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Health services management development: what formal knowledge should support the skills and experience required?

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This study reports on an analysis of 17 postgraduate programs in health services management. Public information was collected from websites in February 2010. Data analysed included core subject abstracts, admission requirements and length and aims of each course. Findings indicate that only three out of 16 subjects identified as core are common to more than 50% of the programs, with the eight most common individual subjects appearing in only a third of programs. This suggests diversity in what is deemed core foundational knowledge in managing health services and the approach taken to management development. We believe there should be greater consensus on core subjects in a specialist health services management qualification.

What is known about the topic? With changes in the organisational structure of health organisations in Australia over the past two decades, managerial positions and roles have also changed. The educational preparation for those managerial roles would also be expected to have changed but core foundational knowledge should remain similar between the various academic institutions.

What does this paper add? This paper indicates greater diversity in core knowledge areas in health services management education than expected despite a similar target audience.

What are the implications for practitioners? There are differences in what are deemed to be core foundational areas of knowledge required in specialist management development between academic programs. Management development requires a balance between knowledge, skills and experience and intending students should seek information from a variety of sources in deciding which program best suits their development needs.

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Running head

Research note

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Introduction

Concern with the performance of health systems is not a new phenomenon. Governments are concerned with containing expenditure, and the 2012 Queensland budget¹ aimed to reduce expenditure by \$2 billion over 4 years, while dealing with rising consumer demands in regard to wait lists, wait times and the quality of care provided. The Australian media have highlighted consumer complaints linked to adverse outcomes. This scrutiny has resulted in several formal inquiries into the performance of individual health professionals (e.g. Dr Jayant Patel and Dr Graham Reeves²), healthcare services (e.g. Acute Care Services in NSW Public Hospitals³) and systems (e.g. Queensland Health System⁴). Recommendations made in recent reports include strengthening clinical leadership and governance, improving the provision of care to particular clinical groups, and developing the healthcare workforce. Garling³ recommended that Nurse Unit Managers spend 70% of their time on clinical duties and no more than 30% on ‘*administration, management and transactional duties*’ (p. 262). The Queensland Health report⁴ made recommendations about changes to undergraduate clinical education (10.4, 10.8, 10.12, 10.13, 10.15, pp. xliii, xlvi, xlvi, xlix, l) but none in regard to managerial education. Health services managers are responsible for implementing many of the proposed reforms. The management development of health service managers includes their educational preparation, in addition to the development of skills and the acquisition of experience. This study makes an early contribution to the development of a research agenda into the educational preparation of managers through an analysis of current tertiary programs in Australia.

Background

Health services, as a context for management practice, provide challenges related to their influence on the quality of human life. As Mintzberg⁵ asserted, ‘managing may be managing, but when practiced in the system of so-called ‘healthcare’ it takes on a wide variety of forms’ (p. 193). Health service managers utilise not only business management skills, such as budgeting, monitoring performance and human resources management, but should also draw on knowledge areas such as epidemiology and public health, health economics and ethics. Health service managers are now more likely to confront complex issues of performance, such as management of adverse events, and to be appointed from a clinical background and this should affect their educational preparation for the role. Mintzberg⁵ suggested that management needed to be re-conceived within the context of healthcare.

Health service management and adverse events

Reducing the incidence of adverse events, and the resource expenditure associated with them, results in more resources available for expected service delivery. Adverse events represent failures in managerial performance and systems. Education is an important part of developing the managerial knowledge and capacity to enable operational as well as strategic decisions to be made. Management not only entails business management skills balancing the use of resources against demand, or efficiency, but also minimising adverse events.⁶ Concerns about patient safety prompted McLoughlin and colleagues⁷ to examine performance improvement initiatives in the United States, United Kingdom and Australia. These countries faced similar challenges in improving healthcare services from safety and quality perspectives. The study identified widespread patterns of errors in clinical care and that individual as well as systemic factors were involved. The Wilson *et al.*⁸ Australian study

found that 16.6% of hospital admissions were associated with an adverse event that resulted in disability or a longer hospital stay for the patient. Half of those adverse events were considered to be preventable, totalling \$1.1 billion, or 1.7 million bed days, in 1992. In 2005 Wilson and Van Der Weyden⁹ questioned whether there had been any improvement in patient safety since the original study.

The emergence of the clinician–manager

In the past twenty years a great deal of effort has gone into organisational restructuring of healthcare organisations in Australia but management performance in hospitals is still questioned. There is a belief that there should be less bureaucracy and more resources allocated to clinical services, but this understates the complexity of managing healthcare delivery. The movement towards decentralised health service structures has seen the rise of clinician–managers in an attempt to narrow the void between clinical and managerial priorities.⁹ Degeling *et al.*¹⁰ suggest that clinician–managers ‘attending to the organisational and financial dimensions of their units’ performance, are expected to engender change in what had been regarded as being the sole preserve of clinicians; that is, the detailed determination of the form of care delivered to individual patients’ (p36). Clinician progression into management has often been linked to seniority and hence clinical leadership.¹¹ This means that promotion may be a consequence of an expert clinical knowledge and power base without necessarily a formal preparation for the managerial role. Such clinician–managers tend to focus on discrete clinical issues within a specific clinical discipline rather than adopt a corporate management perspective.^{12–17} Their pre-service clinical education may not include the level of education that these managerial roles require. Clinician–managers are largely expected to learn what managerial abilities they require on the job; the effectiveness of which is diminished by the demands and nature of the role, overshadowing learning needs. Moreover, on-the-job learning is determined by the job¹⁸ and does not expose the individual to a learning experience.

The advancement of clinicians into management roles has several educational implications. Several authors^{19–21} have commented on the differences between managerial and clinical decision-making processes. Clinical decision making focuses on individual patients, with few if any restrictions imposed by others on the process of decision making or its implementation. Managerial decisions however are much broader in focus – addressing the needs of groups rather than individuals –, are often challenging to implement and demand a focus on the organisation and its context rather than on an individual patient. For clinicians to develop effective decision-making capabilities within the management role a process of transition occurs. This process is dependent on an approach that integrates individual experience with organisational support within a learning framework. Additionally, modern definitions of management regard it as a ‘sense-making process’²² that is bound to context and moderated by individual perceptions. These differ from older definitions that viewed management from a rational linear perspective that, once learned, can be transferred across different organisations.²³ Decision making is central to the sense-making process and as alternatives are considered and evaluated, managers draw on their experiences and knowledge to temper these deliberations. Education, as a primary influence on the development of knowledge, provides a critical resource for this process²⁰ and is therefore an integral part of the transition from clinician to manager. Education also enables managers to utilise their experiences more fully for learning and in a range of management applications;²⁴ it also enables managers to maximise the learning

obtained from work-based experiences; and prepares them for future challenges.²⁵ Degeling *et al.*²⁶ established, in several studies conducted in several countries, that there was a significant difference in thinking between general managers, medical clinicians and medical managers and nurse clinicians and nurse managers on the organisation of work and accountability for use of resources. The concern of this paper in regard to a health service management syllabus is therefore grounded in the need to develop the management skills of clinicians moving into managerial roles who otherwise have little theoretical basis for their practice.

The question for educators then relates to making decisions about the structure and processes of the health services management curriculum. In a rational world, educational programs emerge from a carefully constructed needs analysis that determines whether or not a course is required, the requirements of the cohorts, what it should consist of and how it should be delivered.²⁷ The literature provides many examples of analysis of managerial roles^{12,28,29} but few supporting syllabus decisions in a health services context. Meyer *et al.*³⁰ described the process of course development and embedding graduate attributes; Bennett *et al.*³¹ described the development of curriculum in a public health management program; and Bennington³² discussed the knowledge base required for effective corporate governance in health services development; however none explored syllabus. Health services management programs seem to exist in isolation from one another, each with their own history and justification for syllabus content, but the absence of any significant commonality suggests a need for more research into what exactly are the educational requirements of clinician–managers.

Methods

A Google search was used to collect data. The search strategy sought readily accessible public information regarding postgraduate study in health services management. The search was conducted during February 2010 using the linked terms ‘postgraduate +health services management’. This method of data collection and analysis is similar to that used by Segev *et al.*³³ Seventeen Australian universities offering a Master degree as the benchmark qualification were identified. Each course was then examined for public information relating to the nomenclature, course aims, length, core (mandatory) subjects and content details, and experience required for admission. This was compared with the 12 programs accredited by a professional body.

Data were assembled in a spreadsheet. Because different universities used different terminology to identify discrete taught subject areas (unit, subject, course, credit) and different weights, these were translated into simple counts to establish total units required to complete the award, separated into core and elective units. The individual discrete taught areas, and the synopsis provided, were used to give a code of either 1 or 0.5 to the major focus of the taught core knowledge area into topic areas (See Table 1). These were then compared between programs. A broad topic area was regarded as being most useful for comparative purposes to establish the content of the syllabus.

Results

Of the programs identified the majority had titles including management (10 or 59%), about a quarter with administration (4 or 24%) followed by leadership (3 or 18%). Table 2 lists the various titles with the ‘Master of Health Services Management’ being the most common.

The aims of the programs were broadly similar. Most were concerned with preparing clinicians who were moving into a managerial role or developing into a more senior manager. Most had aims in regard to knowledge and skills that students would be provided, developed or equipped with. Issues and situations were to be addressed, while managing change, leadership and impact were intended outcomes.

The minimum experience required for admission was an average 2 years (range 1–4) in the seven programs that explicitly identified a minimum requirement. A further six programs implied experience by describing the movement or development in a managerial role by experienced health professionals. It was not clear but it was possible several programs might accept applicants with a health-related undergraduate degree without work experience.

The average number of subjects required to be completed was 11.35, with a mode and median of 12 subjects. These were usually studied part-time over 3 years, with a range of 8–16 subjects.

The average number of core subjects was 5.7, with a median of 5, a mode of 4 and a range of 2 – 10. Table 1 lists the topic areas covered in the core subjects identified in each program.

Discussion

Managers of health services are becoming more accountable to the communities they serve.¹² While their level of influence and accountability is clearly dependent on context, health service managers have a significant and direct role to play in shaping service provision, and hence influencing the quality of human life, at individual, organisation and systems levels. Their interactions with resources and people arguably deserve greater visibility in the process of reform and also in the educational preparation for their managerial role.

This study has identified differences in the core foundation of health service management qualifications. The syllabus of each program, and specifically the subjects identified as being core, indicates the relative importance placed on specific subjects with regard to the qualification. There is a generic foundation to the qualification, as well as an elective (optional) component allowing an individual to tailor a qualification to meet their learning and development needs. This study establishes that differences exist in the core knowledge areas offered in different programs. Table 2 establishes that only three core subjects were common to more than half of the programs investigated. This was unexpected as our intentions were to establish core knowledge areas in a specialist health services management qualification to compare and contrast the management development with generic Master of Business Administration type programs. Our findings contrast with those of Segev *et al.*³³ who found that six 'subjects' were common to 23 of 25 MBA programs and that two more were common to 15 or more programs. They assumed that there would be greater diversity between the top MBA programs and others.

Resourcing as a fundamental managerial concern is one of the more common core subjects but it did not appear to be presented in the depth or breadth we expected. Legislation that introduced the area health organisation model, such as the Area Health Services Act 1986 No. 50 in New South Wales, reinforced a need to plan, resource, monitor and evaluate service delivery at a population level, which implies the importance of an understanding of epidemiology and public health approaches, and particularly the New Public Health. The emergence of designated Public Health Units in New South Wales to support area health services should have strengthened the importance of managers developing an understanding of the contributions of such specialist

functions to their roles. As there are differences in knowledge areas and the emphasis placed on them in undergraduate and pre-service qualifications we expected to observe a greater emphasis on resource management areas, specifically financial, human and information. That is not apparent from our investigation.

Prior to the large scale restructuring of organisation reforms that commenced in Australia in the 1980s there was a clear pathway to a managerial role within hospitals. General management took the form of administrative roles, with an emphasis on resource management, and little real influence on clinical services. Hospitals remain the largest and most significant autonomous organisational forms, despite the emergence and development of community health services structures. With the development of networked structures, there has been a reduction in the number of executive positions at the pinnacle of individual facilities, less emphasis and recognition of a pure business management background, and an increase in the number of middle management roles. The NSW Nurses Award in the mid 1980s recognised a clinical as well as a managerial pathway for progression, and while clinical seniority into Clinical Nurse Specialist or Consultant roles required a relevant Master degree there was not an equivalent requirement for managerial positions. There is now a far greater networked bureaucracy within organisations and arguably a reduction in autonomous decision making compared with the stand-alone hospital-based organisations that previously existed. The transition of clinicians into managerial roles and their ability to deal with the management of adverse events remains a challenge.

Conclusion

Academic programs have reacted to the change in the management development requirements of health services managers in markedly different ways. Examination of the syllabus only allows identification of topic areas (hard knowledge) rather than a consideration of the soft knowledge learning such as developing skills of reflection and engaging in collaborative learning through communities of practice. To investigate changes in approach to learning and management development requires a different study to extend from the approach taken with this paper.

Competing Interests

The authors declare that they have no competing interests.

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Table 1. Australian university courses in health administration/ services/ management

University	Course
Australian Catholic U	Master of Health Science (Health Administration)
Charles Sturt U	Master of Health Services Management
Curtin U	Master of Health Services Management
Flinders U	Master of Health Administration
Griffith U	Master of Health Services Management
James Cook U	Master of Public Health – Master of Business Administration
La Trobe U	Master of Health Administration
Monash U	Master of Health Services Management
Murdoch U	Master of Health Management, Quality and Leadership
Queensland U of Technology	Master of Health Management
Southern Cross U	Master of Public Health Leadership
U of Queensland	Master of Health Sciences (Clinical Leadership)
U of New England	Graduate Diploma in Health Management Master of International Health Management
U of South Australia	Master of Health Science (Health Service Management)
U of Tasmania	Master of Health (Specialisation in Leadership or Executive Development)
U of New South Wales	Master of Health Management
U of Technology Sydney	Master of Health Services Management

Table 2. Core subject topic areas

Topic area	Number of programs	Percentage (%)
Management	14	82%
Resourcing	9	53%
Health system	9	53%
Epidemiology	8	47%
Evaluation	6	35%
Quality	6	35%
Law	6	35%
Evidence	6	35%
Health economics	4	24%
Research	4	24%
Clinical Governance	3	18%
Health information	3	18%
Bio-data/statistics	3	18%
Human resource management	2	12%
Policy	1	6%