Opportunities for Action in Health Care

Service Lines: Assuring Leadership for Academic Medical Centers

The Boston Consulting Group
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Academic medical centers today are facing a direct threat as a result of the rapid growth of highly focused enterprises that are carving out portions of the health care industry. These for-profit carveouts organize specialists from several disciplines to treat a particular disease or episode of care. In addition to drawing freely on the innovations of academic medical centers (AMCs)—such as clinical pathways that map the course of treatment for diseases—these companies improve on those innovations by developing more disciplined, cost-effective methods for treating particular diseases. Most carveouts are likely to keep their improvements proprietary, giving them a significant competitive edge.

The growth of carveouts, such as Salick and MedCath, combined with the AMCs’ steadily increasing deficits, could ultimately lead to the dismantling of AMCs. Are there ways for them to meet the challenge? In many cases, yes. AMCs can combat the carveouts by creating organizations called clinical service lines—multidisciplinary teams of physicians, other clinical staff, and administrators. In effect, service lines are financial joint ventures: the hospital and participating academic departments pool their resources and share the profits from treating specific conditions, such as heart disease, or managing a complicated episode of care, such as an organ transplant. By forming service lines, AMCs can retain their unique strengths in specialty care, research, and teaching while providing the packaged services of a carveout.

Service lines should appeal to AMCs for three reasons. First, most patients want a complete, seamless, and timely package of cure and care. Second, payers often want packaged coverage, as is clear from the
rapid growth of case-rate purchasing, which reimburses physicians and hospitals for a comprehensive episode of care (such as treatment for congestive heart failure from admission through follow-up). And third, service lines give AMCs an opportunity to regain leadership in innovation and patient care in all critical cross-disciplinary and cross-departmental treatment areas.

Recognizing the Challenges

Even those AMCs that have understood the need to develop service lines have found them difficult to implement successfully. This is understandable, given the culture and organizational structure of AMCs. In contrast to carveouts, AMCs begin with an academic structure. Academic medicine was originally organized along departmental lines. With time, clinicians, researchers, and academics have become progressively more specialized. Such specialization has allowed independent disciplines to thrive but has hindered cooperation across disciplines. The result is that AMCs cannot manage care as well as carveouts can.

The academic structure has also slowed the pace of cross-disciplinary innovation. Everything about an AMC—funding, recognition, rewards, advancement, facilities—has reinforced the walls around the traditional disciplines. But, as AMC leaders realize, revolutionary advances—such as those in transplant technologies, cardiac care, and neurobiology—often come from cross-disciplinary efforts.

Making Service Lines Work

From its work with several major academic medical centers, The Boston Consulting Group has identified
six areas where AMCs often run into trouble when they try to develop service lines. Answering the following questions should help them avoid these pitfalls.

1. **Does the service line have a clear strategy and precise objectives?** Service lines must be narrow enough in focus to deliver results, but broad enough to encompass a large group of patients. Renal, cancer, and cardiac service lines are three viable options. They have sufficient numbers of patients and provide the focus that broader categories such as medicine or surgery cannot offer. Beyond the competitive and economic considerations, a clear strategy and objectives are important for the following reason: without them, an AMC cannot hope to overcome the culture clashes and management complexity that are inevitable when an organization is created from disparate groups. Indeed, without them, AMCs will find it difficult to win the acceptance of all the groups involved. The strategy and objectives should specify the capabilities that need to be developed. They should provide an overarching focus and clear goals for patient care, research, and education.

2. **Are the most influential physicians leading the design and implementation process?** They must. In many cases, AMCs have run into trouble because the crucial physicians have not been involved in the design of service lines or have not had the responsibility or incentive to produce results.

3. **How will service lines leverage the existing departmental structure?** Service lines should harness an AMC’s intellectual horsepower by complementing the departmental structure. They should not replace departments and cannot survive as powerless add-ons. Departments have three essential roles in a service
line organization: contributing to the governance of the joint venture, attracting and developing specialized clinical experts, and managing the core services that are shared by two or more service lines. When AMCs have not designed clear departmental roles, the result has often been unnecessary costs, management complexity, and stagnant financial performance.

4. Will leaders of service lines have enough authority?
As in any cross-departmental process, effective service lines require a strong governance structure so that managers can make policy decisions quickly, firmly, and fairly. Physicians, aided by strong administrative partners, should manage day-to-day operations. In many disappointing attempts to create service lines, managers—whether physicians or administrators—have been given neither budgets nor authority.

5. Are the financial incentives of the constituents aligned? Invariably, the creation of a service line will require an AMC to overhaul its incentive system. The incentives of traditional AMCs were designed to motivate staff members to achieve the individual strategies and objectives of their respective departments. But once an AMC has instituted a whole new way of working, the old incentive system no longer makes sense. Some AMCs have learned this fact the hard way. Because they didn’t install a new incentive system, they failed to secure the full support of critical physicians and administrators.

6. Are the necessary infrastructure changes being made? Leaders of service lines need as much control as possible over the parts of the infrastructure they use. For example, they should be able to influence decisions about allocating physical facilities and customizing management information systems. Their
involvement is essential if they are to provide a balance to the traditional priorities for resource allocation.

For AMCs to develop successful service lines, their boards, physicians, and management will have to unite behind the effort. Only then will AMCs have a realistic prospect of assuring an economically viable role for themselves as world leaders in patient care, research, and education.

Alexander Nesbitt
Craig Wheeler
Rob Williamson

Mr. Nesbitt is a vice president in the Los Angeles office of The Boston Consulting Group. Mr. Wheeler is a vice president in the firm’s Boston office. Mr. Williamson is a vice president in the San Francisco office.
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