
</tr>
<tr>
<td>Medical College of Wisconsin</td>
<td>• Increase primary care</td>
</tr>
<tr>
<td></td>
<td>• Form integrated delivery system</td>
</tr>
<tr>
<td></td>
<td>• Develop information system</td>
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<td></td>
<td>• Accept risk</td>
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role, the manager builds networks of contacts with individuals and groups who are in positions to provide information to enhance the nature of the organization.

The next set of roles are informational, made up of the monitor, disseminator, and spokesman. In the monitor role, the manager gathers information and seeks to identify problem areas, makes sure that operations run smoothly, and develops plans to improve the organization. This role is important because it allows the manager to understand

Table 2. The manager’s work roles

<table>
<thead>
<tr>
<th>Managerial work roles</th>
<th>Interpersonal roles</th>
<th>Informational roles</th>
<th>Decisional roles</th>
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<tbody>
<tr>
<td></td>
<td>2. Leader</td>
<td>5. Spokesman</td>
<td>8. Disturbance handler</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>10. Negotiator</td>
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what takes place in the organization in relation to his or her environment. As the disseminator, the manager brings external information into the organization and passes information on to his or her subordinates. Contrary to the disseminator role, the spokesman role passes information out to the organization’s environment.

The decisional roles consist of the manager’s roles as entrepreneur, disturbance handler, resource allocator, and negotiator. As an entrepreneur, the manager acts as an initiator and designer of change in the organization; in other words, the manager is the agent of change. As the disturbance handler, the manager resolves disturbances and restores stability to the organization. As the resource allocator, the manager establishes and maintains priorities in the organization by allocating time, money, material, equipment, manpower and reputation to certain functions. At the same time, the manager is responsible for authorizing all major decisions. The final role is that of a negotiator, where the manager participates in various negotiation activities.

Continuing to use Mintzberg’s work roles as the template, this article finds the linkage between AHC strategies and management using the foregoing six AHC cases. The cases revealed that management is critical to the development of new strategies as AHCs undergo rapid changes forced by the managed care environment. Managers are required to improve current management practices through the performance of new roles. In fact, their new roles can be described by the classification of activities developed by Mintzberg. Table 3 provides a summary of these roles as they relate to the strategies implemented by the six AHCs.

Specifically, in the case of TennCare at Meharry and the University of Tennessee, both AHCs determined that upper-level managers are essential to meeting the demands of the health care market. With the advent of TennCare, the spending cap lowered per-service payments. Especially because the two AHCs have higher numbers of participating TennCare patients, decreased payments occurred; because they were not able to immediately reduce their costs to balance with the lowered payments, both AHCs faced huge losses in operating revenue. Complicated by reductions in volumes of clinical services, both AHCs lost larger portions of the market share. Actions of AHCs to meet these challenges can be attributed to their top leaders. For instance, the roles of their managers include developing strategies to increase patient volume through aggressive marketing and networking, such as direct communication and collaboration among various administrative personnel both in and between the hospital and university. This allows administration to receive and request information that will enable them to understand market changes. Networking activities can be explained by Mintzberg’s work roles of the liaison and the receiving and exchanging of information can be described by the role of the monitor. In addition, by scanning the environment to develop ideas and understand trends, administration is responsible for bringing about changes to their organizations through initiating new methods and designing new
Table 3. Roles of managers at the six AHCs in the development of strategies for the managed care environment

<table>
<thead>
<tr>
<th>Roles of managers</th>
<th>University of Tennessee Health Sciences Center and Meharry Medical College</th>
<th>Emory Health Care</th>
<th>Oregon Health Sciences University</th>
<th>University of Illinois at Chicago</th>
<th>Medical College of Wisconsin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liaison</td>
<td>Network to increase its specialty services</td>
<td>Identify and leverage market strengths</td>
<td>Network between hospital and university</td>
<td>Network between hospital and university</td>
<td>Network with community and join external boards</td>
</tr>
<tr>
<td>Monitor</td>
<td>Scan the environment to understand the effects of TennCare</td>
<td>Analyze the impact of the Balanced Budget Act of 1997 and market reforms; enlist participation of faculty and staff</td>
<td>Analyze the pros and cons of forming a public corporation</td>
<td>Monitor relationship with the state</td>
<td>Gather information to develop strategies and opportunities</td>
</tr>
<tr>
<td>Entrepreneur</td>
<td>Market to increase volume of clinical services; increase the volume of Medicaid patients; create an AMC without walls</td>
<td>Seize opportunities to reduce cost; establish seven operational goals</td>
<td>Change management structure to merge administrative functions between hospital and university for rapid decision making</td>
<td>Develop marketing and advertising campaign; increase program development</td>
<td>Develop market strategies to increase volume of clinical services; form integrated delivery system</td>
</tr>
<tr>
<td>Resource Allocator</td>
<td>Allocate funds to develop primary care services; analyze and account for the budget</td>
<td>Cross-subsidize; offer relief from dean’s tax</td>
<td>Convert to 1-year budget cycle; allocate funds to marketing campaign</td>
<td>Appropriate resources to improve facilities</td>
<td>Allocate resources to develop new programs and information systems</td>
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projects. These activities are described by Mintzberg’s work roles of liaison and entrepreneur because as the liaison, the manager seeks to understand trends. As the entrepreneur, the manager takes the trends and puts forth new ideas and projects such as the allocation of resources to expand primary care services with hopes of attracting additional patients. Furthermore, given the reality of decreased services and revenue, there is a greater need to analyze and account for the budget and seek alternative resources. These are exhibited by the managerial performance of the resource allocator role in order to better the positions of their AHCs.

In the case of managerial responsibilities at Emory Health Care, with the appointment of new leadership, its administration initiated a comprehensive centerwide strategic assessment and planning process based on recent government legislation and market reforms. The process took more than 18 months and required faculty and staff participation. The planning process can be equated to Mintzberg’s managerial role of the monitor. That is, prior to the implementation of strategies, administration scans the environment to understand market pressures and political changes, and communicates within the organization to assess its current situation. Administration then determined that Emory must “clearly identify and leverage [their] market strengths, ... engage in extremely selective partnering.” In this case, identification of the market and collaborating with partners are equated with Mintzberg’s role of liaison. Furthermore, administration indicated that resources were especially vulnerable because reengineering of its operations and partnering increased expenses. Cross subsidization was necessary for financially strained departments that served as safety nets. Under these circumstances, the administration’s decisions to adjust clinical revenues by decreasing the dean’s tax from 6 percent to 2.5 percent suggest the use of the resource allocator role. Emory administration’s entrepreneurial role comes across through the establishment of its seven operational goals, which were determined as imperative to its survival and ultimate success.

In the case of managerial responsibilities at the OHSU, the AHC has a team of managers responsible for all decision making. This team merged the roles of the hospital with the medical school to allow for rapid decision making. The director of the health care system is responsible for all clinical activities. Thus, the director must serve as liaison and monitor of situations in the hospitals, clinics, and health plans. The vice president for finance and administration is responsible for budgeting for all clinical, education, and research activities. Such responsibilities fall into the resource allocation role of making decisions related to the budget. Furthermore, the provost and vice president for academic affairs are responsible for educational and research programs. These functions require the performance of entrepreneurial activities to seek and identify additional sources of funding for education and research grants. Consequently, the management team performs all the roles of the resource allocator, entrepreneur, monitor, and liaison, which are demonstrated by Mintzberg’s work roles.

In the case of the UIC, managers have formed strategies to improve existing programs and develop new projects. The vice chancellor performs the roles of Mintzberg’s resource allocator, entrepreneur, monitor, and liaison. For instance, he is responsible for financial oversight, planning, marketing, contracting, and external affairs for UIC.
Managing external affairs requires the performance of the monitor and liaison roles to network and gather information, which is useful to understand changes. In addition, one of his primary roles is to allocate resources by approving the budget for capital improvements. As the entrepreneur, he is responsible for initiating and delegating project development and new programs. His role performance of liaison, monitor, entrepreneur, and resource allocator is necessary to strengthen UIC. In this way, UIC management conducts activities most essential to survival.

Finally, in the case of MCW, administration develops a number of strategies to better its position in the marketplace. Most importantly, it analyzes the environment and realizes the need to make changes in order to survive. Strategies include decreasing costs while increasing revenue. To accomplish this, administration monitors the environment prior to initiating market strategies and decides upon strategies that will increase MCW’s referral base and presence in the community. By establishing relationships with community physicians and other networks, important roles of administration are to liaison by joining external boards to seek information as well as monitoring to understand trends and gain more community support.

Another way to reduce costs is through the development of an advanced information system, which is essential to keeping in touch with changes in the market. Administration realizes that allocating resources to build an information system will be necessary. Without investing in the risk of developing advanced technology, MCW will not be able to compete. Therefore, risk taking is an essential entrepreneurial action of MCW administration as it seizes this opportunity to enhance MCW’s competitiveness. Another risk-taking entrepreneurial decision is to downsize its medical school faculty and residency programs. On the one hand, this leads to decreased costs but also decreases revenue from tuition. This risk-taking decision is difficult, yet essential, because MCW believes its education and research missions should focus on quality rather than quantity. Its administration is responsible for performing the roles of liaison, monitor, and entrepreneur in analyzing the market, understanding its trends, and making risky decisions, requiring the allocation of resources for developing new projects and discontinuing existing programs in response to the demands of their environment.

Based on these case studies, the most frequently identified Mintzberg work roles include liaison, monitor, entrepreneur, and resource allocator. Upper-level managers in AHCs are responsible for fulfilling these new roles to enhance the positions of their organizations. The first and foremost role is that of monitor, internally and externally, to enhance understanding of the effects of the managed care environment prior to taking strategic action. While performing as monitor, administrators rely on their interpersonal skills. Specifically, the role of liaison helps them deal with faculty, staff, and outside partners. Through performance in these two roles, managers will be able to develop strategies. For instance, whether the AHC decides to take risks to acquire new markets, improve existing programs, or adjust internal systems, the entrepreneurial role becomes evident. Finally, the resource allocator is essential for realizing all strategies, through direct allocation of budgets, making alterations, and accounting for more cost effective delivery.
IMPLICATIONS FOR MANAGERS IN AHCS

This article, based on a thorough review of the literature and case studies of AHCS, suggests that AHCS are developing strategies to increase their survival through the utilization of new roles filled by their managers. To be certain that managers are initiating strategies in the best interest of their institutions, this study makes two important recommendations: (1) improving management practices through education and training and (2) changing organizational culture to support management decision making and fostering management growth so that managerial roles match their positions. It is the organization’s responsibility to ensure that tasks correspond to the individual’s abilities.

One finding reveals that organizational culture in AHCS must change to be responsive to managerial needs in their new role performance. An adaptive organizational culture needs to exist for the purpose of enhancing managerial satisfaction which in turn increases performance. Typical bureaucratic culture is far too rigid and not adaptable to change. An entrepreneurial culture, with high levels of risk taking, dynamics, and creativity, will foster innovation, create change, and lead to the growth of managers. Many AHCS recognized the need to assess organizational culture and have taken steps to redesign their work processes.28 On the one hand, redesigning job responsibilities may bring about painful removal of managers who do not fit in the new culture and the replacement of new managers who are able to implement the shared visions and strategies to benefit organizations. On the other hand, part of the redesign process will provide managers a better fit between their interpersonal skills and their new responsibilities. Here, the responsibility of the new organizational culture is to impact the long-term performance of managers as they are vital to the survival of AHCS and determine their ultimate success in the changing health care environment.

A second finding suggests that to improve management practices, education and training need to be strengthened so that managers will have the ability to make the right decisions. In the case of interpersonal skills of managers, not only must they have corresponding degrees and experiences, they must be given opportunities continuously to acquire and retain information for making decisions. In some cases, AHCS already have begun to examine existing processes by merging various hospital positions with those of the medical school.28 This not only strengthens authority, but also clarifies responsibilities and allows for more timely decision making.

For instance, the roles of upper-level managers of AHCS include developing fundamental skills that enable them to deal with changes in the environment that affect their institutions. Not only should executives aim at improving themselves, they also should improve their institutions. Improvement at all levels leads to more competitive advantages for the AMC. This can be demonstrated by sharing goals among all parties. More collaboration enables upper-level administration to communicate more effectively with their subordinates. Administration also should be able to articulate the “big picture” clearly to the people it works with.28 In addition, executives should monitor and keep up to date with changes in the market. This often
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means having to liaison and develop networks of contacts to share and exchange information. For example, the traditional relationship between the hospital and university has been described as isolated and fragmented. Managers need to increase liaison efforts because without this interaction, survival is at stake when upper-level managers are unable to effectively deal with risks and risk-taking entrepreneurial actions, which are required to respond in the competitive environment.

Another area of management improvement is increasing the awareness of managers to examine and account for budgets and to allocate resources. Especially because fierce competition has decreased revenue and its sources, managers are having to make do with less. They must limit the amount of resources by allocating them to worthy programs and projects. The knowledge of allocating resources to worthwhile projects is not by chance. This requires recognizing trends and matching needs. All of these management improvement processes necessitate the increased performance of new managerial roles, which must be taught and managers must gain competency in these areas.

CONCLUSION

This article outlines the current situation of AHCs and demonstrates that survival is at stake. Essential to AHCs existence is organizational structure and management, whereby managers must derive strategies to increase the viability of their AHCs. In particular, managers must exercise the liaison role to build networks of contacts to enhance their organizations, the monitor role to understand market trends, the entrepreneur role to invest in risk-taking strategies to improve programs, and the resource allocator role to authorize decisions related to the budget. AHC organizational culture must support and enable managerial development and growth. To further improve management role performance, AHCs must invest in managerial education and training so that managers will be able to develop specific skills required for the implementation of strategies to achieve organizational success. As AHCs continue to carry out their valuable missions, they will come to recognize and link the performance of their managers to their overall strategic positioning for better competitive advantages in the managed care environment.

REFERENCES


