Academic Medical Centers and the Fallacy of Misplaced Concreteness

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Abstract Academic medical centers (AMCs) are a familiar target of critics who charge the US health care system with indifference to the most pressing needs of the public. AMCs are frequently faulted, for example, for promoting specialization instead of primary care, for favoring high-tech services rather than the promotion of health and prevention of illness, and for failing to adequately meet the needs of the disadvantaged. An organizational perspective, with particular attention to the structure, mission, and environment of this institutional form, suggests that these critiques may misplace onto AMCs responsibility for solving problems with deep roots in the larger political economy of health care policy in the United States. By the same token, however, the pressures of that political economy (i.e., environment) on AMCs progressively strain their structure, mission, and (arguably) their capacity to serve the public interest.

Keywords academic medical centers, health care policy, public health

> If you don't know where you are going, you'll end up someplace else.
> —Yogi Berra

When I joined the faculty of (what is now called) the Mailman School of Public Health at Columbia University in 1988, David Axelrod, commissioner of New York State's Department of Health, was pursuing a long and ambitious agenda that included an initiative (UNI*CARE) to bring affordable universal coverage to the state, new interventions to combat AIDS, and, neither first nor last on the list, carrots and sticks that would at long last induce the academic medical centers (AMCs) of the state (and especially those in New York City) to change their errant ways. (For an insightful account of the health policy action in New York State at the time,

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see Beauchamp 1996.) The commissioner was indignant that these powerful institutions persisted in producing an oversupply of specialist physicians despite the state's need for more primary care; focused heavily on acute (and technology-intensive) services while showing indifference if not contempt for the prevention of illness and the promotion of health; and worked tirelessly to market their services to well-insured patients while sitting, like castles protected by invisible moats, amid lower-income communities badly in need of health care. Unsurprisingly, the AMCs begged to differ.

This late 1980s vignette captures a conflict far wider than a local contretemps between one state health commissioner and one set of AMCs. Scholars, practitioners, and policy makers on the left of the health policy spectrum have long articulated a critique substantially the same as Axelrod's, and the defenders in and around AMCs have long offered a riposte to the effect that, notwithstanding their pioneering efforts to cure disease (both dread and more mundane), they are undervalued and misunderstood by pundits, payers, and politicians who insist that they embrace new missions and constituencies while, perversely, constraining their revenues, thereby driving them into states of crisis and siege that imperil their productivity and perhaps their survival.

The argument of this article is that the familiar critique of AMCs exemplifies what Alfred North Whitehead (1929) called (and which I take some liberties in recalling) the fallacy of misplaced concreteness. The fallacy, as construed here, consists of reifying (concretizing) and laying at the doorstep of a particular type of organization problems that are properly ascribed to large contextual considerations of public policy (and thus to the historical, cultural, and political forces that produce public policy). I argue further that the problem at hand—assessing the validity of the conventional critique of AMCs—is (to follow Wittgenstein) one less amenable to solving than to dissolving and that organizational analysis supplies an effective, albeit too little noticed, (dis)solvent.

Organizational analysis (a term I prefer to the rather more grandiose *organization theory*) is a pastiche of propositions deriving from (among others) Max Weber, Herbert Simon, James March, Michel Crozier, Charles Perrow, Oliver Williamson, and James Q. Wilson, which holds that the behavior of actors across the public, private, and nonprofit sectors is shaped importantly by the properties of complex formal organizations—to wit, their histories, structures, incentive systems, technologies, environments, and missions. Precisely *because* these variables are multiple, mushy, and

overlapping, they are well suited for making sense of the distinctive and particular complexities of organizations and of organizational types.

The AMC as an Organization

Behold, then, the AMC, a formal organization of a quite extraordinary complexity that begins with its structure. Denotations and connotations of the term *academic medical center* differ. At its narrowest, an AMC contains a medical school and a teaching hospital (usually, though not always, affiliated with a university). More commonly (and more in keeping with the moniker *academic health center*), a center also encompasses an allied university-based institution such as a school of public health or of nursing. Prominent AMCs tend to embrace a fourth set of components: university departments such as mathematics, biology, chemistry, and physics (or individual scholars working within them). And some AMCs affiliate with community hospitals and/or other providers for purposes of teaching and caregiving.

Since the 1920s, medical schools "were never to stop growing in bureaucratic complexity" (Ludmerer 1985: 259), a generalization that fits all the components of the AMC, and each of its bureaucratic ingredients is complicated in its own right, to the point of resembling an exercise in herding cats. The organizational interests of medical schools and teaching hospitals may be imperfectly, indeed poorly, aligned, but both seek to impose order and routine on physicians, whose professional training and identity famously resist control not only by laypeople but also by peers who dare to invoke the authority of formal hierarchies (Freidson 1970, 1975; Starr 1982). Undergraduate medical education and graduate medical education have distinct governance structures, the latter controlled by "all-powerful barons" (Ginzberg 1990: 61) at the head of clinical departments answerable to specialty societies and fiercely protective of the "separation of powers" that ensures their "privileges and freedom" (Ebert and Ginzberg 1988: 16). Over time, taxes on faculty practices and a growing corps of salaried physicians who mainly care for patients but hold academic titles have strengthened the leverage of deans, but only to a point. Hot competition among AMCs for stellar physician researchers and state-of-the-art specialists continues to conduce toward considerable insularity and independence of departments and their senior staffs.

University presidents and provosts have agendas of their own, as do professors, who cherish tenure, academic freedom, and (once upon a time) faculty governance. Medical schools, hospitals, nursing and public health

schools, and universities are also governed by boards of directors, the collective preferences of which (and of course the preferences of their individual members) are important, perhaps essential, to their institutions' quest for philanthropic resources and political support. Contemporary AMCs must also cooperate, however uneasily, with managed care organizations (MCOs), a source of pressures—including "the real threat . . . [of] financial insolvency" (Rogers, Snyderman, and Rogers 1994: 1376)—that ripple throughout the AMC enterprise.

Intricate as these governance arrangements are, budgetary relations surpass them in complexity. These complications appear in elaborate and often contested cross-subsidies that may remain substantially opaque even to those who transact them as they endlessly seek to enlarge, juggle, and recoup losses in revenues derived from grants, contracts, GME (graduate medical education) payments, patient revenues, philanthropy, and taxes on physician practices. The institutional precincts of the AMC are scenes of Hobbesian struggles for power and money, and the sojourns of their presidents, CEOs, deans, and chairs can be nasty, brutish, and short.

These centrifugal structural tendencies come accompanied, moreover, by multiple missions. The institutional components of the AMC are expected to conduct cutting-edge scientific research that generates biomedical breakthroughs (that is, life-prolonging and life-enhancing innovations in diagnoses, drugs, devices, and procedures) to deliver care of the highest quality to their patients, and to prepare their students to do likewise.

In 1963, Rensis Likert and Robert Kahn averred that "medical center administrators face one of the most complex administrative tasks we have ever encountered" (qtd. in Lewis and Sheps 1983: 192). More than a half-century of medical and organization evolution and innovation has multiplied those complexities. As Pierre-Gerlier Forest (personal communication, 2017) put it:

> AMCs are the most complex organizations in our societies, embodying as they do: cure and care at the highest level and coordination of both; plus knowledge creation and management; plus training of multiple professional groups from MDs to accountants and social workers; plus financial management, including investment and real estate; plus feeding and hosting thousands of patients and staff; plus interfacing with their environment, notably city authorities for transit, public safety, and infrastructure; plus data management. They are also by definition "open" institutions, which must accommodate the circulation of patients and visitors; and they deal continuously with life and death issues, which demand constant decisions with no, or very reduced, margins of error.

They also labor under a bewildering array of state and federal regulatory bodies and voluntary assessors and accreditors.

These multiplex and coincident complications of structure and mission pose a puzzle of organizational ontology: How is an entity like the AMC possible at all? How can such an assemblage of motley institutional elements cohere and work? Yet this organizational type is alive and—notwithstanding the grousing about crises, sieges, and impending extinction—in reasonably good health, at least as measured by the production of world-class research, top quality care, and well-trained graduates.

Mission and Environment

Two considerations explain the coherence and durability of AMCs. The first is the cohesion of the AMCs' three components around a core mission. I have elsewhere called this mission the "medical cultural nexus" (Brown 2008). This nexus contains five semisyllogistical propositions: (1) a good health care system should rest above all on the latest and most advanced scientific knowledge; (2) the most desirable (life-saving and -extending) fruits of that knowledge take the form of new and improved technologies; (3) medical specialists are crucial both for the generation of such technologies and for their translation into patient care and therefore occupy pride of place in the medical division of labor; (4) optimal medical education seeks at once to advance and deploy the three above-mentioned sources of progress; and (5) a high-quality health care system can be defined as one that honors the four above-listed propositions. One big reason why AMCs cohere is that concurrence on this core mission has created a durable framework and focus for their otherwise fragmentary and free-ranging contributors.

The other explanation is strong support by the AMCs' environment, from myriad nonprofit overseers, private payers, and public subsidizers—payers and regulators that have, on the whole, wished the AMCs well and have helped them prosper. This environmental support extends back at least to the Flexner Report (1910), which argued forcefully for reforms in medical training based on university-based scientific research. It was powerfully enforced by the growth in number, budget, and scope of the National Institutes of Health (NIH) during and especially after World War II (Fox 1987)—a bold adventure along the "endless frontier" of science (Bush 1945) that, crucially, awarded most of its money not to scientists who had civil service status, working in government research agencies, but rather extramurally, to those medical schools, hospitals, and university

departments that combined successfully to compete for funding, a development that generated, then and since, powerful constituencies for medical research in almost all states and congressional districts (Strickland 1972; Fox 1996). By 1960, wrote Rosemary Stevens ([1971] 1998: 360), the nation's medical schools had become, in essence, "arms or branches" of the NIH.

In 1965, the creation of Medicare brought to AMCs the "concomitants of affluence" (Ginzberg 1990: 61)—sizable new revenues flowing into the coffers of hospitals, generous treatment of the capital costs of hospitals seeking to expand and upgrade their facilities and services, and, not least, financial support for graduate medical education. Additional concomitants include the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Department of Defense, the Patient-Centered Outcomes Research Institute, and, of course, firms in a wide, and widening, range of industries. In short, since the second half of the twentieth century, providers, pundits, politicians, policy makers, and the public subscribed wholeheartedly to the medical cultural nexus and, in consequence, handsomely subsidized AMCs in their pursuit of the core mission it implied.

Environmental Change

Over time environmental support for the core mission of the AMCs has grown increasingly ambivalent, as in, "We greatly value what you do, but could you perhaps contrive to do it less expensively?" and "Might you not also devote more resources and attention to other pressing social priorities?" Since 1970, federal policy has tried to slow the growth of Medicare spending by encouraging beneficiaries to join HMOs/MCOs, by paying hospitals prospectively instead of retroactively on a fee-for-service basis, by imposing financial penalties for inadequate performance, by moving toward value-based and bundled payments to providers, and by trimming the generosity of GME payments. These measures of course threaten the finances of AMCs, whose leaders protest that, although their institutions tend to charge higher prices, they also serve patients with more complex and challenging conditions and do so with superior quality of care. Purchasers (which include not only Medicare but also the largely for-profit insurers who now dominate the commercial health insurance market and Medicaid managed care) have been of two minds on the issue: on the one hand, excising the highest-cost providers from their networks is an obvious economizing strategy, but on the other hand, networks lacking providers widely reputed to be the best can constrain market share.

Cost, moreover, is not the sole source of skepticism about the contributions of the AMCs' core mission to the public interest. Since 1970 the accumulating findings of what may be summarily termed *health services research* have suggested that ready access to primary care correlates strongly with improved health outcomes (e.g., Starfield, Shi, and Macinko 2005); that some, perhaps many, medical procedures (such as back surgery) are overused despite lack of evidence of their efficacy (Wennberg 2010; Patashnik, Gerber, and Dowling 2017); that an intelligent commitment to the elimination of dread diseases should focus beyond the medical system, and particularly on lifestyle considerations, such as smoking, diet, exercise, and avoidance of substance abuse, and on toxins permeating the nation's air, water, and workplaces (Lalonde 1974); and that the surest routes to better health may have little to do with the health and medical care systems per se but rather with a long list of social determinants ranging from income distribution to stress (Marmot 2004, 2015). And of course these two environmental destabilizers—costs and corrosive research—interact: as critical findings in health services research call into question the value of money yielded by a status quo of which AMCs are paradigmatic, budget makers and profit seekers come to view AMCs as a proverbial part of the problem, not its solution.

AMCs and Innovation

That AMCs have disappointed those who call for innovation cum renovation of their priorities does not mean that AMCs are not highly innovative—sometimes around and sometimes beyond their core mission.

Innovation around the Core Mission. The basic and deepest-reaching element of the mission of AMCs is the continuing creation of scientific knowledge and its deployment in new technologies. Some of these discoveries emerge predominantly within the walls of the AMC—in the fields of genetics and molecular biology, for example—and may yield valuable patents for the universities in which they occur. Many are interorganizational products, emerging from "the interplay of universities, national laboratories, and industrial firms in an environment shaped by a growing body of governmental rules and incentives" (Gelijns and Thier 2002: 73). The biotechnology industry, for instance, arose from innovations in genetics and molecular biology, and the discovery of medical devices tends to entail especially close interaction between clinicians and industry engineers. AMCs also collaborate with industry in the pursuit of translational research, in the conduct of clinical trials and evaluations, in the training of

scientists, and in the development of interdisciplinary and virtual research centers (Gelijns and Their 2002). Moreover, in the dynamic health care economy, AMCs constantly forge new relations with new types of firms, a leading case in point being collaborations between universities and companies such as Apple and Google, which control oceans of data on their customers that can identify with precision levels of education, places of residence, and consumption habits (including the use of health care) and can be linked to the incidence, progress, and treatment of disease in ways that vastly expand the prospects for population health management.

Innovation around Delivery of Care. AMCs teem with innovations that promise to produce not only continuous improvements in clinical quality but also better value for money. This can be conveniently illustrated by the titles of some capstone topics recently explored and pushed toward development by students (some of them MDs, almost all of them employed in one or another unit of an AMC in a large city in the northeastern United States):

"Engaging Physicians in Data Driven Quality Improvement to Succeed under Value Based Purchasing"
"Best Practices in Telepsychiatry and Their Potential Applicability to an Urban Academic Health Center"
"Alarm Management to Promote Patient Safety"
"Progeny Use in Medical Genetics and Genomics Clinics"
"Implementing an Antimicrobial Stewardship Program . . . to Lower the Incidence of Acquired *Clostridium difficile* in an Urban Public Safety Net Hospital"
"Analysis of a Mobile Health Care Unit . . . [to Advance] Meaningful Use of Medical Services for Improved Population Health"
"Is There a Need for Anemia Management Clinics?"
"Surgical Care Episode Standardization"
Creation of a New "Heart Center for Health"
"Finance and Quality Approaches to Dealing with Sepsis"
"Digital Communication Strategies in a Center for Sleep Medicine"
"A Provider Portal for Product Development"

And the list goes on: mobile care units, hospital-at-home programs, wellness centers, and, of course, population health management.

These and kindred innovations are arguably both prolific and promising precisely because they maintain and enhance the AMCs' core mission. They do not command automatic consensus, however. In each case mentioned above, protagonists depicted highly time- and labor-intensive processes of

discussion and negotiation, both within the innovating unit and between it and other units, before agreement was reached, at which point organizational politics made a dramatic encore during implementation. In AMCs, effective change is usually retail, seldom wholesale. As Edwards and Saltman (2017: 9) wisely observe, organizational challenges in hospitals "will only yield—and only to some extent—to re-thinking how to engage the people inside the organization who receive operational directives, and the structural environment and practical management realities . . . that determine how they respond to those directives."

Cooptative Innovation. The further one moves from the core mission, the more problematic innovation seems to become. A case in point is what might be called "cooptative" innovation, whereby AMCs follow a path, well trod by their godfather, the NIH, that leads to the incorporation of initiatives, to which they were hitherto indifferent if not disdainful, at the margins of their organizational missions. A few years ago, for example, Mary Ruggie (2004) examined the halting assimilation of complementary and alternative medicine (CAM) into the institutional preserves of the NIH and AMCs. Neither institution saw much point in exploring the scientific merits of CAM until the influential Senator Tom Harken (D-IA) concluded that bee pollen worked wonders for his allergies and urged the NIH to sponsor research on this and related cures. Whatever their scientific and personal opinions, NIH leaders invested modestly in a new program on CAM and then increased the funding for a center, and today one finds at paragons such as New York Presbyterian and Johns Hopkins random controlled trials on the curative effects of herbs and spices, tai chi, acupuncture, and more. Into a comparable camp fall an ever-growing supply of new intellectual and clinical fields to which AMCs expose their staff and students, such as information technology, medical humanities, interdisciplinary projects, decision theory, bioethics, and health care policy. Such inclusive cooptative improvisations bespeak responsiveness and avert conflicts but nonetheless lie remote enough from the AMCs' (and the NIH's) core mission that they risk being dismissed as tokenism.

Innovation to Gain Market Power. More troubling innovations may, and increasingly do, derive from the pursuit of margin for the sake of mission. "No margin, no mission" is a venerable mantra and one that today finds AMCs hungry for the mentorship of business school gurus and consulting firms but protesting all the while that excess medical revenues and operating margins are not truly the same as profits. The rationale is obvious: a central fact of their organizational lives today (and for at least the last two decades) is the financial squeeze by payers—Medicare, Medicaid, and

managed care plans—who are determined to pay less to AMCs, compounded by slower gains in research funding that result when growth in the number of competing applicants steadily exceeds growth in the available dollars.

At a premium here are strategies that fortify the bargaining leverage of the AMCs in relation to payers and that bring in more diverse and less vulnerable streams of revenue. Such projects tend to be proprietary and more or less every AMC for itself, but the literature overflows with reports from one or another AMC recounting how in the teeth of adversity it reorganized its operations, diversified its business model, expanded the spatial reach of its market, and the like. No margin, no mission, to be sure, but is there no risk that margin may come increasingly to define (that is, set the contextual parameters within which to contemplate) mission?

Market-minded innovation raises two big questions, one strategic, the other purposive. The key strategic issue is what management analysts have long termed *span of control*: how many subordinate units can leadership oversee before lines of accountability and communication grow murky and muddled? The corollary of span of control is organizational intelligence (Wilensky 1967; March 1999): the channels of information by which leaders come to know what is going on "down there" at lower levels of the organization and "out there" in its satellites and in other organizations with which leaders expect to communicate and coordinate. The enhanced bargaining power a bigger AMC acquires may make it a better AMC—or maybe not. A note of caution may be found in iconic high-performing health care systems such as Mayo, Cleveland Clinic, and Kaiser-Permanente, which have approached expansion gingerly, indeed timidly, not because they lack confidence in their models but because they understand the importance of organizational contingencies, such as an adequate supply of physicians who share the culture of the parent organization, the presence of a reliable niche in the hospital marketplace, and the size of a (well) insured local population whose choices may be in play. One riposte to Steven Brill's (2015: 445–46) proposal that policy makers should encourage "branded, integrated, and regulated oligopolies" that would "allow hospital systems to become insurance companies" is skepticism whether, in the words of one AMC leader, "We could be sure we could integrate everything we added within our culture and standards." Franchising, done well, is harder than it sounds.

On the purposive front, although this energetic market entrepreneurship is said to be justified by a higher good—keeping the world safe for

scientific innovation—it reinforces the increasingly for-profit character of the US health care system in which AMCs operate. For-profit insurers dominate the commercial market for coverage and have made long inroads into public programs: Medicare Advantage plans now reach nearly one-third of Medicare enrollees, managed care plans serve more than 70 percent of Medicaid's beneficiaries, Medicare Part D runs exclusively via private plans, and the Affordable Care Act (ACA) not only took all this privatization as a given but also crafted exchanges that are intended to channel new business to private insurers. Partisans of market approaches contend that the quest for profit (as long as it is pursued without force or fraud) is the best of all possible incentives for the efficient satisfaction of the preferences of consumers. Critics rejoin that gauging success by the size and speed of growth of return on investment to shareholders (with the correlative rolling of executive heads when these indicators fall short of expectations) is ill-suited to meeting the needs and demands of consumers of the peculiar product that is health care. AMCs may have trouble securing their place in a system that increasingly honors and rewards return on investment and its corporate concomitants unless they absorb heavy doses of a foreign corporate culture into the culture to which they have long pledged allegiance. Pondering the state of American medical education one hundred years after the Flexner Report, Cooke et al. (2006: 1340) lament the "harsh, commercial atmosphere of the marketplace" that has permeated many AMCs. When students "hear institutional leaders speaking more about 'throughput', 'capture of market share', 'units of service', and the financial 'bottom line' than about the prevention and relief of suffering," they "learn from this culture that health care as a business may threaten medicine as a calling."

These developments of course do not settle but merely reprise the debate: Do such infusions of profit-mindedness trigger efficiency-enhancing organizational adjustments that are long overdue? Or might they (to recall the ironies of the Vietnam War, which required destroying villages in order to "save" them) destroy the AMCs' vaunted mission in the course of securing the margins required to save it? If and when Brill's integrated hospital oligopolies become insurance companies, which ethos is likely to prevail: the voluntarist, community-serving mission under the nonprofit halo with which AMCs have long sheltered themselves or the conviction of the for-profit insurers that return on the investments of shareholders defines the optimal ends and means of a twenty-first-century health care system?

Innovation in Social Spheres. Finally, demands for innovation may nudge AMCs into unfamiliar sectors and unaccustomed interorganizational

bonds, as exemplified by the (so far) halting progress of the Delivery System Reform Incentive Program (DSRIP), launched in 2014 in New York. The program awards $8 billion to health care systems that strive to reduce use by Medicaid beneficiaries of avoidable inpatient and emergency department care by 25 percent within five years. Early reports on the projects at their midpoint suggest that many AMCs have responded to the new incentives in predictable fashion: using sizable sums to gear up for action by acquiring new staff, assistants and deputy assistants to the new staff, new information technology capacities, new office space, and other infrastructure, and then, remembering (or being reminded) that the bulk of the money is supposed to be going out the door to the community-based organizations that provide or arrange for the social services (housing, substance abuse counseling, nutrition, mental health care, among others) that are expected to reduce the need for hospital care, they emit awkward mating call to these organizations, which may strike the AMCs as deficient in trained staff, information technology capacities, data collection, fiscal reporting, and other prerequisites of the service delivery, and documentation thereof, that will enable the so-called partners to convince funders of their success. One cannot helped wondering whether DSRIP should have gone at it the other way round, that is, given grants to community-based organizations, which would then reach out to and contract with health care partners they deemed suitable. The larger point is that when AMCs venture far from their core mission into the realms of social determinants and social services, the interorganizational relations that ensue may be rocky, and implementation deserves close attention (which it seldom gets). Nor does this larger point (which the full run of DSRIP may of course qualify or refute) augur well for the entry of AMCs into the vexing world(s) of population health management.

Misplaced Concreteness

This overview (admittedly perfunctory) of types of innovation by AMCs, and of the growing arduousness of innovation as it moves ever further from the AMCs' core mission, might seem to confirm the skepticism of David Axelrod and his allies in the public health community toward institutions that have, to recall the title of Stevens's ([1971] 1998) classic book, severed "American medicine" from "the public interest." On this view, the health of the public, like war, is too important to leave to the generals—in this case, to the leaders of academic medicine (or to apologists who cite the suspect scripture of organizational analysis to defend these institutions' stubborn

preoccupation with what they do best and most want to do, that is, with their core mission). This indictment, however, suffers from lacunae of its own, the most important of which is detachment from historical and political context.

Primary Care Shortage. Critiques of the acquiescence of the nation's medical schools in the "irresistible urge to specialize" are at least as old as the Committee on the Costs of Medical Care (Stevens [1971] 1998: 196–97). If, however, the United States suffers from a dearth of primary care physicians (a proposition that the definitional and methodological questions discussed in Miriam J. Laugesen's article in this special issue call subtly into question), this is not mainly because AMCs refuse to boost their numbers but, rather, because US policy makers, after decades of platitudinizing, decline to set rules for the training and payment games that favor primary care. Surveying the scene, Iglehart (2008) concluded that in the United States a strong tilt toward generalist physicians would require that policy makers feel the pressure of a "vigorous public uprising," which has "not [been] on the American horizon" (Iglehart 2008: 643–50) then or since. In other Western societies, which consider access to health care some sort of right, the health care system is expected to honor above all the goal of securing medically necessary and appropriate care for all at a cost bearable both for society and its households—an objective that demands an adequate supply of frontline providers and may mean requiring or encouraging visits to gatekeeping generalist physicians. The number of specialists produced in their medical schools is set by calculations of the needs of the population, and the pay these specialists receive (and therefore the gap between the earnings of specialists and generalists) is limited by bargaining in which governments play a deciding or at least a constraining role. Many physicians in peer nations would like to become specialists and raise their earnings by doing so; if they do not, it is because they cannot.

The United States, by contrast, has never recognized a right to health care; allowed the providers of services (hospitals and physicians) to invent its financing system (Blue Cross Blue Shield et al.) (Chapin 2015); premised that system on coverage for the potentially catastrophic costs of hospital care, not on meeting those of routine visits to primary care providers; has largely ceded authority over the number, training, and credentialing of specialists to specialty societies (Stevens 2006); and has done little to narrow differentials in payment between generalists and specialists. If medical undergraduates who envision a career in primary care in year one may indeed emerge from year four convinced instead that the highest callings of their profession are path-breaking biomedical research and

innovation, publication in the *New England Journal of Medicine*, and an income high enough to speed repayment of their medical school debts (largely absent from the European scene), the conversion surely reflects exposure to the deep-seated cultural norms of American AMCs. And critics are certainly entitled to wonder whether the AMC establishment has given these norms the scrutiny they deserve. After all, as Mark Schlesinger (personal communication, 2017) points out, that establishment "*does* have the capacity, to *some* extent, to set the pace, call the tune, or otherwise direct their innovative impulses in ways that will, over several generations of training and research investment, gradually alter the path of the health care system." Here too, however, organizational dynamics are ever in play: leaders of AMCs and of the organizations that represent them tend to reach the pinnacles of their institutions not because they are itching for fundamental change but because they have proven themselves to be ardent, effective—and sincere—defenders of the roles and missions that AMCs are accustomed to perform and pursue. Furthermore, the enfolding constraints of policy and payment would remain potent even if medical school deans went door to door extolling to their charges the virtues of treating the undifferentiated patient.

The Paucity of Public Health. The proposition that the AMCs, if they truly cherish their nominal mission (improving the health of the public), would affirm and extend their commitment to preventing illness and promoting health by means of public health interventions is also less than intuitively obvious. Many Western systems, which act as if universal and affordable access to care is the best way to forestall illness and encourage health, have public health sectors less institutionally articulated than that of the United States. (Whether this puts them ahead or behind in the public health game is a subtle issue well explored in the article by Sparer and Beaussier in this special issue.) Public health aficionados have long argued that (as one of Axelrod's successors put it in a private setting) "we should give the public not the care it wants but the care it needs" and that the Bloomberg/Hopkins mantra, "saving lives millions at a time," is the highest policy wisdom. This conviction has found some resonance within the establishment; a commission impaneled by the Pew Charitable Trust and the Rockefeller Foundation Trust argued in 1993, for example, that academic medicine should be moving toward population health, a movement into which the trusts recruited seventeen AMCs (Kaufman and Waterman 1993). But as Daniel Fox (2006) has explained, population health (and its management) is not so easily sold to policy makers or to the public. (Michael Bloomberg, who throughout three terms as mayor of New York

City, made improvements in the health of the public his top goal, was distinctive, indeed probably unique, among prominent elected officials, the exception that proves the rule [Farley 2015].) That acute care services get the lion's share of time, attention, and resources in modern health care systems principally reflects loss aversion and intensity of preferences (including, alas, a preference against delaying gratification): I can choose to start my healthy diet tomorrow, but I cannot choose to stop the cardiac arrest I am having today.

The alleged trade-offs between acute and preventive care, the wrongheaded striking of which has brought such censure on the nation's AMCs, is arguably, moreover, an issue of secondary importance. Bradley and Taylor (2013) observe that in other Western nations, the health indices of which tend to surpass those of the United States, combined spending on health and social services is roughly comparable to that in the United States. The difference—that others spend considerably more on social services than on health while the United States does the reverse—suggests that the most effective public interventions may be the layered policies of social protection on display in other Western welfare states. In a similar vein, scholars who have investigated the influence of social determinants on health outcomes tend to have little patience for arguments that deplore the evils of smoking, bad diets, and inactivity while addressing in passing if at all the deleterious effects of income disparities, damaging work conditions, stress, and kindred conditions. That AMCs should summon a stronger voice for policies of social protection is hard to deny. That their preoccupation with a core curative mission powerfully discourages such policies exemplifies the fallacy of misplaced concreteness.

Disinterest in the Disadvantaged. Finally, the notion that AMCs have a special obligation not only to serve but also to superintend health care arrangements for the residents in their service areas (some of which have seen the replacement over time of middle-class residents by lower-income ones with Medicaid or no insurance) harks back quaintly to American values of voluntarism in the good old days when health was understood to be a community affair at the center of which stood local hospitals. Since the 1990s, many AMCs have answered the call, partly in response to demands by federal regulators and state attorneys general that they honor their obligations to supply community benefits. As Blumenthal (2001: 61) observed, "The acquisition of primary care practices, community hospitals, home care agencies, and neighborhood health centers put AMCs in the middle of their communities in a big way"—and to the tune of millions of dollars.

And, as the AMCs are not slow to point out, many of them treat sizable numbers of patients who lack coverage or are on Medicaid.

Health remains a community affair, to a point, but that point has long been shrinking as larger metropolitan, regional, state, and above all federal forces complicate the contexts in which local actors operate. Chief among these supralocal forces is of course coverage. In fall 2017, fifty-two US senators and more than two hundred members of the House of Representatives—all comfortably insured—labored day and night to write legislation that would strip more than 24 million of their hard-pressed fellow citizens of the coverage the ACA lately conferred on them. (Their efforts passed the House and came within one vote of prevailing in the Senate.) At the end of that year Congress adjourned, leaving in limbo health coverage for 9 million children because, in a rush to enact tax cuts for the affluent, the solons supposedly lacked time and money to reauthorize the Children's Health Insurance Program. In his January 7, 2018, article in the *New York Times* titled "Medical Research? Congress Cheers. Medical Care? Congress Brawls," Robert Pear succinctly contrasted the state of funding for CHIP—"in limbo"—with that of medical research, for which "one theme ran through questions from members of both parties: 'What more can we do to help you?'" The needs of lower-income citizens are best answered (as in other Western societies) not by the eleemosynary exertions of AMCs and other providers but by national entitlements to affordable coverage and care.

Conclusion

If the United States had the benefit of hindsight and a chance to start from scratch, perhaps it would do AMCs differently. Instead of entrepreneurially fueled growth within a system of coverage, funded by myriad private payers, that admits government into the mix mainly in a gap-filling role, and instead of encouraging AMCs to thrive by forging cohesion around their mission within a system that largely lacks both cohesion and coherence, the nation might charter organizations to pursue research, render high-end care, and offer training within a framework of affordable universal coverage and firm rules of the game that allot financial support from public coffers and—within this global budget—permit considerable operating autonomy. The United States is not about to start from scratch, however. The ACA, which built on the foundations of employer-based coverage by means of private insurance and even so is now threatened with mutilation, illustrates all too well the resilience of the status quo within which AMCs operate.

In the face of multiplex and unwieldy structures and missions that might seem prima facie to make successful AMCs impossible, these organizations have coalesced around a core mission honoring medical innovation—generated by the best science, deployed clinically by expert providers, and taught rigorously to future physicians. And, especially during what might be called their *trente glorieuses* (roughly 1945–75), these AMCs enjoyed and repaid the generosity of an environment of funders and payers that smiled on that core mission.

All the while, however, they faced critics who have insisted that the AMCs' center of institutional gravity makes too little room for primary care, population-based strategies of prevention and promotion, and the needs of the disadvantaged—an alternative mission that supposedly would not only serve the genuine needs of the public but also markedly slow the growth of health care costs. But these assaults misplace onto concrete (and therefore presumably tangible, reachable, persuadable, accountable, and changeable) organizations responsibility for failures of policy the sources of which lie in the nebulae and vapors of public policy and in the elusive politics that shape it. The late Daniel Patrick Moynihan, Democratic senator from New York, called AMCs "national treasures," indeed, "the very best [such institutions] in the world" (Fins, Leiman, and Pardes 2017: 16). Critics may dismiss these encomiums as (to borrow a Sondheim lyric) "a toast to that invincible bunch / the dinosaurs surviving the crunch." (For more of the dinosaur trope, see Becker et al. 2010.) All the same, one need not share Burkean angst over the fragility of precious institutions to wonder whether it is not sometimes best to leave well enough alone. American AMCs have successfully identified and accomplished a core mission, much valued by the public. Their heart is in what they do, and they do it well. Can policy makers not somehow find a way to secure their foundations and finances and let them proceed in peace?

If one good cliché deserves another, however, one can counter leaving well enough alone with Lampedusa's familiar dictum that things must change if they are going to stay the same. Since the mid-1970s the broad acclaim the AMCs enjoyed (outside the smallish circle of critics discussed above) has become more conditional and contingent as the AMCs get swept along by rising worries about the rate of growth of health care costs and about the clinical and social value all that spending produces. Managed care has sought to trim costs by prudent purchasing, selective contracting, shifting from specialist and inpatient to generalist and outpatient care, and hard bargaining over prices; on all these counts AMCs represent the costly high hanging fruit managers aim to prune. Cuts in Medicare (and

Medicaid) that fall on beneficiaries are more painful politically than are cuts in payments to providers who can suck them up (or not) as best they can, and so the flow of public revenues to providers, AMC and other, grows more slowly. Schemes to attain more value for money—as in value-based purchasing—create new rules of the payment game and therewith high and unshakeable anxiety within AMCs that their fiscal future may change on a dime with the whims of economists and budget makers in Washington, DC, imperiling their fiscal health, perhaps indeed their survival—decision making under uncertainty indeed. (That uncertainty should, but rarely does, apply as well to the designers of these payment systems. New financial incentives may be necessary to set behavioral change in motion, but sufficiency—how far changes forego gaming in favor of the anticipated higher value for money—depends heavily on how those incentives are refracted into and within distinct organizational settings and cultures and on how organizational leaders interpret the implications of the incentives for, as Clifford Geertz put it, "how things go, have been going, and are likely to go" within their institutions (Geertz 1995: 3). For a brilliant discussion of such organizational refraction—in this case, variable hospital responses to limits on the working hours of residents—see Kellogg 2011.

In so turbulent a political economy of health policy, no margin can be trusted to protect mission, and critics predictably scoff that munificently paid CEOs of well-funded AMCs are crying all the way to the bank. The assertion is true—and also, in context, understandable. It is hardly surprising that leaders of AMCs bewail the difficulties their hard-nosed fiscal environments impose on them, and no less so that they redouble their efforts to reap the financial rewards of innovations that keep their institutions afloat (at least temporarily).

Acute managerial stress may be inseparable from the convoluted politics and technocratic policies that purport to contain health care costs in the United States. In principal it would be wise to develop more stable financial resources for AMCs, but in practice no prominent politicians seem prepared to invest heavy political capital in this arcane and touchy issue, and intermittent efforts to supplement or supplant GME payments in Medicare—where they have no logical reason to reside and where they were expected to reside only until Congress found some other way to fund them (Iglehart 2008)—with, say, funding by a trust fund derived from taxes on private insurers, have never left the starting gate. The issues and alternatives got considerable attention during the debate over the Clinton health reform proposals of 1993–94, but reform-minded legislators (such as Moynihan and Democrat Jay Rockefeller of West Virginia) and

medical organizations clashed over how to fund GME and what strings to attach to those funds (Iglehart 1994). Since then "a comprehensive public strategy . . . to cover the added costs of clinical care that accompany medical education activities" (Commonwealth Fund 2002: 58) has continued to elude consensus. Then again, perhaps AMCs should be careful what they wish for: one wonders whether they would fare better on the whole under a more stable system of public funding (with the controls and constraints that inevitably come with it) or under the nerve-racking carte blanche for laissez faire to which they have become (uncomfortably but adroitly) accustomed.

AMCs are unlikely any time soon to escape the ambivalence and ambiguity that have come to complicate their lives. The states of siege and crisis they have deplored for decades are not likely to lift and resolve. Elite commissions and task forces will continue to deliberate every few years and then issue largely invariant laundry lists of musts and shoulds, among which the audience of AMCs will pick and choose (or ignore) according to their organizational cultures and their leaders' tolerance and taste for managerial improvisation. Policy makers will continue to misplace their faith on organizational solutions—MCOs, accountable care organizations, the diffusion of high-performing systems, and badgering of AMCs to step up their multitasking and cure all the system's ills—for want of political will to set the system-wide rules for coverage, prices, and other fundamentals that frame the health care systems of other Western nations. As long as they feel misunderstood and besieged, moreover, AMC leaders are likely to continue to invest most of their formidable political capital in seeking to secure their sector, not in pushing policy makers toward a system of affordable universal coverage accompanied by system-wide rules of the game binding on all stakeholders.

A half century ago AMCs were in a "state of rapid functional transition" (Stevens [1971] 1998: 375), and the condition, still acute today, is very likely chronic. The AMCs will soldier on, savoring the broad and still solid support for their core mission throughout society but lamenting fiscal pressures that, legitimated in the name of cost containment and value for money, increasingly cloud the connections between general social approbation and the particulars of policy. They will continue to improvise variations on their core mission, for instance, the extension and application of evidence-based medicine, the amassing of big (and ever-bigger) data, the refinement and application of artificial intelligence, the elaboration of electronic health records and other advances in information technology, refinements in the protection of patient safety and the reduction of medical error,

"virtual electronic specialty consultations," and other accouterments of "learning health systems" (Grumbach, Lucey, and Johnston 2014: 1109–10) that have (or are said to have) the additional advantage of enhancing the effectiveness and efficiency of their work. AMCs will also, for reasons both of self-protection and responsiveness to external demands, continue to push further along entrepreneurial frontiers—mergers, acquisitions, diversification of facilities, patenting, accountable care organizations, expansion into new markets—that overlay their core mission with the commercial trappings of the increasingly for-profit US health system and that entail tasks for which they may not be (or in truth much want to be) highly adept. They will rationalize these endeavors as necessary and perhaps sufficient to assure them the margins they need to ride the high road along the endless frontier of science. Ends can justify means; all the same, one hopes that amid their entrepreneurial adventures they will remember how to find their way home.

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