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Education for health services administration : an examination of met and unmet needs

Crowe, Walter Ramsey

LAKEHEAD UNIVERSITY

EDUCATION FOR HEALTH SERVICES ADMINISTRATION: AN EXAMINATION OF MET AND UNMET NEEDS

by

WALTER RAMSEY CROWE

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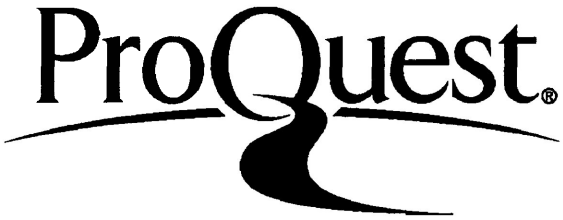

ABSTRACT

Health systems in Canada, as in many other countries, have been crisis oriented. Expenditure upon all areas of the disease curing professions has risen at an accelerating rate in the past decade. The post-war introduction and development of national health insurance has led to massive construction and operating costs of health services institutions, with complex technology and expensive employment of specialists in all areas of medicine and allied health services. A substantial burden has been placed upon the taxpayer. His support of institutional health care remains strong, but governments and their planners are attempting to control the growth pattern by altering the emphasis from hospital care to health maintenance systems. This is causing changes, not least in demands upon present and future managers, and the object of this thesis is to examine these changes, with direct reference to educational implications.

It is held by this researcher that administrators have needs for education which are presently not being satisfied. An investigation of present programs has been undertaken and evaluations made of the extent to which their graduates will be able to meet managerial demands made upon them. Account has been taken of publications by experts in this area, and the writer has discussed

education for health services administration with experts in several countries. Concerns such as health management as a profession; the level of education needed, and the conflict between generic and specialist programs have been carefully examined; all these have been studied in the context of future requirements.

Recent developments in Canadian universities have been investigated. In 1979 significant changes are taking place, affecting several higher degree programs, and caused by the introduction of three baccalaureate degrees. This writer criticizes them in terms of their ability to satisfy unmet needs, and presents his own national program. It is intended to meet and satisfy both ongoing and anticipated future requirements, with the objective that Canadian health administrators shall be better equipped to undertake future complex tasks.

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THE PROBLEM DEFINED

The propinquity of change

This research deals with problems caused by the absence of any nationally accepted educational program for middle and senior level health administrators, directed to meeting future needs for health care.

Canadian health services will change substantially in the future; it is essential that administrators be educated in such a manner that they may cope efficiently with this change. Educational services related to professions have tended to follow rather than lead; this thesis examines expected changes in such a manner that programs may be designed in anticipation of needs being experienced.

Sections 91 and 92 of the British North America Act, 1867 gave provincial legislatures jurisdiction over the establishment, maintenance and management of hospitals, asylums, charities and eleemosynary institutions in and for the province, other than marine hospitals. Thus, health care is primarily a provincial responsibility but is strongly influenced by federal planning, development and financial decision making. The federal government has

jurisdiction over quarantine, establishment and maintenance of marine hospitals, and the quality of food and drugs. It provides services for the military, native people, the Royal Canadian Mounted Police and inmates of penitentiaries.

Latent resident Canadian demand for health care was reinforced by post-1945 immigrants from Europe, many countries of which administered health services. Federal and provincial governments cooperated to design a 'national' scheme to be administered provincially. The Hospital Insurance and Diagnostic Services Act, 1957 permitted the federal Department of Health and Welfare to enter into agreements with provinces on a cost-sharing basis if guidelines were met. All provinces joined, the last being Quebec in 1961. Complementary legislation was enacted to provide for ambulatory and medical services: the Medical Care Act, 1966 which was accepted by every province by 1971.

Health services funding is provided by federal and provincial governments and, to a lesser extent, the consumer. In Ontario, current expenditures are funded by Ottawa and the province, through the agency of the Ontario Health Insurance Plan (OHIP). Two-thirds of capital expenditure is supported by the federal government. The 'consumer' is responsible for payments of dental fees, for drugs and a small proportion of doctors' fees.

In 1977, 6.8 million residents of Ontario were insured under the family plan and 1.5 million held single certificates. OHIP expenditure amounted to $800 millions,

representing 21 percent of the total health spending by the province. Hospitals incurred 53 percent, psychiatric services 19 percent, extended care and rehabilitation 2 percent, but public health care only 1 percent. This low spending on 'preventive maintenance' is causing concern. In an attempt to encourage health maintenance, the former Minister of Health and Welfare of Canada, M. Lalonde gave leadership (1974) by creating the Participaction campaign for personal fitness. He recognized significant problems, which include an excessive rate of cost escalation; over-emphasis on hospital construction to the detriment of other needed health care facilities; paucity of facilities in rural and isolated locations; life style deficiencies due to our mode of living, and demands upon high cost supplementary services; and cost-sharing arrangements between federal and provincial governments, which encourage the use of physicians and of acute-treatment hospitals.

The impact of health care upon the economy was of concern to American writers two decades ago. Dubos (1961:31-32) declared that:

> the modern American . . . claims the highest standard of living in the world, but ten percent of his income must go for medical care, and he cannot build hospitals fast enough to accomodate the sick. He is encouraged to believe that money can create drugs for the cure of disease, but he makes no worth-while effort to recognize, let alone correct, the mismanagements of his everyday life that contribute to the high incidence of these conditions . . ..

Information relating to the growth of institutions is given by the University of Minnesota (1976:3):

> In 1875 there were fewer than 200 hospitals in the USA and only 35,000 hospital beds. Rapid advances in the medical sciences, together with a tremendous rise in utilization of services, created a demand for greatly expanded and improved facilities . . . by 1975 the number of hospitals had mushroomed to more than 7000 with 1.6 million beds . . ..
>
> New types of programs and institutions have been expanding. Community based ambulatory mental health programs, rehabilitation centres, nursing homes . . .. Health care has become the third largest industry.

A data base for change

In North America, expenditure patterns can be expressed by the word: growth. Its rapidity is evidenced by statistics showing that Canadian health expenditures grew at an annual rate of 12 percent, and U.S. growth at 11 percent, between 1960 and 1971. Canadians spent 7.1 percent and Americans 7.6 percent of their respective gross national products in that year; of total health outlays, 51 and 42 percent respectively was upon hospital care. Between 1977 and 1978, American health care expenditure grew still faster than the G.N.P. For the year ended September 30, 1977 the proportion was 8.8 percent for a total of $163 billion, or $737 per person. The hospital proportion was slightly reduced being 40 percent of the health outlay. Whereas in Canada the proportion of government expenditures on defence (for example) fell from

21.5 percent to 4.0 percent between 1956 and 1976; that spent on health increased from 5 percent to 12.6 percent during that same period.

Statistics are not available concerning much of the change described in this research, since its impact is not yet overt. This section attempts to give some indication of the size of the health sector, with comparisons between components.

Table 1 shows both the proportional distribution and trends in personal spending upon health care in Canada (per capita), with actual dollar values displayed in Table 2.

Fifty-four percent of the Ministry of Health budget assisted in the operation of the 236 hospitals. Average per diem costs in 1975 were $120, of which nursing services absorbed $41.65 (35 percent), general administration $15.66 (13 percent), dietary services $9.17 (8 percent), medical records and library $10.10 (8 percent), laboratory, ECG and EEG $8.28 (7 percent), operations and maintenance $6.71 (6 percent), medical and surgical supplies and drugs $6.47 (5 percent), and radiology $4.57 (4 percent). There is high variability between different categories of hospitals, as shown in Table 3.

TABLE 1

PERSONAL HEALTH CARE EXPENDITURE IN CANADA
SELECTED YEARS 1953-1971
$ per capita

Year	General and Allied Special Hospitals	Other Hospitals	M.D.	D.D.S.	Prescription Drugs	Total
1953	18.89	8.32	11.90	4.08	3.29	46.47
1958	27.07	10.44	17.64	5.30	6.58	67.03
1963	47.97	13.98	23.91	7.22	8.53	101.61
1968	86.35	20.67	38.02	10.31	14.34	169.69
1971	120.15	25.82	57.24	13.84	19.56	236.61

Source: Statistics Canada, adapted

TABLE 2

PERSONAL HEALTH CARE EXPENDITURE IN CANADA
IN CURRENT DOLLARS
$ millions

	1962	1965	1968	1971	1974	1976
Medical care	620	790	961	533	726	1031
Hospital care	188	225	283	338	396	430
Drugs, sundries	356	461	602	667	1074	1433
Other	37	40	56	80	208	316
All medical care and health services	1201	1516	1902	1618	2404	3210
Percentage of total personal expenditure	4.4	4.5	4.4	2.9	2.9	2.9

Source: National Income and Expenditure Accounts 1962-76. Ottawa: Statistics Canada, 1977.

TABLE 3

ONTARIO PUBLIC HOSPITALS
OPERATING EXPENDITURE PER PATIENT DAY

	1975	1976
All public hospitals	$109.65	$124.49
Full teaching hospitals	148.32	182.19
Extended care	44.95	52.33
Pediatric	222.49	316.26
Convalescent	58.17	83.52

Source: Ministry of Health, Ontario: Annual Reports, 1976 and 1977.

In the U.S.A. as in Canada, massive increases in expenditure have occurred. In 1929, total health spending was $3.6 billion, of which 13 percent came from public funds. By 1976 the figures were $139.3 billions, with 42 percent from federal, state and local government funds. Labour costs form a high proportion of health care costs, especially in hospitals. In 1977 community hospital costs were $30 billion for manpower and $22.6 billion 'other' costs. There were 2,221,000 full-time and 678,000 part-time employees responsible for the average bed complement of 945,000. In Canada there are 280,000 full-time and 60,000 part-time employees to serve the 1390 hospitals. These totals include 16,000 general practitioners, 11,500 pharmacists, and 1,700 optometrists among others. Hospitals employ 3.5 percent of the entire labour force.

Bennett and Krasny (1977:5) have queried whether our present concern with costs is justified:

> Given the precious nature of health, it could be argued that 7.2 percent of the gross national product is small . . . a recent Gallup poll showed that 84% of Canadians rated health care as good value for their tax dollars - a higher score than that achieved by any other public service.

However, these authors further wrote that:

> Increased expenditures have not - and will not - pay off in freedom from illness and gains in Canadians' life expectancy. There is little doubt that they will buy more comfort, less pain, and more peace of mind. These intangibles do not appear in mortality or sickness statistics . . . whether Canada should be paying so heavily for convenience and comfort is now being questioned, and will be more so in the future as today's financial squeeze moves in the direction of becoming a genuine resources crunch.

A study of rates of change in expenditure was published by Lefebvre (1977:7) using government statistics for 1975:

> The operating expense of public general and allied special hospitals has increased over the past twenty years with an average annual growth rate of 13.6 percent . . . the growth rate is more revealing when compared to the average annual rates of GNP (6.7%) and the population (1.9%) . . . the operating expense increased seven times as fast as the population, and twice that of the GNP.

Messages of change

Change is a dominant feature of today's health care system, and management is faced with challenging tasks to meet and control these changes. External decision-makers such as governments are generating continuous pressure

through budgetary allocation processes and new legislation in particular. Health care services are in the vortex of change, involved with the increasing tempo of scientific and technological advances. The University of Michigan faculty (n.d.:1) stressed changes which are taking place between the various health service organizations:

> . . . once clearcut distinctions between the functions of public health departments, hospitals, ambulatory care facilities and other community health agencies are now blurred. Increased attention and concern over accessibility and costs of health care services have generated new directions in the health care field, including increased governmental and consumer activity, the monitoring of health services, and health planning.
>
> Changes taking place reflect a fundamental shift in social philosophy. Development of integrated, comprehensive health care organizations, coupled with broader insurance protection, is based upon the principle that high quality health care should be available to all. Playing an increasingly important role in achieving this goal is the health services administrator.

The end purpose of health administration has also changed. Whereas the objectives of medical services have formerly been upon administration of the curative sciences, the new attitudes now emphasize the positive aspects of health protection. Conditions must be created in which the healthy individual will be the norm.

The Report of the Commission on Education for Health Administration (1975:19) (the Dixon Report) observed that "health and medical care in the United States has been

characterized by pluralism, fragmentation, and lack of coordination". A positive feature, however, is that:

> Change is occurring within all components of the health and medical care system, and in the ways they relate to each other . . .. Users have become vocal about long standing inequities in the operation of the system. In response, governments have increased their manipulation and control of various aspects of the system. This interaction has been piecemeal and erratic, and in some cases has contributed to the system's problems, rather than alleviating them.

It is interesting that the U.S. public strongly approve high spending on health. An investigation discovered that the three high areas of concern of the public, for which spending was recommended were crime prevention, drug abuse, and health maintenance. President Carter presented proposals on health insurance to Congress in September 1978. Two possible packages were discussed in Newsweek (1978). The Long, Ribicoff and Waggoner proposals: Catastrophic Health Insurance Act would cover expenses above $2000 per family annually and would involve $16 billion each year above the present Federal spending of $60 billion. The Kennedy Health Security Act would be total insurance, using tax revenues, costing $130 billion above the present expenditure. This latter would create massive management pressures, and react upon the educational system. Actual proposals by Carter were vague; details of a full scheme are delayed until 1979, giving time for the development of alternative plans. In the words of

Iglehart (1978:17):

> unlike his 1976 call for a universal and comprehensive plan, with only passing regard for its cost, Carter's principles reflect a very cautious approach toward a national health plan, the kind one might expect from a chief executive who has been attacked repeatedly for introducing too many costly proposals . . . he did not relinquish that dream . . . of national health insurance - that more care can be provided for little more money.

The need for managers

The Department of Health, Education and Welfare, Washington, estimates that the U.S. health system needs 40,000 persons with graduate education to fill positions in health administration; there are at present 5 million workers engaged in health service occupations. The Organization for Economic Cooperation and Development (O.E.C.D.), (1974:9-10) wrote:

> In the last decade, a new set of pressures has come to bear on health care and education. Emanating from citizens, professionals and government leaders alike, they call for changes in the present system, especially for:
>
> improved access to health care in terms of time, distance and finances;
> improved quality of health care, in technical and personal terms;
> more effective control of expenditures; and
> greater cost-effectiveness in these gargantuan systems.

The O.E.C.D. study recognized that most countries are attempting to encourage comprehensive and community-

based primary health care and to reduce dependence upon hospital and inpatient care.

Ray Brown (1973:12) of North-Western University, Chicago, noted that this new emphasis "has caught the health care system short, both quantitatively and qualitatively, of management resources." The pattern established during this century has been for specialized institutions educating professionals for their own expertise: doctors, nurses, physiotherapists and others. O.E.C.D. called upon the education system to reorganize itself, to ensure that students in all health professions become acquainted with community health care as well as hospital practice. The study continued: "Unfortunately, despite exhortations and successful experiments, more than ninety percent of education for the health professions remains deeply rooted in hospitals." Graduates must acquire more than basic skills; they must be given the professional attitudes whereby they will be encouraged to grow in their career, and accept changes of pace and direction in an efficient manner. They must function both as policy-makers and as executives; both are needed as the demand for community health care programs increases.

R.G. Evans, in Andreopoulos (1975:153-4) saw problems in evaluating managerial efficiency:

> The limited possibilities of comparison across hospitals with existing data make confident identification of 'good' and 'bad' management impossible . . . the administrator may not

> have much discretion. Attention shifts to ways of reducing hospital utilization by providing institutional alternatives such as convalescent care, day surgery, home care; by shifting medical practice away from fee for service and toward salaried group practice . . . or simply closing beds.

American government statistics showed that in 1972 50-60,000 persons held executive positions in the health system, 32 percent in hospitals, 35 percent in nursing homes, 18 percent in voluntary health agencies, 11 percent in public health agencies and 4 percent in clinic management, third party plan offices etc. The Dixon Commission estimated that fewer than one in four had undergraduate or graduate education in health administration; most graduates were employed by hospitals or public health agencies.

McLeish and Nightingale (1973:5) studied the issue of changes in manpower needs,for the Department of Health and Welfare, Ottawa. They identified five factors affecting manpower in this decade:

(a) new forms of hospital care leading to reduced demand for hospital staff. These include increases in shared services (group purchasing, for example); reduction in the acute bed-ratio; increased emphasis on extended care;

(b) need for regional coordinators, directors of public health and other regional executives. "The desire to produce more efficiently operating large-scale health divisions will prove irresistable";

(c) community health centres, each managed by a Health Service Executive, will probably be established, to provide a comprehensive and mobile first contact service, yet guaranteeing expert and efficient hospital care within reasonable proximity;

(d) the popularity of group medical practice will increase, leading to further demand for health service executives and business managers; and

(e) natural attrition and emigration will cause fluidities. In the next ten to fifteen years, over half the larger hospitals in Ontario will be losing their administrators through retirement.

R.F. White (1977:3) emphasized the need "to recognize that there are some important differences between health services administration in Canada and its counterpart in either the U.S.A. or Europe. Since the nature of the health services system in this country lies somewhere in between that of the U.K. and the U.S.A., there are aspects of the preparation of administrators to serve in it which should be different from what is required for those other health systems". He realised that experiences of other countries should be taken into consideration, to be used when beneficial.

The University of Toronto, Ontario Health Administrator Survey (op.cit) supplied lists of 'administrative' level occupations, which serve to illustrate the wide range of tasks for which educationalists must prepare entrants to the health services profession. In hospitals the survey listed Administrator (or chief executive officer or executive director); subordinates and administrative assistants; medical, nursing and personnel directors; managers of business office, pharmacy and laboratories. Managers in the Ministry of Health include the Minister, deputies and assistant deputy ministers; directors; consultants; coordinators.

In the local Health Unit are the medical officer of health; deputy and assistants. Similarly there are managers with various titles in nursing homes; consulting firms; district health councils; extended care institutions and professional associations. The variety of employments, coupled with the major impact of health expenditure, combine to give relevance to any study of the efficacy of health administration education programs.

The need for qualified managers 'in the middle' has been recognized for many years by industry, though the majority still are lacking formal education in management. Needs for health administration education at this level are urgent. According to Sangamon State University (1976:1):

> . . . managerial responsibilities in health related organizations cannot continue to be met solely by top level administrators, regardless of their level of competency; middle management personnel must increasingly be relied upon to effectively allocate and manage scarce resources in an exceedingly complex multi-organizational environment . . . There is a growing need for the general public to become both more knowledgeable of, and more responsibly involved in, the process of making health service providers aware of the areas of public accountability they will be expected to satisfy . . . if personnel working within the system are unaware of system strengths and weaknesses the chances of effecting constructive change are minimal indeed.

Problems of education for health administration

There is need for competent, imaginative and responsible leadership in health administration, although

published attacks on the quality of current management are rare. One notable exception was by Bellin (1977:2):

> At no time in the history of modern health administration has so large a percentage of practicing administrators demonstrated an inability to cope successfully with their professional responsibilities. They blame the bitterness of inflation..the rapaciousness of the unions..the financial overrun of costly diagnostic and therapeutic gadgetry.. the social obtuseness of physicians..the Utopian expectations of the American consumer of health care..the demagoguery of community groups..the comparatively low priority of health. Indeed, they blame everything and everybody but themselves.
>
> It is time to call into question the quality of many practicing health administrators in voluntary, proprietary and public hospitals.

Bellin continued:

> The atmosphere is conducive to the production and retention of a new breed of health administrator. And what of the old breed who yearns for the halcyon days of yesteryear when fiscal resources were abundant and never threatened to dry up? Well, whatever happened to those fish that failed to achieve the amphibian state when the local waters of the earth did in fact begin to dry up?

There are dangers in excessive vocational emphasis, and programs in Canada have made major strides in adjusting the balance between vocational and graduate education, by strengthening academic content when there is a danger of too great vocational orientation. An extreme view is that of Hutchins (1936:43): "it deprives the university of its only excuse for existence, which is to provide a haven where

the search for truth may go on unhampered by utility or the pressure for 'results'."

Dalston (1973:206) wrote, concerning long-term care administration, that:

> notwithstanding the recent flurry of activity by universities and colleges in this area, the major response needed of educational institutions to this challenge remains yet to be seen. Provision of skilled and appropriately educated administrators for the 20,000 long-term care institutions in the United States represents a challenging goal...problems in accreditation, reimbursement, Medicare, apathy of private medicine, lack of trained managers, poor public image, the staggering load of 20-25 million elderly persons . . . all bespeak the need for educational programs designed to quickly and markedly upgrade the administrative expertise...to educators, it means we must plan, organize, assemble resources and implement programs to meet this challenge.

Regular programs of study need to be altered to meet irregular requirements and to produce unusual graduates. Such alterations may be expensive, and academics are often reluctant to undertake major modifications.

Not all employers are enthusiatic about recent emphasis upon education for specific aspects of health administration. McCool (1975:67) wrote that:

> business administrators, third party reimbursement agencies and others..regard recent enthusiasm for more education skeptically. They question the intended outcome. With that type of organizational change or innovation will such education correlate? Will criteria be established to measure the achievement of its goals?

> Are the most cost effective teaching mechanisms being employed? Do teachers have the proper credentials and expertise?

Conversely, Shepperd (1976:453) was disturbed by the generally low level of awareness:

> Many laymen seem to believe that physicians, dentists and nurses are trained in their professional schools to be administrators. It is also a common misconception that persons with business administration backgrounds do not need to enhance their knowledge of health affairs . . .. Administrators themselves may feel the need for further training, but they face other barriers in obtaining it - no nearby educational institution, an inadequate educational background, no personal priority for education, lack of financial support, or an unstable work situation.

Summary

In simple terms the problem studied in this thesis concerns the creation of a nationally oriented health administration education program. In complex terms, it deals with the response to a varied series of demands which rapidly changing environments have thrust upon managers and educators. Differences between health institutions and commercial organizations are of sufficient degree to warrant particular attention. The impact of science and technology, medical developments and public demand for better care, have strained managerial competencies. Further, the growth of sedentary occupations, greater human stress, and the apparent preference by many for curative measures rather than prevention, have increased the burdens of institutional

management. In addition, health professionals are often reluctant to assume managerial responsibilities, considering them uninteresting and beyond their training.

It is held by the researcher that there is great need for capable administrators, and that those at present employed need satisfactory educational programs to assist them to cope with change.

Important issues have been raised in this chapter, which will be discussed in detail subsequently. It is now necessary to define and explore the meaning of 'administration' and specifically 'health services administration', before proceeding to examine present university degree programs.

CHAPTER TWO

THE NATURE OF HEALTH SERVICES ADMINISTRATION

The Administrator

This section of the thesis explores administration both as a term and as an occupation, in order to enable a clear definition to be made concerning the scope and content of health services administration.

There is no universally accepted definition; indeed those responsibilities in the commercial sector known as managerial, are usually undertaken by the administrator of health institutions. McFarland (1964:10) explained that "the distinction to be made between the two terms administration and management, if any, is that administration refers to the determination of major aims and policies, whereas management refers to the carrying out of operations designed to accomplish the aims and effectuate the policies."

Administrators cannot rely on predetermined job descriptions. Berman (1975) recognized that "the role an administrator usually plays depends on the personal and intellectual capacities of the individual, the receptivity of the institutional environment to his or her planning and objectives, the degree of accountability and the amount of responsibility given . . .."

There are several approaches towards a definition of management. One, exemplified by H.A. Simon considers decision-making and direction of activities as key components. He wrote (Simon, 1976:246):

> we see then that the work of the administrator involves (1) decisions about the organization structure and (2) the broader decisions as to the content of the organization's work. Decisions of neither type can rest entirely or even primarily upon a knowledge of or facility with administrative theory. The former must be firmly grounded in the organization's technology. The latter requires in addition (a) a thorough appreciation of the theory of efficiency and (b) a knowledge of those aspects of the social sciences which are relevant to the broader purposes of the organization.

Simon observed that requirement (b) casts grave doubt on the possibility of developing administrative ability apart from subject matter competence, except at the very highest levels in the hierarchy. Effective training of administrators lies not in the narrow field of administration theory, but in the broad field of the social services generally.

Early concepts of management included those of the 'human engineers', who developed a structural theory of administration based upon the benefits of division of labour, together with a hierarchy organized to coordinate clearly defined functions. Management should take responsibility for planning work and making its performance physically possible. Managers should be trained to apply scientific

principles, such as management by exception, and the use of standards as measures for comparison and control. The work of F.W. Taylor, the Gilbreths, Urwick, Gantt and others has led to the industrial engineering movement of the post-war years, and management science today.

Another approach deals with theories of human group behaviour. Stemming from the work of Follett, Mayo, Argyris, Maslow and others, there is agreement that management must recognize the social process, whereby workers are understood as people and as individuals. Conflicts between process and structural attitudes to management have been extensive, and are not yet resolved. Follett, in her best known work, Creative Experience (1924) stressed the interaction factor in human relationships. Best results are achieved when differences are resolved through conferences and cooperation; by an understanding of diverse viewpoints and combination of those viewpoints to attain a common objective. She emphasized the necessity of continuing involvement, not ad hoc meetings. Mayo (1933) was the director of extensive studies at the Hawthorne plant of the Western Electric Company, Chicago. Results seemed to indicate the inadequacy of a theory of administration that was primarily economic and mechanistic. Following studies of the effect of changes in the environment upon workers, it became apparent that social factors have greater influence on productivity than do physical working conditions. While wages and working conditions are of importance to the worker, they rank

second to what Mayo termed "a method of living in a social relationship."

It may be that the massive dimensions and size of variables of human attitudes and behaviours will defeat the theorists. Depending upon prevailing economic and political conditions, administrators seem to respond by adjusting their attitudes and behaviours post hoc. These responses are not always relevant, but it is unreasonable to expect alternative approaches when managers are forced to rely on hunch and ingenuity, and upon trial and error. The new sciences that are creating revised ideas of man and his behaviour were listed by Gulick (1975:265) and include modern biology, anthropology, ethnology, ecology, sociology, genetics, psychology, psychoanalysis and political science. He observed that "most of the stereotypes and shadows of 'man' have receded into the past during this half century. Is it any wonder that public administration education has faced, and still faces, problems of adaptation?"

A further approach to administration is that which considers the organization as a system, or set of inter-related and interdependent parts forming a complex whole. This concept has become increasingly discussed since the 1940's, due to rapid expansion of productive organizations, and needs for immediate solutions to unstructured problems. Such developments as cybernetics (control systems), information theory and operations research, coupled with high speed data processing, have given an aura of certainty and

decisiveness to management planning and control which is perhaps not yet warranted. To treat the organization as though it were a biological entity is appealing, but realization of our ignorance of the working of a single human body should alert the systems designer to the dangers of transferring that lack of knowledge to the organizational environment. However, there is value in the attitude which focuses on the whole, parts, and relationships among the parts. Kimbrough and Nunnery (1976:83) believe that "as a way of thinking, the systems movement is of great value to the practicing administrator . . . who will be goal oriented; will examine the context of problems faced; will be aware of the dynamic interrelations among groups, events and ideas; will seek feedback; will examine various alternatives and will be cognizant of possible long-range impacts."

Basic management processes

Whichever approach to management is favoured, there is common agreement that the administrator is involved in some or all of certain specific activities. These are identified by an effective acronym based upon the work of Henri Fayol (1916, trans. 1949), developed by Gulick and Urwick (1937:13): PODSCORB, to describe the job of the President of the United States:

> Planning: deciding in broad outline those matters which will need attention, and methods required to attain the goals set before the enterprise.

> Organizing: developing the formal structure of authority through which work divisions are arranged, defined and coordinated for the objective. This deals with the acquisition and positioning of manpower resources, departmentation, delegation, line and staff etc.
>
> Directing: making decisions, embodying them in specific and general orders and instructions. This function is also people oriented and involves employee motivation, leadership and supervision.
>
> Staffing: the personnel function.
>
> Coordinating: interrelating all aspects of the task.
>
> Reporting: keeping informed those to whom the executive is responsible, as to events occurring. This involves records, communication methods, research and planning.
>
> Budgeting: including fiscal planning, accounting, costs and control.

Although PODSCORB has been superseded, it still seems to be an accurate description of the tasks of managing today.

All managers are involved to a greater or lesser extent in each element - depending upon the level that the administrator occupies in the hierarchy. Thus, the planning component is at its maximum when undertaken by senior administrators; reporting and staffing may be important at every level.

Investigators have studied the activities of managers and find it difficult to identify and categorize. An important part of the managerial decision making process is that of problem definition under conditions of unclear alternatives and hazy consequences. It often appears that

choices are made to satisfy immediate and pressing demands, accepting the pis-aller which involves satisficing rather than optimizing. Mintzberg (1973a:10) saw the manager's job as being one of 'programming', which involves the design and modification of procedures to be implemented by subordinates. Acceptance of the facts of daily administrative time scheduling does not prevent writers such as Goode (1973:30) urging the manager to avoid ad hoc actions: "it is recognized that in most decisions political and emotional considerations are generously mixed with rationality. It does mean, however, that rationality should be maximized whenever possible and the rational elements of the environment must be cultivated by the educational manager."

Whether management is an art or a science, every administrator must acquire expertise and understanding to enable him to perform his duties. Skills of three broad categories are involved, namely technical, human and conceptual. Technical skills are developed by on-the-job learning and through specific related courses and training. Included would be basic management processes such as communication, delegation and negotiation. Human skills are acquired through involvement with work groups, and include leadership and motivation. Conceptual skills require an understanding of the enterprise, both within the legal framework, and beyond - the industry, competitors and the general public. These skills relate to the system, goals and objectives, and policy.

The Administrator of health institutions

As in the commercial sector, there is need for management skills and aptitudes in hospitals, government departments, local health units, nursing homes, district health councils, professional associations, group medical practices, and educational institutions. It is unlikely that definite roles will be established within any of these occupational areas until the activities of the 'administrator' per se are clarified. Recent and traditional spheres for the health services manager have been to advise the governing body (hospital board of trustees, for example) and to execute their policies. The board is composed primarily of interested lay-persons, but modern demands on planning and policy-making skills render some board members incompetent. In any case, policies are increasingly originating from provincial Ministries, rendering the administrator at the one time a Mr. Inside Man (relating to the Board of Trustees) and a Mr. Outside Man (an agent of the government). This in turn implies a value judgment concerning priorities. Since the external relationships are concerned with vital statistics such as global budgets, there may be a lessening attention paid to internal considerations, resulting in greater delegation.

A recent paper by Murray (1978:38) which evaluated work by prominent investigators into the activities of the chief executive officer of a health institution, concluded that the work of Katz (1955) - which identified the

technical, human and conceptual skills discussed earlier - appears valid today "as a theoretical model for a better understanding of management styles". Murray explained that recent pressures upon senior administrators emphasized the type of behaviour closely related to conceptual skills; and he commented: " . it would seem that administration at all levels within health care corporations should begin a process of self-analysis and reassessment of their administrative strengths." The author perceived that there might be improved administrative skills in consequence of this process.

Few writers mention the need for a broad philosophical framework, but the value content of an occupation should not be ignored. At its highest level, administration provides the opportunities for individuals and the organization to survive and flourish. Whereas basic principles of management apply, the health administrator must additionally deal with these concerns:

1) the social and emotional nature of personalized services provided by health institutions; these imply modification of the basic economic motives recognized by many management theorists;

2) the life and death crisis orientation of certain services provided by the health institutions; this leads to uneconomic utilization of manpower and equipment unless strictly supervised by management; and

3) the conflicting and confusing patterns of interaction and authority which

> exist among the numerous and diverse groups of personnel in health care institutions.

There is no standard pattern for health institutions. They range in size from equivalence to a corner retail store, through to a size and capacity similar to that of a large factory. In Canada most health institutions are not profit motivated, and orientation is towards costs and service. They reflect the standards, traditions and values of the curative professions. In addition to group and medical relationships, there is communication with comparatively unfamiliar bodies such as government departments. This has led to the need for political competencies whereby senior administrators attempt to match skills with civil servants; it may be debated whether the energies thus expended are of benefit to the institution.

That not all health administrators operate at this level may be deduced from the comment by Stark, in the Dixon Report (op.cit.:II, 234):

> the present health services administrator is seen as an individual with a limited scope of responsibility, usually restricted to technical and more routine tasks within an institution or agency. He lacks an entrepreneurial image altogether. In some critical aspects of ongoing institutional life he is excluded or instructed to refrain from any direct interference or involvement . . . the role of the hospital administrator ranges between housekeeper and office boy unless he happens to have an M.D. after his name. Then he is generally thought to be misusing his talent on administrative work.

Health institutions are now complex, highly technological, crisis oriented and excessively utilized. The widening horizons of health care demand administrators who have more desire to manage than do physicians forced into the situation willynilly. R. Evans, in Kellogg Foundation Paper (1978:101) identified major obstacles which deter and distract the effective manager. These include:

a) weak 'authority' over key operatives - the medical staffs. Doctors' decisions determine the quality of performance, yet there is no central administrative control of their activities;

b) lack of clear indicators of system performance, for evaluation of managerial quality; and

c) present emphasis upon efficiency at the structure/process level rather than at the entire system level. For example, the number of patients occupying beds at midnight is a vital statistic, whereas little concern is shown for overall quality of operation; this is a cause of sub-optimization.

Health administrators, and especially those in hospitals, are increasingly compelled to look outwards. Budgetary decision-making is now provincial; labour-management negotiations are taking place centrally, and accreditation teams are despatched from the provincial capital. The administrator of a large institution must be a career diplomat, relying upon experts in many fields for the internal smooth operation of his organization. These powerful specialists include industrial engineers, personnel

managers, architects, security staff, cost control accountants and lawyers. Administrators frequently are severely cross-pressured in selecting from several alternatives for decision purposes.

Health system control and Professionalism

Health institution control is vested in a board of governors, but is exercised mainly by two groups: administrators and the medical staff. This dichotomy leads to conflict unless there is a realization that both share the same objective: improved care of the patient. In 1510 Martin Luther, visiting Florence, wrote to the head of his monastery:

> The hospitals are built like palaces, supplied with the best food and drink, and tended by diligent servants and skilful physicians. Beds are covered with clean linen. When a patient is brought in, his clothes are taken off and given to a notary to keep honestly. Then they put on a white bed gown and lay him between clean sheets and two physicians are brought at once. Servants fetch food and drink in clean glass vessels, and do not touch the food even with a finger. Honourable matrons, veiled, serve the poor all day long without making their names known, and at evening return home.

In contrast to that, the report of the public inquiry into the Laurentian Hospital, Sudbury, Ontario (Waisberg, 1976:12) included this finding:

> . . . The corporate organization was neither adequate nor legally set up for the purpose of planning, constructing and equipping

> the hospital. No proper incorporating by-laws for the functioning of the Board were enacted. No legally constituted Board of Directors was elected. The functional organization for the administration of the hospital was inadequate for purposes of planning, constructing and equipping the hospital.

Emergence of the administrator as a separate professional stratum has been discussed and disputed by many experts. At the one end are those who regard medically trained staffs as too precious to waste on management duties; at the other are those who recognize that finance, personnel, records management, dietetics, housekeeping, community relations, industrial negotiations and government liaison, are activities which require skills and experience not provided by clinical education. Hospitals have been leaders in the use of non-medical administrators, and the growth of other health institutions envisaged in the coming decade will cause demands for equally specialized managers.

Bellin (1972:44) believed that the difficulties caused by two authorities in one institution, are solved:

> the original 'Kulturkampf' between M.D.'s and non-M.D.'s is indisputably over . . . the manager is now in victorious possession of the administrative turf of most of the major hospitals in the U.S. The education that leads to the M.D. plus clinical experiences unquestionably provide relevant insights and technical knowledge. The only valid question - does the M.D. who is trained and experienced in health administration have a role for which he is particularly qualified? Yes! He can operate in areas of true 'health' administration - to promulgate, monitor and

> enforce standards of health care. Administrators themselves often administer very little 'health'. More often they administer 'health care personnel' - not the same thing.

It is not yet certain however, that the war is over. At the 1978 annual conference of the Ontario Medical Association, Dr. S. Klein urged that physicians should have a stronger voice in running hospitals. Administrative staffs have become too powerful and often make decisions without physician input, or in spite of physician input. The Minister of Health, Ontario promised to unsnarl some red tape which doctors claim is a major reason for dissatisfaction. He has requested that the O.M.A. and Ministry officials review administrative procedures and report back with recommendations to minimize what physicians see as harassment.

The third volume of the diaries of the present British Prime Minister (Crossman, 1978) contains frank, important revelations concerning his years as Secretary of State for Social Services. One amusing (possibly poignant) entry for 13 September 1968 reads:

> Since each Regional Hospital Board has £20 or £30 million a year to spend it is important to get really efficient administration, and they are struggling to do so against a great deal of opposition from consultants (medical specialists) who are suspicious of the professional administrator, and who fear that he will deny them the freedom they enjoy at present. Doctors seem to me very like difficult mavericks. They behave a bit like dons at universities (though dons are a good deal more cunning).

Debates and the literature on professionalism have generated much heat, a little light, and copious quantities of smoke. This researcher has been compelled to search the literature, since both administrators and their educators are interested in present and potential professional status. This is especially important for the new generation since many of them will be employed by institutions other than hospitals.

Flexner (1915:904) wrote that:

> professions involve essentially intellectual operations with large individual responsibility; they derive their raw material from a science and learning; this material they work up to a practical definite end; they possess an educationally communicable technique; they tend to self-organization; they are becoming increasingly altruistic in maturation.

There is no evidence that health administration is a profession within that definition; but it may be possible to provide at least the educational components that are requisite.

Certain characteristics of professionalism may be identified: a sense of identity incorporating shared values and common role definitions, plus a common language or vocabulary. There must be a system of replenishment through regular selection, training and qualification.

Standards are derived from a body of specialized knowledge: this may not yet apply to administration, whose behaviour is interpreted by theorists rather than

classified by taxonomists. Again, the professional characterizes his relationships by affective neutrality; the health administrator is, however, often involved with the institution in an emotional manner. Professionals are individuals, and are chartered following evidence of satisfactory individual performance. Few health administrators are qualified in this manner, though membership in the Canadian College of Health Service Executives may one day bestow that prestige.

The C.C.H.S.E. has now issued a policy statement (in Contact, November 1978,1) concerning licensure. Following a task force study, the recommendation is that "licensure of senior managers is not advocated at this time". This would seem to indicate that the issue of professionalism is not yet at a decision stage, although a code of ethics has been drawn up and adopted for members of the College (Contact, October 1978,3).

In Britain, comments Shegog (1978:208), health administrators do not impress observers as being a professional corps, ready to advise policy-makers on sensitive issues such as allocating resources and directing manpower. He cites the recurring criticism of health service management, as proof that its image is not yet such as to convince physicians and the public of its value to the health system.

It is not difficult to identify those career activities which contain professionals: the law, medicine,

the clergy, and the military. Others are moving towards such status: veterinary medicine, social work and pharmacy, for example. Austin (1977:70-73, 97) considered that health administration is moving toward professional status, and cites many technical journals as evidence: those of the American College of Hospital Administrators, the American College of Clinic Managers, and others. He is of the opinion that: "health administrators will not be judged so much by their individual activities, but rather by success or lack of success in achieving effective action from the many groups of people who work in or are served by the organization." Change is required: "what is needed is a new kind of professionalism, which is broad in focus; adaptive and ready to change; empathetic to the needs of client and community. The focus must be on the development of strong leaders who do not attempt to practice their trade in a safe, value-free mode. Rather, they must actively participate in the policy-making process and attempt to influence planning decisions in their communities."

Perceived roles for Administrators

The PODSCORB definition of management function is in effect repeated by the Dixon Commission: "health administration is planning, organizing, directing, controlling, coordinating and evaluating the resources and procedures by which needs and demands for health and medical care and a healthful environment are fulfilled by the

provision of specific services to individual clients, organizations and communities." This is placed in a more specific context by the National Staff Committee (1976), which stated that general administration comprises the essential staff dealing with problems common to all organizations, because of the unique requirement for efficient coordination of the many occupational skills represented in health care: doctors, nurses, dentists, pharmacists and opticians, among others. "It is no exaggeration to state that competent and intelligent administration may sometimes be a matter of life and death in a service devoted to the health of millions of people."

Characteristics of administrators change - though gradually - as the problems facing them develop and alter. When the major problems are budgetary, the institution is accountant-oriented. In recent years, the American hospital has become medical staff dominated to the extent of legal liability cases. Most recently, the trend is to professional administrators, reflecting growing concern with health care costs, and increasing government involvement in the funding process. Topical cost-cutting drives may damage health care. Clark (1978) said that "the cost of NHS administration is, in fact, about six percent of its revenue expenditure - a figure low enough to be envied by many industrial enterprises." She appealed for an end to the apparent 'witch-hunt' to cut costs: "the function of management in the health service is to enable patient care to happen. It

does this by providing the system and the support services. When there is no enabling, practice must suffer."

Each administrator holds his own allocation of priorities of tasks. Kooner (1972:361) amalgamated results of two major investigations, those of Connors and Hutts (1967) and Murray et al. (1967): Table 4.

TABLE 4

ADMINISTRATOR'S ALLOCATION OF DUTIES

Activity	Connors & Hutts Teaching Hospital	Murray General Hospital
	% of time	% of time
Planning	25.8	25.5
Directing and Coordinating	4.5	24.6
Extra-mural	36.9	20.9
Personal	3.4	11.8
Controlling	16.5	11.4
Organizing, operating	12.9	5.8
	100.0	100.0

This researcher applied a correlation test to these values. The Pearson r of 0.337 gave a t value of 0.716 (4 degrees of freedom). Tabular values support the hypothesis that there is no real association between the data sets. Given the wide range of duties encompassed by hospital administrators, and vagueness of definitions, it is not surprising that lack of agreement is found. A more recent study by McQueen (1974:31, 41) concerned 796 Canadian administrators: 488 employed by hospitals, 149 in nursing homes, 47 working

in health care association management, 46 in local health units, 44 employed by governments, 17 as consultants and four in district health councils. Again, analysis showed significant divergence between major responsibilities within these occupational categories. Hospital managers and association executives spend their time attending meetings within the institution; planning goals, policies and courses of action occupy much time in hospitals, government local health units and consulting firms. Nursing home executives indicated that directing and advising subordinates were high level activities (third in hospital ranking), as they were in local health units. The latter regarded liaison with government agencies as important, but this occupation was not of significance to other managers. Among other duties included were attendance at meetings, epidemiological studies, investigation of complaints, and evaluation of overall performance of the organization.

The three studies show that any classification of health administration activities must take into account these different levels of ranking between organizations. Mintzberg (1973b) described the ten basic roles of the administrator, with detailed comparisons between health institutions. In brief the roles are:

Interpersonal:

(i) the figurehead - ceremonial and symbolic.

(ii) leader - to bring the needs of subordinates into accord with those of the organization.

	(iii)	liaison - community leadership.
Informational:	(iv)	monitor - to seek and receive information.
	(v)	disseminator - to share information.
	(vi)	spokesman - inform and explain to outsiders.
Decisional:	(vii)	entrepreneur - seek change, problems and opportunities.
	(viii)	disturbance handler.
	(ix)	resource allocator to distribute budgets, and
	(x)	negotiator.

His findings were that hospital administrators rate most highly their roles as entrepreneur, leader, monitor, resource allocator and disturbance handler. Health clinic managers order their roles in this sequence: leader, entrepreneur, monitor, negotiator, resource allocator and liaison officer.

In Canadian institutions, the above general analysis may apply; in addition there are differences caused by distance from urban centres, and due to the rather greater provincial control over health management - particularly budgetary.

Leadership is a responsibility held at every level of management. Great variety of backgrounds, and differences of motivation are found in the 'typical' health institution. The administrator must lead highly skilled scientists, clerical workers, trained nurses, volunteers, boards of trustees and the unskilled; he must motivate the patients

and satisfy critics, government agencies and the media. Leininger (1974:31) wrote concerning the leadership aspects of nursing. They need considerable awareness of politics, economics, social policy, normative values and management strategies and processes. She advised that:

> New strategies and creative plans must be considered to meet the demand for nurse leaders who can function effectively in the present confrontation - negotiation era. Today, leadership success is contingent upon . . . the political, psychosocial and cultural context in which different styles of leadership may gain expression or suppression in different types of institutional settings.

A developing role, mentioned earlier, is that of institutional representative to a wider outside community. Forrest, Johnson and Mosher (1976:434) wrote that: "Hospital administration structures seem to be evolving toward a closer resemblance to the corporate model, with the chief executive officer primarily playing the role of community outreach agent, planner, and reactor to governmental agencies and regulations." These substantial duties serve to emphasize the need for strong delegation and relaxation of daily contacts. The authors suggested that there might be developed a division between the Administrator and a Chief Operating Officer, the latter focussing on the internal operations of the health centre.

Students of the massive British N.H.S. have noted that the three main tasks of management - planning, programming and execution - appear to have been allocated

to senior, middle and first line management, in that sequence. This is damaging to effective organization, since managers at each level must perform all three tasks. Duties are now given to middle level administrators formerly the sole responsibility of senior staffs; this permits top executives to fulfil their role of negotiator and outside representative more adequately.

Summary

Educational planners require both a clear understanding of the duties and responsibilities of administrators, and realization that each level of the hierarchy needs formal education, in order that appropriate educational systems should be developed. An attempt has been made to describe the complex functions of the administrator, with appropriate alterations and modifications needed for health management.

MacEachern (1969:111-112) declared that his ideal would be:

> well endowed with infinite tact and diplomacy, have firmness tempered with consideration for the weakness of others, be an organizer, a leader in the community as well as in the institution, possess ideals and broad vision, a sense of responsibility of his position and the seriousness of his work, but tempered by a sense of humour, be absolutely honourable and just, be a judge of human nature, be industrious and interested in his work, have administrative ability . . . be a man of broad education, an educator, a man of business ability . . . able to work with others.

Each contributor quoted above has added some depth and dimension to the objective of defining administration, and identifying the many duties of the health service administrator. The educational researcher is more easily able to place current educational systems in perspective, the better to identify those which have continuing relevance; those which have become redundant or superfluous, and those which may be regarded as necessary but are not yet accessible to the health administration student.

CHAPTER THREE

DEGREE PROGRAMS OFFERED: 1979

In Canada at the present time, five universities are offering higher level degrees in health administration, with a 1977 overall registration of 162 students; and two are providing baccalaureate education. This chapter briefly describes selected programs in Canada, the U.S.A. and overseas; the objective is to discover those needs that are being met, to facilitate an evaluation later of unmet needs.

It is difficult to appraise the extent of needs, unless a procedure is also available to measure the effectiveness of current programs. Investigations into the literature have not uncovered evidence that suitable evaluation procedures exist. Subjective judgments are published, as for example that of Boissoneau (1975:22) who declared that "the future appears bleak for the individual who wants to devote a career to hospital administration without spending the time, effort, and money to earn a degree from one of the graduate or undergraduate programs in the field". By itself, this would merely stress the advantages of current degrees. He continues, however by explaining that: "no conclusive evidence is available indicating the superiority of program graduates". It may be necessary to reconsider

the structure of Canadian health administration education; this chapter provides the foundations for that examination.

Philosophies, goals and objectives

Many universities describe their philosophies and objectives in calendar statements and announcements. The graduate program at Arizona State University is designed in the belief that health service administrators:

> share with their business colleagues a common need for managerial skills characteristically required to administer most organizational enterprises. Beyond this commonality, however, lies a critically unique imperative - the professional growth of health service administration must be patient-oriented as well as management-oriented. As program students sharpen their problem-solving and decision-making tools, so too must they develop special abilities to enhance the quality of patient care through responsive, concerned and creative administration. Hopefully, this program will engender within its students an appreciation for the crucially important dictates of patient centered management.

Measurable objectives should be specified, to boost and supplement educational goals. This activity requires sophisticated curriculum designers. Scrutiny of many calendars has uncovered little evidence that these academics are involved at present.

A philosophy of health administration education has been classified by McTernan and Hawkins (1972:56) as comprising:

1) the search for unity - fitting different disciplines together;
2) flexibility - the educational process is the means to lead to the dual goal, of providing education and training, and satisfying rewarding careers; and
3) reasoning - such questions as: why a four year degree? Why credit for this course?

Stresses caused by rapid growth and change have deterred many educationalists from developing philosophies and statements of belief. Many do however communicate their objectives, since these may be more easily amended as conditions dictate. Ferris State College, Michigan has advised applicants that:

> the curriculum was developed to prepare men and women to provide high quality managerial expertise concurrently with an understanding of the social value and humanistic function of the enterprise. It is this blend of solid business skills and basic social understanding which makes the health services management graduate unique and necessary in today's health services field . . . it is designed to provide the essential educational background and vocational skills required to enter a mid-level management position within the entire range of the health services industry: hospitals, health maintenance organizations, health centers, health related government agencies, volunteer associations, and the commercial/industrial sales field.

Another college accented the middle-management objective - Appalachian State University:

> Although many of these men and women (with backgrounds in business) enter graduate schools to prepare for careers as top health care managers, there continues to be a strong need for health manpower trained in under-

> graduate schools of business for work at 'middle management' levels. Their education for hospitals, nursing homes, public health agencies and related health facilities and programs was recognized by Appalachian in establishing the Office of Health Care Management.

Many statements are concerned with specific employment opportunities at middle or upper executive levels, and do not disguise the fact that their programs include courses directly related to employment objectives. The University of New South Wales is an example:

> modern administration, if it is to be effective, must draw heavily on the findings of the social sciences, and of mathematics, statistics and accountancy. The principles of these, together with law and areas of specific relevance to health services, are integrated into a course designed to contribute to the intellectual development and decision making skill for a managerial planning role.

Planners and curriculum designers must recognize that "human behaviour is multidimensional, therefore objectives, experiences and evaluational procedures also need to be multidimensional" in the words of McTernan and Hawkins (op.cit.:57). What do students need to know? What aspects of knowledge are most valuable for what ends? What manner of behavioural outcomes are desired? The answers cannot be categorical, and there can be none at all unless planners are experienced both in education and in health administration.

An example of a course structured towards a specific

student group, is that of the Nuffield Centre for Health Services Studies, in the University of Leeds. Their master's degree is designed to interest home and overseas students who wish to understand the operation of a highly centralized health service:

> The growing social, political and economic pressures for rationalization of medical care and health promotion services are leading inexorably to a greater involvement in the funding, organization and delivery of services by governmental agencies whatever the basic political system. The United Kingdom now has nearly 30 years of direct experience of a comprehensive governmental program of health care. Study and experience of the United Kingdom National Health Service is now becoming an invaluable opportunity to both academics and practitioners of health services administration whose systems of governmental participation are still in the process of development.

Middleton (1978:280), a graduate of the course, stressed that the program is directed toward theoretical and conceptual management, and is not intended to produce administrators by rote. Her criticism is that: "covering wide-ranging subjects in short time and only scratching the surface of many of them, it was difficult to be critical in a way expected of us, when we only knew the bare essentials." She did confirm however, that a satisfactory foundation of theoretical knowledge was acquired which will assist graduates "as they continue to think and question in the way encouraged by the Nuffield Centre."

Several degrees are oriented to specific careers or

groups of health administrators. The Graduate School of Management, Northwestern University offers a specialization in medical association management; this is of particular importance since many national health management associations have headquarters in nearby Chicago. Health services associations serve both members, and the 'consumer' public by their encouragement of improved standards of patient care. Major institutions - such as the American Hospital Association - have world-wide membership and affiliations and recognize the commonalities between health care needs and goals throughout the world, and the benefits of information sharing and cooperation. Federal and State laws and regulations which impact upon the practice of medicine, have necessitated increases in staff for interpretation and implementation duties; internal management needs have grown as staff sizes have burgeoned. The Master's degree should provide the skills, education and expertise required by those wishing to enter these associations as managers.

Another specialized program is that of Yale University, in the department of Epidemiology and Public Health. The stated objectives are typical of many but biased towards their major interest:

> to fulfill diverse leadership roles in the planning, management and evaluation of health services. Objectives are to create 1) a basic foundation of knowledge in public health, including epidemiology, biometry, administrative sciences and social sciences; 2) concepts, principles and scientific skills fundamental to the planning, organization, administration and evaluation of health

> services here and in other countries;
> 3) to develop an understanding of health services as part of overall community resources . . ..

The only Canadian degree with such an emphasis is that of the M.Sc. in Health Services Planning of the University of British Columbia whose objectives stress the planning function:

> to encourage students to formulate questions about the existing systems of health care in Canada and other countries, to examine available data about health services in the context of social policy generally, to consider issues and problems in planning and administration of health care and to learn about organization theory and research methods . .
>
> It is anticipated that students will find posts in (a) health care planning and administration in government, commissions, regional authorities, hospitals, clinics and voluntary health organizations in Canada; (b) health care research and (c) international health care planning.

Admission criteria

There has been a rapid growth in the number of degree programs. In 1972-73 there were 67 master's and 13 baccalaureate offerings in the U.S.A. and Canada; at the end of 1976 a survey by Gordon recorded 61 bachelor's degree programs, a 470 percent increase! Enrolments for the 1972-73 session were:

> Master's level: 2785 - 81 percent full time students;
> Bachelor's: 491 - 97 percent full time; and
> Associate degree: 86 - 51 percent full time.

Graduate programs employed 6 full time and 8.5 part-time

faculty, and had 58 students on average. Baccalaureate degree programs employed 3 and 3.3 faculty, full and part time respectively, and averaged 41 students. There were 2100 graduate level and 170 first level degrees granted in health administration in that session.

A major study on admissions policies in general was that of Constable (1977:20):

> With the exception of programs such as music or physical education, in which skills are an important prerequisite to admissions, most academic programs have little to say over admissions. The college admissions office carries out the gatekeeping function, often to the point of explicit quotas for each area . . . any 'selecting out' of students admitted to a program is done through cumulative academic failure. The looseness of this structure is most appropriate to programs geared to individual interest that make no promises about any competencies or responsibilities that their graduates may possess.

Constable suggested that an indication of professional status of a program is the degree to which it has control over admission: "no one questions professional control in other professional areas, regardless of sponsorship. Given limited educational resources, few professional schools can afford the luxury of open admissions". He continued:

> unless one genuinely accepts the premise that admissions to a professional program should be open, that there exist sufficient program and teaching resources to meet anticipated demands adequately, that selection can be demonstrated within a program and after admission as adequate to protect professional practice, then one can only conclude that there is much

unfinished business to be done within many undergraduate programs.

Baccalaureate admissions

The majority of programs show no evidence of strong control by the professional department, other than stipulation of completion of specified secondary school courses.

Concordia College, Minnesota admits only from a completed sophomore year into the Hospital Administration program: this is a common entry point. Most require the official high school transcript and an appropriate test result, such as the American College Test (ACT) or Scholastic Aptitude Test (SAT). Ferris State College searches for a better than average high school student with good communication skills, leadership qualities and a liking for organizational detail. A grade point average of 2.0 or higher is specified.

The Center for Allied Health, Mercy College of Detroit has a Junior level admission, with a minimum transfer of 62 semester credit hours; work in health professions is taken as a contribution to the B.S. degree "minor".

An elaborate policy is outlined by Wichita State University for the Bachelor of Science degree admission. Applicants must complete lower division courses and be admitted to the University. A grade point average of 2.0 is required in all college work. Consent must be received from the Admissions Committee of the Department of Health Care Administration.

Master's degree admissions

The Dixon Commission reported these first degrees held by applicants:

Degree	U.S.A.	Canada
B.A.	32%	17%
B.S.	30	8
M.D.	7	24
Other, R.N.	7	33
B.B.A.	9	12
Master's	12	6

An admission test score is usually required, and most specify a minimum grade point average, typically between 2.5 and 3.3. Subject prerequisites are usually stated in broad terms, although accountancy, economics and statistics are often mandatory.

The University of British Columbia offers its degree primarily to the older, experienced student, who should be a graduate in health sciences, commerce, a social or life science. "Without relevant work experience, students will have little to build on in the discussion sessions, in which major health care problems are explored".

The Université of Montréal requires a degree in administration, economics, nursing or similar. If the degree is in management the applicant is exempted from the first year of the program. First year applicants are interviewed by a Joint Committee of the School of Management and Department of Health Administration; second year entries are referred directly to the latter department.

The new (1978) Master of Science in Health Services degree of the University of Toronto demands at least a 'B' standing for admission. However, for those who graduated more than five years earlier: "applicants must present substantial evidence that, in the interval since graduation, they have achieved qualifications of equivalent stature. Significant professional accomplishment will be taken as evidence of this."

Degree programs may have a strong quantitative bias, as does the MPH in Hospital Administration of Yale University. Applicants are required to have completed courses in at least two of these areas: mathematics, statistics, operations research, computer science, economics and accountancy.

Program specifications

The earliest attempts to implement courses in health administration were made at the University of Cincinnati in 1919 and at Marquette University in 1926. Davis (1929:29), the proponent and pioneer wrote that: "a rightly planned learning process should give no less practical a training than an apprenticeship and should short-circuit its deficiencies and wastes."

He commented upon the demise of early programs, though excellent work had been performed by the Committee on the Training of Hospital Executives, whose report appeared in 1922 (published by the Rockefeller Foundation); and the American Hospital Association Committee on the Training of

Hospital Executives (1925).

Growth in health services had been substantial. From 1879 to 1929, the population of the U.S.A. had doubled; hospital beds had increased from 35,000 to 860,000 a fifteen-fold rise. Hospitals had become a "billion dollar business" by 1929, with 5,000 identifiable positions as hospital executive managers.

Davis believed that broad management education was needed: "the first call on the administrator is not to look up answers, but to know how to solve problems". He questioned 24 senior administrators of well-known hospitals. Most had 'drifted' into the profession and realized that their management background was deficient. Although all regarded practical hospital involvement as essential, apprenticeships were recognized as deficient, being uneven in quality and time wasting.

Davis proposed a two year graduate course in hospital administration:

Year 1	Year II
Accounting	Practical Work
Statistics	Seminar
Organization and Method	Business Policy
Economics/Social Science	Public Health Law
History/Status of Hospitals	
Seminar and Practice	

In the first year, the work load would be eighteen hours weekly plus private studies; in the second, twenty hours practicum plus five hours classes.

By 1934 Davis had established a graduate course

at Chicago University, the oldest degree program, and one which has awarded 432 M.H.A. degrees through 1974. Slow developments led to Northwestern University M.H.A. degree (1943); Columbia (1945), Minnesota (1946) and the first in Canada - Diploma, School of Hygiene, of the University of Toronto (1947).

Attempts at an educational philosophy were made in the Prall Report (Joint Commission on Education, 1948), and in the Olsen Report (Commission on University Education in Hospital Administration, 1954). Both Commissions and universities directed their attention to hospital management, and all programs contained a full residency year. However, increasing dissatisfaction by faculty and students led to the reduction of this latter requirement, giving place to increased on-campus courses.

The baccalaureate degree

Undergraduate programs began in 1966, and by 1976 there were 60 in the U.S. and one - at Lakehead University - in Canada. In 1978 a further 70 are being planned.

Analysis by the Dixon Commission showed the 'typical' degree structure:

Health Management:	required courses	17%
:	electives	7
Directly related areas:	required courses	22
:	electives	8
General education:	required courses	31
:	electives	15

An example of this liberal arts approach, is the Concordia

University B.A. in Business Administration. Following two years of liberal arts (50 percent) six courses in economics and business management are taken, together with two in hospital administration. A summer residency is also required.

St. Francis College, Brooklyn also has a strong liberal arts bias: 33 percent of credits. These include philosophy, fine arts, English, Sociology and public speaking. Thirty of the 126 credits concern health administration, including institutional management, community relations, geriatric care and legal aspects. Management courses include accounting, data processing, statistics, behavioural science, personnel management plus electives.

An interesting degree is that offered by the University of New South Wales, Australia: the Bachelor of Health Administration. It is one of the few first degrees whose objective is senior management:

> People working with Australian health services who expect to fill senior administrative positions in this field. In the future it is likely that the degree will be regarded as the basic qualification required for positions such as those of chief executive officer or manager of medium and large sized hospitals, and for other senior administrative and planning positions within the health services.

The program is based upon three years full time, or six years correspondence course studies. The latter includes an annual residency of one week in Sydney, Melbourne or Perth. Subjects are heavily professional/management biased, broadly

focussed on health rather than hospital management.

Another interesting offering is that of North Dakota State University. Students in the College of Arts, Humanities and Social Sciences have the option to take a minor concentration in Health Services Management, whatever major they are taking, and without extending the time required for the degree. For this option the courses are: personnel, finance, principles of management, health services management, medical sociology and field experience. A wide range of options is available. A residency is required following the junior year.

Sangamon State University is located in Springfield, the capital of Illinois. The B.A. degree in Health Services Administration incorporates courses in public affairs, and is also heavily biased towards generic studies in management (53 percent of hours). These include foundations of management; systems, mathematics, and administrative uses of accountancy. The health management component (20 percent) comprises health systems in society, the U.S. health system and an elective. The University requires a 'public affairs colloquium' plus experiential learning (residency).

The master's degree

Common designations are M.P.H., M.S., M.B.A., and M.H.A. - the latter mostly awarded by Canadian universities. Business Schools are increasingly involved in health management education. Some faculty are slighted by the

attitude of other professors that the discipline is unacademic and technology oriented. However, the educationalist and philosopher Alfred North Whitehead (1927:137-138) pointed out that:

> the novelty of the business school must not be exaggerated. At no time has the University been restricted to pure abstract learning. The University of Salerno, in Italy, the earliest of the European universities, was devoted to medicine. At Cambridge in 1316 a college was founded for the special purpose of providing 'clerks for the King's service'.

A major challenge to students is the thesis requirement, although its rationale is seldom discussed. In Canada half the programs require it, although only in one-third of U.S. schools is it mandatory.

Advice is offered by the University of Alberta which recommends the thesis route for students who have a primary interest in acquiring research skills, and learning how to apply them to problems associated with optimization of the effectiveness of health care delivery. The non-thesis option is for those who choose to emphasize skills related to the administration and management of personal service agencies in the health and welfare fields.

Common study areas in master's degree programs are:

> theory of administration and organization
> organization of medical care
> data processing
> health economics
> hospital administration
> financial management and
> health planning.

The emphasis placed upon baccalaureate liberal studies is absent at this level.

The most popular 'track' in the graduate degree is hospital administration. Rather less common are specializations in public health management; ambulatory care; mental health and long term care. Some universities provide opportunities for functional specialization, such as planning, systems analysis; finance; policy, and personnel administration. There is strong debate as to the benefits of special area studies, and Meilicke (1977:6) of the University of Alberta, believed that:

> the old dilemma about whether the graduate program should produce generalists or specialists can be solved . . . in two ways. The assignments, projects and field experiences for any given student in any given course can be tailored to either specialized or to generalized interests and a modicum of specialized coursework, and the residence practicum, can be focused upon specific interests. In addition, through options and electives, including a non-thesis option, a wide range of interests can be catered to, including not only specialized administrative interests but research and planning as well.

The Joint Committee of the Medical Group Management Association and American College of Clinic Managers favour the 'core' approach, avoiding specialization. Rapid changes in health care systems demand managers who have basic ideas and can accomodate change. Again, planners may be unable to achieve a balance between supply and demand, should excessive specialization be introduced, and students whose specialty

becomes less demanded will suffer from loss of employment mobility and opportunity.

Due to the vast extent of manpower demand, however, viable specialist programs have been created. One is that of Xavier University, in Cincinnati, which offers a degree in Management Engineering. Its objectives are to prepare quantitatively oriented health care executives, who can analyze demands for health care; determine appropriate allocation of scarce resources; improve organizational performance, and evaluate the impact of services rendered upon the health status of the community.

The first year offers a broad selection of courses in management, analysis, hospital organization, finance, medical trends and medical care organization. Following a three month field placement, the second year, of 24 credit hours consists of Health Information Systems (6), Operations Research (6), Applied Research (6) and three days weekly in a health institution.

The Master's program at Northwestern University, Illinois, was founded in 1943 by Dr. Malcolm T. MacEachern, the 'father' of hospital administration. The three stages recognized by the Graduate School of Management are first, a nine course core and electives in a rigorous two-year academic program. The core comprises basic health care administration, policy and planning, with electives in broad management subjects; second, a two-pronged field experience of a three month residency and field study; third, placement in

strategic and responsible health services position.

A new degree of the Nuffield Centre for Health Service Studies, University of Leeds, commencing in 1977, is the M.A. in Health Service Studies, referred to above, This is intended for experienced health services workers in Britain or overseas, with a high level bachelor's degree. Two main areas of concentration are offered, for both of which written examinations and a dissertation are required. (a) Health Services Administration involves study of social policy; Health and Disease; Administration, an elective (eg. sociology of health, industrial relations); (b) the Health Planning option involves theory and practice of health planning in place of administration.

Another specialist Master's course is that given by the Center For Studies in Aging, of North Texas State University, Denton. The course is intended for those wishing to become assistant administrators of retirement facilities and multi-purpose homes for the aged, and to participate in the planning, coordination and administration of public and private programs in aging. The 42 credit hours include six hours of problems, in lieu of a thesis and internship; 15 hours in psychology and sociology of aging and community, and management courses; and seminars on the administration of retirement facilities.

In Canada, five graduate courses are available. The two-year M.H.A. course of the University of Ottawa was introduced in 1964. 68 credit hours form the degree, of

which 46 are required: administration, accountancy, law, health management, statistics, health systems, finance and economics. A course in research design leads into a major research project in the second year. Options are structured (ie. from a given list) plus 18 credit hours from a list of free options.

Between years a residency of 3½ months is required. Admissions are stringently regulated, with 25 carefully selected students in each of the two years. Advanced standing is given for courses previously taken, and options replace these.

The Diploma in Hospital Administration was introduced by the University of Toronto in 1947, and had graduated 300 students by 1974. The D.H.A. required that a period of twelve months be spent as resident in hospital administration in a hospital selected by the academic authority and located in or near Toronto. However, recent modifications allow for a period of up to six months of the residency away from the hospital - in long term care institutions or a Ministry department, for example. This writer was informed, however, that most students prefer the facilities and discipline of the internal hospital residency.

Lengthy planning culminated in a new Master of Health Sciences degree, begun in 1978 and offered by the School of Graduate Studies. Ten full courses are required, including Community Health Care and an approved project or field practicum. Advanced standing may be granted to a

maximum of three full courses, based on the merit of graduate or equivalent work. Emphasis is still placed upon basic methods used in community health, with a 'common core' course offered each term. Basic theory is introduced at an early stage, and it is a principle of the organizers that as much elective time be allowed as is feasible. A recommended pattern of courses would be:

Community health core: individual and community health; Canadian health system; issues in community health (1.5 credits)

Specialty core: health appraisal methods, theory of administration; economic problems; financial analysis; public administration; health law (3.5 credits)

Practicum and seminar (2.5 credits)

Electives (2.5 credits)

The Master of Health Services Administration (MHSA), was introduced at the University of Alberta in 1968 in the Faculty of Graduate Studies and Research. Two years of study are required for the MHSA:

1) qualifying year - 15 hours of classes weekly, including health systems and agencies, epidemiology, accountancy, health economics, statistics, problems and issues in health and welfare delivery. A series of guided electives is given, allowing some area concentration: hospital, medical care, social welfare and nursing service administration;
2) the summer is spent on a four month practicum;

3) the candidacy year allows choice of thesis or non-thesis routes. The former involves 6 to 9 hours of classes; the latter 12 or more; based upon seminars, and courses in statistics, finance, planning and economics.

The University reported that the 13 students admitted in 1975 held degrees from seven Universities. These ranged in level from B.A. through to Ph.D.

In 1956 the M.H.A. was established as a French language program in the Université of Montréal. The first year develops the basic science of administration, together with theories and methods: statistics, finance, psychology, marketing, managerial accounting, industrial relations, organizational theory. A one-week intensive course is provided in group dynamics, and computer programming laboratories are given.

A residency is required of four months in a hospital, health institution or related agency.

In the second year students take research methodology, communications and parliamentary procedures and health services organization; options include health planning, medical care management, human relations, law and economics.

By 1974, 180 students had graduated.

In September 1978 the title was changed to Master of Science in Health Services Administration. Also announced at that time was the introduction of the first Ph.D. program in Canada in community health, with health administration as an optional track. Two students are (1978) registered.

The M.Sc. in health services planning, introduced by the University of British Columbia in 1972, is inter-disciplinary and is aimed at the older student who has graduated in commerce, a health or social science or one of the life sciences.

Prerequisite courses include statistics, introduction to clinical medicine, administrative behaviour or sociology, and micro-economics. Core courses are in epidemology, organizational behaviour, health economics, policy, health services institutions, and research methods. A wide range of electives is provided to encourage any interest - primary health care, hospital management or social medicine, for example.

In terms of registrations, all Canadian graduate programs are small, as indicated by Table 5.

TABLE 5

GRADUATE PROGRAMS IN HEALTH SERVICES ADMINISTRATION GRADUATES TO JUNE 1977: CANADA

University of Toronto	324
Montréal	195
Ottawa	144
Alberta	62
British Columbia	8
	733

Source: Kellogg Foundation (1978:8)

Examination of calendars and announcements of graduate and baccalaureate degrees, emphasizes the wide diversity of goals and objectives; academic requirements; curriculum content; location of departments within faculties; width of offerings and electives; policies concerning thesis, and employment objectives. A matter of particular importance, relevant to the problems defined in this thesis, concerns the practicum - the opportunity for newcomers and experts to meet.

The administrative residency

Several colleges have commented upon their residencies. Ferris State College wrote:

> An on-the-job experience is provided in selected institutions or agencies related to the student's interest. He obtains first hand knowledge of the operational world of work by devoting full-time effort to observing and participating in the management function. Depending upon background and interest, the internship may either be in one department or rotational. Routine written reports are required and a management project. Faculty direction is provided by telephone and on-site visits.

Many institutions have follow-up courses, as does Ferris. When the student returns to campus, individual meetings take place with faculty, and group sessions with fellow students. Internship projects are reported, and presented to junior level students.

North Dakota State University regards residency as

an opportunity for the student to "make judgments regarding his personal professional future in health care administration." The university recommends to employers that a combination of departmental rotation, and project assignments be used. It is anticipated that the student will be encouraged to participate in actual trustee meetings; to attend medical staff meetings, and to participate generally as a member of the administrative team. Much will depend upon the calibre of the student:

> While contact with a health care facility and an experienced administrator is provided, the burden of personal and professional development falls mainly on the student. Preceptors who develop a confidence in the student's maturity of judgment and administrative capabilities may choose to assign the student to specific tasks which will provide actual administrative responsibility and limited authority.

The Dixon Commission investigated the length of residency requirement and discovered that 22 percent were still of one year duration (U.S.) and two programs in Canada required 9 to 12 months. However, 53% (U.S.) and 60 percent (Canadian) were of six months or less duration. Pressure by academics to increase the teaching content will probably favour the shorter period in future.

Writers have investigated the qualities of practicum experience. The Center for Research in Ambulatory Health Care Administration, Denver, wrote in 1977:

> This type of direct, experiential learning is felt to be important because of the

> dynamics of interpersonal relationships between physicians, other staff, and patients, and also because of the operational and administrative problems specific to group practice . . . with today's emphasis on ambulatory care in general, and group practice in particular, it is evident that more group practice administrative residences are needed.

Vargas (1962:733) listed four important practical objectives, attained particularly if an efficient initial orientation period is given:

> development of initiative, group direction, joint work and ability to take, at the right time a managing position;
> development of ability as director, rather than as department head;
> assimilation of knowledge taught by the preceptors and of hospital administration philosophy; and,
> attainment of hospital experience through performance of assignments in various departments of the organization.

He believed that: "the preceptors need to understand the objectives of the residency, which should not be used to fill gaps in executive personnel, for instance".

Both clinical experience and daily contact with working situations are required. It is debated by academics, how lengthy a period will suffice, since there are increasing pressures upon them to provide theoretical concepts in classroom settings.

Schneeweiss, Gordon and Cohen (1973) in their lively review of experiences with the Ithaca College program, discussed pros and cons of internship. One career aspect which has arisen affecting baccalaureate students is that:

"they return from their internship saying that they are afraid opportunities will be closed to them unless they have their Master's." Although Ithaca faculty believe that they are educating for intermediate level posts, they "inadvertently may be giving rise to a knowledge base which is more appropriate for persons placed higher in hospitals . the job market might also be a contributing factor to the desire for graduate training".

Most Ithaca students have been placed in hospitals or nursing homes, mainly at student request. Payments were once common but rapidly declining; the estimate was in 1973 that none would be paid by 1975, since the efforts required to discover hospitals willing and able to contribute had become excessive.

The authors observed that: "internships are almost unanimously rated the high point of a student's academic career. Most students are remarkably transformed by this exposure to competent professionals, particularly to their preceptors . . . after a taste of the 'real-world' in the health field, they come back dedicated to the idea of pursuing a career in health and hospital administration". However, the writers are considering a preintern 'clerkship' to prepare unsophisticated students to face the daily turmoil more effectively.

A new approach is being applied by Duke University (1977): a post-graduation training. Assignments are developed jointly by students and faculty to complement the career

objectives of the former. Objectives are stated as being: "to assist with the socialization process into the profession, to promote the development of sound judgement, and to serve as a bridge between the academic content of the program and the real world of the practitioner."

Employment following graduation

Much has been written concerning employment of students following professional and academic programs. Many manpower studies have been published dealing with anticipated future needs of graduates. This section deals with explicit evidence and statements from experienced writers, and from calendars; these will suffice to provide evidence of employment opportunities anticipated by planners.

A contributor to the report of the Commission on Education for Health Administration (1977:44-45), L.A. Hill acknowledged that the student has a greater interest than his instructors. The latter are concerned with long-term changes and trends; the former ponders whether he should work in a hospital, and if so, which kind.

Most graduates seem to have obtained their desired positions in health administration. Raffel (1977:24-35) reported on known employment of 199 graduates from the Pennsylvania State program in Health Planning and Administration (baccalaureate degree): 144 students had jobs or were engaged in further studies. The majority were in hospitals, planning agencies, environmental health offices,

nursing homes and health departments. Of the 24 who continued to further studies 7 were in medical school, 8 in a graduate health administration degree, and 3 in a nursing degree. Others were in dentistry, teaching, business and engineering. In an earlier study, Raffel had written that "an increasing number of agencies are taking practicum students term after term, presumably based in part on overall satisfaction with previous student performance." A survey by Gordon (1975) of 41 baccalaureate programs, identified and classified their objectives as to employment of graduates. Some were vague, such as "for positions in the health field"; many intended their students to enter middle management, and a substantial number (13) had as their objectives "to assist when applying for admission to graduate school." Gordon emphasized that: "there is little guidance as to the anticipated end product . . most programs are not sure themselves what they are striving for". She continued that:

> A potential barrier to the maximum utilization of undergraduate health administration, is the degree to which employers are willing to accept the baccalaureate degree in lieu of the graduate degree. At one extreme the undergraduate administrator could be perceived as an individual with training equal to that of a graduate student who might take over a top administrative position. Tacked onto this perception may be a cheaper price tag. At the other extreme, the undergraduate could be perceived as inadequately trained with a superficial knowledge of health, which would make him more trouble than he is worth.

A contributor to the Commission on Education for

Health Administration (op.cit.:62-63), H.J. Cohen, strongly attacked the lack of knowledge on the part of educators of careers now followed by baccalaureate graduates. Although more than one thousand had graduated, and in spite of the work of Raffel and Gordon, "shockingly elementary questions remain unanswered. Who is the average baccalaureate level trained administrator? Where is he working? What is he doing and how well did his academic training prepare him for his current position? Will he be ready to assume more responsibility without further education?". The feasibility of establishing a central register does not seem to have been explored.

Many colleges are optimistic concerning demand for their graduates. Utica State College holds that dynamic and challenging careers are available, based upon new concepts in health delivery systems, together with the impact of current and proposed health care legislation. The federal law that legislated the Health Systems Agency Program, should create an entirely new functional job market for persons possessing a baccalaureate degree in a health related profession. The prospect of a National Health Insurance program will create a demand for administrative positions at the middle management level.

At the level of higher degrees, the University of Iowa undertook a study of 344 M.A. and 55 Ph.D. graduates. Of the M.A. alumni, 56 percent were working in community hospitals and 11 percent in teaching hospitals. The

proportion in federal and state health organizations was 16 percent; 9 percent in clinics; 2 percent were teachers and 3 percent were engaged on advanced academic studies.

Of the Ph.D graduates, only 18 percent were in health care management. Two thirds were employed in education (including educational administration): another 13 percent worked in research or research management.

In Canada there has been no controversy concerning the appropriate employment levels of graduates, since the number of baccalaureate holders is very small to the present. Dalston (op.cit.:207) was concerned about the high cost of education at master's level (he estimated that a graduate would cost up to $30,000). He enjoys a low faculty-student ratio, an extensive library and carefully organized field placements. Baccalaureate courses may be less expensive, but the objective of the end product may be the same level of executive management. However, some educational experts urge that undergraduate programs should educate their students for positions which are supportive of professional administrators holding a master's degree. This point is made by Singleton, Weston and Slater (1977:7):

> Many health professionals consider health care to be the most complex, labour intensive, and radically changing industry . . .. Faced with increasing complexity, community pressure for accountability, and meeting human needs in health, administrators of small, medium and large hospitals alike recognize the necessity to have more highly trained and skilled middle management personnel to assist them in meeting their administrative responsibility.

Moyerman (1975:7) foresaw the permanent levelling off in demand from hospitals, and felt that graduates would need to seek positions in other health related fields, or accept jobs at lower administrative levels within hospitals: "potential employment opportunities are apparent in nursing homes, mental health, ambulatory care and voluntary health agencies; these are major sectors of the industry which currently attract relatively few professionally trained administrators."

Canadian programs: 1979

One established undergraduate degree is in operation, at Lakehead University, offering a full major in health administration; another major commenced in fall 1978 at York University. At Montréal a specialized certificate course may be combined with others for advanced standing toward a degree. For middle and senior level administrators, the only non-campus, non-degree course is that of the Canadian Hospital Association. Its correspondence program: Hospital Organization and Management, has been in existence for 26 years.

The Master's degree programs have been described. Each is small in terms of registration; competition for admission is keen, and there is to date no evidence of unemployment among its graduates. However, attendance implies two years away from paid employment - a discouraging factor for those who cannot obtain paid leave of absence.

As in the U.S., there is a large unmet need for middle managers whose education will serve to assist them in meeting the major challenges of change in the 1980's and beyond. The Bachelor of Administration degree of Lakehead University was designed to satisfy at least some unmet needs, albeit for a small number of participants. It consists ofathree-year full-time program of fifteen credit courses. Ten courses are taken within a general management "core", and five selected in the health administration "major".

The core subjects comprise:

Principles of Administration - broad introduction to management using a systems approach; includes elements of decision-making and the role of the administrator.

Basic Economics - elements of micro- and macro-economics.

Introductory Accounting - for both service and commercially oriented organizations.

Data Processing - to help students become knowledgeable users of the computer resource, with business and general applications. The university has powerful equipment and supports batch and interactive systems.

Decision Making Techniques - use of quantitative methods for decision making, using the computer as a tool, and emphasizing interpretation of results.

Operations Management - production management problems and tools of operations research. No attempt is made to slant this course towards a particular industry.

Human Resource Administration - behavioural aspects of management, leadership and use of human resources.
Financial Analysis - a problem-solving approach, stressing the realities of the Canadian financial environment.
Marketing Management - to create an awareness of the system which matches products and services with consumer needs.
Accounting: non-profit organizations - for government and non-profit institutions, with emphasis on budgeting, fiscal processes and financial record interpretation.
Canadian Economic Problems - with a critical review of proposed solutions.
Administrative Policy - a comprehensive interpretation of policy formulation; problem-solving and the adaptation to environmental realities.

To the above core are added courses in elements of English composition, and Report Writing as required. Students also choose one course at first year level in Sociology or Psychology.

The degree is made up of four "majors": accounting; personnel administration; marketing and health services administration. The health majoring student meets students with diverse interests in each of the above core courses.

The major commences in the second year, the student taking: Canadian Health Care Organization and Canadian Hospital Administration. These elementary level courses are given to ensure that every student has the opportunity to understand the basic elements of the system. Many

students have had experience in the system (nursing, laboratory and other occupations) and these enable informed and useful discussions to take place. The courses are frequently addressed by speakers from the local or national health community.

In the third (final) year, required courses are:

Legal Aspects of Health Care - to give an appreciation of the legislation which affects all health service managers: presented by an experienced local administrator.

Health Planning and Evaluation - a seminar course considering future needs and developments in health systems, both short and long term.

Advanced Hospital Administration - selected topics of interest to institutional administrators.

To complete the required component, a major research project is undertaken: Independent Research, whose topic is selected according to the experience and interests of the student.

A list of electives is presented, consisting of courses offered in the Schools of Business, Nursing, Physical & Health Education, and in the departments of Psychology, Social Work and Sociology. Courses available in 1978 included:

Materials Management - dynamic aspects of the purchasing function.

Systems and Computers - there is not a strong emphasis on data processing, but in the third year students have the

option of selecting any course in this area for which prerequisites are satisfied.

Physical and Health Education - Community Health

Nursing - Practice in Nursing Administration

Sociology - Sociology of Medicine

The objectives of the designers of the degree were, basically, to give administrators an opportunity to obtain a degree designed to 'specifications' resulting from the work of investigators mentioned in earlier chapters of this thesis; and to supply health institutions with well educated middle managers, who can fit into the changing structure of the health services.

The School of Business Administration has adopted the policy of granting advanced standing to graduates of acceptable programs: business diplomas of community colleges; baccalaureate degrees in other disciplines, and management qualifications in (for example) accountancy. Thus, it is possible to graduate within two years of admission.

There has been some lack of interest on the part of local health institutions, although courses are offered in the evenings on a rotating basis. Since there are three general hospitals; a District Health Council; many group medical practices, and a District Health Unit, there is no satisfactory reason for this coolness. Attempts are being made to strengthen contacts, and meanwhile courses are running with satisfactory registrations from full-time

health majors, nursing and other students.

Given restricted resources, the degree has attracted some attention, with students registering from other provinces as well as Ontario. However, due to its small size, it cannot be said to be a major component of health administration education in Canada; the greater part of previously unmet needs are still not met.

Summary

A wide range of degree programs is available in the U.S.A. at associate, baccalaureate and master's degree level. Emphases include general health administration, long term care, group practice management and specific functional areas. Growth in registration has been substantial during the past decade; to the present, job opportunities seem to be adequate and satisfactory. Educators recognize the probable extent and direction both of growth and decline, and will probably be in a position to ensure that courses are suitably modified to accomodate these changes. Confusion is, however, very prevalent among colleges as to the level of employment to which their graduates are directed; some have de-emphasized employment objectives entirely.

Pattullo (1978:26) identified some likely circumstances affecting education, some of which are relevant to the thesis. These include:

1) debate about recertification of administrator competency. There is at present no certification of health service managers, but opinions expressed by those concerned with standards of performance might encourage professional societies to plan for a certification program;

2) effective articulation of undergraduate and graduate programs, which is non-existent at present;

3) elimination or improvement of some undergraduate programs which are of suspect quality. Membership in the Association of University Programs in Health Administration, is some guarantee of standards; and

4) attempts to bridge the gap between theory and practice, by closer interaction between faculties and managers.

This thesis is directed at the Canadian situation. All programs were at Master's level until 1975. These have been examined, compared and contrasted with selected U.S. degree programs. It has been shown that wide ranging changes in patterns of health services will be experienced in the coming decade, and needs for education in the 'new' health administration must be identified, evaluated and satisfactorily met. Using available published materials, and the researcher's own experience and knowledge, the following chapter compares needs which seem presently to be met, with those that seem to be unmet and should be satisfied. Suggestions are then made as to how these gaps might be filled, including descriptions of recently introduced programs whose impact has yet to be felt.

CHAPTER FOUR

EVALUATION OF MET AND UNMET NEEDS

Sources of demand for education

The extent and nature of anticipated changes in health services, and management of their institutions have been examined earlier in this study. A critical message was delivered by Senator Kennedy (1971:39), which gave impetus to efforts to improve all aspects of health services administration: "the system is riddled with waste, and inefficiency, grossly uneven quality, highly inflated costs, and severe shortages of medical manpower."

Our capacity to plan, organize, finance and deliver medical care has developed more slowly than the body of scientific medical knowledge. We have a well developed technological base, but health service systems that are unable to cope with changing and expanding community health care needs. We require administrators who can function at both the operating level and at the policy-making level, acting as architects for community health care programs. It is then the responsibility of educationalists to determine the most appropriate pattern of institution-based programs which, together with off-campus and continuing education courses,

will best meet the identified needs in the future. This section of the thesis attempts to specify the extent of unmet needs.

Dressel (1964:26) defined 'need' as "a discrepancy between the characteristics which students presently have, and the characteristics which it is judged they ought to have." He recognized that educational objectives may be derived from the needs of students, the needs of society and from authoritative statements of the purposes of education, which match previously unperceived needs.

Due to rapid expansion of populations in Europe and North America; movements into urban dense conglomerates; rising standards of living with even greater rises in expectations, and identification of diseases and ill health at a greater rate than heretofore, the health services have had no opportunity to develop a logical, sound structure. Massive investment has been undertaken within hospitals and other health institutions, but with a corresponding neglect of satisfactory health maintenance and primary health care. The former Minister of Health for Ontario, F.S. Miller, said in 1974: "We think it necessary to find a new, comprehensive health care planning base - not a series of fragmented plans relating to the need or concerns of one group of facilities, or one group of individuals . . . but, instead, one comprehensive plan based on the real needs of the total population of each geographic area." The health administration education system has patterned itself upon this

fragmentation, and is now seeking a new structure.

It may not be expedient to follow the patterns of other major health services. Despite thirty years of national health services in Britain, the major organizational revision introduced in 1974 appears to have failed to improve the level of efficiency. In fact, more problems are arising due to over-elaboration of consultative machinery, inability to get decision-making completed nearer the point of delivery of services, and what some contributors to U.K. professional journals have described as unacceptably wasteful use of manpower resources.

It seems relevant to an understanding of unmet needs, to pursue comments on obstacles to efficiency in health services. The Business Graduates Association, London (1975:2-3) highlighted these areas:

a) organizational complexity caused by advances in medical skills, with increased burdens upon facilities, equipment and staff. Poor conditions have, in turn, deterred qualified managers from entering the profession;

b) problems caused by the unwillingness of medical staffs to assume managerial roles which they fail to perceive as legitimate duties;

c) imprecise relationships between inputs and outputs, rendering development of systems and a data base impossible. There is a lack of quantitative information concerning demographic trends,

> health status indicators and epidemiology statistics, as examples. Thus, disclosures in April 1978 by the Thunder Bay District Health Council - in Panorama of Mortality caused strong responses. Although matters discussed in the report - alcoholism, deaths from highway accidents and heart problems due to poor life-styles - have been serious concerns for decades, there has been a lack of knowledge of their extent.

It is accepted by many writers that senior managers require special forms of education to prepare them for roles in public service. Individuals who are responsible for modern dynamic health services need skills and management approaches of a high level of sophistication. This is true no matter what previous training they may have received in medicine, nursing or health technology. Oscar Wilde wrote that "experience is the name everyone gives to their mistakes"; experience is too slow an educator to meet modern needs. Mondragon, in the Dixon Report (op. cit.:II, 185) stressed that:

> the American health care non-system, and the educational community which prepares its administrators, must undergo a complete reorientation. There must be correlation and communication between the health care hierarchy (students, educators and practitioners) and the community (individual patients, government, third party payers, employees and society). The needs and values of society must be reflected in the

> practices and values of those who would serve that society.

The need for a values-oriented education is of concern to thinking educationalists. Etzioni, also writing in the Dixon Report (op.cit.:II, 21) desired that every educational program should insist that a strong "normative background of health administration" be developed. Health management trainees should be aware of the benefits and drawbacks of passive versus active administration. Etzioni referred to the U.S. Bill 5954 designed to amend the Public Health Service Act to provide: "in the training of health professionals, for an increasing emphasis on the ethical, social, legal and moral implications of advances in biomedical research and technology." It may be that medical students are being exposed to this emphasis. The furious recent debates concerning laboratory experiments in recumbent DNA and genetics engineering, which erupted in public meetings in Boston, should - by this token - be part of the values education of the modern health administrator. This researcher cannot reconcile these demands with the most basic needs for simple management skills evidenced by earlier statements; there are major needs yet to be met. Indeed, there is no agreement whatever on the meaning of 'normative' in this context; it is evident from discussions in universities that strong divergencies of opinion exist. The probability that no normative level has yet been attained may be inferred from a statement by the Director of Columbia

University School of Public Health, Dr. Bryant: "there has been a failure of high quality care to trickle down to the entire population. Many people have only limited access to quality care, and some are excluded from any care at all."

Educational imperatives for need satisfaction

In a manpower study for the Canadian government, McLeish and Nightingale (op.cit.) investigated the qualities most likely to be of value to enable the health delivery executive to cope with modern demands and stress: a grasp of team work and group behaviour; insight into financial management; ability to cope under conditions of continuing change; and avoidance of undue stress. Some of those qualities would be enhanced by efficient curriculum design. It will be a measure of the skill of the educator to succeed in meeting the demand for satisfactory programs of study directed at these rather nebulous but critical matters.

McLeish et al. discovered that many respondents to the manpower survey felt that Canadian university health management programs were not currently geared to meet the demand. Sangamon State University faculty (op.cit.) recognized however, that all changes do not move in a coordinated manner: "a new program cannot be too 'new', or the risk of total rejection is increased. In the health field . . . educators must be increasingly aware of the growing influence of new voices helping to shape goals and policy-making decisions. It is stressed that educators

should keep current relationships with relevant social sectors, and maintain 'a posture of flexibility and adaptability'."

Educational planners are under pressure to provide 'relevant' courses, particularly those dealing with management skills that can be applied on the job. In response, some educators regard critical thinking and appreciation of the ethical and moral responsibilities of managers as being of crucial importance. Bellin (op.cit. 1972:36) wrote that the educated health administrator is one who has received a fine academic training but who has also served "seasons in the administrative trenches". He stressed that scholars must relate closely to real-life situations and pattern upon appropriate human models "upon whose operative templates the students may consider moulding their own careers with appropriate modifications." The problem remains that of identifying the appropriate human model. Should he or she be a conservative, entrenched hospital administrator with belief in firm, hierarchial control, or a young, dynamic operator of a neighbourhood health centre, more attuned to reading "China Reconstructs" than the "Harvard Business Review"?

In the words of the Dixon Commission (op.cit. I:19):

> Health and medical care in the United States has been characterized by pluralism, fragmentation and lack of coordination. Now, trends are in motion towards higher levels of organization (systems) and more collective financing (national health insurance). Community-wide integration of health and

> medical care activities is being attempted through comprehensive health planning and related activities, so that locations of physicians practices, construction of new hospitals and the illness experience of minority groups may be viewed and approached as interrelated phenomena.

Courses should be provided which are related to State and district planning, regulation and organization, involving all types of health and medical care institutions, agencies and programs; they should consider preparation of administrators for their participation in the establishment of social policies, having as long range objectives clear statements of goals and priorities for action at national, state and local levels.

It may be that short courses, and multi-professional seminars would assist, by supplementing the individual-oriented degree programs. The Personnel Management Report of the British Health Service (Department of Health and Social Security) recommended that "staff who manage together should develop and learn to apply their management skills together, whenever their training needs are compatible." Although joint training by universities and the health authority may be more easily provided by the centralized health service of the United Kingdom than within the more diversified and scattered provincial systems of Canada, it is foreseen that more cooperation will develop between the provinces and universities. Growth of district health councils will serve to encourage coordinated health planning, leading in turn to development of common purposes and

identification of common management needs. Again, provincial health organizations such as the Ontario Hospital Association could liaise with the nationally oriented Canadian College of Health Service Executives. This might be a desirable example to health institutions of the new concept of consensus decision-making by influence and negotiation.

One aspect of cooperation that will prove beneficial to educators, is the provision of teaching materials, bibliographies and references being published at present by the Canadian College of Health Service Executives. Using the expertise of Dr. Meilicke of the University of Alberta and others, elaborate joint teaching aids are being issued.

Lifelong learning and continuing education

This research is concerned mainly with on-campus, formal education. It must be recognized however that a serious need exists for adequate provision of life-long learning facilities. The University of New Hampshire (1977:1) stressed that:

> A baccalaureate degree is a beginning rather than a terminal point in your educational experience. A commitment to life-long learning is necessary for effective health administration and planning. On the job experience and continuing education through workshops and seminars are important. Some professionals will also want to improve their knowledge and skills through graduate studies. Those health administrators and planners who actively participate in life-long learning will have many career opportunities available to them in leadership roles that require high levels of responsibility and authority.

The Kellogg Commission Summary Report on Education for Health Administration (1974) placed strong emphasis on learning opportunities for the practising hospital administrator - this was recognized by them as an important unmet need.

As pressures mount for evidence of management expertise, so will hospital administrators seek opportunities for professional development. The University of Minnesota has established an Independent Study Program to help those who cannot pursue full time, on-campus studies. They use concentrated on-campus sessions, discussion groups and independent home study. Success in these courses brings credit toward requirements for the master's degree. In July 1974, the University of Cincinnati developed an external master's degree in health planning/administration. Both campus and off-campus students use the same faculty, satisfy the same degree requirements, and work towards the same objectives. Learning is based upon the concept of individualized, self-paced, student-directed efforts, designed for persons already employed in the community health system. Many students had degrees in medicine or dentistry, several had master's and doctoral degrees, and the consensus is that this joint education opportunity meets urgent needs.

Widening the horizon, the Dixon Commission stressed the need for a national, non-governmental program for life-long learning and non-traditional study, comprising non-resident external degrees, inservice training, reciprocal

credit granting, and national programs of certification. Many models exist of these, in particular the external degree which is expanding into the U.S.A. The progenitor of this was London University, England, offering degrees from baccalaureate to doctorate in every discipline except medicine.

The problem of granting credit for previous education and experience is of interest to many educators. Kirkwood (1976:149-150) wrote that:

> many purists bristle at the suggestion of granting credit for anything learned outside the hallowed halls of ivy-covered buildings, despite the fact that field-trips, foreign study, internships, practicums, practice teaching . . . are well - and in many cases long-established features of many degree programs. But if one labels such attempts experiential education, and if one seeks to expand their dimensions to include similar off-campus learning prior to enrolment, then to some the very integrity of the academic degree is suddenly at stake . . .. When traditionalists argue that experiential education should be translatable in terms that place it on an exchangeable par with other forms of academic currency, their contention should be respected and the effort made.

Researchers who interview health service administrators are aware of their attitude, that knowledge is valid regardless of source, and that life experiences are as important a dimension of the measurement of the educated person, as are university credits. This writer believes that institutions should award credit in recognition of capabilities implied by valuable practical experiences, rather than crediting the

experiences themselves. Meyer (1976:11) stressed that organized evaluation should take place to ensure that prior learning is of an appropriate standard. Decisions must be made to determine what is to be credited, when the credit action is to be accomplished, and whether or not prior learning needs are to be related to future goals. Most faculty however, seem convinced that adult students do not perform as well as full-time younger students. "Ironically", noted Morris (1975:23), "these assumptions are expressed most often by those who have had very little contact with adult learners or who have not been able or willing to adapt to a different teaching approach. Instead, the tendency is to insist that part-time students and programs must change and conform to the 'standards' of the wonderful, more familiar world of full-time study . . .."

Credibility for the movement was gained by the action of the Kellogg Foundation, which established in 1975 'Centres for Advanced Study' and 'Nontraditional Education and Lifelong Learning'. These task forces were supported by substantial awards, and several institutions are now providing programs. Thus the Graduate School of Business at the University of Chicago is developing a master's program for experienced health executives who are not formally prepared but require part-time graduate education. Trinity University, Texas, has received an award for the establishment of a regional centre to provide lifelong learning opportunities and non-traditional education on an

individualized basis for administrators of long-term care, mental health and hospital institutions.

An illustration of a (non-Kellogg supported) credit awarding program is that of the Bachelor of Science in Health Care Administration, at Iona College, New York. Graduates are trained for middle management positions. Those with previous education and/or work experience in allied health occupations may receive credit, and EEG technicians, x-ray technologists, nurses and respiratory therapists are among those registered. The B.S. degree requires completion of 120 credits, 36 being in the major area. Up to 90 credits may be transferred from programs of other colleges; up to 40 of these can be obtained on the basis of an acceptable 'life experience' portfolio and transcript.

Generic and specialist approaches

Many writers recommend the generic approach as the means of meeting some educational needs. Meilicke (op.cit.:4) identified health as a component part of social services, giving "powerful academic reasons for an integrated and generic approach". Social services represent one system of similar and interrelated human needs as well as of common organizational inputs, processes, outputs and environments. Meilicke continued: "both class and field work exercises of human administration students should be designed around that generic set of fundamental concepts, problems and

techniques that are common to all social services needs and programs."

There would appear to be two alternative strategies. The one is the generic approach as discussed above. The other approach recognizes the strong movement toward specialization in management, reinforced by increased costs of providing general management education. Brown (op.cit.:11) wrote that:

> One can raise serious questions as to how much functional specialists need to know in general about the health field, in order effectively to carry out their function. The cost of formal education being what it is, it would seem best that he make his educational investment in the concepts of his specialty and depend upon experience to teach him his way in the health field.

Most authorities attempt to design programs for a combined approach. Berry (1976:2) listed those matters which must be included in elementary skills and competencies:

. the ability to describe, analyze and interpret the environment: social, economic, political, professional, technical and historical dimensions;

2. a study of the planning, financing, operating and regulation of health institutions;

3. problem solving approaches to the design and implementation of health programs;

4. coordination of health and social services;

and 5. introduction of specialization in one or more areas, through education in management of hospitals, long-term care institutions, mental health, insurance and other sectors.

The Dixon Commission recommended a balance between generic and specialist curriculum content. The two cores of health: disease on the one hand, and health care management on the other, forms one sector. The other is generic, namely the theory and skills of the administrator.

The syllabus would include a "mutually reinforcing combination of didactic work and experience, linked together by community service and applied research projects - involving students, faculty and practising administrators."

Cross-fertilization of ideas can be encouraged by "strong interdisciplinary relations between health educators and relevant academic disciplines in the parent institution", and also by the education of generalist health administrators in the use of specialists, such as accountants, engineers and financial experts.

Although the generic approach may economize upon teaching staffs, there is a danger that the broad, all-encompassing viewpoint may satisfy neither the students nor their future employers.

Met needs: general and specific

No educators would claim that their courses entirely meet their objectives; it is instuctive to examine the views and opinions of those who do believe that satisfactory progress toward implementation has been achieved.

Sangamon State University attempts to meet imperative needs caused by the enlargement of public involvement in the

health services system; it claims that the baccalaureate degree satisfies these needs through its assistance to middle managers. Graduates are intended to be able to function as supportive middle management, enabling senior administrators to carry out their functions more effectively. Degree holders understand the predominant characteristics of the American health services delivery system, particularly the interrelationships between the numerous provider organizations (including sources of finance), consumers and other interested groups. Graduates are able to assume functional responsibilities within all areas of the health service, without being restricted to one major area.

It is difficult to maintain that needs for graduates are not being met, when statistics are considered. In 1974 alone, 1005 master's degrees were granted in North America in health administration, 17 percent over the 1972 and 3.6 percent over the 1973 numbers. The educational system held 1240 U.S. and 66 Canadian first year, and 866 and 64 second year students - 3.8 percent higher than in 1973. Statistics indicate very narrow concentration of interests. 44 AUPHA member and associate member colleges offered master's degrees (U.S.), and graduates had concentrated as follows:

Health and Hospital Administration	1165	94%
Comprehensive Health Planning	35	2.8
Longterm Care Administration	18	1.45
Mental Health	7	0.60
Others: medical care, systems engineering, health records, personnel	12	0.96

Although students were located in many differing facilities, the great majority were directed towards acute care institutional management. Of the 44 members of AUPHA, 10 were Schools of Public Health, 10 graduate Schools of Management, 6 Schools of Medicine and 6 Faculties of Graduate Studies. Whether pressures of demand for administrators of other than hospitals will persuade these departments to broaden their scope, cannot yet be assessed.

However, Meilicke (op.cit.) is more supportive of the work of Canadian graduate programs:

> they have responded well in the last ten years to changing needs in the field, and to advances in teaching techniques and materials, by modifying their philosophies and objectives so as to emphasize health services administration more, while still retaining much of what was best in the traditional, vocationally-oriented, institutional management approach . . . the content and format of a graduate program reflecting the concept of human services administration does not require revolutionary changes in existing graduate programs.

Meilicke's credo is clear: that future challenges are to improve the academic and scholarly quality of the Canadian programs, while continuing to involve the practitioner in academic planning and in teaching - but in different ways from those of the past.

Growth of baccalaureate degrees has been very rapid. In 1976 there were programs in 32 U.S. states and in 2 Canadian cities. The majority are in the East, although California is the leading state (11) followed by Texas (7).

Singleton et al. (op.cit.:10) compared curriculum design resulting from their study with program brochures of 70 undergraduate health administration departments. There was little similarity, and differences were attributed to:

1. the department in which the program is located;
2. its status - own department, division or school;
3. its goals - specialist, or general education; and
4. the size and prestige of the university.

A descriptive overview and catalogue of university programs has been published by the Association of University Programs in Health Administration, entitled Health Services Administration Education 1979. It includes information on health services administration, full descriptions of all accredited programs and discussions on educational and career opportunities. Gordon (1977:40) commented on the need for the publication and remarked that:

> the variety of size, locations and institutional foci of baccalaureate health administration programs is indicative of the range and variation of offerings. Many have developed in relative isolation, unaware of the success and failures of programs whose experiences might be beneficial to them.

This is one of three A.U.P.H.A. publications issued in December 1978 of relevance to students of health administration education. The Task Force issued An Introduction to Baccalaureate Education for Health Administration, including an annotated select bibliography of papers and articles; and S.M. Gordon's Baccalaureate Health Administration: A Resource

Book is a comprehensive survey of all programs, with much career and placement material.

Generalizations that graduate or undergraduate programs are meeting identified needs cannot be proven except in individual, publicized cases. The following section describes specialized offerings which do meet needs, or are in active planning stages to do so.

Identified needs and specialized courses

There are few innovative specialist programs, although many degrees contain specific majors or electives. Four areas of interest are now described, with particular examples of each.

1. Long term care administration

Aging has come to be viewed as a social problem. Older people are more visible today because of their increasing numbers and greater life expectancy. Social scientists and medical experts are showing greater interest in all aspects of old age. One of a few educational institutions is the Center for Studies in Aging, in the School of Community Service at North Texas State University. The Center offers a master's degree, and has extension courses for continuing education. The objective is quite simply to prepare students to be assistant administrators of retirement facilities and multi-purpose homes for the aged; to participate in the planning, coordination and administration of public and private programs in aging.

A Canadian design, not yet in operation, is that produced by Dalston (op.cit.:209). He observed that "in spite of

the flurry of activity recently by universities and colleges, the main response of educational institutions to this challenge remains to be seen." Matters of particular moment which affect the willingness of educationalists to provide services, are questions of licensure of managers; the poor image of small and badly managed facilities, and the nature and extent of a practicum. Dalston's recommendations are for a degree at master's level, covering diseases relevant to long term care institutions; gerontology; community health and the functions of voluntary agencies, and an overview of economic and social aspects of Canadian life. He would design his programs so that graduates are able to move within the system, into other departments or agencies as required.

2. Hospital trustee education

Hospital governing boards are de jure in control of the institution, although daily responsibilities are delegated to the lay and medical administration. Waisberg (op.cit.:132) stated that "the hospital trustee role is a demanding one with heavy responsibilities. It is not an office that everyone is capable of filling adequately . . . competence is the most important criterion." Having investigated the complex problems of the Laurentian Hospital, Sudbury, he was moved to write: "Unhappily, there is no sure way of providing that persons who become trustees have the requisite talents. There is no 'hospital trustee admissions test'." Judge Waisberg followed his investigation into the affairs of the hospital with a recommendation that

all the trustees be dismissed. Two years later, following an investigation into the affairs of the Vancouver General Hospital, the British Columbia Minister of Health also dismissed the entire board of trustees at that hospital. These major incidents in 1976 and 1978 will certainly lead to consideration of educational programs affecting such boards.

Weeks and DeVries (1978:72) who listed and briefly described fifty programs organized by health service associations and universities, wrote that the objective is:

> to prepare board members for their expanding role and responsibility as trustees in today's changing political and social environment. This new role requires that trustees possess an understanding of certain aspects of medical law, approaches to the assessment of medical and hospital care, hospital licensing and accreditation, labor relations, and cost reimbursement to health facilities.

Most programs given are short courses. Home study courses are provided by the Trustee Education Program at the University of Minnesota. However, graduate schools - with few exceptions - have not involved themselves in trustee education. Weeks and DeVries (ibid.:90) comment that:

> Clearly, the service associations and societies have led the way . . . perhaps graduate programs should consider offering basic teaching skills to their students so that future health care managers feel comfortable with trustee education, have some understanding of adult learning methods, and can effectively coach other senior administrative officers as they relate to governing board members.

In Canada, the Canadian Hospital Association sponsors a five day continuing education session for trustees, medical directors and graduates of programs and courses in hospital administration.

An innovative non-degree program was introduced in 1975 by the British Columbia Health Association. Its acronym: GAMAT, representing Government personnel, Administration, Medical and Association personnel, and Trustees, advertises a program intended to develop and implement comprehensive educational activities for trustees at provincial level. The Association recognized that:

> Ultimately accountable, legally and morally for the operation of the institution - including standards of patient care, the Board assumes complete authority over, and responsibility for, the conduct of health care services.
>
> Recognizing that the informed trustee is a vital component of the health care delivery team, the B.C.H.A. pledges its resources to provide a comprehensive educational program for B.C.'s health care trustees.

3. Health institution financial management

A joint venture of the Kellogg Foundation and the Hospital Financial Management Association, courses have been introduced into syllabuses of four universities. Using a common core of studies, one-year programs are offered by Colorado, Ohio State, South Carolina and Tulane Universities. Graduate level credit is awarded, and in two of the universities students are permitted to continue into an MBA program following a second year of correspondence studies.

4. Community health planning

This concentration is offered by several colleges, sponsored under U.S. Public Law 89-749 of 1967 which established as a national priority, promotion of the highest level of health attainable for every person, in an environment which contributes positively to healthful individual and family living.

One participating institution is the University of Cincinnati, offering both the B.S. and M.S. in community health planning and administration. This college almost succeeded in establishing the first formal health administration degree in 1919. The university commented (op.cit.:1) that it missed its chance to make history at that time but is pleased to be in the forefront of developments in community health planning at this time. Programs include policy analysis, consumer advocacy, ethical and value issues, health and medical care, prevention, social change, accountability, humanistic administration, and equity in the allocation and distribution of community resources. Graduates are directed towards health systems agencies, planning councils, medical group practice, neighbourhood health centres and mental health institutions.

Identified unmet needs

Although the Dixon Commission (op.cit.:I, 53) was optimistic in its observation of the dynamic future for health administration education, it was less sanguine about

the present situation:

> the field of education for health administration is relatively young, flexible and unentrenched. It should - and can with sufficient expenditure of effort and wise allocation of resources - use these attributes to advantage in developing educational strategies responsive to needs in the health and medical care system.

Regarding the extent of the changes required: "it has been obvious to the Commission that basic reform rather than simple revisions are necessary in several aspects of health care education." Surveys carried out in recent years indicate that there are gaps in the availability of formal health education programs. Dixon was critical, observing that:

> it is not reaching many who carry health administrative responsibility, nor is it reaching a majority of those working in other than hospital and health departments. As pressure grows for the application of expertise in newly-legislated agencies and programs and in established settings which are undertaking new activities, additional demand will be placed on the education system.

It is probable that special programs will be needed to meet unusual circumstances. Intelligent planning and anticipation will reduce their cost, and ensure that students who have to specialize are not forced to undergo more expensive or longer education than more fortunate colleagues in general courses.

Surveys of unmet needs

This researcher has met with many administrators, and educators in college and university programs. He has discussed unmet and met needs with these persons in Canada, the U.S.A., and Britain, and spoken with graduates of Canadian programs. Due to absence of funding the writer was not able to conduct a survey of students or alumni, but obtained details and results of Canadian and U.S. investigations; these are presented briefly here, together with the ideas which he has assimilated from direct contacts with his own management students, other graduates, university program directors, and executives of professional associations.

Whilst the results of the several surveys do not coincide, patterns do emerge and it is believed that improved management education could result from careful amalgamation of these results.

Nightingale and Cameron (1972) examined the opinions of 1009 graduates of the five master's degree programs in Canada; of the University of Saskatoon extension course, and of a random sample of 200 recent graduates of the Canadian Hospital Association's senior executive extension program: Hospital Organization and Management. Each attempts to educate both inexperienced and senior administrators, and the range of educational levels promised complete and worthwhile

information and ideas.

A satisfactory response rate was achieved ranging from 55 percent in Montréal, to 83 percent at the University of British Columbia. Of the 600 respondents, three quarters were employed in hospitals (two-thirds of those in community general hospitals), and 10 percent in the government service. Only 2 persons were employed in clinics! Evidence provided by further surveys does not show that the balance in the direction of hospitals is being redressed.

The 1972 survey was only partially intended to elicit responses to educational needs, the primary objectives being to identify details of employment and salary levels. Since 68 percent were top level administrators of hospitals, and other senior staffs of universities, consulting firms etc., the interest as a whole in <u>future</u> education was not great. However:

> A high priority of the Master's program in the coming years should be the upgrading and retraining of senior health service executives. There are continuing education programs for health service managers at Alberta, Montreal, Ottawa and Toronto which help to meet the needs for upgrading skills of those already in the health care system, but it appears that few managers go to the seven programs studied here (p. 5).

Inclusion of a particular course is no guarantee of merit. Respondents were asked to evaluate courses, and those that were 'not taken but needed, or insufficiently covered', in numbers of respondents, were:

Hospital and Health Administration (148), behavioural sciences (126), personnel administration (115), quantitative methods (97), financial management (92), and to a lesser extent, public health systems, and computer science.

Some considered certain courses 'not useful' which would be valued by other respondents. Thus, in reply to the question concerning courses taken but judged 'not useful', the greatest responses were: financial management (41), public health (49), hospital and health administration (27), quantitative methods (25) and behavioural sciences (21).

In 1975, Blaney, Gordon and Gamm distributed results of a questionnaire used at a conference of hospital administrators. The profile that emerged was that 76 of the 79 were hospital managers. Most had graduated from high school; one quarter held a B.A., B.Sc., M.A. or M.Sc. degree; half had taken the H.O.M. course of the Canadian Hospital Association. When asked to identify their main competencies, top place strengths were in personnel management, financial and budgetary affairs. They admitted to having lower abilities when attempting situation analysis, working within a framework dealing with punctuality, and handling desk work.

In reply to a question concerning their frustrations, respondents mentioned government interference, industrial relations, report writing, and relationships with medical staffs.

In the opinion of the respondents, the most important study areas would be personnel management; staff, trustee

and public education; hospital and medical law, and community relations. Voted the least important were medical practice; community education and involvement; preventive health care, and health care facilities design - most of which these administrators meet on a daily basis.

A 1975 publication of the Canadian College of Health Service Executives was entitled: Report on the College's Survey of Attitudes towards a Proposed Baccalaureate in Health Services Administration. The survey elicited responses from 231 members of C.C.H.S.E. (holders of master's degrees were excluded). 84 percent of the respondents were employed in hospitals, mainly in acute care institutions; all respondents held middle or senior management rank. It was discovered that three-quarters were above 40 years of age; half had attained grade 13 or less; 23 percent were community college graduates; only 19 percent had baccalaureate degrees. Two-thirds had completed the H.O.M. course of the Canadian Hospital Association, though it was noted that fewer young administrators were registering for this than formerly.

The main purpose of the survey was to obtain ideas concerning needs for a baccalaureate degree in Canada. The majority would welcome and support such a degree, and a high proportion of the younger managers (aged below 40 years) were personally interested. It was commented that: "obviously the baccalaureate is perceived differently from, and more favourably than, the other health management qualifications" (p. 6). The outcome of this survey is

described in a subsequent chapter of this thesis.

The University of Toronto 1976 Ontario Health Administrator Survey (op.cit.) focused upon the ideas and opinions of 796 top health administrators. Skills which were given top ranking by respondents included decision making, dealing with government policy, report writing and public relations. Managers of health units also regarded knowledge of epidemiology and health promotion and maintenance as important. In reply to questions concerning areas of change, the most commonly mentioned were health applications of computers; social policies and health services; regionalization; operations research and systems analysis; community involvement, and long range planning.

Older administrators (over 50 years) had less education in management than younger managers. It may be assumed that the target group for new programs will have full secondary school graduation, and a high number will have some management training.

It is anticipated that a substantial number of retirements from senior health management positions will occur in Canada in the next decade. This leads to a need for education aimed at smaller, decentralized facility positions, due to new emphases upon extended care and ambulatory care. The editors of the Toronto Survey stressed that: "it is the responsibility of training programs, continuing education programs and the government to plan for the number of administrators required, and for these

changes" (p. 95).

Response to researcher's investigations

This writer managed to meet with administrators, educators and program graduates locally and in several other centres, as described below.

The most important non-educational institution which influences health administration education, is the W.K. Kellogg Foundation, founded in 1930 and one of the five largest philanthropic organizations in America. It does not operate educational programs but, as explained to me by Mr. R. DeVries, it provides financial aid and moral support. Foundation grants are aiding development of undergraduate and master's programs, with particular emphasis at the moment on educational endeavours aimed at containing costs of hospital care. DeVries made the strong point that Americans spent $141 billion for medical care and health services in 1976 compared to $122 billion in 1975 and $43 billion in 1966 - a rate of growth far higher than the general rate of inflation.

The Canadian College of Health Service Executives has received major assistance from the Foundation - as discussed in chapter six.

In Chicago, the writer spent some time with executives of the American Hospital Association, discussing the philosophy of undergraduate programs. A Director, Dr. D. Drake, made the point that educational programs should

encourage skilled health practitioners - such as nurses - many of whom are entering management without adequate management preparation. Although 80 percent of nurses are employed within hospitals, others who should be eligible are nurses in public health and nursing homes.

Following discussion, a list of major areas of course content was drawn up; although not in any way different from many, it at least confirms the ideas of other interested investigators. There should be courses in health administration; financial aspects; management science; economics of health care; regionalization, and comparisons with the commercial sector.

In Canada, a visit was made to the School of Health Administration, University of Ottawa. Dr. Babson (the Director) believed that clear distinction should be made between baccalaureate and graduate programs. This point is important, since much confusion exists in the U.S. as to the objectives and intended levels of each category.

The first degree should be aimed at three specified groups:

1. young persons with supervisory ambitions;
2. those presently employed at or below supervisor level - on part time or extension basis; and
3. experienced nurses.

The correct approach for those with higher level management ambitions is a science or liberal arts degree, followed by

the M.H.A.

This matter of first and second degree choice is discussed later in the chapter.

A discussion ensued as to appropriate content for a baccalaureate degree, and these components were recommended: elements of mathematical programming; commercial and institutional accounting; micro-economics and elementary econometrics; the health system at federal, provincial and local levels, and computing.

Faculty of the Graduate Program in Health Care Administration at the City University of New York were of the same opinion as faculty in Ottawa. Dr. Levey, the Director confirmed that baccalaureate programs should be aimed at those wishing to attain middle management status, and discussed the increasingly stringent requirements for hospital and other health positions. For example, in the U.S. there is now strong and increasing pressure to ensure that administrators of nursing homes obtain a master's degree.

The CUNY program is jointly sponsored by Baruch College and the Mount Sinai School of Medicine. Having 16 large downtown hospitals available gives the faculty opportunities to experiment, not feasible in smaller centres. Thus, Rosen and Rudich (1977:562) described the administrator/physician liaison program introduced recently to familiarize quality of care, in preparation for dealing with expanded quality assurance requirements. Seminars are conducted by faculty of the Department of Health Care

Administration, and Department of Community Medicine. The philosophy is expressed thus:

> It has frequently been stated that if a definite portion of health administration curricula could be devoted to interaction between students and practising physicians, distrust and hostility on both sides might be reduced.

Evaluation by students suggests that the seminars are achieving the objectives to a large extent.

Discussions took place with Dr. Schulz of the Center for Health Sciences, The University of Wisconsin at Madison. He is an experienced administrator, educator and author, in charge of a large master's level program. Matters of relevance to this thesis were covered. He noted the growing tendency for physicians to group themselves into clinics, giving rise to need for management skills either on the part of the doctors or - more likely - by professional administrators. There are now several clinics in Thunder Bay, each incorporating a dozen or more physicians, and managed at a high or indifferent level. Schulz suggested programs for the managers, and also recommended that 'clinic managers could become resource persons to give presentations to administration classes'.

Schulz mentioned - as did most others - the growth of nursing homes. As political and economic pressures cause hospitals to be used less for chronic cases, more patient recovery will take place in these homes.

A lengthy visit was made to the School of Applied

Health, at Ferris State College, Michigan. This has a large B.S. program in Health Service Management, with many options. The Director, J.C. Booth, has access to instructors in many allied health fields, since the campus includes what is claimed to be the largest pharmacy school in America, plus colleges of nuclear medicine, nursing, medical records and dentistry.

Booth stressed the need for elaborate course planning, with well declared objectives. For specific courses, he suggested consideration of English (especially communication skills); health education including human anatomy and physiology; political science, and introductory data processing, in addition to commonly accepted courses such as hospital management.

Professor Booth holds strongly the view that different levels of management have different interests, and require different education. The Chief Executive Officer must be educated to establish public policy and long-range organizational goals and objectives; to adjudicate the 'need' versus 'demand' for health care services in the community; to integrate and coordinate various levels and types of service; to initiate legislative efforts; to develop public confidence in the organization; to generate public funds and private donations. In short, he must have a 'macro' view of the health care industry. He must be educated to plan, organize, direct, control, develop, implement, budget and report. The mid-level manager (e.g. department head, or Administrative

Assistant) is educated for the "how to do it" function rather than the "what to do" function.

Professor Booth complained that he is constantly bombarded with demand for the addition of specialized courses and "they just don't fit into four years".

Master's program graduates were contacted in Toronto and Thunder Bay. The sample was small but certain points of interest were made:

a) the rigorous nature of courses is appreciated at least in retrospect. The daily activities of administrators do not allow of introspection; alumni believe that well integrated theoretical concepts emerge without conscious effort, to the benefit of decision making;

b) the practicum has proved to be the most valuable part of the course. Most of this writer's contacts had managed entrée into health institutions most interesting to them; they were accorded good facilities and benefitted;

c) to abandon employment for two years studies is very difficult; and

d) older alumni were critical of lack of provision for continuing education. Within two or three years, administrators were suffering from loss of topicality.

Summary

Dressel (op.cit.:22) noted that education may follow society's recognition of unmet needs:

> Education, as an instrument for the perpetuation and improvement of society, is necessarily responsive to the needs of the society in which it is embedded . . .

> whether educators consciously sense needs and respond to them or wait until inexorable pressures force change, education does change . . .. Education for contemplation has been overshadowed - even in the liberal arts colleges - by the necessity for earning a living.

When these needs have been forced upon the attention of educators, objectives of proposed programs of study will be influenced by examination of needs of the prominent groups - which may be students, society in the form of the health services 'consumer' or from "authoritative statements of the purposes of education, with further examination and screening by reference to an educational philosophy and to known principles of learning" as Dressel has written.

Post-war development of huge health systems in many countries has given rise to structured health administration programs. Formal education has been reserved for the higher administrative levels, and recent recognition of unmet needs has caused an upsurge in the numbers of programs aimed at middle levels of the hierarchy. In Canada, this development is in its embryo stage, and may yet be considered an unmet need situation. The challenge to provide exciting, rational and motivated formal education for present and future managers is great; in particular, there is need to decide which institutions require the greatest assistance, based on technological forecasting of their growth patterns. Candidates for attention include community health centres, group medical practices, and regionalized government departments.

Whether educational systems should be based upon well-defined values is not clear. Certainly most agree that the administrator has great moral responsibilities, but professional education, particularly that provided by management schools, has not been noted for its involvement in values education. This is not a criticism, since the writer is aware of the positive, beneficial contributions to administrative efficiency which have been made by management educationalists.

In summary, it must be stated that no clear categories of met and unmet needs can be discovered. Broadly, graduate programs are meeting demands from public hospitals for senior administrators. In many cases the courses are received with approval, though surveys quoted in this chapter suggest areas not properly developed. At baccalaureate level the list of needs which are unmet is greater; we do not have agreement as to the nature of employment of the graduate, however; nor whether he should receive generic or specialist education.

Identification of unmet needs in Canada is rather simpler than in the U.S. Health care systems are changing rapidly, and there are areas of unfilled need at middle management level. In the final chapter of the thesis, recent developments are described which may satisfy these needs to an extent. Before these developments are recorded, an investigation is made into curriculum planning so that more specific recommendations may be made: which level of

degree; what planning of curricula is involved, and finally, what courses and course emphases are most suited to match identified needs.

CHAPTER FIVE

CURRICULUM PLANNING AND DEVELOPMENT

Guidelines

There is lack of agreement among experts as to principles of curriculum planning and development; many, however, have firm ideas and opinions. Harris (1960:361) wrote that: "in the early history of education, the curriculum was a social and intellectual bank in which was deposited the accumulated wisdom of a people to be drawn on as needed . At present the trend is toward a flexible curriculum, where the planning is done primarily in terms of developing needs and abilities of the learners against the background of the needs of society, the relative usefulness of various knowledges and skills, and the logical and psychological nature of learning." This statement, relating mainly to school environments, is also of direct applicability to the health administration system.

By curriculum development is meant - in the words of Koopman (1966:9): "that aspect of teaching and administration that designedly, systematically, cooperatively and continuously seeks to improve the teaching-learning process", again a statement of activities which are being performed in many professional university faculties.

In the previous chapter, a study of met and unmet needs was undertaken. Given some agreement as to the nature and extent of unmet needs, certain preliminary stages of program development must precede curriculum planning. These are:

a) generation of educational and professional goals, with ranking in terms of importance. It has been seen how problematic this may be, due to major changes envisaged in the near future;

b) determination of the present status of each goal;

c) identification and analysis of discrepancies between goals and the present status of programs; and

d) priority assignment intended to reduce the above discrepancies.

Given that the above four points have been fully considered, five requisites are to be met during passage towards implementation, namely:

i) consensus and agreement among the team as to the objectives of health management development;

ii) establishment of regular procedures to ensure that training needs are updated;

iii) specifics to be developed within courses such as prerequisites and sequences, with provision for advanced standing;

iv) careful consideration of needs - as described in chapter 4 - enabling designers to aim courses at appropriate levels; and

v) criteria for regular evaluation.

This approach is often recommended by experts in educational planning, and scrutiny of calendars suggests that several American universities have used the sequence. The new master's program at Toronto University was created following very lengthy procedures of this nature. Regular, if not drastic evaluation is of particular importance, in view of major changes taking place in the health services. Thus, in 1962 Vargas could write (op.cit.:731) that "the fundamental goals of the academic program in hospital administration are the technical preparation and human orientation of students to . control the hospital efficiently and with benefits to the patients." Today, the words 'hospital' and 'patients' are given less prominence and debate is more concerned with planning, health, and the consumer.

Writers on undergraduate curricula - such as Veysey (1973) and Dressel (op.cit.) recognize three 'major poles of curricular differentiation' (Veysey), namely depth, through selection of a departmental major, or division of a discipline; integration and prescription versus freedom to choose electives; and breadth, involving provision of few or many problem areas. Depth curriculum advocates would permit academic freedom (at least outside the major) and provide the student with abundant course offerings. Breadth advocates would allow the student to range widely but perhaps restrict electives to prevent students from unduly scattering their energies. The situation found in today's colleges and

universities emphasizes the depth approach. Shortages of faculty and the return to 'discipline' remove from students the complete freedom which was nearly attained in the 1960's. However, voices are still raised in favour of choice, notably Raffel (1975:12):

> If required or optional professional courses are added, there will be less opportunity to take important cultural enrichment offerings which contribute to a fuller understanding of society and life. In practical terms, is another course in advanced studies in health systems more important than the trade-off: perhaps a course in modern philosophy, art history, urban geography, or political science?

Opinions proffered by executives within the health system suggest that those working in health management are not seeking an intellectual experience. To cope with trade-union negotiations, and manage budgetary planning is the extent of their objectives. However, in curriculum determination, account must be taken of identified ends, whether or not these are realized by potential students. If it were in the control of present managers and students, courses would be pragmatic, dealing with short-term, concrete, routine matters; long-term planning and theoretical concepts would be eschewed. However, if universities <u>are</u> to determine curriculum content and program emphasis, it becomes vital that intellectual competencies are developed to the maximum extent. It is important that a suitable bridge be found to overcome gaps between application and ideas; between daily routine and ability to think. R.F. White (<u>op.cit.</u>:1977)

said that "today's executive must be more familiar with the 'whether to' than the 'how to' literature. This involves such matters as changes from a closed to an open system with the accompanying need for a shift from bureaucratic to 'matrix' organization, allowing input for an expanding number of professions." White continued by recommending the abandonment of an apprenticeship model for education: "potential administrators should adopt a critical approach to existing arrangements and be continuously responsive to new possibilities."

Curriculum development should benefit by use of technological forecasting. The Dixon Report (op.cit.:II, chap. 3) attempted to discern future needs following rapidly changing social circumstances. It saw improved organization of social services by 1985, with housing, income, education and employment departments linked to health management. Communication between health care institutions will be improved, and emergency health services more easily available. Manpower will still be required: "effective health administrators will be in short supply. Many of the current administrators will lack the experience, outlook and training to qualify for the management tasks that lie ahead in the new health setting. Managers will enter the health field from other fields, and bridge the gap."

One likely source of administrators is the School of Business. The Business Graduates Association (op.cit.:6) supports this in effect:

> This range of knowledge and skills can most effectively be developed within a well-designed management education program covering the whole range of subject areas, and effectively interrelating them . . . only their inclusion in an integrated course will do.

The Association does not, however, approve admitting students to standard business courses:

> It is the result of substantial differences between profit seeking organizations and the health service that a special program is needed for health services management, rather than utilizing existing programs which are primarily geared to profit seeking institutions.

Curriculum Materials

The advice of the philosopher Alfred North Whitehead (op.cit.:41-42) should be heeded by program designers:

> Whatever the detail with which you can cram your student, the chance of his meeting in after life exactly that detail is almost infinitesimal; and if he does meet it, he will probably have forgotten what you taught him about it. The really useful training yields a comprehension of a few general principles with a thorough grounding in the way they apply to a variety of concrete details. In subsequent practice the students will have forgotten your particular details, but they will remember by an unconscious common sense how to apply principles to immediate circumstances.

Student motivation is important, and competent faculty should challenge their classes with highly complex situations stretching across academic discipline barriers. Students with professional, para-professional or technical backgrounds - such as in nursing or dietary occupations -

wish to learn of the management function, and supervisory skills. They believe they know the health services content, but lack a macro-view of the scope, variety and inter-relationships of the health system. Students with no health experience or education must be individually assessed, to ensure that the diversity of previous study areas and interests will not preclude rapid attainment of a common basis for the establishment of group learning dynamics.

Associate, Bachelor's or Master's degrees?

A matter of contention in university circles is the level of degree to be offered. In the U.S.A. three options are available. First, the Associate degree from one of the many Junior Colleges. These have no relevance to Canada, and will not be discussed further. It is necessary to attempt to differentiate between the objectives of baccalaureate and master's degree programs.

Bellin (op.cit. 1977:3) stressed that today's graduate school programs are well within the abilities of undergraduates, to no-one's surprise: "if today's high school students are able to gain a mastery of courses such as calculus, philosophy and economics - once reserved exclusively for university students - then surely there is no reason to assume that university students cannot learn biostatistics, epidemiology, and the politics and economics of public health." Bellin queried whether the true differentiation were not the maturation and work experience

of the older student, giving "visceral insights that ordinarily elude the immediate post-adolescent", and expressed concern at premature undergraduate vocationalization.

There is no 'depth' in most management courses. Bellin declared that: "rarely do students venture in intellectual depth beyond the introductory levels, even in their so-called 'majors'. At most, many of these subjects may be worth a lecture or two provided there are accompanying readings. Comparisons are odious, but should we not ask ourselves why the companion departments of biostatistics and epidemiology in schools of public health have more credible curricula?"

Brown (op.cit.:19-20), was equally dogmatic. Discussing development of baccalaureate programs he wrote: "one problem is that it short-cuts the individual's general education without providing any very meaningful exposure to either basic courses in management or those in the health field. About the most that can be taught in such programs are the tricks of the trade, and these are best learned on the job. A more appropriate answer would be the development of continuing education programs, to meet management training needs for those institutions too small in size and complexity to justify employment of a master's level program graduate."

This writer disagrees with Brown, and supports Bellin: "Undergraduate programs are here to stay.

Accordingly, for a graduate school to become de jure as well as de facto they must improve curricula in order to render superior in-depth education beyond the introductory level - and to require such in-depth mastery in more than one area. At the very least this calls for . a minimum of two calendar years of didactic courses, including subject matter whose normative habitat has hitherto been in schools of public health and business."

There are privileges accorded to graduate level students and faculty that are not available to those studying and teaching at the baccalaureate level. Growth of professional pride in the objectives of baccalaureate degrees will doubtless arise, and this will be accelerated should planners design their programs to be foundations for life-long learning rather than media through which short-run employment may be obtained.

Gordon (1975:op.cit.) adopted a rather defensive stance, protecting the career options of baccalaureate program graduates. She said that: "despite our lack of a job specification, we assume that our graduates will serve a useful purpose in the health field. However, we do not have satisfactory data to test this assumption." She then examined employer acceptance of the lower level degree: "while the accomplishment of the graduates will ultimately affect their legitimacy, perceptions that employers currently have of this new personnel affects not only their hiring, but the range of positions and salaries offered to

them."

Davis (op.cit.:63) as long ago as 1929, rejected the concept of undergraduate training:

> the offering of a bachelor's degree in hospital administration is not believed to be educationally sound. Such a plan requires that the student specialize during his junior and senior years; but it is impossible that sufficient practical work can be given for students so young, to make a course satisfactory from a vocational or cultural standpoint.

Writers have more recently complained that baccalaureate programs appear to be aimed at levels below which managers will be expected to function. This writer's analysis of calendars and bulletins failed to give assurance that colleges are fully aware of this danger. Many descriptions of objectives are general, although couched in impressive terms such as (typically): "the curriculum includes study of the social, political and economic forces that shape the problem-solving and decision-making processes of health care resources management."

Popham (1975:78-79) wrote that: "even though many more educators are superficially aware of the potential merits of measurable objectives as a new instructional tool, there are still too many curriculum designers who have only a nodding acquaintance with the intricacies of such objectives . Too many have encountered a few trivial, albeit measurable objectives and have concluded that only unworthy kinds of goals can be translated to measurable

objectives."

Courses and course emphasis

Several published surveys discuss and tabulate content areas which respondents regard with greatest and least favour. The Blaney et alia survey of British Columbia managers listed labour relations, interpersonal relations, management techniques, legal aspects, trends in health care, finance, organization and planning, and medical staff relationships as prime interests. Curriculum planners would not find such a general list of great assistance in the design of dynamic programs! In a survey of continuing education needs, University of Missouri (1976) respondents emphasized finance, government regulations, personnel management, medical staff relations, planning and legal affairs, as important.

At the University of Wisconsin (1974), faculty, preceptors and students involved in studies at master's level, compiled a similar list of required course areas. A "four sector approach" was discussed by the University, comprising: a) a group of subjects giving some fundamental understanding of economics, sociology, psychology and statistics - taught by instructors who could also show some knowledge of health administration; b) behavioural and quantitative aspects of organizations; c) specifics of the health system; personnel, programs, organization, law and processes, and d) development of problem-solving and

decision-making skills: planning and implementing; synthesis and applying theories to specific problems, and development of an action orientation.

Such an approach would involve more than the two years normally available, in the opinion of this writer. It might be undertaken most satisfactorily by a large department which can involve its graduates in continuing education following formal graduation.

Summary

The intention of this section of the thesis has been to examine principles of curriculum planning, with some attention paid to program development.

Thus far, this researcher has presented details of administration of health services with particular emphasis upon changes to be envisaged. Many aspects of education for health administrators have been studied, in order to highlight the fundamental proposition: that there are major needs that are being met; others are as yet unmet, and it is now stated that the latter can be met in a manner satisfactory to the Canadian health services system.

In chapter six, new programs are discussed that are about to become operational and which are intended to satisfy many unmet needs. Should these be found lacking to any significant extent, the writer presents a national plan which is designed to meet these shortcomings, and enable health service administrators to obtain more nearly the educational content they need and sometimes seek.

CHAPTER SIX

THE WAY AHEAD

Review of needs

In previous chapters, attempts have been made to identify and evaluate needs. Changes which are taking place and those which are anticipated, necessitate the reorientation of education for health services administration. In summary, major matters for consideration should be:

1) changes in the pattern of education, to encourage managers to enter 'non-hospital' institutions, and to recognize and provide for different managerial requirements within these organizations;

2) adequate provision for life-long learning. The technology of health care will change within each decade; management styles will alter accordingly, and the educational system must cope by supplying continuing educational opportunities;

3) ways and means to ensure that education will keep pace with professional managers' needs, and not lag seriously behind them;

4) provision of values education, without hindering demands for pragmatic, performance-oriented courses. This assumes that standards are developed, and that what is 'normative' can be recognized;

5) establishment of adequate and well-balanced content for programs, to include a suitable mixture of generic and specific courses or majors. Results of many surveys are available to guide planners and assist them both

broadly, and towards specific courses of study;

6) adequate but not excessive attention to middle management needs. It often appears that courses for the department head are specialized and of short-run applicability. New curriculum planners should design educational systems to facilitate long-term growth on the part of middle management graduates, assisting their progress into more senior ranks;

7) need to articulate baccalaureate and graduate degrees; differences are not clear, and it has become apparent that progress will be made only when there is harmony and unity of objectives; and

8) need to provide a national system of education for health service administrators: this matter is discussed in the present chapter.

Available models

Two models are available for consideration, upon either of which a Canadian plan could be based. First is the educational support system for the massive National Health Service of the United Kingdom. This includes officially sponsored executive courses; studies for examinations to qualify for professional membership; and full-time degree programs. Despite the centrally managed nature of the health services, health administration education is scattered, fragmentary, and to a substantial extent, dependent upon the initiative of individual students. The British have a lengthy tradition of management education performed under the auspices of professional associations: Certified Accountants, Chartered Accountants, Chartered Corporate

Secretaries, Chartered Shipbrokers, and many others. Courses are given by technical colleges, polytechnics, and highly organized privately owned correspondence schools. There are specialist health management societies, which act both as evaluators of professional competence (through systems of examinations), and as communications channels through which members are made aware of each others interests, and are able to inform and influence other workers in the health field. Drawbacks to education in this manner are many. Methods of study are variable with wide differences of standards between colleges, and correspondence programs. More young people commence studies than are capable of professional membership - this leads to failures and disillusionment. Students work in isolation and lack the benefits of association with others.

Although this writer recognizes the value of the majority of professional examining associations he does not recommend this pattern for Canadian health administrator education.

Degree courses do exist in Britain, but are at present uncoordinated. The Business Graduates Association (op.cit.:9) identified four inadequacies relating to the entire structure, namely:

a) small, weak faculties within colleges and universities lack resources to provide full all round coverage in management studies;

b) most courses are of short duration,

and do not permit development of familiarity with even basic techniques and skills;

c) there is a slender research base for much of the educational content. In order to create a dynamic system of management education, there is a requirement for substantial investment in time and manpower: there is no evidence that this is available; and

d) there are fragmented educational processes, each associated with a separate qualifying group. As managers these persons - nurses, pharmacists, accountants, personnel managers - will be required to work together but lack any common ideas or training.

The second model is that of the United States. The purpose of the Commission on Education for Health Administration (Dixon, op.cit.) was to study all methods of health management education. Many of its recommendations can be adapted for use here since health management problems are common to both countries. The Dixon Report contributed substantially to the thinking and behaviour of many persons in health education, but Canada should develop its own educational structure.

An attempt has been made by this writer to create a viable, middle alternative which could operate in Canada. Considerations include:

. the nature of federal/provincial relations. In fact, health service policies are determined by each province. However, they are all funded to a substantial extent through federal payments, and are all affected by the two health statutes which created the current system. Differences between provinces are more in

details than in fundamentals; emphases may easily be accomodated. Modern communications and computerized information systems enable a centrally managed educational plan to be seriously considered.

2) there are strong political reasons for a Canadian identification. It must be admitted that the Canadian health system is really a mixture of the British N.H.S. and the U.S. third party payment, private enterprise system. However, modern concerns about high costs, poor life styles and environmental matters, coupled with a moderately strong nationist feeling, may be sufficiently urgent to encourage the development of an educational plan focussed on Canadian conditions.

An alternative solution

The 1975 investigation undertaken by the Canadian College of Health Service Administrators, examined attitudes of its members to prospective educational opportunities. Most of the sample of 231 members claimed that they would be personally interested in registering for a degree program. This, together with an observed diminishing of interest in qualifications obtained through correspondence courses, led to questions as to how formal education might be structured. "A large majority of those interested in enrolling in a baccalaureate degree feel that the program should be equivalent to a three year degree, or a three year degree with a fourth year option." The three year degree at Lakehead University was in operation at the time of this investigation.

Many respondents (77 percent) believed that advanced

standing should be granted through the system of challenge examinations; the high level of experience of most members would certainly qualify them to take advantage of such a provision.

Most innovative programs include an on-campus requirement; respondents indicated that they would be able to obtain study leave - the majority averaging three weeks each year.

Detailed investigations were undertaken into the curriculum preferences of respondents. A summary of the highest rated courses is given in table 6.

TABLE 6

C.C.H.S.E. INVESTIGATION
CURRICULUM PREFERENCES OF RESPONDENTS

Compulsory	Electives
Hospital Organization and Management	Mental Health Organization and Management
Communications	Quantitative Research
Finance	Computers
Basic Economics	Mathematics
Basic Accounting	Extended Care
Health Care Policy and Planning	Social Psychology
	Biology
	Public Administration

Personnel management and labour relations (omitted from the

survey) would probably also be highly rated. Those receiving low ratings were basic statistics, organizational behaviour, epidemiology and medical sociology. Following the survey, the Canadian College formed a committee of interested educationalists and other health administrators from across Canada, with the view to involving universities in the formation of a baccalaureate degree. This writer was a member, and attended meetings. Eventually he disagreed with certain basic philosophies, and withdrew from the committee.

Following several meetings the C.C.H.S.E. approached the Kellogg Foundation in May 1976 with a proposal:

> to develop an external baccalaureate degree in health administration, equivalent to a four year residential degree, by establishing a National Coordinating Council, drawing membership from the participating Universities and the membership of the C.C.H.S.E.

The proposal to the Foundation examined present educational offerings, and discussed perceived gaps and problems. Two important concerns were, that those who would wish to study in one of the five graduate schools do not have a first degree or it is in a non-favoured area or discipline; and that present programs involved two years of full-time study, which was not feasible for employed administrators.

The college emphasized that the Dixon Commission found that provision of learning opportunities for practicing administrators is an unmet need, and Dixon made proposals

to overcome this. The Commission recommended consideration of a non-residential, external degree, and this was built into the proposal as an objective:

> to develop, implement and evaluate a non-residential undergraduate degree, to be given by three selected universities, to build knowledge and skills required for effective management of the health care system.

Needs of practising managers may best be secured by the establishment of nationally acceptable guidelines. Course organizers would provide learning situations appropriate to the adult status and experience of students. In the words of one adherent college: "promoting the continuing competence of practicing health administrators is one of the most important issues of health administration education. Lifelong learning opportunities will be necessary to develop administrative competence in an age of accelerating changes."

The outcome of the application was described in a news release:

> The W.K. Kellogg Foundation announced in October 1976 a grant of $690,000 to support the development of baccalaureate programs in health administration in Canada.
>
> Development of suitable course materials will be undertaken by the graduate programs in health administration at the University of Alberta and University of Toronto.

The C.C.H.S.E. Report (1977:2-3) to the Foundation described the program:

> It involves a cooperative effort by practitioners and faculty in the design and implementation of baccalaureate education in health services administration. The central mechanism is a National Coordinating Council for Baccalaureate Development, drawing its membership both from the field and from the academic community. This council has the responsibility for recommending general policies and guidelines, reviewing the detailed programs at each participating institution, identifying core curricula, stimulating developments of programs in areas not well served at present, reviewing the contracts for course development, exploring ways to provide for standard transferability of credits and the recognition of non-credit programs, and evaluating the programs.

The objective for credit transferability is: "to seek ways to provide for standard transfer of core credits between participating universities, also of non-core credits from these and other universities." Unfortunately, the next decision is less constructive: "the task force discussed the non-credit extension courses, but did not believe that a direct credit assignment would be possible within current policies used by Canadian Universities." However, 'special project' credits may be considered for successful completion of the two-year Hospital Organization and Management Certificate course of the Canadian Hospital Association. For those who apply following graduation from non-credit diploma programs, consideration is being given to establishment of a project work requirement, and to challenge examinations.

Each participating institution has agreed to plan and implement a degree program equivalent to a four-year

(honours) on-campus degree, whose core comprises one-third of the required credits: "each institution has flexibility in the offering of its own program provided the policies of the NCC are adhered to."

The core curriculum of the Canadian College Program

Most of the undermentioned will be calendared at each institution, supported by College developed health related readings, examples and cases. Approximately 20 credits will be required for graduation.

In General Management: courses in management theory, probability and statistics, decision making, organizational behaviour, finance, personnel and labour relations.

In Health Administration: sociology of health, health care economics, the Canadian health system, health institution management, community environmental and occupational health, health care policy and planning, and law.

A balance between management skills, health adminstration and a liberal education is important, as is the emphasis placed upon 'health' rather than 'hospital' administration.

A field experience proposal is being developed. Bellin (op.cit. 1972:40) stressed that: "until we generate field residency programs of a quality equal to the best residencies in clinical medicine - or the best legal clerkships with leading judges for aspiring young attorneys - we are perpetrating a swindle on fledgling administrators, and even more important, retarding progress in the field."

Fortunately, many applicants for the new degrees will already be experienced, but good quality residencies will still be mandatory.

Participating institutions

The program began in 1977 at the Department of Administrative Studies of Atkinson College, York University as one of the fourth year options for the Bachelor of Arts (Honours/Admin.) degree. Classes are offered on-campus in three hour segments of evening instruction each week during the academic year. There is a requirement of twenty full credits, including four in 'general education'. Based on 75 hours per full course, the part-time student might expect to complete three courses each year (including summer session), thus needing seven years of uninterrupted study (shorter if advanced credits earned), but more probably nine or ten years.

By August 1978, 117 students had registered, 24 being in the fourth academic year of the degree. Administrative Studies chairman, Professor James Radford advised the press that the first graduate will emerge in 1979.

Courses given at present are: Canadian health system, sociology of health, economics, health facility management, health care planning and law.

A major in the Bachelor of Commerce program of the School of Business at the University of Saskatchewan in Saskatoon, will form another supported institution's

degree. It will be offered on an external basis, primarily to Western Canada, and Professor Frank Silversides has said that the planned starting date is January 1979.

The University will provide a widely varied format including correspondence courses, regional seminars, audio-visual and other 'non-traditional' forms of delivery. Twenty full courses will be required, less advanced credits.

The Director has had extensive experience in operating a non-degree correspondence/residence program for many years. He reported that one hundred students had pre-registered by August 1978, pending final approval of the new program by senior university authorities.

The third institution is the Canadian School of Management, affiliated with the Northland Open University. Its program will lead to a Bachelor of Administration degree. Each semester course will combine independent study with seven intensive tutorial sessions, held every second Saturday; these latter will take place in regions where sufficient registration exists. There are 32 one-term courses, plus three special projects and a major report: these will equate to a 20 credit degree, and are expected to take about $5\frac{1}{2}$ years to complete.

The first year places emphasis on the liberal arts, communication, behavioural disciplines and basic economics. In the second year, general management, personnel and labour relations, law and quantitative methods are studied. Students in year three take specific health care subjects;

and in the final year will study health care planning and an in-depth project.

It is claimed by the Canadian School of Management that the format will appeal: "less to the young regular student than to the working adult who can study at home." Each centre will require a group of at least twenty students, who would enrol within a radius of 60-80 miles from the learning centre, and attend three-hour sessions. Korey (1978), the Director of the program, anticipates that work will commence in September 1978, directed from an office located in the OISE building, Toronto. He has urged interested persons to register early, since facilities for large enrolment are not available. By August 1978 a total of 39 had enrolled in the program.

Dr. Korey has said that the new Canadian School of Management is an experimental program, utilizing a more flexible approach to recognizing prior learning for advanced standing. Because of the non-traditional approach, C.S.M. has informed its potential students that their credits may not be recognized by other universities.

This researcher has been unable to trace details of the Northland Open University, save that it is located administratively in Yellowknife and holds membership in INTERVERSITAS and the Union for Experimenting Colleges and Universities (UECU).

Another institution which is associated with, but not part of the national degree system, is the Université

of Montréal. A Certificate in Hospital Management is earned through correspondence studies and regional seminars, or by evening studies on campus. The Certificate involves 30 undergraduate credits, and may be combined with two other certificates to meet the requirements for a general (90 credit) baccalaureate degree.

The other undergraduate program in Canada is offered by the School of Business Administration, at Lakehead University. This differs substantially from all the above in philosophy and in details. It is a three year degree in health administration and is entirely 'on-campus'. An attempt has been made to add an additional program attracting 'off-campus' students, who would receive credit for experiential learning; who could take certain courses by correspondence; and who would attend campus sessions at intervals. This development is at present in abeyance, and much of its philosophy supports the national program recommendations described later in this chapter.

A critique

When the above programs are fully operational the Canadian College intends to develop further materials and offerings. Present concerns are for development of teaching materials; the need for experienced faculty; methods of improving managers ability to attend courses, especially in remote areas; and articulation of these degrees with those at master's level.

It is too early to comment upon the actual performance, since only Lakehead University has, as yet, graduated any students; and one program is not in operation. However, it is valid for this writer to comment upon his perceptions of the proposals of the Canadian College and its three constituent university programs.

First: this writer expressed reservations to the council concerning their choice of a four-year honours degree. It is his belief that a degree at this level is primarily intended for those directing their ambitions towards graduate study. Naturally, if a three year program is unavailable, there may be no alternative; but in this event, either option could have been selected. It seems to this writer that the busy administrator, without previous valid university credits and even without reach of a major institution, will need to devote an excessive length of time (at least six years) to continuous part-time studies. This is almost the period which a more fortunate school-leaver would require to gain a doctorate in philosophy! Optimistically, the most likely source of graduates will be among those who work in Toronto, have acquired five or six credits in business, social sciences or nursing, and can attend the Atkinson campus for three or four years without significant absences.

Second: it may be that the diverse, innovative approaches will create a refreshing qualification, which will be imitated in many countries. Each institution will vie with the others for favourable comments and media exposure,

and there could be major benefits. However, experience suggests that a program will be successful - once outside funding has ceased - in direct proportion to the interest and support it has generated with the administration of the institution. It is to be anticipated that there will be one program that is strongly favoured, whilst the others will experience a decline.

Third: the Dixon Commission commented that: "existing formal degree programs give low priority to special education for individuals who fill roles collateral to the administrator - board members, physicians, consumer representatives, for example." There is no evidence that the College has this as a priority although absence of courses dealing with these areas in graduate programs would suggest that one of the new institutions could concentrate upon these specializations.

Strongly supported by the Kellogg Foundation, and administered centrally by the Canadian College of Health Service Executives, the baccalaureate program has opportunities for success scarcely known heretofore. The large numbers of administrators in health service institutions who have no university qualification, plus ample evidence from the United States that degree status for professionals will be mandatory, indicate that a substantial demand is most likely. The quality of the program design will determine whether the obvious needs can be met.

A new, national approach

Following detailed consideration of the literature, and many discussions with educators, planners and potential students, this researcher has an understanding of the areas of unmet need. He has developed a program of education for health administration which could be viable, innovative, educationally satisfactory, and suited to Canadian national conditions. Full program development would require extensive planning and design by a committee of experienced educators; such is not within the limitations approved for this thesis.

Basic principles of the design have been:

. that it should be accessible to present administrators - those who desire continuing education, and those with the option of attending full-time degree courses; and to those who wish to enter the occupations included in the 'health administration' orbit;

2. that it should be designed by practitioners, with input from bureaucrats and educators;

3. that it will be financed in part by the health professions, Ministries of Health, and others who will expect to utilize the new quality administrators; and

4. that it should adopt the generic approach but allow for specialized interests; these will be designed in a modular manner and added as required.

In broad terms, the components of the new system are:

a) an Advisory Council consisting of government representatives (federal, provincial and local), delegates of the

Canadian Hospital Association, Canadian College of Health Service Administrators, University and community colleges, and the Association of University Programs in Health Administration. There should be a membership not in excess of 25 persons, including at least one alumnus of the program.

The purpose of the Council would be to ensure that educational programs maintain their Canadian orientation; that new developments would be communicated; and that funding for research and development would be vigorously sought and fairly distributed.

b) Three graduate degree programs would be supported namely, the University of Toronto - with a satellite operation at Dalhousie University; the University of Alberta - with a satellite operation at the University of Manitoba, and the University of British Columbia.

Choice of these institutions has been based upon knowledge of the academic levels and interests of the universities, and with a view to effective geographical spread. Advantage would be taken of the major Health Sciences Centre at McMaster University, by informal links with each graduate program. This would enable experimental studies to be undertaken, particularly in the area of clinical/administrator relationships. When the new Memorial University Centre is operational, a similar arrangement could be undertaken.

Graduate programs would be of two full years duration,

with a residency between the years subsidized by the Advisory Council. Each would offer a generic program, but would also include one specialist 'minor': extended care, mental health, industrial engineering, and planning and research, as possibilities.

The master's degrees would each be centered within a different faculty, to encourage differences of approach. The major universities would have ample resources in terms of library, data processing and faculty.

The fourth program, in Montréal would continue to educate French speaking administrators, and would have access to all facilities of the English speaking universities.

c) five baccalaureate degree programs, which should be sufficient to cater for demand for middle level managers. These would be centered in:

i) Simon Fraser University: a full time degree, with an obligation to develop innovative continuing education projects, and off-campus work. Liaison with U.B.C. would be made, to ensure that the objectives of graduate and baccalaureate degrees are kept separate.

ii) University of Saskatchewan: a full-time course, but strong emphasis upon innovative off-campus education, mainly correspondence courses which are at present being developed for the Canadian College.

iii) University of Ottawa: the French commitment of

this University should be upheld - undergraduate courses in French. In addition, a major in long-term care administration should be given, and (if demand is sufficient) courses with a government planning emphasis.

iv) Dalhousie University: full-time studies with regional emphasis; off campus and correspondence courses. Close liaison will be maintained with the Health Sciences Centre at Memorial University, Newfoundland.

v) Lakehead University: a full-time degree program in the School of Business. Additionally, a non-traditional off-campus program would be given. Experienced health care workers who are moving into management require comprehensive education. On application, their credentials would be assessed and advanced standing granted. Thus, a head nurse with an R.N. and ten years experience, would be granted (say) four credits standing. She would be given a study program and would register for correspondence courses or attend a local campus for basic management education. Each summer for four weeks, she would attend campus for intensive, advanced health management education. In this manner, workers from across Canada would have a facility to study, plus recompense for previous education and experience.

d) An Administrative Staff College would be set up, close to a major health sciences centre: Toronto, McMaster, Edmonton, or Winnipeg would receive offers. Major functions of this College would be:

i) to develop new approaches to education for health administration: case studies, films, new teaching methods, funding systems;

ii) to maintain close liaison - whilst keeping full independence - with C.H.A., C.C.H.S.E., AUPHA and others, to provide a front line educational service with moral and material support given by these powerful organizations;

iii) to furnish needed 'off-campus' course summer accomodations so that requirements of Lakehead University and others would be met. The location could be in the same centre as the college, or in such a centre as the Banff School if preferred; and

iv) to enable senior administrators to pursue their goals of continuing education. Short courses would be given for all health care executives whether in government, health institutions, unions or in teaching.

The matter of a Staff College requires serious consideration. An Administrative Staff College was founded in 1948 at Henley, England, now being the longest established management school in Europe. Many thousands of senior

managers from industry, commerce, financial institutions and the public service have attended courses. Early in 1972 it formed a link with Brunel University, London, with the objective of developing research and graduate work in management studies.

A call was made for an American college by Albright (1962:133-150). He stressed that vast and rapid transformations in American culture call for more complex, pervasive administrative roles. There is need for a faculty to develop broad professional perspectives for experimental research, and for intermittent in-service preparation for promising administrators. Ideal candidates would be such career executives (35-50) who can be released for up to three months. They would have leisure for personal reflection, reading and independent study. No degrees or competitive grades would be given, since a major objective would be to develop conditions for maximizing self-awareness.

Presentations would be made in such areas as contemporary culture and society; administration and leadership; contemporary organization; and structures and principles.

In Canada, a conference was held at the Banff Centre, School of Management Studies (1974:4). It was agreed by experienced health administration educators, that senior management courses were required: "emphasis should be on those individuals who are, or will be, in the position to influence the future direction of the health care delivery

system, and who are capable of effecting change within that system." Objectives would include establishment of a forum for multi-disciplinary discussion of major current health problems; and understanding of social, political and economic environments; and inter-disciplinary problem solving. "The centre should not be concerned about integrating or coordinating their courses with existing courses, except to avoid duplication."

For the past three years, three-week courses have been held in February at Banff. In 1976, 26 attended of whom half were employed in Alberta and 27 percent in Ontario. Half were 'general managers', one quarter were M.O.H. consultants, 18 had a degree and 16 had the H.O.M. certificate. 16 were employed in hospitals.

In 1977 33 attended with wider provincial representation. Again, one half were 'general managers', 22 had a degree and 15 held the H.O.M. certificate with 8 physicians. The average age was 43 (range of 28 to 59 years). 16 were employed in hospitals, 8 in government departments and 4 in public health.

This useful development would form the basis for the Staff College.

It is not claimed that the national proposal satisfies all observed needs; it creates a format enabling many unmet needs to be satisfied, and the forum within which debates can be held with the idea of meeting other requirements as resources allow. The entire country would

be associated with the endeavour, and it could be anticipated that the benefits to health management would be clear and substantial.

Summary and conclusions

It is necessary to rethink the structure of health administration in Canada; the purpose of this thesis has been to recognize the problems and measure the extent of needed realistic solutions. Boissoneau (1975:op.cit.:32) stressed that:

> It should be clear to hospital administrators that their effectiveness is being evaluated . . . the field should make certain that the educational component is being used to the fullest extent. Today hospital administrators have an opportunity to improve their knowledge in many ways. That chance may not be available tomorrow on a voluntary basis.

Ruchlin, Pointer and Levey (1973:104) dealt with major changes that could be envisaged, should the trend away from hospital care become apparent and significant. The paper concluded:

> While the realization is widespread that new directions are mandatory in the realm of educational planning, and while a few preliminary steps have been taken in this direction, the fact remains that the knowledge base required for such educational planning is scant.

Martin - in Kellogg Foundation papers (op.cit.:54) made a strong appeal for cohesion. He is Executive Director

of the Canadian Hospital Association, which gives his viewpoint particular importance:

> there is great need for undergraduate education for health services administrators. This need should be satisfied immediately and health associations and universities should collaborate in finding a suitable and acceptable solution to this need. The new baccalaureate program should be part of an educational continuum and should be well articulated with pre- and post-programs for health services administrators . . .. Continuing education sessions for health services administrators should be creditable towards obtaining a university degree, and the whole education system for health services administrators should be well integrated from beginning to end.

A major realistic effort has been made by the Canadian College of Health Service Executives to create a nation-wide baccalaureate degree for Canada. This writer approves the effort, but is strongly of the opinion that it is insufficient, and is in some ways wrongly oriented. He has presented his own national plan in this thesis. Canada would, for the first time, have a health administration education system which would be directed towards the needs of the future. Since there would be central direction but substantial autonomy maintained by individual institutions, both control and innovation could be expected.

It is necessary that health service administrators should be equipped to face the major challenges caused by rapidly changing conditions in the health area. The purpose of this thesis has been to establish the needs for education, emphasizing the problems faced in providing this education.

In conclusion, the writer has outlined his concept of a Canadian national educational scheme to satisfy many of the unmet needs. It is his earnest hope that the thesis is accepted on this basis; and that further research might be encouraged to develop this scheme, to plan programs in detail, and to undertake required studies in anticipation of eventual implementation.

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