PREPARING MANAGERS FOR THE U.S. HEALTH CARE SYSTEM: MODELS FOR DESIGNING AND ACCREDITING QUALITY CURRICULUM

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The health of the public and the role and responsibilities of governance and public systems in assuring a healthy population are key issues for civil society. Every country in the world faces the challenge of assuring the health of their populations and of providing access to health services with limited resources and cost constraints. While this challenge is universal, the health systems designed in response to this challenge vary greatly. The different economic, social and political realities of nations and states create unique systems, and within each nation, transition and reform are essentially continuous. Commenting on the U.S. health system, Derzon (1988) suggests it is hard to conceive of any set of organized human endeavors that has been more heavily impacted by the forces of change than the delivery of health care services. Similarly, the rapid social changes in the CEE since 1989 have had an impact on both health and its determinants and on the organization of health care systems (Kickbusch 2002). For most of these countries, reforms in the health system remain a critical and unfinished agenda (Peterson 2002).

Regardless of their level of economic development or wealth, health systems in all countries face an ongoing struggle to manage multiple demands and pressures (Fried & Gaydos 2002). Included amongst these pressures are achieving an appropriate balance between access and costs, between public and private provision of services and between the need for preventive and curative services. The point of balance for these forces is predicated largely on the policies of governments and the practice of public administration nation-by-nation.

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Sound health policy provides the foundation for achieving the goal of public health and for the successful delivery of public health services (Curran 2002). Policy development and health system design, including financing and organization, emerge from the dynamic interplay of government, social and economic conditions. The interplay of these sectors is also influential, if not critical, in the health status of populations. Public administration, as a pivotal component in many of the forces that determine health and health systems, can provide a bridge of collaboration between sectors as well as between policy and management.

DEFINING PUBLIC HEALTH SYSTEMS

Public health is a broad term with no universal international definition and structure (Bobak, McCarthy, Perlman & Marmot 2002). The broadest of definitions include functions of the state other than health care and public health services such as education, housing and transportation. Other definitions include health service provision and management, while narrower definitions focus on the essential public health functions that include monitoring population health and its determinants, health promotion and prevention, and protection of the environment.

Definitions focused on public health functions create a distinction between organized societal efforts focused on populations (public health) and clinical medicine and curative services (health services delivery) focused on the individual. Distinguishing between public health and health services delivery is common in the United States as well as other countries of the world and a key differentiation is in the assignment of responsibility. Population-based public health services in the United States are provided by governmental agencies at the local, state and federal levels while the delivery of services to individuals is largely outside governmental agencies and provided by a vast array of public, private, for-profit and non-profit organizations.

Both population-based and health services delivery systems are integral to achieving the goals of public health. Researchers and practitioners alike are calling for more integration and more cooperation between the two systems. Analysis of health systems within countries must include both systems, and recognize the distinct challenges for government roles and responsibilities within each system and in efforts to achieve more integration.

PUBLIC HEALTH: POPULATION-BASED EFFORTS

In the U.S., governmental public health agencies at the local, state and federal levels provide a critical foundation for the public health system (Boufford, 2002). These three tiers of governmental agencies must work together to make public health services available in every community. There are more than 3,000 local public health agencies, 3,000 local boards of health and 60 states, territorial and tribal health departments in the United States (IOM 2002a).
Local public health professions work with their communities to identify health problems and define resources and programs to address them. The National Association of Local Boards of Health (NALBOH) in partnership with other public health organizations has identified the fundamental responsibility for local agencies as ensuring: 1) that their communities have access to essential public health services and 2) that these services improve community health. The state health departments assure the safety of water and food supply, maintain information systems to detect health threats and assist local officials in responding to health needs of their communities. State health departments serve as a link between localities and the federal government. The federal public health agencies assist in the development of national policy, provide information, set standards for regulating the quality of services, and finance programs for special populations and specific national health problems. Federal public health agencies may be housed in either the Department of Health and Human Services (HHS) or the United

States Public Health Service (PHS). The Centers for Disease Control and Prevention (CDC) housed in the HHS in partnership with other health agencies have developed model national public health performance standards and are facilitating their use by state and local health systems and local public health governing bodies. These standards are not imposed by the federal government but serve as an instrument to assess and guide agencies.

Public Health Professionals

The American Public Health Association (APHA) is the oldest and largest organization of public health professionals in the world. This Association brings researchers, health service providers, administrators, teachers and other health workers together in a multidisciplinary environment of professional exchange, study and action (APHA 2002). Individuals who pursue a career in public health can take many routes into the field. While a degree in public health is considered optimal, achieving the goal of public health requires many disciplines and individuals with wide-ranging expertise, experience and education. The directors of government public health agencies are frequently physicians, however, many, if not most of the physicians in these positions, also earn a master's degree in public health (MPH).

A recent report by the Institute of Medicine (2002b) states the importance of recognizing a new definition of public health professional and the inclusion of a number of types of schools, programs and institutions beyond traditional Schools of Public Health. The working definition of a public health professional offered in this report is "a person educated in public health or a related discipline who is employed to improve health through a population focus." These professionals require a broad range of skills and information and may be educated in schools and programs of public health, but also in schools of medicine, nursing, law, and urban planning to name a few. Though public administration is not mentioned directly in the report, the concepts of policy, law, regulation, urban planning, zoning, design, construction standards and others

commonly taught in public administration programs are included as key components in addressing population health issues. An understanding of the multiple determinants of health and their interactions is critical to shaping new knowledge, programs and policies relevant to both individual health and health care, and to population health (IOM 2002a).

PUBLIC HEALTH: ORGANIZATION, FINANCING AND DELIVERY OF HEALTH SERVICES

Compared with other industrialized countries, the United States has shown a distinct reluctance to move into a unified publicly owned and financed health services system. The U.S. health care delivery system has been described as less a system and more a fragmented array of care providers, payers and patients (McAlearney, 2003). Organizations providing and financing health care services include public, private, for-profit and non-profit organizations. Government activity in health care can be considered along three dimensions: financing, delivery and regulation.

The U.S. federal government's role in the health care delivery system is largely financing through programs such as Medicare and Medicaid. Medicare is a national health insurance program for citizens 65 years of age or older. Medicaid is a federal and state partnership health insurance program that provides basic health care for low-income individuals, mostly children or pregnant women. In 2000, public sources paid for 43% of personal health spending in the United States (KFF 2002).

The federal government sets regulations for Medicare providers and provides general guidelines for state regulation of Medicaid. Other regulatory activities at the federal level prohibit discrimination by providers and establish criteria for approval of drugs and medical devices. The federal government currently provides health services directly to special populations - the Veterans Health Administration and the Indian Health Service.

States vary in their financing, delivery and regulatory roles. On a broad basis, however, states have a substantial financing role through participation in the Medicaid program (a federal/state partnership). States contribute dollars to the education of professionals through subsidies to medical and professional schools. In the regulatory arena, states establish standards for insurance, health care facilities and personnel (licensing) and establish health codes through the state health department. States are direct providers of mental health services.

Historically, local governments subsidize public hospitals and fund local health departments that establish local health codes. The role of local governments is increasing in recent years, however, as they face pressures to address issues not traditionally assigned to localities (Clark 2000). Health care problems and solutions are being pushed down to the local level at the same time that funds and support from state and federal government are being decreased. Clark (2000) contends that local residents no longer tolerate the "passing the buck" answer that health care issues are the responsibilities of some other jurisdiction (state or federal). He suggests that local governments can turn the situation into an opportunity to increase local control and to foster civic responsibility and participation through multi-sectoral solutions.

An "uneasy equilibrium" between public and private control and financing of health care (Anderson 1985) exists in the U.S. This uneasiness is also seen in regards to the extent to which market mechanisms influence the system. The United States has moved significantly towards a market system following the failed attempt at comprehensive national health care reform in 1994 (Schroeder, 1999). In the past, public policy initiatives and governmental activity, primarily centered on Medicare and Medicaid, had been the motivating forces for change. After years of describing the American health care systems as being policy driven, it would now have to be said that the system has rapidly become market driven (Williams & Torrens 1999). In recent years,

pressure for change in the U.S. health care system has largely been driven by market forces in the private sector, primarily from employers and other larger purchasers of health insurance. Private health insurance, provided and purchased by employers and individuals, is the most common funding source for health spending in the United States. Private insurance companies may operate as either non-profit or for-profit entities. Private sources, including private insurance and consumer out-of-pocket costs, accounted for 57% of personal health spending. Of this percentage, private insurance accounted for 35% of the dollars spent (KFF 2002). The majority of Americans (67%) have insurance coverage through employer-based insurance programs (KFF 2002); however, this number is expected to decrease given the current economy in the U.S. Insurance products are increasingly limiting consumer choice of provider and the types of services covered through managed care arrangements.

Many observers see the wide array of private and public health services programs and insurance products as a strength of the U.S. system (Upshaw and Deal, 2002). However, more than 41 million Americans (15%) are uninsured, making public responsibility for health services an important national issue. A press release by the American Public Health Association in January 2003 notes "The number of Americans with little or no health insurance contributes to the poor state of the nation's health. …. Widespread lack of coverage affects not only the uninsured and their families, but also the communities in which they live." Renewed calls for a national health insurance system for all Americans are being heard (Davis 2003) and the U.S., like other countries, must find a way to balance the "uneasy equilibrium" to assure access and improve the health of the public.

Non-clinical (Managerial) Professionals

Leaders and managers in the organization and delivery of health care services are the product of multiple educational backgrounds and multiple career paths in both the public and private sector.

As in the public health arena, multiple disciplines and individuals with wide-ranging expertise, experience and education may pursue professional paths. Common degrees, however, include health services administration, business administration and public administration.

PHYSICIANS IN EXECUTIVE ROLES

Unlike many countries of the world, in the United States physicians do not dominate leadership in administration of the health care field. While physicians do seek leadership roles in the areas of public health, health policy and health administration, the numbers are considerably less than one might see in other countries. Even when serving in executive positions, physicians generally report to a non-physician executive. The American College of Physician Executives (Grebenschikoff, 1997) found that ninety percent of physician executives reported to a Chief Executive Officer and another five percent reported to a Chief Operating Officer. Leland Kaiser, founder and president of Kaiser Consulting, remarks in an article on U.S. health care trends that "one of the strengths in our country is that we have non-physician CEOs ……. *In the future*[2], I don't see them as a majority" (Weber, 2003).

While in the minority, physician executives are found in every sector of health care. Only a third of physician executives either have or are working on a management degree (Weber, 2003), although numerous accredited and non-accredited master's level programs exist that are tailored for physicians. Many physicians working in public health or public policy possess a degree in Public Health. And physicians in either management or public health have the option of taking numerous non-degree educational and training programs to gain the knowledge, skills and values required for management positions.

PUBLIC HEALTH AND PUBLIC ADMINISTRATION: A BROAD-BASED EFFORT

[2] words in *italics* added

Opportunities to make significant contributions to the public's health and to the effective and efficient delivery of health care services abound for individuals trained in public administration, In regards to the health status of individuals, there is a general consensus that changes in health are related to changes in social and economic conditions. Public administrators and policy analysts should be at the forefront of developing and advocating sound social and health policies. In the delivery of public health and health care services, public administration can provide expertise in organization and management, decision-making and problem solving, budgeting and financial processes, information management, and program formulation, implementation and evaluation. Public administration can play a major role in the development of partnerships within and across the public and private sectors and demonstrate, through practice and training, a broad approach to the challenges of a healthy society and the management of health care systems. In this process, individuals trained in public administration and public policy can contribute and play a vital role in the development of policy as well as in the development of new systems and collaborative partnerships.

PUBLIC HEALTH AND HEALTH ADMISTRATION EDUCATION IN THE U.S.

The educational background and training of individuals employed in health systems and in public policy and governmental positions in the U.S. is varied. There are numerous starting points and multiple routes to a successful career. There is no single set of preparation or credential requirements. The multiple disciplines that intersect and may provide the initial foundation for a career in the health care field include public health, management, business, medicine, health administration and public administration.

The knowledge, skills and competencies founded in these disciplines provide a rich foundation for shared leadership and collaboration. The multiplicity of backgrounds and career paths recognize, if not promote, multiple contributions and perspectives.

ASSURING QUALITY EDUCATION

The United States has no Federal Ministry of Education or other centralized authority exercising unitary national control over postsecondary educational institutions. The States assume varying degrees of control over public education, but, in general, institutions of higher education are permitted to operate with considerable independence and autonomy.

In order to insure a basic level of quality, the practice of accreditation arose in the Unites States as a means of conducting non-governmental peer evaluation of educational institutions and programs. The standards of accrediting agencies are established in collaboration with educational institutions and programs in the area of expertise. Peer review is a hallmark of both the setting of standards as well as the accreditation process. While many schools offer non-accredited programs in the areas of public administration and health services administration, accreditation is viewed as a commitment to quality and recognition of the established standards.

THE ROLE OF PUBLIC ADMINISTRATION EDUCATION

The National Association of Schools of Public Affairs and Administration (NASPAA) is the membership association of graduate programs in public administration, public policy and public affairs in the United States. NASPAA's mission is twofold: it seeks to ensure excellence in education and training for public service and to promote the ideal of public service. The core focus of NASPAA affiliated programs is administration and policy; however, programs may provide a specialization or concentration track. Health sector management concentrations comprise one of the most rapidly growing tracks within NASPAA. NASPAA estimates that

currently 50-60 of their member programs offer specializations in health services administration (McFarland 2003).

The Commission on Peer Review and Accreditation (COPRA), the accrediting body of NASPAA, provides voluntary peer review evaluations of master's degrees or degree programs in public affairs, policy and administration. The COPRA has identified the question of how to treat the growing trend towards specialty degrees and specializations in non-profit and health care administration as issue to be addressed. Currently, these specializations often seek an additional accreditation from a specialized accrediting body. For specializations in health services administration, accreditation may be sought from the Accrediting Commission on Education in Health Services Administration (ACEHSA).

In 2000 NASPAA established a formal section on health sector management with an extensive agenda and two major priorities (Hewitt 2003). The first priority was the development of a better informed perspective on health sector management programs and the second priority focused on establishing a relationship with the Association of University Programs in Health Administration (AUPHA) and ACEHSA to ensure comparability in health care management education..

The following year, results of a web survey of NASPAA schools were presented by Marshall, Hewitt and Badger (Hewitt 2003). This survey indicated wide variation in requirements, electives and credit hours suggesting a need for further assessment. A proposal was submitted and funding awarded from the Robert Wood Johnson Foundation to do a study to assess the variations between programs. This project, currently underway, examines program curriculum, syllabi, students, faculty and alumni variables. Brenda Marshall and Anne Hewitt will provide preliminary findings at the 2003 NASPAA Health Care Management Sector Meeting.

Health Care Management Sector members have strongly supported the development of guidelines for all MPA programs which offer health care management concentrations. Sector members are also exploring the following alternatives: (1) seek dual accreditation with ACEHSA, (2) pursue a separate NASPAA health concentration accreditation, (3) improve NASPAA accreditation recognition by external stakeholders and (4) engage in joint marketing efforts without pursuing accreditation development (Hewitt 2003).

A table providing the broad categories of standards for accreditation by NASPAA and COPRA can found in Appendix A. The full standards and guidelines for accreditation can be found at http://www.naspaa.org/accreditation/accreditation.asp

HEALTH SERVICES ADMINISTRATION

The Accrediting Commission on Education for Health Services Administration (ACEHSA) is recognized to grant accreditation to individual academic programs offering a professional master's degree in health services administration in the United States and Canada. The programs accredited by ACEHSA are housed in a variety of disciplines and may be found in Schools of Public Administration, Public Affairs and Policy, Schools of Public Health, Schools of Health Related Professions, Schools of Medicine, and Schools of Business.

The ACEHSA is organized to establish criteria for graduate education in health services administration, planning and policy, to conduct surveys that will encourage universities to maintain and improve their programs; to determine compliance with the Commission's criteria; and to provide ongoing consultation to health services administration programs. Through the peer review process, the Commission seeks to assess and promote quality education in health services administration.

A table providing the broad categories of criteria for accreditation by ACEHSA can found in Appendix B. The full standards and guidelines for accreditation can be found at http://www.acehsa.org/criteria.htm

SCHOOLS OF PUBLIC HEALTH

The Council on Education for Public Health (CEPH) accredits Schools and programs in public health. The CEPH believes that accreditation attests to the quality of an education program and also represents peer recognition. Schools of Public Health are required to have a specialization in Health Services Administration. As with NASPAA specialization programs, many of these health services programs also receive accreditation by ACEHSA. Fifteen of the 32 accredited Schools of Public Health in the U.S. offer ACEHSA accredited health administration degree tracks and are AUPHA members. Currently there is a proposal for CEPH to recognize ACEHSA accreditation to avoid an overlap in the process of dual accreditation.

A table providing the broad categories of standards for accreditation by CEPH can found in Appendix C. The full standards and guidelines for use in accreditation can be found at http://www.ceph.org/benfit.htm

The Association of Schools of Public Health in the European Region (ASPHER) provides peer reviews in public health training in Europe and plans to eventually establish accreditation. ASPHER is primarily concerned with strengthening public health and has played a central role in seeking a higher level of expertise in the health sector (http://www.ensp.fr/aspher).

SHARED STANDARDS AND CURRICULUM CONTENT

A review of the broad categories provided in Appendices A-C demonstrates that while organized into different categories, the primary concerns of program mission, curriculum and faculty are shared. Appendix D provides a comparison of the broad categories of standards for

accreditation by the three accrediting bodies and Appendix E displays the commonalities in the basic body of knowledge, understanding, skills and values suggested in the curriculum criteria. Please note that for NASPAA the content knowledge reflects general administration and policy and is not specific to health services. The CEPH does not provide specific requirements for the five areas of knowledge basic to public health (see Appendix C). Instead the criteria state that the school of public health must provide depth of training sufficient for a student to pursue a professional degree. The content displayed in the Appendix E reflects the general definition for health services administration by CEPH as a core area of knowledge.

Boufford (1999) presented an agenda for managerial education in health services administration. She noted that the process of educational design at the professional school level must be a combination of the core knowledge and skills needed in the field, influenced by the challenges that graduates will face. Boufford distinguishes between a numerator-oriented model and a denominator-oriented model of the health care delivery system. The numerator model responds to the needs and demands of individuals seeking care while the denominator model responds to the community's health, a population focus.

The population focus on health that is critical today (IOM, 2002a) should be considered in the development of health programs in all countries. A population focus takes us beyond medical/curative service delivery and emphasizes the multi-sectoral determinates that influence health and acknowledges the collaborative efforts across sectors and stakeholders necessary to assure the population's health. Future leaders in health care must provide a board focus and develop collaborative models across multiple sectors. Public administration can be one of many routes for leadership in health care and may provide expertise across multiple sectors.

In discussing international models, Boufford (1999) suggests that "…. there is an important convergence of opportunities to learn from each other at both the policy and the operational

levels" (p. 285). As programs in public administration in both the U.S. and internationally review the appropriate curriculum content for public health, health administration and public administration, they should consider opportunities and challenges facing their graduates and the health systems of their countries on both the individual and community level. The design of education for health care systems should address the leadership challenges as well as the curriculum content and competencies required to address those challenges. Some of the basic questions should be:

- What is the organization of the country's health care system?
- What leadership challenges does the system and its structure pose?
- What are the challenges in training public health leaders in the country/region?
- What skills are needed to lead in the country/region and system?
- How can your program(s) provide the appropriate education and training for health care leaders?

SHARED LESSONS FROM THE U.S. AND OTHER SYSTEMS

In July, 2002 the USAID sponsored a conference on Ten Years of Health Systems Transition in Central and Easter Europe and Eurasia in Washington, D.C. with the objective of providing an experience that could be the foundation for future health transition efforts of country leaders and donors (http://www.eruasiahealthtransitionconference.org). A central theme to the conference focused on shared learning. Learning from others can provide models for adaptation to local realities as well as prevent health systems from repeating the mistakes of others. On a regional level, "expensive and time-consuming mistakes have been avoided by developing partnerships and collaborative programs with other countries" (Deac, 2002).

Within countries, public administrators and policy makers may help avoid expensive and time-consuming mistakes by spearheading a collaboration between public health, governments, and

health services delivery organizations within their systems as well as across the country boundaries. Sharing programs and courses across the educational schools and institutions may also lead the way for future collaboration and understanding.

The role of public administration in the health system of each country will vary. The contribution of public administration, however, can be significant. Public administration practitioners and educators are at the threshold of the future preparing a workforce for leadership to improve population health.

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APPENDIX A
CATEGORIES OF STANDARDS FOR NASPAA/COPRA ACCREDITATION

ELIGIBILITY FOR PEER REVIEW AND ACCREDITATION
Eligibility
Institutional Accreditation
Professional Education
Program Length

PROGRAM MISSION
Mission Statement
Assessment
Guiding Performance

PROGRAM JURISDICTION
Administrative Organization
Identifiable Faculty
Program Administration
Scope of Influence

CURRICULUM
Purpose of curriculum
Curriculum Components:
Management of Public Service Organizations
Quantitative and Qualitative Techniques of Analysis
Public Policy and Organizational Environment
Additional Curriculum Components
- General Competencies

Minimum Degree Requirements
Internships

FACULTY
Faculty Nucleus
Professional Qualifications
Practitioner Involvement
Faculty Quality
- Instruction
- Research
- Experience and Service

Faculty Diversity

ADMISSION OF STUDENTS
Admission Goals and Standards
Baccalaureate Requirements
Admission Factors

STUDENT SERVICES

Advisement and Appraisal
Placement Service

SUPPORTIVE SERVICES AND FACILITIES
Budget
Library Services
Supportive Personnel
Instructional Equipment
Faculty Offices
Classrooms
Meeting Area

OFF-CAMPUS AND DISTANCE EDUCATION
Definition and Scope
Program Mission, Assessment and Guidance
Program Jurisdiction
Curriculum
Faculty
Admission of Students
Student Services
Support Services and Facilities

APPENDIX B
BROAD CATEGORIES OF CRITERIA FOR ACHESA ACCREDITATION

PROGRAM MISSION, GOALS, OBJECTIVES AND PERFORMANCE
Mission, Goals and Objectives
Students and Graduates
Research and Scholarship
Service
Institutional Support

TEACHING AND CURRICULUM
Curriculum Design
Curriculum Content

FACULTY
Qualifications and Availability
Responsibilities
Recruitment, Development and Evaluation

APPENDIX C
BROAD CATEGORIES OF CRITERIA FOR CEPH ACCREDITATION

MISSION, GOALS AND OBJECTIVE

ORGANIZATIONAL SETTING
External
Internal

GOVERNANCE

RESOURCES

INSTRUCTIONAL PROGRAMS

The areas of knowledge basic to public health include:

1. Biostatistics - collection, storage, retrieval, analysis and interpretation of health data; design and analysis of health-related surveys and experiments; and concepts and practice of statistical data analysis.

2. Epidemiology - distributions and determinants of disease, disabilities and death in human populations; the characteristics and dynamics of human populations; and the natural history of disease and the biologic basis of health.

3. Environmental health sciences - environmental factors including biological, physical and chemical factors which affect the health of a community;

4. Health services administration - planning, organization, administration, management, evaluation and policy analysis of health programs; and

5. Social and behavioral sciences - concepts and methods of social and behavioral sciences relevant to the identification and the solution of public health problems.

RESEARCH

SERVICE

FACULTY

STUDENTS

EVALUATION AND PLANNING

INSERT APPENDIX D

APPENDIX E
CURRICULUM CONTENT

The required curriculum must include a basic body of knowledge, understanding, skills and values relevant to health services management.

ACEHSA	NASPAA	CEPH (HSA)
Structuring, marketing and positioning health organizations		
Financial management	Budgeting and financial processes	
Leadership, interpersonal and communications skills Managing human resources	Human resources	
Managing information resources	Information management, technology applications and policy	
Statistical, quantitative and economic analysis	Economic and social institutions and processes	
Legal and ethical analysis – business and clinical decisions	Political and legal institutions and processes Decision-making and problem-solving	
Health policy	Policy and program formulation, implementation and evaluation	Evaluation and policy analysis of health programs
Health status and determinants, Managing risks		
Development, organization, financing performance and change of systems	Organization and management concepts and behavior	Planning, organization, management
Outcomes measurement, Methods for process improvement		