
COMPETENCIES TO WHAT END? AFFIRMING THE PURPOSE OF HEALTHCARE MANAGEMENT

JAMES W. BEGUN, PhD, PETER W. BUTLER, MHSA, AND MARY E.
STEFEL, PhD

ABSTRACT

The 2001 National Summit on the Future of Education and Practice in Health Management and Policy in Orlando, Fla., was a significant event in the continuing evolution of the profession of healthcare management. The 2001 National Summit signaled a crisis of sorts, with widespread calls for transformation in the education of healthcare managers in the United States. Recommendations from the Summit focused on bridging the academic -practitioner divide, strengthening the applicant pool, and affirming the distinctive nature of healthcare management.

The primary lasting consequence of the Summit has been the movement to link the educational curricula of healthcare management programs to competency frameworks. In the meantime, however, healthcare management holds an increasingly tenuous position as a profession. In the rush to address concerns of employer stakeholders, the educational community has neglected attention to more foundational questions about the purpose, values, and role of the healthcare manager.

Educators can assume a more proactive leadership stance in distinguishing healthcare management from generic management and in defining a profession that inspires “the best of the best” to enter the field. As a foundational step, we propose explicit adoption of an Oath for Healthcare Management for those entering healthcare management.

Please address correspondence to: James W. Begun, PhD, Division of Health Policy and Management, School of Public Health, University of Minnesota, D262 Mayo Building, MMC 510, 420 Delaware Street SE, Minneapolis, MN 55455; Phone: (612) 624-9319
Email: begun001@umn.edu

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INTRODUCTION

The 2001 National Summit on the Future of Education and Practice in Health Management and Policy was organized when the field of healthcare management was at a turning point. The advent of integrated delivery systems, public awareness of quality issues in America's hospitals, and ever-escalating healthcare costs were undermining confidence in the management of the U.S. healthcare delivery system. There was concern that academic programs were not providing adequate skills and knowledge for future healthcare managers, and that the continuing professional development activities aimed at mid- and senior-level executives did not meet the changing needs of the field. The field was "at a critical juncture" (Dalston, 2001, p. 203).

Convened in Orlando, Fla., the two-day conference brought together some 200 leaders in healthcare management education and practice to analyze current education and leadership development efforts, and propose new initiatives for improvement. This was a unique opportunity for the varied stakeholders in healthcare management education and practice to interact and dialog, and there has been no similar effort of this magnitude or impact since that time. As the health sector continues to evolve and experience profound changes, it is now prudent to ask if and how the efforts of the 2001 National Summit have led to improvements in healthcare management education and practice.

BACKGROUND

The 2001 National Summit was sponsored by the Robert Wood Johnson Foundation and the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services. It was hosted by the Association of University Programs in Health Administration (AUPHA), the Accrediting Commission on Education for Health Services Administration (ACEHSA), and the Healthcare Research and Development Institute (HRDI). ACEHSA is the predecessor agency of CAHME (Commission on Accreditation of Healthcare Management Education). HRDI included practitioners from some of the nation's most prominent healthcare organizations.

During the 2001 National Summit, thought leaders in the field addressed the evolving role of the healthcare management executive in improving the American healthcare system. Presentations focused on how best to prepare those entering the field as well as continuing the development of both mid- and senior-level executives.

To draw on the richness and diversity of the attendees, the conference planners created a series of working groups. Each group was facilitated by an academic and a practitioner. The groups were tasked to address three key concerns ("National Summit ...," 2001):

1. What constitutes an effective national strategy to support specialized education in healthcare management?
2. What steps are necessary to improve the supply and placement of effective executives and leaders in healthcare management?
3. How should programs in healthcare management be measured, evaluated and compared?

The results from these working groups were distilled into recommendations that were designed to set the agenda for the next generation of healthcare management education and practice (Appleyard, Lofton, & Greene, 2001). Not surprisingly, the recommendations also reflected the concerns and challenges that were identified by those individuals and groups organizing the 2001 National Summit.

Bridge the academic-practitioner divide

A central concern was the growing gap between academia and the field of practice. The historical roots of many healthcare management programs were with the field of practice. Faculty members in these early programs were often former or current practitioners, and the typical “hospital administration” programs involved one year of on-campus study followed by a yearlong administrative residency in a hospital.

As healthcare delivery became more complex and as the focus shifted from managing hospitals to managing healthcare organizations more broadly (i.e., “hospital” administration programs became “health” administration programs), the academic content deemed necessary for effective healthcare management increased. When ACEHSA made two years of full-time study a requirement for accreditation of graduate programs, many programs eliminated the yearlong residency and instead substituted a summer internship as a field-based requirement.

At the same time, healthcare management programs were gaining greater credibility within the broader university, and the job requirements and expectations for faculty members grew. A doctoral degree typically was required for full-time, tenure-track faculty, with research and scholarship requirements to hold an academic position. The research valued within the academic community often had little relevance for practicing managers. Few practitioners had the desire or the skills to pursue this type of faculty role, and a growing number of full-time faculty had no experience in the field. Nor were there many concerted efforts to address this growing gap.

Participants in the 2001 National Summit strongly recommended that there be multiple efforts to improve communication and collaboration between the

academic and practitioner segments of the professional community for the benefit of future and current healthcare managers and leaders.

Strengthen the applicant pool

A recurring theme during the 2001 National Summit was concern about the quality of the applicant pool for graduate programs. It was generally expressed that the field was not attracting a sufficient number of talented young people and that there was a substantial gap between the diversity of patients served in the healthcare system and the applicant pool. While the number of women graduates of master's programs exceeded 50% in 2001, the number of minority applicants lagged far behind (Grady, 2001). Studies by the American College of Healthcare Executives (ACHE) repeatedly showed that minorities were significantly under-represented among practicing healthcare managers (Friedman, 2001).

Strengthening and diversifying the applicant pool were considered key steps in creating a healthcare system that can provide effective and equitable healthcare services in a context that respects the norms and values of the patients served. Participants discussed multiple ways of achieving this goal.

Measure excellence in healthcare management education

Another Summit theme dealt more specifically with the educational offerings at the graduate level. Review for accreditation had evolved, it was argued, to an "up or down" decision. Accreditation no longer distinguished degrees of quality between programs, so that programs that just barely met the accreditation criteria were treated the same as those of the highest quality, a situation that enabled mediocrity in the field. The accreditation criteria were largely focused on program inputs and university processes (Warden & Griffith, 2001). Other than the highly subjective rankings provided by *U.S. News and World Reports*, there was no way to measure outcomes or distinguish the quality of the 67 programs then accredited by ACEHSA (Gellmon, 2004).

As a means of defining excellence in educational programs, several 2001 National Summit sessions were devoted to defining core competencies for specific curriculum areas. For example, competencies were developed in ethics (Chaiken, Porter, & Schick, 2001), organizational behavior and theory (Friedman & McCaughrin, 2001), quality improvement (Baker & Wakefield, 2001), human resource management (Counte & Newman, 2001), financial management (Mauer & Grazier, 2001), and diversity leadership (Dreachslin & Agho, 2001). Those reports represent some of the earliest efforts at competency development in the field.

At the same time, it was acknowledged that healthcare management invests far less in continued professional development than other professions. It was argued that the available continuing education efforts were not robust enough to create the type of leadership needed for the evolving and increasingly complex delivery system (Griffith, 2001).

Thus, the recommendation was to create an advanced leadership institute that would fill these continuing education needs (Warden & Griffith, 2001). This institute would create opportunities for high-level continuing education as well as explore ways to measure competence at all levels of the field, from entry-level managers to senior executives. By their very nature, competencies are outcome measures and could provide a means of distinguishing excellence.

Affirm the distinctive nature of healthcare management

The Summit also provided affirmation that healthcare managers benefit from specialized programs of study. While core business skills provide a foundation, their application to the healthcare setting is often unique. Further, the complexity of the healthcare setting, the expectations of the public, the high stakes of the endeavor (Friedman, 2001), and a multitude of other factors underscore the need for an educational approach that does more than provide strong business skills.

Part of this education should focus on professionalism and the core values that distinguish healthcare management from generic management. These values can include a commitment to public service (Warden & Griffith, 2001) or a sense of wanting to serve a social need from a communitarian perspective. The recommendation, while not explicit, was that the field should preserve the values that are a key part of what makes the profession distinct and unique.

RESPONSE OF THE FIELD TO THE 2001 NATIONAL SUMMIT

We first note that our field continues to struggle with the 2001 National Summit's recommendations around strengthening the applicant pool, particularly its diversity. While comprehensive evaluative data are hard to find, it seems abundantly clear that ethnic and racial minorities are woefully underrepresented in executive suites, in the student populations of most graduate healthcare management programs, and among educators, particularly when considered relative to the diversity of individuals and communities served by healthcare delivery. Efforts to increase diversity by the field's practitioner organizations, including the ACHE and AHA, are laudable, but they need to be invigorated and accelerated, particularly in the educational sector.

The primary lasting consequence of the 2001 National Summit has been the movement to link the educational curricula of healthcare managers to

competency frameworks, particularly at the master's degree level. Several of the papers presented at the Summit reflected an attempt by faculty experts to delineate competencies in specific domains, as noted earlier. Many of these early efforts at competencies lacked measurable, behavioral components. They focused on knowledge rather than also incorporating students' skills and abilities – or the outcomes of the learning process. Today, competency frameworks generally derive from consensus around key behavioral attributes of successful healthcare managers in their job settings (Garman & Johnson, 2006; Garman & Scribner, 2011; Schewchuk, O'Connor, & Fine, 2005).

The push towards competency-based education did not come in a vacuum, as it was part of a general movement by higher education to equip students with knowledge, skills, and abilities (KSAs) that would be valuable in the workplace. As well, a few healthcare management programs were already making individual attempts to define competencies for the master's level programs.

The development of competency-based healthcare management education was aided by another significant outcome of the 2001 National Summit: the emergence of the National Center for Healthcare Leadership (NCHL). While this organization currently focuses its efforts on developing healthcare leadership at the mid- and senior-levels, as well as coordinating administrative fellowship training through the National Council on Administrative Fellowships (NCAF), its early work included the development of a competency model (Calhoun et al., 2004) that was adopted by many healthcare management programs. At about the same time, the Healthcare Leadership Alliance, a consortium of professional membership organizations in the healthcare field, developed its own model that was used by other graduate programs in the field (Garman & Johnson, 2006; Stefl, 2008).

By 2008, the criteria for accreditation in health administration education required that all accredited graduate programs adopt a competency model. By this time, ACHESA had transformed into the Commission on Accreditation for Healthcare Management Education (CAHME) by expanding its membership to include practitioner organizations. (ACEHSA had previously derived support from professional membership organizations and AUPHA only.) Including practitioner organizations was viewed as one way of bringing academia and practice closer together.

CAHME's competency requirements have evolved over time. All accredited programs must now adopt a competency model that fits the program's mission and the type of positions its graduate enter. There is no one universally-accepted competency model. Over time, CAHME has placed greater weight on measurable outcomes, including measurement of the competencies within

a program's model for each student. While the competency framework movement certainly has shortcomings, it has been a major statement that educators are interested in engaging with employers of graduates.

As well, educational programs in healthcare management have continued to expand in number, particularly at the undergraduate level. As noted above, NCHL has emerged as an association devoted to developing and recognizing healthcare leadership, particularly at the mid-level and senior-level. Even more important than the development of individual leaders has been the focus on the development of the senior leadership team. Most large healthcare systems have established leadership training in-house or have arrangements with organizations to provide leadership training. Overall, these developments arguably have helped to bridge the academic-practitioner divide.

TENUOUS POSITION OF THE HEALTHCARE MANAGEMENT PROFESSION

However, despite the developments, the field faces serious new challenges today. Most occupations strive to be labeled and treated as "professions." Healthcare management is no exception. Professional status brings with it respect, financial reward, job autonomy, and career satisfaction. Occupations that are deemed professions arguably attract and retain higher quality workers, because of the association of professional status with higher income, social status, and career satisfaction. Professional status affects the degree to which healthcare managers are respected within their organizations, particularly because healthcare managers are surrounded by clinical practitioners who more readily assume the mantle of professionalism. Professional status affects the degree to which healthcare managers are respected within their local communities, including by others in the organizations with which they interact. Finally, professional status is related to the ability to influence public policy agendas and outcomes at the local, state, and national levels.

Historically, movements by the field of healthcare management to upgrade entry-level education to the master's degree, to standardize curricula, to form a primary professional association, and to adopt a code of ethics, are all hallmarks of professionalization, and practicing healthcare managers today commonly consider themselves "professionals."

The professional community of healthcare management includes not only practitioners and their professional associations, but stakeholders such as employers, researchers, and regulators. Educators are a key component of professional communities. Because specialized knowledge and its control are the heart of the concept of professions (Abbott, 1988; Freidson, 2001), the educational sector is a key actor in defining, sustaining, and changing the professional community. Educators screen and train the incoming supply

of professionals, and they are in a position to influence the values as well as the technical knowledge of new entrants and practicing professionals who pursue continuing or advanced education. In licensed professions, educators become even more powerful, controlling entry when licensure requires a formal educational degree.

Periodically, the educational sector has transformed the status of a given profession. The Flexner Report in medicine, the emergence of optometry from the occupation of opticianry, and recent movements to upgrade entry-level education in such professions as physical therapy, pharmacy, and nursing, are examples of the power of the educational sector to lead change in health-care delivery. In this sense, individual educators and their associations are social change agents, in addition to serving as guardians of the profession's knowledge base.

The extent to which the educational sector interacts with and influences the field of practice in a profession varies over time. The 2001 National Summit can be understood as an effort to increase and improve linkages between the educational sector and the practice community of healthcare managers. In doing so, the educational sector became more responsive to the demands of the practice community.

Legitimacy of the profession

A key element of professional status is the legitimacy granted by society (the public and its representatives) to the profession (Abbott, 1988; Begun & Lippincott, 1993; Khurana, 2007). Legitimacy is the basis for the claim to an exclusive work domain. Professions earn legitimacy in part through pursuit of the public interest, even when it clashes with professional interest. This is the "grand bargain" that professions make with society (Susskind & Susskind, 2016).

The "trust" perceived by the public in members of a profession is an imperfect but interesting indicator of such legitimacy. In the U.S., the nursing profession is continually rated as highest in public trust (Norman, 2016). Nurses are trusted to put the interests of patients ahead of their own. Such a position of trust certainly is an advantage in nursing's professionalization efforts, which include higher entry-level requirements for advanced practice (e.g., the doctor of nursing practice degree: DNP) and the pursuit of equal payment for many services traditionally provided by physicians. The high level of trusts enhances nursing's influence in organizational and public policy forums.

The legitimacy of healthcare management is much more problematic. Healthcare management is both part of and separate from the generic field of management. Healthcare management benefits from the advances made by

the general management knowledge base that apply in the healthcare arena. (“Evidence-based management” is the most recent summary expression of that benefit.) On the legitimacy front, however, the linkage of healthcare management to the larger field of management is challenging at best, and troubling at worst. Managers in general are not perceived as professionals by the public – or if so, they are rarely viewed in the same category as clinical professionals. The public’s trust rating of managers is typically at the bottom of the list of professions. For example, HMO managers are rated as having high ethical standards and honesty by 12% of the public, compared to 84%, 67%, and 65% respectively for nurses, pharmacists, and medical doctors (the three highest of 22 occupations). “Business executives” are at 17% (Norman, 2016). In his study of the history of American graduate business education, Khurana (2007) implicates MBA programs as a primary culprit. He argues that business education has abandoned moral ideals in favor of a perspective that managers are merely agents of shareholders who are interested primarily in maximizing share value.

New threats to legitimacy

In the years since the 2001 National Summit, the knowledge base of healthcare management has changed in ways critical to the legitimacy of the profession. Relevant evidence has rapidly accumulated relating to the influence of the healthcare delivery sector on the achievement of population health.

The root causes for most health outcomes are factors such as social support, job status, income, education, and physical environment, collectively referred to as the social determinants of health (Marmot & Allen, 2014). The popular County Health Rankings Model of the University of Wisconsin Population Health Institute, for instance, estimates that 40% of health outcome variation is explained by social and economic factors, 30% by health behaviors, 20% by clinical care, and 10% by physical environment (University of Wisconsin Population Health Institute, 2017a). Frieden’s Health Impact Pyramid is divided into sectors based on factors that improve health for more people at the lowest unit cost. The base layer of the pyramid is socioeconomic factors. The next layer is “changing the context to make individuals’ default decisions healthy.” Preventive interventions are next, followed by clinical interventions and finally, counseling and education (Frieden, 2015).

At the same time, evidence of the shortcomings of U.S. healthcare delivery on key indicators of population health – particularly in relation to other countries – is rife. Managers in healthcare organizations are urged to re-double efforts to standardize and integrate clinical services and to measure and improve clinical quality and performance, with a primary focus on individual care. For

example, according to White and Griffith (2016), "The purpose of any HCO [healthcare organization] is to provide care to individual patients. The purpose can be expanded to 'population health,' but the larger purpose depends upon excellence in care to individual patients" (p. 5). In fact, though, healthcare management alone cannot come close to resolving the challenges of population health improvement. Kindig (2010) refers to this as an "inconvenient truth ... since the actors...are spread across the public and private sectors (government at all levels, employers, health care organizations, school boards, community organizations), there is no one actor or agent accountable and responsible for such broad population health outcomes as mortality, morbidity, and disparities." Improvement in population health is dependent on public policy and on programs that address the social determinants of health. Yet, more than 90% of health expenditures in the U.S. are devoted to clinical care activities (Begun & Malcolm, 2014).

As arbiters of the knowledge base of the profession and as social change agents, educators are responsible for acting on what they know. We know that social determinants are key to improving population health. Graduates of our programs work in and lead a diverse set of organizations, not just hospitals and health systems, but insurance companies, public health organizations, associations, and a multitude of other important organizations. Each of these graduates needs a lens on how they can partner with others to help address the increasingly quantifiable factors impacting health.

DISTINCTIVE NATURE OF HEALTHCARE MANAGEMENT

The tenuous legitimacy of healthcare management as a profession underscores the need to affirm the distinctive nature of healthcare management, and to act on that affirmation. The distinctive nature of healthcare management has long been recognized by many in both the practice community and the educational sector (Luke & Begun, 1987; Mick, 2004; Welton, 2004). In his Foreword to the published summary of the conference, Steven A. Schroeder, then President of the Robert Wood Johnson Foundation, articulated this challenge:

Leaders in health administration set the tone for the delivery of health services. At a time when health care organizations face enormous financial and competitive pressures, it is especially important for leaders and managers to safeguard and reaffirm the organization's continuing commitment to health care's mission and highest ideals. A critical component of strengthening management and leadership capacity is addressing the ethical challenges they face and underscoring the institutional values that lie at the heart of their work. (Schroeder, 2001, p. 1)

However, attention to the competency movement subsequent to the 2001 National Summit has largely obscured any efforts to address the challenge of safeguarding healthcare's "institutional values" and "highest ideals."

We present a current version of the rationale for the distinctive nature of healthcare management, taking into account changes over the past two decades in information technology, science, public policy, and demography.

Consider five different characteristics of the healthcare delivery sector that suggest that the sector requires a management profession of its own. These include: (1) a scorecard that includes measurable public goals, unlike those applied to other businesses; (2) non-profit or public governance for a majority of the industry's organizations, which requires that institutional assets must be used to serve specific populations within the constraints of a charitable or community mission; (3) recognition that the data and evidence now available will dramatically improve the public display of the contributions being made by different interventions, including community and public policy interventions, to improve health; (4) a very high level of teamwork at both the consumer and organizational level to be successful; and (5) a set of values that ensures transparency, input, and integrity at a time when the public is increasingly concerned about accountability of traditional American institutions.

An organizational scorecard aligned with public goals

Most businesses will measure their successes primarily by financial metrics. This is not a surprise and is understandable whether the company is privately held or publicly traded. Strong earnings, balance sheets, and growth are all closely followed and rewarded by owners and investors. The scorecards for many of the organizations in healthcare delivery use many of the same measures of success. However, if the public vision for healthcare aspires to provide access to affordable care and, increasingly, to improve the health of the population being served, the scorecard the public expects to be used can be at odds with traditional business scorecards.

To whom should healthcare organizational leaders respond? Bondholders expect strong balance sheets, market strength, and growth to ensure their bonds are risk-free. Even boards of trustees frequently revert to a set of financial metrics that gives them comfort in assessing their organization's competitive position in the market. However, what about the public being served? If organizations open their doors widely to provide access to those who may not have the ability to pay, and if organizations go beyond treating illness and invest in the health of a population with no business model to support the investment, will they weaken their competitive position? Will those holding business-focused scorecards penalize their efforts? If we do move to

a population health system that is supported by responsibility for capitated payments for a population being served, the foundation will be laid for a new scorecard. Most believe that the transition to such a system should be pursued, but it will take time, leaving a mixed set of incentives in place for many years.

Even without transition to a new payment system, events will occur that will beg for leadership that looks beyond its organization's economic walls to support community-wide efforts. A recent example was the Ebola outbreak to which many leaders – but not all – stepped forward to organize the necessary preparations. It took time, money, and thoughtful leadership. Hurricanes and wildfires have required similar responses. Leaders who can cross the public and private sectors to act on behalf of the community stand out. These scenarios require following a management compass that points beyond the bottom line of the organization they lead to the collective good of the people they serve. The national vision, translated into local metrics, will at times need to take precedent over individual organizational success.

Non-profit/public ownership and governance

A large majority of hospitals and health systems operate either as private non-profit (approximately 60% of the total) or public (approximately 20% of the total) entities, as do some payers and many social and public health agencies. Non-profit status requires adherence to a charitable mission to use assets in ways that are consistent with the articles of incorporation. Non-profits are governed by boards to provide assurances that the principles are followed. One of the provisions of the Affordable Care Act requires institutional community health needs assessments that include specific goals and milestones against which they can be evaluated. It is an accountability for non-profits that helps highlight the outwardly looking management perspective that must serve the greater good. Disparities in health in one's community, for example, will be difficult to overlook as both the accountability and data available to measure progress will be increasingly available. In most businesses, success is measured by the ability to continue to attract consumers and meet the financial expectations associated with selling services. It is not that this straightforward measure of success is not applicable in healthcare, but it is that these results must be within the context of a broader accountability beyond the baseline expectations. For public organizations, the responsibilities to the community are even more obvious. Elected representatives of the public on governing boards are expected to promote the health of their constituents across a broad geographic area.

Even if a healthcare provider is for-profit and not subject to the charitable obligations through ownership, there is a strong argument that social responsibility, and responsibility to local communities, are necessary components of the strategy of the contemporary for-profit corporation (Porter & Kramer, 2011; Kaplan, Serafeim, & Tugendhat, 2018). In the healthcare delivery sector, for-profit organizations must provide for access to their services such as the Emergency Department, without requiring the consumer to demonstrate the ability to pay. In addition, because most providers receive over half of their money from Medicare and Medicaid, those governmental payers have their own guidelines that require compliance that may be more directly responsive to the needs of the providers' communities. A large number of sole community, for-profit hospitals serve rural communities where they are extraordinarily intertwined with and committed to the health of the entire community. They are linchpins of the community's health as well as its economic well-being.

Big data in a digital world

The development and use of technology to spread messages and data throughout the world is touching every aspect of our lives. Healthcare is no different. Every tool used to diagnose and treat patients has embedded technology that captures and connects results to electronic health records and beyond. The information is also captured real time, dramatically reducing the time required to gather information critical to decision-making. Looking beyond clinical diagnosis and treatment, data relating to population health have also grown exponentially. Disparities in the health of populations down to a zip code level are being documented. The reasons for the disparities, much due to social determinants, are also becoming better understood. This all leads to being able to direct investments more precisely to affect the burden of illness and life expectancy itself. The data give us not only information relevant to the direct health care services being provided, but can begin to account for what other members of the healthcare system's "ecosystem" may contribute. Evidence-based guidelines for population health interventions are being improved and widely disseminated (CDC, 2017; University of Wisconsin Population Health Institute, 2017b). As noted previously, health services hold a minority position in affecting health when compared with the combined influence of other social determinants such as education, jobs, and nutrition. This emerging understanding is simply one other way for health leaders to understand that their job in their organization involves making sure that the sum of the parts, of which they are but one, is greater than the whole.

High level of teamwork, within and outside the organization

Teamwork seems to be the mantra for success in many businesses, so why is it even more important for healthcare delivery? First, within the organization, the delivery of healthcare calls for an unprecedented level of coordination among the caregivers. The coordination is essential first for safety reasons, whether it is a pre-surgical huddle, rounding on the floors, or critical and timely discharge planning. Teamwork around key processes such as appointment scheduling, prior authorizations, and communication every step of the way, separates mediocrity from high-level performance. Developing individuals to be comfortable with and supportive of the value of teamwork is not easy without leadership attending to its importance.

Second, teamwork among organizations is critical, particularly in addressing population health. Assuring a coordinated experience for patients means working with multiple organizations that may be under the same corporate umbrella, loosely affiliated, or completely independent – and perhaps even a competitor. Addressing social determinants means working with a wide variety of community partners. Leaders need to understand and work with many stakeholders who may not hold any accountability to them, or even be from competing organizations. Identifying who these individuals and organizations are, communicating efficiently and effectively, and being an enabler versus a barrier is something that requires constant attention and practice. Modeling of the collaborative behavior needed goes a long way to creating the professional culture needed for widespread success.

Values-driven leadership

Values are the foundation on which leadership competencies must sit. All businesses require solid values, but healthcare organizations, which put real lives at stake, are bound to a higher set of values than others are. Empathy for the patient, client, or consumer takes on added significance.

In fact, empathy for the community is needed as well. Can the leader listen to all the voices, hear the nuances that require sensitive and targeted efforts to diverse individuals and populations that do not benefit uniformly from the same interventions? Some businesses permit segmenting of customers and targeting a niche population or providing a niche service. Most healthcare organizations, if serving the greater good, cannot leave individuals or communities behind. They need to embrace diversity and be inclusive to be successful. It starts with knowing and appreciating the characteristics of those being served, but needs to be mirrored with a values-driven workforce reflective of those being served.

One cannot think of too many businesses where traditional values around inclusiveness, integrity, transparency, and accountability are more important. Traditional organizations that once enjoyed very high credibility are being challenged. Banks, universities, police departments, and governmental agencies are under pressure to demonstrate how their traditional goals, structures, and values are creating the outcomes people expect at a cost they can afford. Healthcare is no different. Leaders will need to double down on providing the leadership needed to ensure the work being pursued is beyond reproach, and their errors are transparently communicated along with a culture that supports continuous improvement in what they do.

AFFIRMING THE DISTINCTIVE NATURE OF HEALTHCARE MANAGEMENT

An oath for healthcare management

One way to help distinguish the healthcare management profession is to embrace a Hippocratic Oath of our own. The Hippocratic Oath is often formally endorsed by physicians entering practice. It establishes a high bar for ethical behavior. Wouldn't such an oath make sense for healthcare management? Isn't healthcare management even more responsible than the separate clinical professions to make sure that their collective effort is deployed in a way that benefits the greater good? If healthcare management is not a key leader in this collaborative effort, who is?

Several of the behaviors consistent with the distinctive nature of healthcare management could be summarized in a powerful statement that would be pledged by new graduates and widely publicized and modeled by those in leadership roles. The oath would not be a broad ethical code such as the ACHE Code of Ethics. Instead, the oath would emphasize the unique characteristics of healthcare management relative to generic management, and would seek a balance between the profession's traditional attention to clinical services and the growing awareness of the importance of community programs and public policy. It would also be aspirational and idealistic, both to attract new entrants who are so motivated and to reinforce idealism in practicing managers. A draft of such an oath is given in Table 1. The oath speaks to leadership within one's organization, community, and profession.

Table 1

Oath for healthcare management

As a healthcare management professional dedicated to enhancing the health and well-being of individuals and communities, I pledge to ...

Within my organization

- 1 Strive to provide access to affordable health care to all individuals and populations I serve.
- 2 Provide exceptional health care that eliminates preventable errors and provides comforting and welcoming services whenever and wherever they are most needed.
- 3 Model and facilitate collaboration among the health professions and team-based services.
- 4 Support a diverse and inclusive workforce and work environment essential to meeting the needs of the people being served.

Within my community

- 5 Partner with organizations outside of my own to coordinate care and address the social determinants of health.
- 6 Sacrifice an organizational priority to meet a greater community need, when called for.
- 7 Advocate for public policy consistent with the service mission of healthcare delivery.

Within my profession

- 8 Give back to my profession by volunteering my time, talent, or resources, in support of preparing the next generation of healthcare managers and leaders.
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Implementation of the oath could be informed by recent movements within the business education community in support of an MBA student oath initiated by business school students (Anderson & Escher, 2010; "MBA Oath," n.d.) and within the healthcare community in support of the Charter on Professionalism for Health Care Organizations, initiated by a number of healthcare delivery professionals, with healthcare management notably absent (Egener et al., 2017).

Consequences for educators

To distinguish healthcare management as a profession means distancing "professional" healthcare management programs from "less professional" programs. This is because many educational programs will choose to remain

responsive to employer organizations that need not treat healthcare delivery as distinctive, and where generic management is viewed as an appropriate framework. These include programs that largely service non-delivery segments of healthcare, such as consulting and supply chain management. Many MBA programs devoted to healthcare delivery are directed at business opportunities in the start-up digital world or product lines that are targeted at a wealthy population. Such programs do not benefit from the more holistic community lens that a leader must embrace if the program goal is consistent with national, public expectations. A more exclusive definition of the field is consistent with arguments made by Mick (2004), Smith (2004), and others in response to suggestions to broaden the definition of the field (Begun & Kaissi, 2004).

We also would expect educational programs that recognize the distinctive nature of healthcare to have curriculum content consistent with the oath. Programs would actively promote the distinctive nature of healthcare management in their curriculum and extracurricular opportunities. Currently, accredited graduate programs are required in their curriculum to facilitate development of (1) knowledge of the health-sector and healthcare management; (2) competencies in communication and interpersonal effectiveness; (3) competencies in critical thinking, analysis, and problem solving; (4) competencies in management and leadership, and (5) competencies in professionalism and ethics. These requirements are so general as to be of little use in distinguishing healthcare management from generic management. More pointedly, a forward-looking, distinctive curriculum would include strong coverage of knowledge about public policy and the competency of policy advocacy. The curriculum would cover developing, assessing, and using the evidence base on programs that address social determinants, as well as community health assessment. Competencies for developing and leading multi-sector collaborations would be included. Zismer (2013) provides a list of similar “public health” content translated to the competency level.

Regarding the communitarian values promoted by the profession, we suggest that programs assess values in the student admissions process, as well as promoting community service values in coursework and extracurricular activities. Many programs currently review evidence of service activities of applicants, for example, as a reflection of their values.

Consequences for practitioners

The commitment to a distinctive profession needs not only to be screened for, taught, and reinforced in educational programs, but reinforced throughout a career. We expect that practitioners committed to a distinctive profession

would articulate the values in a healthcare management oath in the organizations in which they work. They would also be partners to academic programs in recruiting students and in working with those programs.

Affirming the distinctive nature of healthcare management also would help clarify the scorecard by which practitioners should be judged. Leaders of healthcare delivery organizations are constantly torn by what “scorecard” is used to measure their performance. The rating agencies want higher market share, volume increases, more days cash on hand, etc. To some extent, so does the governing board, but the board also values high rankings in reputational surveys, as well as quality and exceptional service. As for improving the health of the population, the scorecard is very difficult to create, assess, and reward for higher performance. A recent systematic review of definitions of “high-performing healthcare delivery systems” concluded no such universal definition yet exists (Ahluwalia, Damberg, Silverman, Motala, & Shekelle, 2017; Pronovost, 2017). As with our field’s competency models, with a heterogeneity of definitions of performance, the risk always is that we pick the one that makes us look best locally, rather than the one that challenges us to strive collectively toward better outcomes universally. Inclusion of community health indicators in the scorecard of healthcare delivery organizations would assist them in moving more rapidly to partner with appropriate organizations to move the needle on such indicators.

CONCLUSION

Evidence on the relative benefits of clinical and population health interventions, value-based payment reform, digitalization, and interprofessional team-based care are among the many developments that lead to a reconsideration of the attributes that can uniquely define the healthcare management profession. An oath for healthcare management would make clear that we are not just in a business that happens to deliver healthcare, but instead are improving health through organizations that happen to run as businesses. If we can gain a consensus around the distinctive nature of healthcare management, it will differentiate our educational programs from those that lack this mission-based focus. Such changes would help to increase the legitimacy of the profession in the eyes of the public and would help attract a diverse and “best and brightest” student population to a career of consequence, further realizing the intentions of the 2001 National Summit.

REFERENCES

- Abbott, A. (1988). *The system of professions: An essay on the division of expert labor*. Chicago, IL: University of Chicago Press.
- Ahluwalia, S. C, Damberg, C. L., Silverman, M., Motala, A., & Shekelle, P. G. (2017). What defines a high-performing health care delivery system: A systematic review. *The Joint Commission Journal on Quality and Patient Safety*, 43, 450-459.
- Anderson, M., & Escher, P. (2010). *The MBA oath: Setting a higher standard for business leaders*. New York, NY: Penguin Group.
- Appleyard, D., Lofton, K., & Greene, B. (2001). Synthesis of breakout session reports. *Journal of Health Administration Education*, 19(Special Issue), 187-200.
- Baker, G. R., & Wakefield, D. (2001). Domains and core competencies for effective evidence-based practice - Quality improvement. *Journal of Health Administration Education*, 19(Special Issue), 177-185.
- Begun, J. W., & Kaissi, A. (2004). Definition and scope of health services administration. *Journal of Health Administration Education*, 21(2), 227-240.
- Begun, J. W., & Lippincott, R. C. (1993). *Strategic adaptation in the health professions: Meeting the challenges of change*. San Francisco, CA: Jossey-Bass.
- Begun, J. W., & Malcolm, J. K. (2014). *Leading public health: A competency framework*. New York, NY: Springer Publishing.
- Calhoun, I. G., Vincent, E. T., Baker, G. R., Butler, P. W., Siniotis, M. E., & Chen, S. L. (2004). Competency identification and modeling in healthcare leadership. *Journal of Health Administration Education*, 21(4), 419-440.
- Centers for Disease Control and Prevention (CDC). (2017). The Community Guide. Retrieved from <https://www.thecommunityguide.org/>
- Chaiken, M., Porter, R. D., & Schick, I. (2001). Core competencies and ethics. *Journal of Health Administration Education*, 19(Special Issue), 149-157.

- Counte, M. A., & Newman, J. F. (2001). Essential competencies in human resource management. *Journal of Health Administration Education, 19* (Special Issue), 167-172.
- Dalston, J. (2001). The agenda for the future. *Journal of Health Administration Education, 19*(Special Issue), 201-209.
- Dreachslin, J. L., & Agho, A. Domains and core competencies for effective evidence-based practice in diversity leadership. *Journal of Health Administration Education, 19*(Special Issue), 131-148.
- Egener, B. E., Mason, D. J., McDonald, W. J., Okun, S., Gaines, M. E., Fleming, D. A., Rosof, B. M., Gullen, D., & Andresen, M. (2017). The charter on professionalism for health care organizations. [*Academic Medicine, 92*, 1091-1099.](#)
- Frieden, T. R. (2015). The future of public health. *New England Journal of Medicine, 373*(18), 1748-1754.
- Friedman, E. (2001). The health care executive as a singular presence. *Journal of Health Administration Education, 19*(Special Issue), 69-80.
- Friedman, L., & McCaughrin, W. C. (2001). Outcome competencies for organizational behavior and theory. *Journal of Health Administration Education, 19*(Special Issue), 173-176.
- Freidson, E. (2001). *Professionalism: The third logic*. Chicago, IL: University of Chicago Press.
- Garman, A. N., & Johnson, M. P. (2006). Leadership competencies: An introduction. *Journal of Healthcare Management, 51*, 13-17.
- Garman, A., & Scribner, L. (2011). Leading for quality in healthcare: Development and validation of a competency model. *Journal of Healthcare Management, 56*, 373-382.
- Gellmon, S. B. (2004). Stakeholder satisfaction with the accreditation process. *Journal of Health Administration Education, 21*(2), 241-268.

Grady, R. (2001). The mandate and challenge of increasing diversity in health care management. *Journal of Health Administration Education*, 19 (Special Issue), 81-92.

Griffith, J. (2001). Report of the National Summit on the Future of Education and Practice in Health Management and Policy. *Journal of Health Administration Education*, 19(Special Issue), 5-18.

Griffith, J. R., & White K. R. (2005). The revolution in hospital management. *Journal of Healthcare Management*, 50, 170-189.

Kaplan, R. S., Serafeim, G., & Tugendhat, E. (2018). Inclusive growth: Profitable strategies for tackling poverty and inequality. *Harvard Business Review*, 96(1), 127-133.

Khurana, R. (2007). *From higher aims to hired hands: The social transformation of American business schools and the unfulfilled promise of management as a profession*. Princeton, NJ: Princeton University Press.

Kindig, D. A. (2010, June 7). Obstacles to population health policy: Is anyone accountable? [Blog post]. Retrieved from <http://www.improvingpopulationhealth.org/blog/2010/06/obstacles-to-population-health-policy-i-is-anyone-accountable.html>.

Luke, R. D., & Begun, J. W. (1987). Industry distinctiveness: Implications for strategic management in health care organizations. *Journal of Health Administration Education*, 5(3), 387-405.

Marmot, M., & Allen, J. J. (2014). Social determinants of health equity. *American Journal of Public Health*, 104(S4), S517-S519.

Mauer, R. T., & Grazier, K. (2001). Development of core competencies in health care finance. *Journal of Health Administration Education*, 19 (Special Issue), 159-165.

MBA Oath (n.d). Retrieved from www.mbaoath.org/mba-oath-legacy-version/

Mick, S. S. (2004). Must we broaden the definition of health services administration? A response to the Final Report of the Blue Ribbon Task Force. *Journal of Health Administration Education*, 21(2), 173-177.

National Summit on the Future of Education and Practice in Health Management and Policy. (2001). [Brochure]. Orlando, Florida, February 8-9.

Norman, J. (2016, December 19). Americans Rate Healthcare Providers High on Honesty, Ethics. Retrieved from <http://news.gallup.com/poll/200057/americans-rate-healthcare-providers-high-honesty-ethics.aspx>

Porter, M. E., & Kramer, M. R. (2011). Creating shared value: How to reinvent capitalism – and unleash a wave of innovation and growth. *Harvard Business Review*, 89(1-2), 1-17.

Pronovost, P. J. (2017). High-performing health care delivery systems: High performance toward what purpose? *The Joint Commission Journal on Quality and Patient Safety*, 43, 448-449.

Schewchuk, R. M., O'Connor, S. J., & Fine, D. J. (2005). Building an understanding of the competencies needed for health administration practice. *Journal of Healthcare Management*, 50, 32-47.

Schroeder, S. A. (2001). Foreword. *Journal of Health Administration Education*, 19(Special Issue), 1-2.

Smith, D. G. (2004). Blue ribbon kudos. *Journal of Health Administration Education*, 21(2), 179-183.

Stefl, M. E. (2008). Common competencies for all healthcare managers: The Healthcare Leadership Alliance model. *Journal of Healthcare Management*, 53, 360-373.

Susskind, R., & Susskind, D. (2016). *The future of the professions: How technology will transform the work of human experts*. Oxford, UK: Oxford University Press.

University of Wisconsin Population Health Institute. (2017a). County health rankings and roadmaps: What and why we rank. Retrieved from <http://www.countyhealthrankings.org/explore-health-rankings/what-and-why-we-rank>

University of Wisconsin Population Health Institute. (2017b). What works for health. Retrieved from <http://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health>

Warden, G. L., & Griffith, J. R. (2001). Ensuring management excellence in the health care system. *Journal of Health Administration Education*, 19(Special Issue), 19-32.

Welton, W. E. (2004). Managing today's complex healthcare business enterprise: Reflections on distinctive requirements of healthcare management education. *Journal of Health Administration Education*, 21(4), 391-418.

White, K. R., & Griffith, J. R. (2016). *The well-managed healthcare organization*, 8th ed. Chicago, IL: Health Administration Press.

Zismer, D. K. (2013). An argument for the integration of healthcare management with public health practice. *Journal of Healthcare Management*, 58, 253-257.