
INVITED ESSAY

An Educational Program for Health Care Managers in the Twenty-First Century

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In the past two decades, the health care industry has emerged from a heterogeneous set of tens of thousands of individual ambulatory, acute, and long-term care units to collections of institutions that are moving to more tightly managed, horizontally and vertically integrated, competitive systems.

My prognosis is that the next stage of most of the large systems will be to deliver "total health care" from birth to death, including insurance mechanisms and covering all forms of care delivery. Next, after this total health care stage, these systems will become part of large conglomerates that furnish financial insurance, estate planning, investments, and real estate to consumers along with other "total personal needs" activities.

At the present time, large multihospital systems have appeared in both the not-for-profit and the for-profit sectors of the industry. Mergers and acquisitions are continuing to proceed at a pace paralleling that which has occurred and is occurring in other industries. Just as in these other industries, the multi-institutional health care systems have moved to a more oligopolistic and centralized structure.

In view of these changes and of what the future may be, the issue for health administration education and management is:

What should be the required core curriculum to educate the managers and leaders for these systems in their competitive environment for the decades to come?

The answer to me is obvious! *We must educate these managers and leaders in the same skills and knowledge base as the managers and leaders of other major industries.* Our health care managers and leaders face and increasingly will face the same management decisions as their compatriots in high tech, banking, consumer products, franchise industries, airlines, basic manufacturing, and virtually all other industries.

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But what does it mean to educate leaders? It means providing the skills, experiences, and knowledge base that develop and enhance the leadership qualities in our students. It means creating a total framework for helping students learn to:

- make clear decisions, often under ambiguous conditions
- resolve conflicts
- allocate resources
- communicate effectively to groups and individuals
- select teammates
- develop working relationships
- motivate peers and subordinates (recognizing and developing their potential)
- establish and use information networks
- maintain introspection and perspective to ensure that learning continues
- exercise an awareness of the social and ethical implications of managerial policy
- retain a curiosity and excitement for new ideas and processes
- set goals clearly and help people move toward them in the most effective way possible

The two keys to developing and enhancing these characteristics are: (1) identifying and selecting students who demonstrate the will to lead and who show potential in managerial skills and (2) placing these students in situations in which they can practice and perfect these skills and acquire the knowledge base for management while receiving systematic evaluation of their performance.

The students must be given the latest advances in discipline-based theory applied to managerial practice. The core curriculum must encompass essential knowledge gleaned from managerially relevant disciplines such as economics, statistics, individual and organizational behavior, and management science. It must further combine this knowledge with a deep understanding of the functional activities commonly practiced by managers such as marketing, accounting, finance, human resource management, policy and strategy, information systems, operations management, and communication.

Because this is basic knowledge every student needs to prepare for advanced and more specialized courses in a field such as health care administration, a program for the education of managers and leaders necessarily takes a minimum of two academic years. The majority of courses taken in the first year are the core courses. The primary content of each core course comprises the fundamental theories and methodologies of the subject matter applied to actual managerial situations. There are, however, certain broad trends and developments that are cutting across core disciplines and functions: changes in the regulatory and

economic environment in which managers operate, not only in health care delivery but in most other sectors of the economy; shifts in the norms and values governing behavior at work; development and application of new information-processing technologies; the internationalization of most multisite, multimarket, multiproduct corporations. Consequently there is need for an integrating activity to focus on these trends and developments.

A core curriculum would consist of such courses and content areas as shown in Figure 1. Once these fundamentals have been acquired, the students have received a broad vision of how an institution operates in the context of the national and international economy, its competitive environment, its own goals and policies, and its human and capital resources for a wide range of companies and industries. In the second year the student should follow an area of concentration or "major" which will give in-depth specialization still within the context of general management skills. In health care administration such course work would include: health policy and planning; health economics; health care financial management; health care marketing; health care operations management; legal aspects of health care; the management of large multi-institutional systems; and health care governance, administration, organization design, behavior, and structure.

In the process of learning in course settings and in extracurricular activities, there must be extensive exposure to situations that demand the use of leadership skills. This involves making presentations of the student's work before groups, working in teams, handling cases that contain conflicts, and tracing sources of dissent. It involves becoming involved with professional clubs and meetings, interacting with executives on and off campus, and working on a summer internship with executives on a problem or problems of significance to the institution. The student must be given many opportunities to think and make decisions from a leader's perspective. This perspective includes not only the integration of the knowledge base mentioned above but an awareness of the ethical consequences of decisions and actions.

In this discussion I have gone beyond just the core course needs of the student on the path to becoming a manager and leader in the health care industry of the twenty-first century. I have discussed the larger environment in educating the student for this leadership role. I have also discussed some of the specialized topics that should be covered in the second year of the student's program. You will note that other than micro and macro economics, human resource management, and organization behavior, I have not drawn on the social and behavioral sciences to any great degree. This was not an oversight. The manager and leader of today and tomorrow must be skilled in handling organizational and behavioral issues but must also have the extensive knowledge base of the functional areas of management as well. In two years there is not time to do more. Hence the student's organizational and behavioral skills

FIGURE 1: Courses and Content Areas of a Health Care Administration Core Curriculum

CONTENT AREA	Bus. Eth.	Econ.	Stat.	Policy /Strat.	Mgmt. Sci.	Human Res.	Fin.	Mktg.	Acct.	Inf. Sys.	Oper. Mgmt.	Comm.	Internat. Mgmt.
CORE COURSE													
Micro Econ.		X								X		X	X
Macro Econ.		X								X		X	X
Acct.	X	X	X		X		X		X	X		X	X
Finan.	X	X	X		X		X		X	X		X	X
Mktg.	X	X	X	X	X	X		X		X		X	X
Oper. Mgmt.	X	X		X	X	X		X	X	X	X	X	X
Organ. Behav.	X					X							
Policy/Strat.	X			X				X				X	X
Commun.												X	
Stat.			X										
Mgmt. Sci.		X			X		X	X		X	X		
Info. Sys.	X					X				X		X	
Human Res.	X					X						X	X

must be honed in the experiential activities of the classroom, extracurricular involvement, and the summer internship. This honing is accelerated for those students who have had at least two years postbaccalaureate work experience prior to pursuing a master's degree in health administration.

You may also note that I have not mentioned any course work in individual, social, and environmental determinants of health and disease. Such courses may be quite useful for a student pursuing employment in a public health department or a health agency of the state or federal government. They are significantly less useful than other courses for the student pursuing a career as a manager or leader of a large health care delivery institution, or system of such institutions, which are horizontally or vertically integrated and more and more frequently doing business in unrelated health and nonhealth enterprises. They could, however, be available for the students' electives.

Finally, I should mention that for health care administration programs, schools, or colleges that do not have available the core courses mentioned above and that find it difficult to attract the quality of faculty needed to teach such courses, it may be possible to construct an interschool degree with the business school in their university or another university. Of course it means giving up some of the autonomy and governance for the degree, but it may attract students who would otherwise not enter the program and thus yield a net benefit to both programs. It is also important for the graduates of such a program to have access to the placement services of the business school because more and more of the very large health care institutional employers are looking to the business schools for their new management trainees.

Commentary

GEORGE H. SCHMITT

In his article entitled "An Educational Program for Health Care Managers in the Twenty-First Century," William Pierskalla raises a very valid question: "What should be the required core curriculum to educate the managers and leaders for the decades to come?" I think this question should be broadened to inquire: How should programs for health care managers be adapting to the major changes occurring in the industry?

For years, most programs have concentrated on training future hospital administrators. As the environment is rapidly restructuring the health care industry, opportunities for new types of health care managers are emerging. I think that it is extremely important that health administration programs expand their emphasis beyond that of hospital administration of freestanding institutions to encompass the emerging and growing health professions, i.e. nursing homes, alternate delivery systems, financing systems (i.e. HMOs, PPOs) and managing within multi-institutional systems. These organizations and settings, like hospitals, need highly trained health managers, and, unlike hospital administrators in freestanding institutions, there is a growing need for managers in these fields.

In this article, Pierskalla makes four major observations:

1. that health administration programs should emphasize core business disciplines similar to other industries,
2. that in the second year, the student should follow an area of concentration,
3. that these programs should encourage and integrate practical experience with their basic course work, and
4. that these programs should not emphasize public health aspects, i.e. individual, social, and environmental determinants of health and disease.

I agree with the author on all four of these points. However, I think that it must be observed that most of the major programs have already addressed those issues. Most of today's programs are emphasizing core business skills, much like their brother MBA programs. In fact, many have successfully co-

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mingled their programs with existing MBA programs. I would like to expand on this point and add that in addition to a business emphasis, I believe students should be taught to be strategic managers, i.e. integrating strategic thinking into daily management activities. Students with these skills will be the leaders in tomorrow's organizations.

The other issue of Pierskalla that I would like to comment on regards the integration of practical experience with the basic course work. I wholeheartedly support the concept of practical experience in conjunction with the classroom. There is no substitute for "learning by doing" and I believe that programs should encourage extracurricular activities through the use of independent studies, student work-study programs, and formalized internships and fellowships. I would also like to encourage my colleagues to support these students through their continued sponsorship of internships, fellowships, and independent study programs. It is an investment in the future of health care.

In summary, health administration programs should continue to adapt their curricula to meet the changing challenges before all health care managers. These programs must broaden their perspective to train and develop not only hospital administrators but the vast array of new health care managers that are emerging. Additionally, these programs must continue to develop a curriculum that encourages core business skills, strategic management, and entrepreneurship. Finally, students should be encouraged to seek "real-life" experience through the formalized structuring of extracurricular activities and postgraduate fellowships. Only with this kind of training can we expect tomorrow's health care managers to be able to maintain the integrity of our health care system in these dynamic and challenging times.

Commentary

JOHN E.F. HASTINGS, M.D., D.P.H.

To a Canadian the fascination in the position set out in Pierskalla's article comes from a realization of the extent to which our respective sociopolitical concepts and attitudes, and hence our health and social systems, have diverged in recent decades. Although the major constitutional responsibility for health care lies within the provinces in Canada, the post World War II federal government has used its predominant powers over personal income tax and corporate tax to stimulate the development of a series of universal health and social funding programs, first through a conditional grants-in-aid approach and since 1979 through a tax points transfer and block funding approach. These are publicly administered and jointly financed approximately half by the provinces and half by the federal government. In most instances, the main characteristics and benefits are similar among the provinces. Often based on earlier provincial innovations and experiences, for example, public hospitalization insurance and medical care insurance in Saskatchewan in the late 1940s and the early 1960s, the federal initiatives started in 1948 with the National Health Grants Program. It was designed to help develop provincewide infrastructures for services such as public health departments, diagnostic laboratories, cancer diagnosis and radiotherapy units, and hospital construction. Beginning in 1958, the Hospital Insurance and Diagnostic Services Program provided provincially administered and cost-shared coverage for universal standard ward inpatient hospitalization, hospital emergency services, and selected hospital-based diagnostic services. As a result of the Royal Commission on Health Services from 1960 to 1964, the Health Resources Fund shared with the provinces the cost of planning, constructing, and renovating teaching and research facilities for health services personnel. From 1968 on, the Medical Care Insurance Program, also on a cost-shared and provincially administered basis, provided universal coverage for physicians' and certain other professional health care services. Parallel to the health care funding programs, a series of social benefit programs were introduced. Some were administered by the federal government, such as Old Age Security Pensions and Unemployment Insurance, and some were administered by the provinces but with costs shared, such as the Canada Assistance Plan for

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a range of public assistance circumstances. Publicly administered Workers Compensation Programs had functioned in the provinces for several decades, and the federal government had either provided directly or funded through provincial plans, services to native groups, the armed forces, and certain others.

Since the 1970s the provinces have broadened the range of services and benefits to their populations, with variations in the precise mix. They support (with less than total cost coverage except for selected lower income groups) long-term care, some home care, ambulance and emergency services, and for selected groups, certain basic drug and dental benefits. In 1977, after several years of discussion and negotiation, the federal government shifted its form of funding from conditional grants-in-aid to combined increased tax point transfer and block grants, with a limitation on the rate of increment. The change was in part in response to growing federal concern about cost pressures, the open-ended nature of the grants-in-aid programs, and the provincial demands for greater control over the allocation and use of resources in their health care systems. The federal government recognized the need to preserve their financial contribution and the basic program features of universal availability, public administration, and the interprovincial portability. Although negotiations continue, with occasional disagreements between and among the various governments as to the precise nature and details of funding, there is no fundamental disagreement in Canada about the value and popularity of the health care funding programs and their success in achieving equity and security for Canadians.

During the last decade and a half the provinces have applied cost constraints, with varying rigor, through global budgeting with controlled increments in hospitals, attempting to plan the introduction of high technology, controlling physician fee schedule increments under Medicare, licensing generic manufacturers to produce federally approved drugs and pay royalties to the original manufacturer, attempting to limit wage settlement increments (including for a time mandatory wage controls on public sector employees) and administrative costs to 3 percent or less. As a result, during the 1970s and early 1980s Canada had a stable expenditure on all health care of between 6.8 and 7.4 percent. Since 1983, however, in part because of strong upward cost pressures and in part because of the denominator effect of adverse economic circumstances, the percentage has risen by a point or so.

The Canada Health Act of April 1984 passed with support from all parties because of concern for universal access and equity. Most provinces were assessing some direct charges for hospital care, and a minority of physicians were opting out of Medicare and billing patients over the allowed amount. The Act penalized provinces permitting these practices by withholding federal funds comparable to the estimated extent of the additional levies. Although opposed by provincial medical associations, most provinces have passed legislation pro-

hibiting these extra charges. In Ontario, the result was a partial doctors' strike in late June and early July of 1986. As of this writing the strike has been replaced by a court challenge of the legislation.

Provinces have also been drawn into health services planning, either areawide, or through regional advisory bodies, as in Ontario, or semi-executive bodies, as in Quebec. They are involved in health manpower planning, and in setting and enforcing standards for a range of health care establishments. However, except in Quebec, which has restructured its health and social services on a public systems basis, change in the provinces is incremental and gradual and not strategically planned.

Although governments have taken an increasing role in health care, Canada's health services pattern remains pluralistic with the nongovernment sector continuing to play a significant part. Most doctors and dentists, many pharmacists, and a proportion of other health professionals are independent practitioners, paid largely on a fee-for-service basis either by the public plans, other insurers, or directly. Other groups are salaried depending on the location of their work. The traditional professions and a number of newer ones are largely self-governing and self-regulating with general provincial oversight.

Almost all hospitals in Canada are owned by voluntary corporations, religious bodies, or local governments; operate on a non-profit, publicly accountable basis; and are funded primarily through public sources. Proprietary hospitals are uncommon. Most convalescent, chronic care, and nursing home facilities remain in the nongovernment sector, either nonprofit or proprietary, but they must adhere to publicly set standards and derive much of their operating revenue from public sources. Pharmaceutical manufacturers and distributors are publicly regulated, but remain in the private sector. Voluntary agencies, self-help, and other consumer groups are a growing and active force.

There are some who would like to see the private, for-profit sector play a larger role in the health systems, and expand from its present role in nursing homes and residential care into acute and chronic care institutions. In fact, a handful of joint involvements for capital and management purposes are under way or are proposed in several provinces. Institutions are encouraged to seek additional resources through fund-raising activities, and to contract for maintenance services. Medical, dental and business associations press governments to permit more private entrepreneurial development, arguing that it will be more efficient and alleviate the effects of system underfunding. There is evidence that the federal Progressive Conservative Government and some of the provinces are somewhat open to these views. An example is the expected change in federal drug patent legislation to permit once again a period of exclusive patent. This reflects the more private business orientation of the government, a response to intensive lobbying by large international drug manufacturers, and a response to pressure from the United States in free trade discussions. Many

Canadian consumer groups, nonmedical and nondental professional groups, and provinces are worried about erosion of the public health care approach, the possibility of increased costs, loss of equity and planning and operational control of the health system which could result. On the other hand, health care analysts are looking for ways to emphasize better resource use, perhaps through competition, care mode choice, or HMOs.

I have deliberately emphasized the different Canadian context because so much of Pierskalla's proposal is based on the extensive and growing private, entrepreneurial sector involvement in the U.S. health care system and the growing power of its philosophy and practices in the nonprofit and public sectors. Although there certainly is interest in ways to promote more comprehensive and coordinated care and innovation in Canada, there is still only limited predisposition among Canadians to throw themselves open to what most of them see as excesses of commercialism in the U.S. system. The result appears to be all the high technology care that money can buy for some, but for others, a shocking indifference and inadequacy of care.

Thus, Pierskalla's concept of huge systems providing for "total personal needs" conjures up for me and for many other Canadians a picture of "big brother" and excessive control of resources and services by groups not accountable directly to the public, of which we want no part. Big business or for that matter big nonprofit conglomerates present a picture with little to distinguish it from right-wing or left-wing authoritarian societies. Excessive control of people's lives is control, whatever the banner under which it operates.

Having strongly expressed my opposition to the "gospel according to Pierskalla," I must hasten to note that most Canadian health administration educators and practitioners would support his emphasis on sound conceptual and practical knowledge and skills to enhance planning, decision-making, and creative management abilities, and to the extent possible, leadership qualities. The Canadian Health Administrator Study emphasized many of the same goals and management-focused knowledge bases outlined by Pierskalla [1]. It is, however, essential for managers and leaders in Canada to understand the health system in which they work, and the social and behavioral values and mechanisms of Canadian society. In a sense that is precisely what Pierskalla has done for the U.S. context. He has called a spade a spade. It is not for the outsider to judge the accuracy of his portrayal of U.S. society, its aspirations, and future. It is simply not one that I would wish to see in Canada.

One curriculum approach, which some Canadian programs follow, is to put the core management subjects in the first year, and the health content in the second. We in Toronto believe that it is preferable to split these among the two years of education and training, because we see them as equally important to practice rather than as basic and secondary. But we also see value in diversity. As our Canadian programs vary somewhat in their goals and emphases, the

approaches may vary. We see that as a strength. In Toronto we do not believe that that practicum component is extracurricular, but rather that it is a necessary and integral intellectual growth experience which must be carefully integrated into the overall program. The expectations from the experiences that Pierskalla describes are not wholly different from ours. Toronto, in fact, believes the supervised practicum element to be of such fundamental importance that we include a base program attachment for each student from the start of the program and have two practica. The first practicum, of three months' duration, is intended to broaden the students' knowledge of the health system, and the second, six-month practicum requires an in-depth experience with responsibility, usually in the sector the student expects to work in on graduation. Throughout, close collaboration among student, preceptor, and faculty supervisor is essential.

There is no doubt that Pierskalla's positive paper has provoked a response! Perhaps that, after all, is what he really wanted.

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Commentary

HOWARD L. BAILIT, D.M.D., PH.D.

In his provocative editorial, William P. Pierskalla calls for a health administration curriculum that will foster students who can "make clear decisions, often under ambiguous conditions." As a senior academician and administrator, Pierskalla has taken his own advice and has offered us his clear decisions on the appropriate training for health administrators. He would be the first to admit that these recommendations were made under very ambiguous conditions. What the reader has to decide is whether clear decisions are necessarily correct decisions.

The article starts off with several predictions for the future of the health care system. These predictions are not particularly convincing, and in some ways they detract from the article. They are not convincing because many economic and societal developments could radically change present trends in the health care system. They detract from the article because the need for well-trained leaders in health administration does not depend on the Pierskalla scenario. The need exists now and will continue to exist in the future.

At one level I find the basic premise of the proposal correct. Effective senior management does require the recruitment of first-class students into a rigorous program of study for a period of at least two years. Certainly, graduate schools of business in the better universities have the requisite resources in course offerings, talented faculty, and intellectually demanding academic environments to prepare the future leaders of health administration.

However, academic excellence and rigorous courses are not limited to business schools. Some of the better schools of public health and graduate schools of arts and sciences have first-rate health administration programs. They also provide courses in the fundamentals of management that prepare students for senior positions in the health care industry.

I had problems with some of the specifics in recommended courses. For example, I believe that effective leadership in health administration requires an understanding of community disease patterns and an appreciation for the economic, political, and social factors that determine the demand for care, the activities of regulatory agencies, etc. Formal courses are necessary to provide

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students with an understanding of these issues. The delivery of health care is not the same as providing hamburgers or producing widgets. Health care has a special place in society and will always be a heavily regulated industry. It is naive to assume that only students headed for careers in public health need to understand these environmental issues.

This secondary issue aside, the primary weakness of the Pierskalla thesis is the assumption that all health care administrators require intensive training of the type proposed. The fact is that the health care industry is large and diverse, and there is a place for administrators other than at the CEO or executive level. Competent people have to run record rooms, serve as assistant financial managers, and take responsibility for food services.

Pierskalla has offered us an elitist program for the select few. Admittedly, more programs of this type are needed, but not all health administration programs could or should head in this direction. The majority of educational programs in health administration are likely to continue to be based in schools of public health, departments of community medicine, and lesser known graduate schools of business. Most students entering this field will be effective individuals but not academic stars. These comments are not unique to health administration. All occupations have room for both the exceptionally talented and the "merely" competent person.

I want to conclude by thanking Pierskalla for giving us his views at this critical time in our profession. Taking a controversial stand represents the quality of leadership that the health administration educational community must have to prosper in this difficult period.

Commentary

JOSEPH D. RESTUCCIA, DR.P.H.

The key issue underlying William Pierskalla's "Educational Program for Health Care Managers in the Twenty-First Century" is the role of the professional health care manager.¹ Pierskalla has based his proposed program on a technically rather than professionally oriented role. Consequently, his program is grounded in the development of generic management skills necessary for the execution of generic management policy. The knowledge base, especially the health content knowledge, necessary for policy formulation and its execution in a health care delivery setting is notably lacking. In particular, I will focus on what Pierskalla points out are the salient omissions in his proposed curriculum, course work in the behavioral and social sciences and in the determinants of health and diseases.

Before discussing the specific role these areas of study play in the health care management curriculum, let me state the premises of my argument:

1. A necessary (though not sufficient) goal of any health delivery organization is to improve the health of the population it serves. This premise implies that other, more financially oriented criteria such as organizational profit and growth, are to be regarded as instrumental goals or as constraints to the goal of service to a community rather than goals in themselves.
2. The primary task of management is to assist an organization's directors or trustees to select goals. This involves identifying alternative goals, their expected outcomes, the value of these outcomes and the probability of obtaining them.
3. A second essential task of management is to determine the optimal means by which such goals can be achieved. This involves identifying alternative courses of action and their probabilities of achieving selected goals.
4. A final essential task of management is to implement the selected course of action. This involves mobilizing the organization's human and capital resources to efficiently seek achievement of selected goals.

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Given these premises, it is clear that professional health care management requires a broader education than is provided by the primarily skills-based approach Pierskalla proposes. The professional manager must be able to effectively deal with uncertainty. To do so, in turn, requires the manager to think independently, to exercise direction based on an understanding of the bases for decision making.

Consider, for example, the role of knowledge about the determinants of health and disease (and its basis in the discipline of epidemiology) to health care management. Without this knowledge, a manager lacks the ability to assist in appropriate goal selection or to select the optimal means to achieve them. The state of the art in identifying the existing as well as potential clients of a health delivery organization or system, its service population, is rooted in epidemiology [1]. Without it, how will the health care manager identify the population at risk for disease, the health needs of the population, the alternative services to address these needs, and the expected outcomes of alternative services and delivery mechanisms? Absent this capability the manager is likely to equate need with demand and seek short-term, financially oriented goals at the expense of long-term, health-oriented goals [2]. Evident demand for amply compensated, high-technology services such as coronary care units and bypass surgery to treat heart disease will likely be met, for example, while the often latent need for treatment of underlying conditions such as hypertension will go unrecognized. Thus, the ethical obligation for health care managers to identify health needs is manifest, especially if one accepts the first premise I proposed.

However, even if one takes a more narrow view of the role of health care organizations, one that asserts the organization's first priority is its bottom line, the obligation still holds for pragmatic reasons. In fact the obligation is of particular importance if Pierskalla's forecast that "the next stage of most of the large systems will be to deliver 'total health care' from birth to death" [3] is correct and if resources are limited by payment systems such as those based on capitation. If so, the health care manager must identify the trade-offs involved in alternative treatment modalities including their long-run costs and benefits to the organization as well as the population served. He/she may well learn that a carefully targeted hypertension screening and treatment program not only improves the personal health of the population served by the health delivery system but, by obviating need for more expensive treatment modalities, the organization's own long-term financial health as well [4].

The fourth premise is most relevant to the need for inclusion of course work in the behavioral and social services. Health care delivery organizations are professional organizations in that the production function is under primary control of professionals, especially physicians. Thus, optimal goal achievement requires the ability to work with professionals—to establish the organizational structure and processes that will influence professional behavior to achieve

goals in an efficient manner [5]. This requires a keen understanding of professional behavior, an area of study that has received enormous attention from the behavioral and social services, particularly medical sociology. In addition, similar arguments can be made for the health care manager's need to understand patient behavior and community power structure, areas of study also central to the behavioral and social sciences.

Pierskalla acknowledges the need for skills in handling organizational and behavioral issues. However, due to the constraints on the time available for graduate health care management education, he assigns primary responsibility to meet this need to "the experiential activities of the classroom, extra-curriculum involvement and summer internship" [6]. My contention with Pierskalla's proposition is that experiential activity devoid of a theoretical context in which to place this activity severely limits the student's ability to generalize beyond the particular experience. An important role of theory is to stimulate the student/practitioner to creatively respond to situations that differ from those he/she has experienced—to recognize how effective responses to a particular, experienced situation should be modified in similar but not identical situations subsequently experienced.

My points of contention with Pierskalla's proposed curriculum should not be interpreted as advocacy of separate courses in determinants of health and disease and the behavioral and social sciences. Rather, I am advocating that health care management educators ensure inclusion of the relevant theory of these disciplines as they apply to health care management in the curriculum, whether it be in a separate core, health care management course (i.e., "Medical Care Organization", "Introduction to Health Care Delivery Systems," and the like) or integrated into other required courses (as well as health electives). To do otherwise, I believe, is to abdicate our responsibility to educate leaders who will creatively shape the health care system's response to society's health needs rather than train technicians in servitude to the more narrow demands of their corporate masters.

NOTE

1. Because of limited space, I have discussed only this issue. However, Pierskalla's essay contains two other controversial issues that at least warrant identification. The first is his forecast that most health care services will be delivered by much more centralized and integrated organizations that deliver financial and real estate services as well as health care. The second is the implication that health care management programs should serve only the "student pursuing a career as a manager of a large health care delivery institution or system of such institutions" and not the "student pursuing employment in a public health department or a health agency of the state or federal government."

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