1996 ANDREW PATTULLO LECTURE

A Vision of the Role of Health Administration Education in the Transformation of the American Health System

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According to the Biblical proverb, "Where there is no vision, the people perish." According to Tom Peters, the process of developing a vision is "the highest level of abstraction."

INTRODUCTION

Upon being invited to give the Andrew Pattullo Lecture, I called Andy to get his advice and to encourage him to attend, and he assured me that he would try to be here. Today, unfortunately, Andy is not able to be with us in person. I wish you could all get to know him and feel the inspiration of his personality and his vision of health administration education. His life force is more essential today than ever in this field. An Andrew Pattullo Lecture is a pale substitute for the real thing, but I will do my best to bring to you some of the inspiration and excitement that Andy still brings to me when I think about the underlying theme of this lecture series: the future of professional health administration education in the public's interest.

The Andrew Pattullo Lecture was established on three key principles: (1) that the administration of health services is one of society's most complex

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The Andrew Pattullo lecture, delivered at the AUPHA Annual Meeting, honors the role of the late Andrew Pattullo, former W.K. Kellogg Foundation senior vice-president, in the development of health administration education. The purpose of the lecture is to provide a forum for leaders with an interest in and knowledge of health care to share their views on future directions of health administration education. This article is the text of the 13th annual Pattullo Lecture, delivered at the Annual Meeting of the Association of University Programs in Health Administration, Atlanta, Georgia, June 8, 1996. Address communications and requests for reprints to Robert M. Sigmond, Scholar-in-residence, Temple University, 2912 Sterling, 1801 JFK Blvd., Philadelphia, PA 19103.

managerial assignments, (2) that professional education is a requirement for health services administration to serve the public's interest, and (3) that the educators' perspectives should be enriched with insights from outside the usual focus of the health administration field.

Whether or not this lecture will enrich your perspectives, preparing it has certainly enriched mine as I struggled to provide a useful outsider's concept of health services administration in the service of the public's interest. Although I have been teaching in AUPHA programs for over 40 years, and was furnished offices by three different universities, I always thought of myself as an outsider, part of the extended family, never seeking tenure, never serving full-time, rarely involved in departmental or university affairs, and viewing the AUPHA programs primarily as a source of intellectual stimulation through contacts with students and faculty. My expectations in that regard have been exceeded over the years beyond my wildest dreams. This lecture gives me an opportunity for a partial repayment of my debt by offering some thoughts on the central role of the public's interest in your work.

In recent months, I have read the eleven previous Pattullo Lectures in print as well as numerous other papers on health services administration education. In addition, I have explored issues facing the AUPHA programs with many professors, visiting four different campuses during the past six months. As a consequence, I have new understanding of the difficulties facing any university program determined to serve the diverse interests of students, faculty, alumni and the university in ways that clearly serve the public's interest as well.

I am impressed with the current AUPHA leadership's emphasis on re-articulating the obligation of the programs to serve the broadest public interest, even during these very tough times. A good many faculty members fully understand that when well-trained managers work long hours to respond positively to the many demands made upon them every day, the results of their work do not necessarily add up to serve the public's interest. There is no Adam Smithian "invisible hand" at work here to assure that what is best for patients, care givers, managers, faculty and students is also good for populations and communities. An explicit commitment by the faculty to a shared vision of a health system managed in the public's interest is required, exemplified by how the academic program itself is managed. Without such an explicit commitment, short-term and narrower interests almost inevitably take precedence and obfuscate if not obliterate the public's interest. In my recent travels and reading, however, I have been encouraged by encounters with leading health services managers who are building

public service commitment into their management processes, and also some AUPHA faculty trying to stir fresh winds within academia.

Defining The Public Interest

In preparing this lecture, I put a good deal of effort into making sure that I knew what I meant by "serving the public's interest". There is nothing in the literature that explains what this phrase means in health administration. I've arrived at a very simple definition which seems to say it all:

In the administration of health services, the public's interest requires appropriate response to consideration of both the involvement of and the benefit to everyone in the planning and oversight of any service for individuals or groups.

As Alexandre Dumas the elder put it in a quite different context, "all for one, one for all". We must simultaneously strive to do right for every sick patient, for every individual and for entire communities. To do less is to fail to live up to our fundamental professional duty.

Some of those who have reviewed preliminary drafts of this lecture have complained that my effort to define the public interest in a health administration context is much too simple, and not explicit enough. In my definition, how much consideration of involving everyone? How much consideration of benefiting everyone? And does "everyone" really mean everyone in the world— or where? And what is an "appropriate response?" And why the focus on "planning and oversight," in contrast with operations? Each of these questions deserves an answer.

Only "planning and oversight?"

Starting with the last question first, serving the public's interest is uniquely an issue in planning and oversight, because in operations, the focus is necessarily more narrowly on the individuals being served, and on well-defined tasks, without diversion of energy to matters involving the entire public. A narrow perspective is required in order to get things done efficiently, but the public interest requires that activities are planned and evaluated in a broader perspective.

Consideration of involvement of everyone?

Managing in the public interest requires consideration of involving everyone because everyone is involved somehow, and because the nature of their involvement has a lot to do with results. We may not approve of how everyone is involved, but that does not provide a basis for avoiding some consideration of everyone's involvement in the system in our planning and oversight activities. In teaching an introductory course on health services management, I spend quite a bit of time in the classroom exploring how each student is actually involved in managing her or his own health, the extent to which the rest of the "health care system" is involved, including the student's extended family and the various communities that the student feels have some influence on her or his behavior. Students begin to understand the extent to which the most expensive elements of the health care system are out of synch with the activities of individual consumers, patients and others when it comes to impact on life style, health promotion, self care, or even "compliance" with care giver prescriptions. Also, students begin to understand that, even with the breakdown of the traditional family, the student and the student's extended family are much more involved in the student's health care than are the expensive elements of the health system. They begin to understand why individual involvement must be given explicit consideration in realistic planning and oversight of health services. This does not mean that everyone must be involved in the planning and oversight of health service systems. The emphasis in the planning and evaluation processes is on consideration of the involvement of everyone, not on their actual involvement in these processes, as desirable as that might be. In the past, too much energy has gone into involving individuals in more effective health system planning, as contrasted with the system's focus on more effective individual and family planning of their own health.

Consideration of the benefit to everyone?

Management in the public's interest requires explicit consideration of the benefit of services to everyone, not just to those who actually receive the services. This is a difficult phase of planning and oversight of health services, particularly at this period of history, when we are just beginning to give systematic, explicit attention to the benefit or lack of benefit for those actually receiving specific services. Given necessarily limited resources, however, some consideration of the benefit to everyone is required in planning and oversight of health services, beyond those actually receiving services.

Do you really mean everyone?

In the administration of health services, it is obviously not possible to involve and benefit everyone in the world. But without at least initially considering everyone who may or may not be targeted, it is difficult to focus explicitly on specific populations and communities, the key to measuring health services effectiveness. With respect to acute care, especially in an emergency, health systems are necessarily programmed to take care of any one, if only by referral processes. But most other services are programmed more explicitly in terms of commitments to particular populations, enrolled or unenrolled, and to particular geographic communities that must be identified for effective planning and evaluation purposes.

How much consideration?

Many will wonder just how much consideration should be given to involving and benefiting particular populations and communities. Of course, that will vary with every situation, and comprises one of the key issues in any exercise of health services planning. In most cases, the answer is very little. In other cases, a great deal. The only clear cut answer that can be given to these "how much" questions is that if the public's interest is not considered at all, the planned service will only be in the public's interest by chance. The essence of sound management is to improve the odds and not leave things to chance.

What is an appropriate response?

Here again, there is no simple answer with respect to assessing appropriate responses to specific situations, and as yet no methodology for systematic appropriateness review in these situations. If the definition of the public's interest in health services administration is accepted and put to use, the development of sound methodology for assessing whether various initiatives are appropriately responsive can be anticipated.

Why not define the public interest in health administration in much more specific terms?

For example, here is a more explicit definition:

The public's interest requires efficiently delivered health services of high quality at affordable costs made available to all of the people, irrespective of the source of or the

adequacy of payment, and to have the total available resources for health services wisely distributed to maintain and improve the health status of communities and of all of the people to the extent achievable through sound management and community involvement.

Personally, I feel very comfortable that this more detailed definition reflects the public's interest, but recognize that it includes many characteristics that others might not agree are necessary, desirable or achievable. It seems to me that managers can serve the public's interest very well with somewhat less specific commitments that will bring together rather than divide those who are involved.

If this lecture has no other impact within the field of health administration education, it is my hope that it will stimulate discussion of the role of AUPHA and its constituent programs in serving the public's interest, leading to a consensus that can assure the continued vitality of AUPHA and its constituent organizations.

Clearly, health services do not have to be managed in the public's interest; nor do all health services managers require a professional education. The key issue is the role of professional education in providing society with health services managers who know how to value and serve the public's interest.

My Thesis

The basic thesis of this lecture is quite straightforward. When it comes to serving the public's interest, health services managers have a real problem: the health services sector is so fragmented, and under so many pressures from so many special interests that few managers have the time to think in terms of also serving the public interest, or to have practical ideas of how to go about it. Like virtually all activities in the health care field, the programs that educate health care managers are both part of that problem— and an important part of its solution. The AUPHA programs can provide leadership by demonstrating and teaching the role that management can play in serving the public's interest, while also serving valid self-interests in a competitive environment. The potential is there, in the many faculty members and program directors who have a vision of health services as more than a commercial business of furnishing clinical services at competitive costs to the sick and injured. At its best, the health care field embodies the deepest values of humankind and public service. A commitment to a shared vision of a health system serving the public's interest can help all elements of the health system to overcome the handicaps associated with

excessive fragmentation. Most evident and most serious is the fragmentation reflected in the schisms between the public and private impulses in the health field.

Some years ago, the late Wilbur Cohen, remembered by many as a key player on the team that gave birth to Medicare and Medicaid, lectured on his vision of the future American health system. His thesis was that its future depended almost entirely on the relationships that would be developing between the public and the private sectors. In the discussion period following the lecture, he was asked in which sector he placed the great non-government universities and other non-government tax-exempt institutions in his vision of the future: are they part of the private sector or part of the public sector? His reply was right on the money: "That depends entirely on how each of them behaves."

My review of the textbooks and the scholarly papers being currently produced by AUPHA faculty reveals that almost all treat the terms "public" and "private" as essentially synonymous with government and non-government. They implicitly categorize the government as the (sometimes misguided) agent of the public's interest, and the entire non-government sector, whether investor-owned or not-for-profit or even not-for-profit tax-exempt, as the private sector, primarily accountable to and for private interests. I submit to you that this leads to intellectual confusion with respect to the public's interest which interferes with our nation finding real solutions to its health care problems. The emphasis on serving the public's interest as highlighted in the Pattullo Lecture series applies to health services managers in non-governmental as well as governmental organizations.

By my count, a majority of the AUPHA programs are owned by governmental units; the rest are units of tax-exempt not-for-profit organizations. But I am not able to distinguish any difference between the programs that are part of governmental institutions and the others. In terms of serving the public's interest, ownership does not appear to be relevant. As Wilbur Cohen observed, behavior is what matters. In any organized activity, behavior depends less on ownership than on management processes, starting with vision and mission, followed by strategic planning, operational planning, implementation, and evaluation. All organizations in all sectors can be managed to serve the public's interest. All AUPHA programs that maintain professional standards should identify themselves as in the public sector and behave accordingly.

Do We Agree That There is a Problem?

I assume that everyone here today agrees that the profound public concern about the health services in our country is not yet being adequately faced up to either by the programs in health administration education or anyone else, for that matter.

I will mention only one aspect of that concern: health care costs. Today, these costs are seen as a major factor in the recent unprecedented closing down of the federal government and the projected bankruptcy of the Medicare trust fund, reflecting the inability of politicians to deal realistically with the health care cost problem. In the Summer, 1995 issue of *Frontiers of Health Services Management*, I urged health service professionals to speak out now on what they know to be true: that "with community control, support and patience, they can manage to overcome the fragmentation of the health care system and guarantee access to decent health care for everyone at much less cost" (Sigmond, 1995). Notice, I did not say at a much lower rate of increase, but with actual reductions in community health care costs. We spend almost double per capita what other developed nations spend, and based on available international data, our results are not as good as in many other countries.

We have the know-how —but we don't teach enough of what we know— about the community benefits in terms of improved health and lower costs that can result from coordinated community governance and management of community networks, reflecting a shared vision. We don't consistently teach that at the community level, the community interest and the public interest are essentially the same thing— and that community accountability is the key to public accountability. We don't spend enough time and energy on the various ways to govern and manage community-accountable health systems.

We do teach about effective institutional management, but without emphasizing the importance of a community and public service perspective. We don't teach that with a basic community collaborative perspective, the institutions can be managed to combine the continuous improvement of health outcomes with the conservation of enough resources to resolve many of the community's and nation's critical non-health problems at the same time. We don't teach that with a public interest perspective, almost every element of our society can achieve reasonable health services-related goals more effectively than with a narrow self-serving perspective. There are plenty of examples of moves in the right direction. We can teach others. We can provide intellectual leadership. We can manage to make a measurable difference in cost effectiveness, in life expectancy, in quality of life, and in the

public's health in the broadest sense of that term. That is the current challenge to professional health administration education, as I see it.

My intention here is to take note of the transformation of the health system over the past 60 years or so, as reflected in a few key publications, hoping to provide some useful insights that might help the programs in health administration education to transform themselves by more specific efforts to serve the public's interest.

The Transformation of the American Health Care System

The Committee on the Costs of Medical Care

The American health system was first discovered by the Committee on the Costs of Medical Care (familiarly known as the CCMC) during its explorations from 1927 to 1932, much in the way that Columbus discovered the New World, which had of course had been there all along. The health system had been developing for well over a hundred years, but had never before been identified or described as such, although Michael M. Davis came close in his writings as early as 1917.

In an earlier pioneering survey in 1927, CCMC Study Director Harry H. Moore had suggested that there was no health care system at all, or at most a very confused state. We still have authorities questioning whether we truly have a health system, often referring to the "non-system". Of course, as former California Health Commissioner Les Breslow so often pointed out, if you think that there is no system out there, just try to change something! You will find that there is indeed a very strong and entrenched system, with multiple and often conflicting goals and not fitting any simplistic models very well. Modern system theory teaches us how to view all of the complex elements of health care —including the people— as interrelated parts of a health system, which in itself is a subsystem of the broader, even more complex human services system.

One of the lasting accomplishments of the CCMC was its scholarly work describing the system in all of its inter-relationships, with 26 major reports of fact-finding studies, covering every aspect of the field (with the singular exception of environmental health) (CCMC, 1932).

Even more noteworthy than its amazing thoroughness and splendid scholarship, however, was the CCMC's vision of a system that would provide good care for all at reasonable cost, safeguarding quality, and preserving the essential personal relationship between patient and physi-

cian. The only elements of what we currently regard as important to the health system which were excluded from the CCMC's vision are commercialization of both provision and financing of care and "contract medicine" that does not reflect professional commitment to the public interest. These were concepts explicitly rejected by the CCMC as inconsistent with its vision.

The CCMC members and staff not only were pioneers in discovering the American health system, they also were the first to have a vision of a system working in the public's interest— that is, for all the people.

It was this vision of a system that could actually work for all —a really exciting idea— that had captured the imagination of just about everyone I met when I first became involved with this field 50 years ago. Oddly enough, most of these idealists—just about everyone in health administration was an idealist in those days— had never heard of the CCMC or if they had heard of it, they associated it more with the detailed majority recommendations of the CCMC as contrasted with the much simpler vision of the entire CCMC membership: a health system organized to serve for all the people.

For those who don't yet make my own personal distinction between a vision and an hallucination, let me suggest that this distinction is helpful in efforts to attack current problems with an eye on a much brighter future. An hallucination is a dream of the future seen in enough detail to be divisive, whereas a vision makes up in inspiration what it necessarily lacks in detail. In terms of recent experience, Ira Magaziner, Hillary Clinton and their task force produced a 1300 page road map that seemed to most people to be more of an hallucination than an inspiring vision.

By contrast, the President's original espousal of a health system incorporating six elements —remember them: security, simplicity, savings, quality, choice and accountability— was more like a vision, but still lacked inspiration. Inclusion of the key missing inspirational element —making the United States the healthiest nation in the world— might have rallied the nation around a Clinton vision.

Back to the 1930's, the CCMC members were in agreement on a very simple and for that time, a very inspiring vision —a health system that works for all. In addition, the majority of the Commission produced more detailed recommendations that were divisive. These recommendations involved not only such readily accepted (though not easily implementable) notions as community coordination, expanded professional education, and public health as a process rather than as a purely governmental function, but also two controversial proposals: group medical practice and community

group payment. These two notions are still dividing us 64 years later, though no longer to the same extent. Group practice is now accepted as one alternative method of organizing medical practice, but still divides the medical profession in many communities. To this day, few understand the CCMC majority's concept of group practice as shared accountability and shared resources among physicians, not necessarily related to shared financial arrangements. Currently, the best of the emerging physician-hospital organizations do capture a good deal of the essence of that concept.

Most of us thought that group payment had eventually become accepted by everyone, but is again coming under attack by those advocating payment from individual accounts, even by Medicare beneficiaries.

The struggle over these two issues generated so much controversy during the decades following publication of the CCMC final report in 1932 that the general acceptance of the CCMC vision—of a health care system that worked for all—became obscured and all but lost.

At the same time, key members of the CCMC staff and others searched for and found exciting "natural" developments springing up in communities throughout the nation, to be shaped into significant innovations, based on the inspiration and insight provided by the CCMC vision. That great pragmatic visionary, Rufus Rorem discovered Justin Ford Kimball in Dallas, Texas charging school teachers fifty cents a month for his hospital's services, and saw the beginnings of community-based prepaid health insurance for service benefits. Along with John Mannix and others, he promoted this concept with hospitals and community leaders all over the country, leading to entirely new formulations of financing health care services. Rorem's efforts to use the CCMC vision to inspire community coordination of increasingly complex and costly technology and services in New York City, Philadelphia, Pittsburgh and elsewhere were less successful, but his incrementalist approach to transforming the health care system had significant impact in many communities (Rorem, 1982). Eventually, government's increasingly dominant role in financing and planning undermined the forces for community collaboration.

In the post-World War II period of technology expansion, the CCMC vision and the incrementalist approach to transforming the system were tracked most effectively in a series of inspiring books and articles by Anne and Herman Somers, starting with their landmark *Doctors, Patients and Health Insurance* which appeared in 1961 right through to *Health and Health Care* in 1977 (Somers, 1977).

Eventually, the concept of a cost-effective health system became linked with the growing commercialization of many provider and payer organiza-

tions, with the federal government providing the safety net, phenomena far removed from the CCMC vision.

The Starr Transformation and the Magaziner Hallucination

This point of view was reflected in Paul Starr's *Transformation of American Medicine*, an early 80's scholarly tour de force that incorporated elements that the CCMC had overlooked —especially profit-driven enterprise and a greatly expanded role for the federal government— but left out its vision (Starr, 1982). Starr's work is important because it clearly focused the extent to which medical care was evolving away from serving the public's interest by becoming more and more money-driven.

This perspective dominated health policy discussion during the years following the publication of Professor Starr's book, culminating in the disaster of the hallucination of the Health Security Act which killed President Clinton's unique opportunity for national leadership in achieving visionary reform.

The Revived Transformation: the CCMC in Modern Dress

Even before the recent failure of the reform initiative in the Congress, however, some intellectuals as well as leading health care executives were coming up with new formulations of the old CCMC vision of a health system functioning in the public's interest. They explicitly incorporated the elements not visible in the CCMC vision: an appropriate role for commercial entities and the necessarily larger regulatory and safety-net roles for government that money-driven medical care requires. Their primary focus is again on collaboration and cooperation at the community level.

The struggle over health care reform in Washington has obscured this revival of the CCMC vision in modern dress at the community level, especially as reflected in the visions of Dick Davidson and the American Hospital Association (AHA, 1993), the Belmont Group (IAF, 1995), the Catholic Healthcare Association (CHA, 1993), as well as the initiatives of the Healthcare Forum and other health services, professional and community groups. All of these visions recognize the importance of competition as a major force, without relying on the marketplace to govern the health care system in the public's interest.

Not always identified with a specific vision or even with a notion of reform, health system transformation has now shifted to the community and regional levels, and is proceeding rapidly if not consistently in the

public's interest all over the country, with the pace of change seeming to accelerate rather than to slow down and stabilize. In contrast with the CCMC era, the main driving forces at the moment appear to be the marketplace, money and survival.

But there are other initiatives underway inspired by the Healthy Cities movement and by those with a continuing commitment to community benefit. (CHCCU, 1996). All the evidence suggests to me that the public's interest will be well served only where community health goals and community forces are firmly built into the management of the new developments so as effectively to humanize the sometimes mindless marketplace and bureaucratic regulatory forces.

The concept of community-involved and community-focussed collaborative health care systems committed to continuous improvement of the health of all, as well as to making the best use of scarce resources, is beginning to gain a foothold throughout the nation since the failure of the national legislative initiative. Being nurtured primarily in the not-for-profit sector, this concept is also found within the Department of Veterans Affairs and some other governmental units. More recently, the theme has been picked up for funding by the W.K. Kellogg Foundation with the AHA Hospital Research and Educational Trust, and also in the most recent writings by such respected academics as John Griffith and Steve Shortell. In John's case, compare his most recent published paper with his books (Griffith, 1996). In Steve's case, compare his most recent book with his published papers (Shortell, 1996).

The scene is set for a rebirth of the CCMC vision and Rufus Rorem's incrementalist approach to transformation. The academic programs can play a significant role in giving this development shape and substance and credibility. A brief review of the transformation of these academic programs may provide some perspective for a vision of their future in this respect.

The Transformation of the Programs in Health Administration Education

In the Beginning

The earliest programs in health administration education were founded in the early thirties, shortly after the publication of the CCMC recommendations. All of these programs—explicitly or implicitly—started with a shared vision, based on the CCMC's work. The students were being trained

specifically to become the leaders of the nation's health services institutions in transition—primarily hospitals in those days— and most graduates achieved this objective within one to three years of graduation. The primary emphasis in teaching was on institutional management, but with the institutions seen as evolving medical service centers with emerging institutional responsibility for clinical activities. Following the lead of the CCMC, they advanced the notion of these institutions as community health service centers. Such centers were seen as having responsibilities not only for inpatient and emergency care, but also for ambulatory care, and for community health services. In those days, it was obvious that health care was very much a community affair.

What the early programs may have lacked in terms of traditional academic discipline, scholarship, research, and identification with academic colleagues in related disciplines, they made up in their involvement with the rapidly growing health services organizations in the community, much like their counterparts in medical schools.

The heads of the programs were not infrequently the administrators of the university hospitals, and their faculty often headed up other service programs of the academic centers. Like their counterparts in the medical schools, they were leaders in the field of practice, not only in their immediate geographic areas but nationally. They exerted influence well beyond the classroom and the university. In those early days when the program directors were providing leadership to the field, the students were required to spend half their time in residencies in service settings in order to earn their degrees (Sigmond, 1966).

Achieving Academic Credibility

By the late 1960s, the programs were aspiring to become respected participants in the academic world, with major emphasis on scholarship and research, and with a much higher proportion of the students' time spent in formal study at the university. The residency typically was reduced to a few months in the summer within the expanded two year academic program. Soon, the programs were well established nationally and even internationally, with the leadership of Gary Filerman at the AUPHA helm and the establishment of the Accrediting Commission. But these major advances came at the expense of the influence of the programs amongst the managers of health care organizations.

Responding to the Competitive Marketplace

In the 1980s, the programs were responding to, and even encouraging, the commercialization of the nation's health system. There was little evidence that they were motivated by a vision of a health system that worked effectively for all. The 1985 Pattullo Lecturer, Bruce Vladeck, pointed out that you can not effectively educate people to manage a system without a sense of what that system should look like. At about the same time, however, a Foundations-funded survey of problems with health management education took a different tack (Kovner, 1986). The report of this survey focuses on specific management issues, but includes no mention whatever of vision or mission or even the public interest. Its exclusive emphasis was on the necessity for the programs to adapt to the fact that the voluntary charitable organizations had to change into competitive enterprises in what is repeatedly characterized as the "health care industry."

Let me comment on that. No other human services field with a basic community commitment describes itself as an "industry." Think of the meaning of the "higher education industry," the "church industry," the "welfare industry." At first, the terms sound ludicrous. Then it becomes apparent that they describe the companies which provide goods and services to the schools, churches and welfare agencies, not to the mission-driven organizations themselves. Those with a vision of health services dedicated to community benefit do not describe health care as an industry.

Whether or not the health services field is termed an industry, clearly both the exploitation of and control of greed are very important elements of managing the various elements of the health care system. They must be incorporated as a major element in the health administration curricula. But the processes for managing economic incentives are really not that different in our field than in other sectors of the economy, except as these incentives are to be linked effectively with weaker but surely more precious altruistic incentives. Taking powerful economic forces into consideration without explicit and continuous attention to the public's interest creates the danger —both in managing the system and in teaching how to manage the system— that those forces will take over.

Last year, a decade after publication of the 1986 study, the Pattullo lecturer, Walter McNerney, was again worrying about "our vision for the future: our ends, not just our means". Despite much effort by AUPHA programs to become relevant to the investor-owned health care industry, the captains of that industry have not generally shown much interest in supporting the AUPHA programs.

To give the purely "industry" segment of the health care field its due, it

is taking much waste —and community service— out of the health system, and is getting rich in so doing. At this time, that can still be accomplished in many places without causing much pain, using mainstream management processes that are taught in all business management programs. This does not require any special understanding of the health field. But when efficiency and frankly financial goals become dominant, not many of us want to rely on such a system for our own and our families' health care.

My sense is that the leading educational programs are beginning to provide crucial intellectual leadership concerning the growing importance of serving the public's interest, especially in an increasingly competitive environment. Programs are making changes in their curricula, their teaching, their consultation and community service activities, and even in their research projects to reflect this new stage in the transformation of the American health system.

I submit that now is the time for the educational programs to give more explicit managerial attention to this internal academic "transformation in progress," and to begin to apply best managerial practices to the management of their own internal departmental affairs, so as to respond most effectively to this challenge. The impact of modern management techniques in transforming the American health system can be profound, but the programs will not be able to fulfill their potential to help until they apply those techniques to the management of their own affairs. That idea may seem straightforward enough, but is counter to their history and to their positioning within the current academic world.

Managing the Transformation: The Current Challenge of the Programs in Health Administration Education

The Search for Identity and a Shared Vision

Managing the transformation of a complex organization, no matter how large or small, is a lot easier to teach than to do. Especially within an academic program, the place to start is with a disciplined search for its unique identity within the university and its vision of the future —shared by the faculty— that confirms its identity.

Identity

In his Pattullo Lecture ten years ago, Bruce Vladeck suggested that the leaders of each of the AUPHA programs think over and articulate why our

programs are important as separate and legitimate undertakings, why health care is different from other areas of human activity, why that difference requires a different orientation and different commitments and different skills. He suggested that unless you go through that process, you will truly be lost. I have to agree with that.

From my point of view, the programs are unique because the health care system necessarily involves not only care of individual patients and the collective care of enrolled populations, but also care of geographically-defined communities. If only patients and enrolled populations were involved, mainstream management of professional services would probably be quite sufficient. But caring for patients, populations and communities involves new management approaches that recognize, exploit and inter-relate three quite different mind sets and data sets and managerial disciplines. These three approaches simultaneously address the same problems from three different perspectives. If the responsible managers work do not concentrate on coordination of these different perspectives, they will frequently be working at cross purposes, unaware of either the unnecessary costs they are generating or the opportunities they are missing. Increased productivity and enhanced outcomes depend on bringing the three perspectives into cost-effective interaction, a unique management challenge not found elsewhere in the management world. Purely business management techniques by themselves are not powerful enough and are not easily adaptable to the necessity to assure effective interaction among clinicians, insurance experts, community activists, public health officials, families— and more.

The desired outcomes for patients, enrolled groups, and communities — all three— can only be achieved through coordinated interactive managed efforts, with greatest attention to the most cost effective modalities, often outside of the classical medical model. That frequently requires special attention to community organization, community forces, community accountability, and earning community trust. Relatively small expense is associated with effective initiatives to care for communities and thereby improve the health of the people as well as the cost effectiveness of the services, especially when carried out as integral parts of programs centering on patients and populations (Kovner, 1994). This is the complex management challenge —managing in the public's interest— that is the justification for the programs in health administration, and gives them their unique identity in the management world as well as in the health care world.

It is not my intention to suggest that programs without a vision of the public's interest, as I have defined it, are immoral or without vision. Not at

all. Nor do I suggest that specific health care services cannot be managed effectively by focussing only on individual patients and enrolled populations. Rather, I am suggesting that the system will work much better in terms of outcomes and cost effectiveness when the public's interest is consistently incorporated into planning and decision-making processes. Health service in the public's interest is not some wooly, soft-headed, liberal notion of do-gooders and dreamers who aren't in touch with the real world and don't know about the bottom line. Rather, it is the key to fiscal stability of organizations as well as to better health outcomes (Sigmond, 1995).

Once a program acknowledges its identity with the public's interest, it will inevitably discard value-neutral objectivity in developing a shared vision, and then in everything else it does, with the single exception of its research methodology.

The corrosive effect of value-neutral objectivity with respect to policy is brilliantly set out in the must-read book by Heilbroner and Milberg, analyzing The Crisis of Vision in Modern Economic Thought (Heilbroner, 1995). Their analysis of why the absence of vision has undermined the relevance and remedial power of modern economics is a useful introduction to Mark Pauly's equally brilliant but sadly sterile analysis of community benefit in a recent issue of Frontiers of Health Services Management (Pauly, 1996), —and to the value-free insights of the economists who contributed to the Baxter Health Policy Review Volume II, developed under the auspices of the Association for Health Services Research (Altman, 1996). Since this influential scholarly work is "directed primarily to those working at the community level in a diversity of settings," academic programs dedicated to the public's interest have an obligation to place its value-free analysis in perspective.

There is only one positive thing to say about lack of a shared vision: it is certainly preferable to the current double vision that is characteristic of so many health service managers these days. They have both a vision of a dominant, supremely efficient commercialized health care marketplace and an inherently incompatible vision of a healthier community. With double vision, it is virtually impossible to have any notion of what direction you are going in or even where the road is when you are heading in two directions at once.

Visions and Visioning as Tools of Management

Only as an AUPHA faculty gets into a robust shared visioning process, a key management tool as it has evolved in some service settings, will the faculty be able fully to understand why and how a shared vision is an essential management tool for health care managers coping with everyday problems.

Some faculty members have argued against the notion of a shared vision either of the future health system or of the academic program. They fear that it will impose a rigidity of thinking inconsistent with the pursuit of knowledge, and may even threaten academic freedom. This concern reflects misunderstanding of what a shared vision is and how it can serve as a tool of management, even in an academic setting. As in other settings, an effective visioning process might well begin with clarification of possible misconceptions. Most important, a shared visioning process has as its goal the development of a vision that is based on and consistent with the individual visions of all those involved, but does not require each participant to abandon her or his own vision. The effort is designed to find the common denominator reflected in the various individual visions, not a compromise. A faculty group without a variety of philosophical viewpoints lacks the yeastiness that is essential to productive teaching and research. A shared visioning process attempts to identify common values, not to coerce faculty members to accept a vision in which they do not fully concur. Unless ideas are under constant challenge, they lose their zing. Dissenters should be tolerated not only in the name of academic freedom, but in the name of effective search for knowledge and innovation and excitement. At the same time, it is important to those who challenge conventional thinking to establish some degree of commitment to common values.

Faculty who resist a shared visioning process have much in common with those physicians who volubly resist medical quality management, clinical practice guidelines, and "evidence-based" medical practice. They see these as intolerable intrusions into their professional autonomy. Worse, they view them as sometimes amateurish, poorly grounded in science, and a poor substitute for the clinical acumen that develops out of years of practice in an environment of vigorous peer review. Over time, however, if they are practicing in settings that impose these techniques intelligently and soundly with respect for the patient/physician relationship, they come to realize that their fears were unfounded. Autonomy is not compromised by medical quality management, except in the sense that the freedom to engage in bad practice is reduced, as well as the threat of outside interference. Then, their contrariness can instead become an insistence that the medical quality management is effective. Then, they will be ready to accept the concept of quality management that embraces a larger perspective then the individual patient, encompassing enrolled and targeted populations as well as entire communities.

Effective professors as well as effective managers can demonstrate that the essence of organizational management of professional affairs is in

establishing and strengthening the interdependence —but not the identity— between each individual's vision and an organizational shared vision. The search for a shared vision is a search for the highest conceptual common denominator among individual visions within the organization, not the lowest. Once this notion is understood within an organization, resistance to a shared vision usually begins to melt away. I feel sure that will be the case in most academic programs as elsewhere.

Most vision statements incorporating the public's interest in health care can be expected to refer to the goal of ever healthier individuals and communities, sustained by consumer-responsive, community-controlled, prevention-focussed, cost-effective, well-managed community care networks dedicated to continuous quality improvement. The vision of an academic program would be expected to include providing intellectual leadership for its communities' health networks through its teaching, research, scholarship and community benefit activities.

But the process of developing such vision statements, and the way such statements are used as management tools, are much more important than their precise content.

The Challenge of Transforming Academic Programs into Managed Academic Programs

Any health administration education program that engages successfully in a visioning process resulting in a shared vision of the health system and of the academic program itself will thereby embark on a course of change. The program will assure its future not simply by adjustments in curriculum, teaching and research, but perhaps more fundamentally by rethinking its own organization and management, internally as well as within the University. Once these change processes are underway, the program will find itself making even more important changes in its relationships with the communities and the entire health system where it is located.

After all, expertise in organization and management of elements of the health system is the program's uniqueness. The time has come for the programs to apply their intellectual rigor to themselves. If how they are structured and managed disregards the basic principles of management that they are teaching, the teaching is undermined.

Warning: Avoid Hallucinating

When a shared vision has been agreed upon, there will be temptation to develop detailed plans for quickly turning the vision into reality, planning

for a completely transformed academic program. This could be an intellectually stimulating exercise, but it is dangerous because certainly there is insufficient knowledge, and inadequate consensus to support such a development. Producing a detailed plan for profound changes means producing an hallucination. It almost always will stir up dissension, and interfere with real progress.

A much more realistic way to go is to stimulate the faculty to explore practical, incremental changes relating to their individual activities that may not be terribly radical or threatening to anyone. Such initiatives will have the effect of supporting and confirming the shared vision, leading to ever more innovative pragmatic initiatives.

In emphasizing incremental, readily acceptable changes stimulated by the shared vision, I am not suggesting that the program forgo a long range strategic planning process. The point is that the vision does not take over that process, it only contributes a higher level of abstraction and a bit more inspiration, as it does to all managerial activities.

Picking Low Hanging Fruit

The advocates of total quality management and continuous quality improvement have popularized the notion of innovation by starting with picking the low hanging ripe fruit as a basis for gaining the credibility, confidence and skill required to move to higher and more difficult objectives. This approach has a lot to recommend it in transforming a program in health administration education. In many instances, the new shared vision will reveal low hanging ripe fruit that hardly anyone had noticed, as was the case when Rufus Rorem observed that community prepayment's time had come.

What might be some examples in the current health administration education world? Each of you would know better than me. Here is just one that comes to mind, based on my own personal experience: a more dynamic relationship between teaching and the community's health service organizations, centering on the part-time students.

Part-time students

Today, in academic programs, the part-time students greatly exceed the number of full-time students. Almost all of them work in the local health sector and almost all have their tuition paid at least in part (assuming their grades are satisfactory) by their employers, generally as an employee benefit rather than as one element of a comprehensive executive development program. At Temple University where I serve on the faculty, most of

these students take courses in the late afternoon or evening and are extremely interested in relating their studies to their aspirations in their current job settings. In teaching these students, as contrasted with the full-time students in the day program, I am always impressed that collectively, any class of even 15 or 16 knows a lot more about the details of whatever I am talking about than I do. Very challenging.

Working with Tony Kovner a few years ago at New York University, I learned that classifying the part-time students by employer revealed that a number of the local health services organizations were investing (without even knowing it) significant amounts of money in the graduate program in the form of tuition paid as employee benefits. We began to explore the idea that these employers might be approached to consider collaborative educational initiatives to convert their investment in employee benefits into a systematic executive development program for selected students/managers. By closely linking what the students are doing in their jobs with what they were learning at the university, their supervisors would be tied into the teaching experience even as the faculty became involved in the practical problems being faced. I can think of no better way for any academic program to get started on innovation inspired by a public service vision.

At my university, the individual in charge of marketing business school courses to industry noticed that a fairly large number of employees of one of the major suburban hospitals was signing up for the late afternoon section of H.A. 500, Introduction to Medical Care Organization. Since he knew the Vice President of Human Resources at that hospital from Rotary Club lunches, he talked to him about putting the class on at the hospital, so the students would not have to come down town. This year, the class was held in the hospital's own conference center, with four physicians, five nurses, and 13 other students from the business office, social service, public relations, and more. In talking with the hospital CEO at an alumni gathering, one of our faculty learned that the CEO did not even know that he was housing and paying for this graduate course. This week, we began discussing possibilities of involving the CEO in the organization and management of the course, of relating what is being taught to the hospital's vision, mission and strategic plan, as well as to what is going on in each of the departments where the students work. We are trying to avoid hallucinating about the notion of establishing our first formal teaching hospital affiliation arrangement similar to what that hospital has with our medical school, about bringing the CEO onto the faculty, and about collaborating in the hospital's transformation to a community care network. We aren't talking about any of that right now. It's too soon and we would surely get it wrong.

Other low-hanging ripe fruit may be found in the informal relationships between individual faculty members and various elements of the academic medical center.

Still other faculty members may be inspired by the shared vision to see that their consulting activities might be enhanced by more systematically involving other faculty, perhaps leading to consideration of an organized practice plan as in the medical school clinical departments.

Faculty engaged in research may be inspired by the shared vision to think about larger projects that require an organized departmental approach to research that could attract resources not available to "lone ranger" researchers: additional doctoral candidates and other first class students— and money.

Still other low hanging fruit may be found among the community service activities in which many of the faculty and students are involved. The shared vision might lead to a more disciplined departmental initiative that enriches these experiences for them personally as well as beginning to involve the department in a leadership role. My sense is that very exciting opportunities are out there, especially involving small community hospitals in one-hospital towns that are attempting to make the transition from isolated hospital care to an integrated community care network. Many opportunities also can be found involving long-term care institutions. Some of these opportunities might involve faculty and students in managing health services while teaching and learning, as the medical school faculty and students do today in clinical service settings.

Implications for AUPHA

Finally, what about the Association of University Programs in Health Administration? I have three suggestions:

First, the Association can provide leadership in promoting visioning and visions as tools of management in the public's interest. There are lessons that the Association can draw from the visioning initiatives of the American Hospital Association, the Catholic Healthcare Association, and the other organizations which participated in the two VisionQuest conferences sponsored by the Healthcare Forum in recent years. The VisionQuest experience suggests to me that the right way to go involves promotion of a shared visioning process at each of the academic programs. A logical starting point for such an initiative might be an effort to involve as many program directors in recasting the Association's own vision. What would also be

most useful is AUPHA sponsorship of research about visioning, for example through comparative case studies in academic and practitioner settings.

A second step that AUPHA could take at this time is to provide leadership in encouraging a greater emphasis on visioning, transformational leadership and community benefit in the Criteria for Accreditation of the Accrediting Commission on Education for Health Services Administration and in the Self-Study Guide. There is currently no explicit reference to community service or community benefit in the criteria on curriculum. There is one passing reference to community service in the section on research, but none at all in the current edition of the Commission's Self-Study Manual.

Third, AUPHA could undertake a major leadership initiative to carry out Strategy 6 of the Pew Health Professions Commission, disregarded and languishing since 1993:

Establish a national health care administration forum to ensure continued dialogue between the leadership of academic programs and the practicing community. (O'Neil. 1993)

This forum could function in much the same way that similar organizations help articulate practice and professional education in engineering and business administration. I am pleased to report to you that in reviewing this Pattullo Lecture with Dick Davidson, he pledged his strong personal support of such an initiative.

Let me share an anecdote. When health administration education lost its federal funding recently, neither the American Hospital Association nor the American College of Healthcare Executives nor any other health services organization expressed objections to the Congress or the Administration, although I am told that the ACHE was prepared to do so, if asked. But it may not have occurred to the AUPHA leadership that the professionals educated over the decades would be willing to go to bat for continued funding. Alumni giving has not increased to make up the gap. It seems that there is precious little sense of interdependency between the teachers and the taught. This has to be rebuilt from scratch, based on exploration of the causes of the current mutual lack of inter-reliance. This will be much easier to accomplish and to have measurable results if more of the AUPHA programs individually are developing mutually advantageous collaborative partnership initiatives in their own communities. The constituency should also be actively involved in the many current exciting collaborative initiatives developing at the national level. This includes the follow-up to

the National Congress sponsored by the American Medical Association and the American Public Health Association in Chicago this past March and the emerging National Coalition for Healthier Cities and Communities.

Summary

In summary, it is my conviction that each of the AUPHA programs would be well advised to re-discover a shared vision of health care as public service, caring for communities as well as for patients and enrolled populations. I am also convinced that each program should be shaping a shared vision of the role of the academic program in providing intellectual leadership in this respect. These processes can be designed to have impact on all of the activities of the program, starting with low hanging fruit, and moving higher with growing confidence and commitment.

The key task for AUPHA as an organization right now is to re-examine its own vision as a basis for providing strong leadership to the field. This involves promoting visioning as a management tool, helping to sharpen the accreditation requirements in this respect, and carrying out the recommendation of the Pew Health Professions Commission to bring the academic and practitioner worlds into closer synch. The talent and the zeal are evident. What is required now is the will to make changes.

Continued transformation of the American health system and of the academic programs in health administration are both inevitable. Managing the transformation is more exciting, more productive, more professionally satisfying and more fun than just surviving or not surviving at all. Managing a transformation is not easy, especially in academia. Just watching it happen is not nearly as satisfying or as much fun.

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