



7-2012

Prescriptions for Change: Can Ideas from Health Care Cure Higher Education's Ills?

Peter D. Eckel

University of Pennsylvania, eckelpd@upenn.edu

Follow this and additional works at: https://repository.upenn.edu/gse_pubs

 Part of the [Community College Education Administration Commons](#), [Community College Leadership Commons](#), [Educational Leadership Commons](#), [Educational Methods Commons](#), [Education Economics Commons](#), [Higher Education Commons](#), and the [Higher Education Administration Commons](#)

Recommended Citation

Eckel, P. D. (2012). Prescriptions for Change: Can Ideas from Health Care Cure Higher Education's Ills?. *Trusteeship Magazine*, Retrieved from https://repository.upenn.edu/gse_pubs/449

This paper is posted at ScholarlyCommons. https://repository.upenn.edu/gse_pubs/449
For more information, please contact repository@pobox.upenn.edu.

Prescriptions for Change: Can Ideas from Health Care Cure Higher Education's Ills?

Abstract

Takeaways

Higher education shares some important characteristics with the health-care sector. Both are dominated by large cadres of highly educated staff, have complex bottom lines, are market-driven and strongly influenced by public policy, and are made up of value-driven organizations.

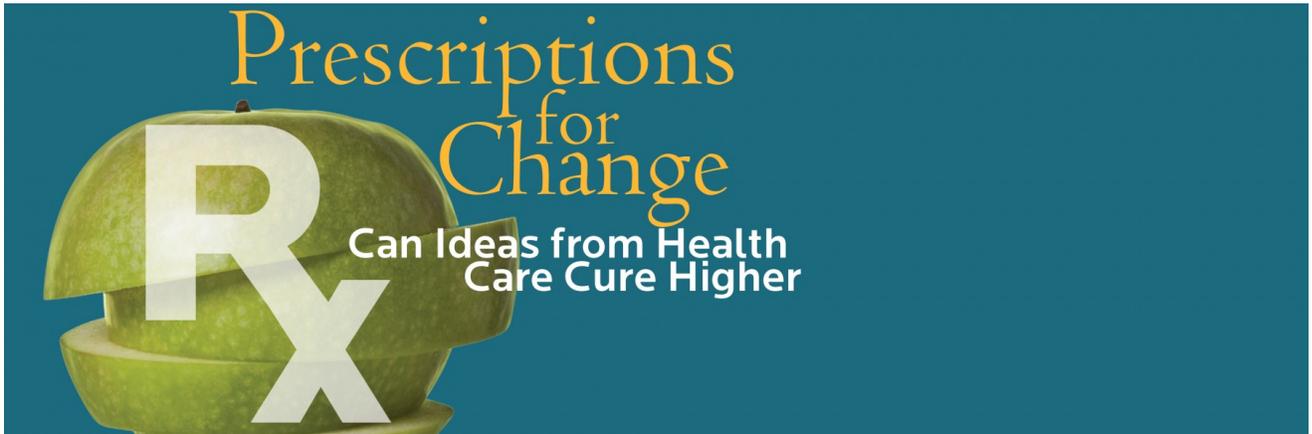
Health care appears to be one or two decades ahead of higher education in its transformation into an industry that is more outcomes-based, cost- and price-sensitive, and responsive to customer needs.

Some of the insights that higher education can gain from health care include: Flawed systems generate flawed results; the focus should be on needs, costs, and undervalued services; wisdom comes from customers; change is driven by hard facts; and balancing demands with purpose is most important.

Disciplines

Community College Education Administration | Community College Leadership | Education | Educational Leadership | Educational Methods | Education Economics | Higher Education | Higher Education Administration

TRUSTEESHIP MAGAZINE



◀ PREVIOUS ARTICLE

NEXT ARTICLE ▶

Prescriptions for Change: Can Ideas from Health Care Cure Higher Education's Ills?

BY PETER D. ECKEL
JULY/AUGUST 2012

TAKEAWAYS

Higher education shares some important characteristics with the health-care sector. Both are dominated by large cadres of highly educated staff, have complex bottom lines, are market-driven and strongly influenced by public policy, and are made up of value-driven organizations.

Health care appears to be one or two decades ahead of higher education in its transformation into an industry



that is more outcomes-based, cost- and price-sensitive, and responsive to customer needs.

Some of the insights that higher education can gain from health care include: Flawed systems generate flawed results; the focus should be on needs, costs, and undervalued services; wisdom comes from customers; change is driven by hard facts; and balancing demands with purpose is most important.

Higher education is facing a series of tough questions:

- Is its business model broken beyond repair?
- How can costs that are fast outpacing median family income be reined in?
- How can higher education demonstrate that students are getting the quality education they expect and deserve?
- Is higher education competing in ways that lower costs, increase access, and improve quality?

The answers are difficult to determine, and higher education has few precedents from its past on which to draw. It may be better served by board members and other college leaders looking outside its boundaries to other sectors.

Health care in particular may prove useful, as it shares some important characteristics with higher education:

- Both sectors' fundamental purpose is service to others—in the form of education and research or provision of medical care.
- They are dominated by large cadres of highly educated staff (faculty members and physicians) who operate with great expertise and autonomy and expect to have a strong say in the business and operation of their organizations.
- Both sectors have complex bottom lines that extend beyond the financial into areas difficult to quantify on a balance sheet (learning and health).
- Their business models—which rely on third-party payers and auxiliary activities outside their core missions—are opaque, making it difficult to trace cross-subsidization.
- Both are market-driven industries that are strongly influenced by public policy, which shapes what they do, whom they serve, how they operate, and the environment in which they compete.
- Finally, both sectors are made up of value-driven organizations. While the bottom line is important, values are what really drive these organizations and provide a common calling for the work each undertakes.

If the commonalities between health care and higher education are meaningful, potential insight into higher education's tough questions may come from the fact that health care seems to be 10 to 20 years ahead of higher education in its transformation into an industry that is more responsive to customer needs, outcomes based, and cost (and price) sensitive. It is from this premise that the National Association of College and University Business Officers (NACUBO), with support from Lumina Foundation, recently

convened higher education and health-care leaders in three regional meetings. Nearly 120 participants focused on the prescriptions from health care that higher education may want to consider.

REALIZE THAT FLAWED SYSTEMS GENERATE FLAWED RESULTS

Health care is recognizing that bad outcomes are often the product of flawed systems. The dominant fee-for-service model that provides revenue for providers based on volume—the more patients you see and the more tests you administer, the more income you generate—is ineffective. It hasn't focused on the right outcome: improving the health of patients. According to James D. Bentley, an independent health-policy analyst and former administrator of both the American Hospital Association and the Association of American Medical Colleges, “In health care, we are now trying to think differently about value as coming from better coordination of care and for providing evidence-based practice.” With this new focus, the value of care is what will drive revenue.

Another lesson is that faulty systems constrain leaders and set potentially counterproductive priorities. Says Mitchell R. Creem, chief executive officer for the Keck Hospital of the University of Southern California (USC) and the USC Norris Cancer Hospital: “Well-intentioned leaders have had to make decisions about institutional survival based on a flawed system of priorities. We have the difficult and often conflicting job of balancing the population's needs for prevention and wellness programs with the need to care for the sick, for which we get paid.” Without a system that rewards people for being healthy, medical leaders will struggle to balance the work that should be done with the work that must be done, notes Creem.

Similarly, flawed systems exist within higher education, where chief executives and boards face tough choices with regard to mission and institutional viability. For instance, in the face of pressures to increase completion rates, do institutions and boards decide to reduce remediation because they know it will drive up costs to prepare those underprepared students to succeed? Do institutions develop partnerships with K–12 schools to help prepare students before they enter higher education, even though they may enroll elsewhere? Do boards expect institutions to assess learning from the time students arrive compared with when they leave the institution?

These are important questions about core mission and fundamental purpose that boards must ask themselves, the answers to which can be skewed by current systems. Boards should be asking what their real priorities are and whether they are really spending the right amount of time on them. “What leaders of both the health care and higher education industries must not lose sight of is that despite the drive to produce greater results for less, we are mission-based service organizations,” says Creem. “And that means that the way people experience our hospitals and universities is as important as the specific products or services they receive.”

CONCENTRATE ON NEEDS, COST, AND UNDERVALUED SERVICES

Health care has seen that “disruptive innovation” often arises from a keen focus on customer needs. Joanne M. Conroy, chief health-care officer for the Association of American Medical Colleges, points to medical MinuteClinics as representative of a model that emerged to meet a real need for fast care, at a set price, for a limited set of services such as kids' physicals for sports and for flu shots—market needs that were typically undervalued, notes Conroy. The emergence of these clinics made some nervous, particularly those in primary care, since these clinics were offering the low-hanging-fruit services that many primary-care physicians provided, adds Conroy.

If college boards are not already asking what student needs exist on their campuses that could be answered by thinking differently about their service-delivery models, they should be. The challenge for boards is to conduct an environmental scan in new areas to see which organizations may be after their low-hanging fruit. New technology providers, for instance, are increasingly keen on introductory courses, distance learning, the transfer market, and student assessment.

Technology has obviously ushered in new tools that are not only making health care more sophisticated and more efficient, but are also allowing individual consumers to answer some of their questions before they even go to a doctor's office, says Conroy. It complicates, if not shifts, the knowledge centers of medicine. Sometimes, however, innovation can also come in the form of what one chooses not to offer. "In health care, how much of what we recommend to patients is necessary? Where are some opportunities for greater efficiencies by eliminating tests that patients don't need? Or by offering lower-cost options? We've already seen how higher co-pays can drive patient behavior to choose generics over name-brand pharmaceuticals," notes Conroy.

In health care, as in higher education, service models are in continuous need of innovation. "We are seeing more experimentation in the use of extenders—care providers, such as physician's assistants or nurses, who have a limited scope of practice but who increase patient access and provide care more efficiently. They call someone with a greater level of expertise for when patient circumstances are more complicated than they are trained to handle," explains Conroy. While 90 percent of patients may say they prefer to see a physician, if you also ask about their preference if they had to wait three weeks to do so, 70 percent of those 90 percent would opt for seeing an extender, notes Conroy. The extenders in higher education historically have been teaching assistants and are now adjunct instructors. The new extender may well be technology, which has long promised and is only starting to deliver on its promise to take learning beyond the classroom.

This disruption is hitting higher education on a growing scale. Providers that seek to make education available any time and any place via technology are now part of the landscape. Institutions such as Stanford University, Princeton University, and the University of Pennsylvania are offering MOOCs—massively open online courses—which are free versions of courses offered on their brick-and-mortar campuses. Some of those courses are giving grades, which increases their potential as transfer courses. Nontraditional owners of content, such as the *Washington Post* and the textbook firm Pearson Publishing, are moving into instruction and content delivery.

The Western Governors University and University of Maryland University College—institutions that focus on degree completion and adults with some college education—are further examples of meeting customers where they are. These and other institutions offer much of their education online or in highly convenient formats for their students, who are often working adults. Western Governors University offers a competency-based curriculum, further changing the dynamics of teaching and learning. As technology becomes more sophisticated and as new generations of young users grow up with new notions of community, how might the physical nature of more traditional, residential campuses be further challenged?

SEEK WISDOM FROM YOUR CUSTOMERS

At Kaiser Permanente's Sidney R. Garfield Health Care Innovation Center, patients' feedback and input helps with facility design and process redesign. "Engaging the patient in the process of care, and designing facilities and services around them and their families, produces a happier patient, actively engaged in their

recovery,” explains Christine L. Malcolm, academic medical center practice co-leader for Navigant Consulting, Inc. and a former senior executive at Kaiser Permanente. “For instance, we know that patients do better at home, and at Kaiser Permanente, we were committed to making home the hub of patient care.” Putting patients in the driver’s seat was a difficult switch for many doctors and health-care providers. If it didn’t shift the source of expertise, it added another dimension.

How might this translate for education? What kind of environment do students want? asks Malcolm. “Will your physical campus continue to be the hub for education in the future? Can students afford to stay in your dorms in the future? Can they afford to be full-time students?”

In the same way that clinicians may think they know what patients need, many faculty members and university leaders, including trustees, may think they know what students want, says Malcolm. Turn that assumption on its head and consider what big ideas can come from your students, their parents, and the future employers of your students, suggests Malcolm. “This approach,” he explains, “can reshape how and where you provide service and instruction to students in a way that can help you compete effectively.”

Board members can play two roles here. First, they can be a key source of input and feedback, tapping their experience and knowledge of other sectors to help institutions think differently about emerging educational needs. Second, they can ensure that the input is acted upon in ways consistent with the mission. This is particularly important when the insight is counterintuitive to practice. For example, alumni working groups can provide faculty with keen insight into the ways industries and fields are changing to rethink what students will need from their education.

It may not be as easy for higher education to listen to its key customers—students—for dramatic advances. Nevertheless, students, their families, and employers do have much to share that can improve higher education’s quality as well as its productivity, and boards have a responsibility to ensure the academic quality of their institutions. Streamlining credit-transfer systems and clarifying articulation agreements represent one step. Problem-based learning that puts the student at the center of interdisciplinary instruction may more deeply engage students in the types of intellectual content in which they are most comfortable. As a university president once said, “The world has problems, and universities have departments.” A familiar, real-world, problem-based approach that engages students in ways they want to be engaged may prove beneficial.

LOOK AT THE HARD FACTS

In health care, change is often driven by unnerving facts—for instance, when someone who should not have died during a procedure does die, says Conroy. “We examine the case for evidence of human or system errors. As a culture, we say this is unacceptable and needs to be fixed. We have physicians and nurses in agreement that we can’t accept those mistakes as unavoidable consequences of care. All this drives teams working across traditional silos to figure it out. Real change occurs when you have principled leadership, real data, and a culture that refuses to dismiss the uncomfortable truth,” suggests Conroy.

Bentley concurs. “From an institutional standpoint, it may be that you are the third hospital in a two-hospital town. When you have a threat that is clear and understandable to all, you are more likely to get movement.” And it may be that very threat of survival that helps drive innovation, suggests Bentley. “Innovations often come from those second-best places in town. Because they have a clear goal in mind, they may be more flexible about making necessary changes to attain that goal.” Similar patterns exist in higher education. Innovative academic programs in cutting-edge fields often emerge from those “second-

best places,” where faculty members approach their collective work creatively and with strong determination and commitment.

Although higher education is an enterprise about data and learning, it too infrequently uses its own data—particularly those that may make it uncomfortable—to alter its habits and practices, although this is starting to change in meaningful ways. For instance, institutions that tap existing data are able to see retention problems earlier and identify what types of students are at risk and in which courses. They ask what can be learned by analyzing student success in key gateway courses by race and ethnicity, gender, age, veteran status, preparation level, or whatever set of characteristics might be strategically relevant for the campus. How might institutions use data mining to understand patterns of student success and risk? Higher education has successfully used fine-grained data concerning enrollments and institutional aid. To what extent and in what ways might similar strategies and efforts be tied to student retention and success?

The question, then, is, how do you *use* the data to focus campus attention, agree on the problem, and work collectively toward solutions? It is one thing to have the reports, another thing to get them off the shelf and use them constructively. Progress based on data can be difficult to achieve, as data can be threatening. While numbers are definite, their meaning is open to interpretation. Who makes sense of the data, how, and with what messages can either put people on the defensive or attract them to the cause. This work is the “principled leadership” mentioned above.

FIND THE RIGHT FOCUS

While higher education can learn a lot from health care, one particular lesson from the three meetings stands out as a cautionary tale. When we lose focus on what really matters—why people commit to their institutions and the purposes they serve, and the special contributions that health care (or, as the case may be, higher education) makes to the human endeavor—we risk everything, regardless of revenue, efficiency measures, benchmarks, quality indicators, and strategic priorities. Too often in both health care and higher education, it is these more quantifiable matters that garner attention. USC’s Mitch Creem recounts the evolution of large-scale change (if not turmoil) within health care and how the challenges of the day created a narrow sense of focus that ultimately impeded the industry’s change efforts.

“Twenty years ago in health care, it was all about the numbers, ratios, and bottom line,” says Creem. “As an industry, we needed something more transformative. We needed to return to our values with long-term planning and a set of goals that we could all agree on and commit to.”

While health care is fundamentally a business of the heart and soul, higher education is fundamentally a business of the mind and soul. Without keeping that ideal in the forefront, we may make progress on the metrics, ratios, and numbers, but in the end these achievements will mean little if we don’t stay focused on higher education’s fundamental principles and purposes.

Like health care, higher education is a mission-driven enterprise; it is about improving lives, building communities, and creating a more informed and just world. These notions are what attract people to commit to higher education. In times of change, if not turbulence, leaders must work hard to keep the right focus and to balance demands with purpose. For it is fundamentally a focus on purpose that will give higher education and its leaders the energy, passion, and commitment to do what it does and what it needs to do: Prepare a nation, if not a world, for a different and better future. The importance of that focus is the key lesson from health care. And one that higher education can ill afford to ignore.

QUESTIONS FOR HIGHER EDUCATION'S FUTURE HEALTH

The challenges and insights from health care provide an important lens through which to focus the efforts of board members and other higher education leaders. Of particular note are the questions that health care's trajectory raises for higher education:

- Where are we as a sector headed?
- What are our most difficult challenges?
- And to what extent is higher education up the proverbial creek?

ABOUT THE AUTHOR ▶

Peter D. Eckel is vice president of governance and leadership programs at the Association of Governing Boards of Universities and Colleges.

RELATED

LEGISLATION THAT IMPACTS THE BOTTOM LINE

HOW THE TRUMP ADMINISTRATION FY2018 BUDGET PROPOSAL IMPACTS HIGHER ED

WHAT THE BOARD NEEDS TO KNOW ABOUT THE TRUMP ADMINISTRATION'S SKINNY BUDGET

REAUTHORIZATION OF THE HIGHER EDUCATION ACT (HEA)

TOP STRATEGIC ISSUES IN HIGHER EDUCATION

© **AGB**

1133 20th Street N.W., Suite 300

Washington, D.C. 20036

Tel 202.296.8400

Fax 202.223.7053