PERSPECTIVE

Ensuring Management Excellence in the Healthcare System

Gail L. Warden, FACHE, president and CEO, Henry Ford Health System, Detroit, Michigan, and John R. Griffith, FACHE, Andrew Pattullo Collegiate Professor, School of Public Health, The University of Michigan, Ann Arbor

Since the report of the Committee on the Cost of Medical Care (Falk et al. 1933) in 1930, healthcare has grown steadily in cost, contribution to life, and social importance. The central issues raised by the Committee—access and finance—remain central three generations later. Quality has recently been added to the problems of access and finance. The Institute of Medicine's (IOM) report, *To Err is Human*, documents a dismaying level of preventable risks (Kohn, Corrigan, and Donaldson 2000). IOM's second report, *Crossing the Quality Chasm*, proposes a bold agenda to move our system of finance and care forward to "Stage 4"—a level where safe, effective, patient-centered, timely, efficient, and equitable care is routine (Committee on Quality 2001).

A key part of achieving "Stage 4" lies in preparing men and women who can manage the complex organizations that provide and finance healthcare. In the 1990s we learned three main routes to improve performance: (1) prevention, (2) appropriateness of services, and (3) coordination of services. Formal organization and trained management will be essential to all three.

Improving the skills of healthcare managers depends on how we solve six problems:

1. Achieve the vision of healthcare as a commitment to the worth of individuals and communities. This goal, in the words of the Committee on Quality of the Institute of Medicine, of providing healthcare that is "safe, effective, patient-centered, timely, efficient, and equitable" demands a new level of management performance. To reach it, management must expand use of quantitative comparison to "best in class" and benchmarking on access, satisfaction, quality, and cost. The transition requires financial support for the development of managerial technology.
2. Strengthen the recognition of managers' contribution to the health enterprise. The funding system must reward responsive provider organizations and individuals and encourage others to follow that success.
3. Attract a fair share of the leading intellectual talent in each cohort, and promote healthcare management as a rewarding professional endeavor. A program to promote healthcare management, expand scholarships, support mentoring

and encouragement for young managers, and expand opportunities for underrepresented minorities and women will attract talented young people to the field.

4. Develop a formal education program that recognizes both the unique needs of healthcare and the learned skills of management. The Association of University Programs in Health Administration (AUPHA) and the Accrediting Commission for Education in Health Services Administration (ACEHSA) have begun to specify learning outcomes, prioritize them in terms of practice needs, and measure student learning. We urge foundation support for this endeavor and the explicit endorsement and support of professional associations and employers of healthcare managers.
5. Expand and improve continuing professional education. Education beyond the entry degree must be systematically improved by an alliance of large healthcare buyers, provider associations, consulting houses, professional organizations, and universities. An accreditation mechanism should insist on outcomes learning assessment and should coordinate learning opportunities with entry education. Healthcare organizations should help each manager with annually reviewed specific learning goals and a subsidized plan for fulfillment.
6. Identify healthcare managers of exceptional potential, and develop their skills for the most-senior leadership roles. Few will rise to the most-demanding posts in the largest healthcare organizations. They need a training facility that rivals the best of the large public companies. An "Advanced Leadership Institute" should be a collaboration and led by the best among provider, insurance, and academic organizations.

ENHANCING THE VISION AND VALUES OF HEALTHCARE

Apprenticeship and mentoring shaped today's leaders, and we believe the tradition of mentoring should be expanded and reinforced for today's beginners. Continued close relationship with more senior professionals is the best way to build and reinforce the vision and values essential to truly good healthcare.

The Vision

Most early leaders in healthcare management had a vision that stressed the primacy of patient care. The aim of management is to put the interest of the patient first, regardless of race, creed, or ability to pay, and to seek complete health rather than just to cure the ailment at hand. This is a critical moral commitment to the same core value as the caring professions. Any philosophy that puts management values contrary to the caring professions will be corrosively destructive.

The early leaders also recognized that the healthcare enterprises must pursue a conscientious relationship to their community's health. They envisioned a system that designed its services and programs around community needs and that facilitated easy access to a full range of healthcare services. They recognized the

desirability of measuring patient satisfaction and the status of the community's health. This vision makes health a collaborative, community effort. It promotes a communitarian commitment that has intrinsic value beyond healthcare (Putnam 2000). If anything, it is more important in the twenty-first century than it was in the twentieth.

The Values

The rewards of the marketplace must not be enough for healthcare managers. They must gain deep satisfaction from public service. Our system of recruitment and rewards must encourage young managers who are seeking service and communitarian rewards.

The only way the United States can cross the quality chasm is to continually improve our healthcare organizations. Improvement requires managers who are sensitive to the costs borne by healthcare workers as organizations change, skilled in recognizing and measuring them, and compassionate in settling them but steadfast in their commitment to the patients.

In the tradition of voluntarism, individuals and organizations have learned to contribute time, expertise, and facilities and to collaborate across cultural boundaries. Out of voluntarism emerges a social consciousness—a feeling that individuals and their organizations count and that the organizations should be open to everyone. This is the core virtue of community life, and it is more important to American society than healthcare itself.

Over the years healthcare organizations have also served as incentives to attract physicians, ways to support commercial enterprise, and major community employers. These other goals have positive value, but when the central role of healthcare institutions is not in the interest of public service, society loses trust, challenges their tax status, and reduces charitable support. What we must preserve in the twenty-first century is the balance between these goals and the unique contribution as centers of community health. Our training must prepare our healthcare managers to deal with that complexity and ambiguity.

To implement the communitarian vision, healthcare managers must accept the importance of communication, representation, negotiation, and compromise. Participative dialog is fragile; it persists only when rules and culture deliberately support it. Managerial training must include the skill to design and maintain participation in a diverse society.

Strengthening Managers' Contribution to the Healthcare Enterprise

In the last two decades management of American industry has undergone a renaissance that has restored the country's global competitiveness and contributed to an unprecedented boom. The tools of this renaissance—continuous quality improvement, "balanced scorecard" measures of performance throughout the organization, empowerment of workers, new approaches to collaboration across traditional lines,

improved use of outsourcing, supply chain management, and strategic partnerships with outside organizations—constitute a revolution in management practice (Brown 1997). Willingness to accept change, focus on customers, and reliance on data have replaced old attitudes of inflexibility, introspection, and personal authority. This is the transition that supported the 1990s' economic boom, and this is the transition that the healthcare industry is struggling to make.

The complexity of healthcare makes the transition difficult. The traditional structure of independent primary caregivers, specialists, and support services is a major cause of the variation in cost and quality. Only recently have we learned to systematize these contacts by grouping similar patients (Herzlinger 1997). Insurance-benefit structures and payment mechanisms create barriers that bias caregiving away from the optimum. The not-for-profit structure of acute care removes an important reward for entrepreneurship. Finally, geography complicates healthcare. Healthcare does not lend itself to centralization.

Healthcare management can be realistically described as an arena where the need is pressing, the risks are high, the complexity is great, and the monetary rewards are relatively low. A series of conditions are necessary to stimulate change in healthcare and to support managers leading that change. The critical requirements are:

1. A broader understanding of goals and the potential. Quantitative comparison, comparison to "best in class," and benchmarking on the dimensions of success—access, quality, and cost—will improve the governance ability to set goals and the management ability to translate these to achievable targets.
2. Support for the development of information systems, communication devices, and training systems. At the present time, the federal government spends $15 billion in research, almost all of which are directed to clinical issues. The bipartisan plan is to double this investment. The desired result is to extend life, and thereby increase healthcare expenditures. If management is to keep up, its technology must expand as well. Promoting the Agency for Healthcare Research and Quality to a broader role and a larger impact would give managers tools to deal effectively with the complexity.
3. Revisions to the funding system that reward responsive provider organizations and individuals and encourage others to follow that success. As in the for-profit sector, capital should flow to organizations that meet social goals. The uniformity of current funding hampers innovation, reinforces the status quo, promotes individualism rather than teamwork among caregivers, and, in recent years, has left even the best-performing organizations short of capital.

Attracting a Fair Share of the Leading Intellectual Talent

Quantifying the need for healthcare managers is difficult. People enter the field from a variety of sources, including specific graduate preparation, from caregiving

professions and from other business. Although shortages in specific areas have been reported, particularly for the most-senior managers, the long-term need is less to expand the numbers than to increase management skills. Our goal should be to equip entrants at a uniform level and expand the skills and knowledge throughout careers, much as the rise of the MBA and the development of corporate training programs have strengthened American business. This begins by identifying the promising candidates from the various entry streams, stimulating their ambition, and systematically preparing them.

Salaries are only part of the recruitment problem. For at least a generation, the market has set salaries in healthcare management lower than private commerce but higher than government. This basic market pattern would not be easy to change, but change may not be necessary. Significant numbers of bright, energetic, well-educated young Americans finish college seeking a way to make a difference in society rather than simply to make a material contribution. Rather than modifying salaries, we should make the healthcare path more immediately attractive. The problem for these young people is the cost of pursuing their dream. Graduate education costs essentially the same whether one is pursuing healthcare management or corporate finance. However, the immediate monetary reward—the first year salary—is very different. Commercial management or specialty medicine provides compensation at about twice the level of service in the not-for-profit sector. The contrast is particularly compelling when the student borrows for the graduate education. An education debt that is equal to your annual pay is frightening; one that is half your annual pay is merely burdensome.

We suggest three recruitment strategies:

1. A national system of scholarships would substantially increase the number of very well-qualified applicants to healthcare. If support is limited to tuition, the costs would be on the order of $20,000 to $40,000 per new candidate, which is a small amount compared to the costs of the healthcare enterprise or the current subsidies offered for post-graduate medical education. An interesting possibility is to offer the scholarships to individuals contingent upon their acceptance to accredited graduate schools but leave them freedom to select the school they would like to attend. This approach would make the schools compete for the funds, providing them with an incentive to improve.
2. Healthcare employers must move to attract competent managers from the pool of bright college graduates. The opportunities include initial employment within the organization, support for healthcare graduate study, and mentorship. Few healthcare organizations make this investment today. The large healthcare systems and insurers should find employment opportunities for baccalaureate graduates that allow them hands-on experience and a chance to understand the rewards of healthcare management. Pre-enrollment employment eases the financial burden of graduate education. Truly able students could be assured of a scholarship and encouraged to include this experience.

3. Promote the field more effectively. Many able students simply do not learn about the rewards and opportunities in healthcare; Web and on-campus promotion might change this, however. Professional associations, foundations, and large healthcare organizations should meet the costs because they will be the beneficiaries. The graduate programs themselves can improve their efforts. An accreditation criterion could require a promotional program with evidence of reach and frequency.

Developing the Entry Education Program

Formal education in healthcare management has spread widely in recent decades. An estimated 100 graduate-degree institutions, and perhaps 200 undergraduate, are now offering health management degrees. The field is a "buyer beware" market. Many programs are not accredited and show no interest in seeking peer approval. Information on the success of graduates is missing, even from the most prestigious programs. Accreditation and peer-review activities are at the process level rather than an outcomes level of student mastery.

AUPHA and ACEHSA have already begun programs to change this. Their model calls for academic specification of outcomes, prioritization by leading professionals, and development of measurement devices to assess student learning. The outcomes are specific skills and knowledge—tools the student has mastered. Once prioritized learning outcomes are specified and measured, they can be used in many ways. The first applications will be not to the students but to programs, providing them with data that reveal their own profile of strengths and weaknesses. The measured outcomes should guide remedial continuing education, as well and shape new continuing education by increasing the uniformity of preparation. Accreditation should become a public, audited, and quantitative statement of student capability.

This movement to outcomes learning assessment is consistent with other professional fields; it has had enthusiastic reception among faculty. We anticipate that the outcomes data will force extensive changes in the educational process. Many existing programs will face hard decisions on revision or withdrawal from the field. A fact-driven marketplace is exactly what we need. Today's weaknesses lie in the tendency to substitute mediocrity for excellence, to design programs that prepare managers to be average rather than best, and to tolerate the achieved rather than the achievable.

We believe the continuation of the outcomes assessment program is the most critical and fundamental step in improving healthcare management. Three conditions are essential for this program to succeed:

1. Foundation support for the outcomes assessment project is essential and high priority.
2. The employers of healthcare managers should insist on documented achievement by the educational programs, as they do in medicine and as others do in other professions.

3. Foundations, healthcare management professional associations, and major employers must actively support continuing improvement in entry education. The needs include accreditation but also forums for educating and supporting faculty. The outcomes assessment project will permit each program to profile strengths and weaknesses, set improvement goals, and measure progress. These improvements may include the use of Web-based instruction or other technology that changes traditional teacher roles.

Expanding and Improving Continuing Professional Education

Continuing education will be essential for twenty-first century healthcare managers and will continue to fill three different roles. First, remedial and refresher education will include knowledge and skills for managers who enter healthcare from the caregiving professions, accounting, law, and other industries. Second, it will expand the skills and ambitions of managers so they can be promoted. Third, it will support learning new skills and processes.

Managers often fail because they lack skills, which they might have learned under more systematic dissemination of management practice. Major concepts, such as total quality management, are subject to widespread distortion; it is little wonder that many implementations fail. Less-publicized improvements simply are not widely recognized. The innovations of the twenty-first century are likely to be sophisticated structures and processes, which managers must study before they can implement.

New theory and practice is likely to be a major element of continuing education. Much mid-career education can be experiential. Experiential learning should be planned and need-based, and it should be supported by a mentor.

Special efforts are clearly necessary to support women and minorities to the higher ranks of management. Although women have been entering healthcare management in substantial numbers since 1975, they still do not participate appropriately in senior management. Many of the graduate programs have worked to increase the percentages of under-represented minorities. This effort, too, has failed to reach the senior-management level.

Present practice falls short of these goals in several ways. First, healthcare managers have no guidance on the priorities for their continuing education (Dessler 1994). Second, quality of current offerings is also uncertain. Third, continuing education has unfortunately become confused with entertainment, leading to poor attitudes on the part of both teachers and students. Finally, the investment in continuing education is only a fraction of what is desirable. Although the experience of other industries suggests the investment in management training is cost effective, efficiency will become a factor as the healthcare investment is expanded. Home study, Web-based learning, and programs presented on-site for several employees have obvious advantages.

We need to totally restructure continuing education in healthcare management. Few, if any, healthcare organizations can afford to follow the example of large

commercial companies and support an internal management college. Education beyond the entry degree must be supplied by an alliance of several organizations. Provider organizations, consulting houses, professional organizations, and universities have a stake in restructuring continuing education. The large healthcare buyers also have a role.

We suggest the following first steps for such an alliance:

1. Establish an accreditation mechanism that establishes more rigorous criteria on content and teacher qualifications, insists on outcomes learning assessment, and moves to coordinate learning profiles beginning with formal education. This mechanism, logically, must be closely associated with the existing graduate degree accreditation and, certainly, it must be coordinated with it.
2. Install routine educational profiling of each management employee, including specific goals for next promotion opportunities. These should be matched with a subsidized plan for fulfillment, using a variety of cost-effective learning opportunities.
3. Participate in AUPHA's outcomes assessment project to identify priority needs and evaluation methods. The broader the participation in the outcomes assessment project, the more valid the results are likely to be. For the practice community, valid outcomes should pay off with substantially better-prepared managers.
4. Affiliate more closely with accredited academic programs to ensure consistency of educational quality and to promote interchange between the academic and practice communities. Continuing education should be of the same quality and rigor as degree education. Its content is likely to be more innovative and applied, and it can point the direction for change in academic programs.

We believe these steps would improve the value of continuing education to employers, managers, and the public.

Developing Managers for the Most-Senior Leadership Roles

Skilled senior managers are especially critical to larger provider and insurance organizations. These individuals will have extensive influence, so organizations, and we, must educate them with special care.

Not every graduate can or should aspire to the top executive positions, but every graduate should be encouraged to progress as far as he or she can. From that pool we must draw the few who will be senior executives in the largest organizations in healthcare. We must make those jobs attractive and achievable, and we must select the best and the brightest to fill them. Identifying the best and the brightest at each step of their career is possible because they simply outperform their contemporaries. The best and the brightest need exposure to the best organizations. The Kaiser-Permanentes, Partners, Uniteds, Intermountains, and

Henry Fords of the world must each develop a stronger succession program. The reality is that these places generate the next generation, not just for themselves but often for many smaller organizations.

We believe the select few should have an Advanced Leadership Institute (ALI)—a training facility for excellent managers that rivals the best of the large public companies. No single healthcare organization will have the resources to support such an endeavor. It must be a collaboration led by the best among provider, insurance, and academic organizations. We envision direct purchaser participation as well, partly to gain cross-fertilization with other industries. An ALI could offer final and mid-career preparation on an invitational basis. A self-perpetuating board that draws on leading academic faculty, practitioners, and prominent public corporations should govern the ALI, and it should affiliate closely with degree accreditation programs.

In addition to supporting the ALI, each large healthcare system must develop a comprehensive leadership strategy that includes:

1. assistance to qualified graduate programs in recruiting qualified students and in providing initial experience prior to graduate education;
2. competitive recruitment from qualified graduate programs;
3. deliberate survey and recruitment of promising clinical managers;
4. annual profiling of manager development;
5. mentored and planned experiential learning;
6. selective use of qualified continuing education programs, requiring outcomes learning assessment as part of the programs;
7. special programs to meet the needs of disadvantaged minorities and women;
8. support of the mechanisms for qualification in graduate education and continuing education; and
9. expanded programs for managers of exceptional potential.

SUMMARY

We believe that if we improve healthcare management, we will improve quality, reduce cost, and open opportunities to expand access. The present support for healthcare management, however, needs improvement in every aspect. Beginning with attracting young people, progressing through entry education, continuing education, and the special preparation for senior management, what we need overall is a program of continuous improvement. We need specific goals, measures of how well we achieve those goals, and accountability for that achievement. We need programs that attract and reward excellence and that make mediocrity untenable. The purpose of this article is to identify and expand the elements of such a program.

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