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FOR MANAGERS OF A CHANGING ENVIRONMENT

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MANAGING IN HEALTH CARE INSTITUTIONS: THE ISSUE OF PROFESSIONAL DEVELOPMENT FOR MANAGERS OF A CHANGING ENVIRONMENT

By

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ABSTRACT

MANAGING IN HEALTH CARE INSTITUTIONS: THE ISSUE OF PROFESSIONAL DEVELOPMENT FOR MANAGERS IN A CHANGING ENVIRONMENT

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Health care organizations have become extremely complex hence health care management has also taken on a complexity of its own. Health care managers must therefore be very versatile in management skills while being very knowledgeable in health care issues. One cannot expect to be fully prepared for a life-time career of health care management by an academic program alone. Further growth and professional development are demanded in a highly dynamic environment such as health care.

In this study of health care managers, an attempt was made to provide a foundation for further discussion on continuing education and professional development needs by utilizing the perceptions of health care managers. A questionnaire was developed and distributed to 189 managers. The data provided an indication of the problems and issues that were present in health care management development. The data also provided the perception of health care managers on the skills that would be needed for effective management. The results of the study indicated that the professional development needs of health care managers were very specific hands-on skills which were not normally part of an academic curriculum in management. The identified skills were *communication, leadership and results management*, in that order. The data showed that the future skills could be obtained from the pursuit of short, focused course offerings. Health care managers were very conscientious in the pursuit of continuing education and professional development activities but not necessarily with a focus. Understanding what practitioners viewed as desirable skills for the future health care industry would be valuable to the professional governing body, educational institutions, health care institutions, and also to

the managers - present and future.

The focus of the study was managing in health care institutions and specifically, the issue of professional development for managers in a changing environment. In the 1990's, health care organizations were "re-organizing", "downsizing", "rightsizing" and "re-engineering" processes in an effort to cope with decreased funding and at the same time satisfy client needs and expectations. All of that activity has caused the health care environment to be one of constant change. Identification of the issues faced by health care managers in their pursuit of continuing education and professional development will help to provide break-throughs in meeting the management needs of the present and future health care industry.

DEDICATION

I dedicate this dissertation to my late maternal grandmother, Frances Ann Charles, my late mother, Isa (Charles) Isaac and her three sisters - Mary Charles-George, Catherine (Charles) Nisbett and Betty Charles (deceased) for their instilling in me, the importance of a good education; to my children - Bernard and Alison; to my brothers - John, Alfred, Terry and Lascelles; and also to my cousins - Cromwell Nisbett (deceased), Dr. Burnell Nisbett, Lorna (Nisbett) Callender and Terry Nisbett.

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CHAPTER 1

INTRODUCTION

FOCUS OF THE STUDY

The focus of this study is Management in Health Care Facilities: The Issue of Professional Development for Managers of a Changing Environment. Before one can pursue an in-depth discussion on the main topic, one is obliged to set the tone with a review of the health care environment, providing some historical and current information on health care in Canada in general and on Ontario in specific. The topic begs for some discussion about change and it is against that backdrop that the issue of health management development will be pursued.

Why is there a concern/interest regarding the need for continuing education for health care managers? The answer might be found in the examination of managerial appointments and career advancement practices in health care organizations and in Ontario in particular. The health care environment has a history of promoting from within where individuals with clinical expertise are promoted to managerial positions and it is not unusual for those individuals to be lacking in formal management training. In 1989, Storch reported that 25% of Chief Executive Officers of Canadian health care institutions (hospitals with over 100 beds) have health occupation credentials as their primary academic qualification. Individuals working at lower levels in an organization are performing jobs that likely fulfill needs other than those required for the higher level positions; they might make poor candidates for promotion. The supervisor/management positions require balanced achievement and power drives, while the staff subordinates are generally higher on need for affiliation. (Chusmir, 1986).

One can surmise that there might be a felt responsibility by the organization to provide the required training as a form of professional development. Without a mandated body

for overseeing continuing education and professional development for health care managers, employers cannot be guaranteed that the management staff is current in health care management knowledge and skills, except in situations where the corporation supports and facilitates educational opportunities for its management staff.

To put things in perspective, Hastings and colleagues in 1981 noted that unlike other professionally-trained health groups, health administrators are not licensed or registered; they have not all graduated from accredited training programs in health administration; they do not necessarily belong to the same or any professional association; and they do not all use the same title (Hastings et al., 1981). That sentiment was also shared by Mindell and Barsley in the same year as Hastings (Mindell et al., 1981).

There are a number of important environmental issues which must be kept in mind as one examines the capabilities of managers in the health care industry. The economy in Canada and Ontario is still recovering from the recession and is not likely to experience a drastic recovery in the near future. The federal government is passing a large proportion of the burden of the cost of health care to the provinces through reduction in transfer payments.

More than one-third of Ontario provincial spending is allocated to health care. Hence it is a primary target for reduction in the tough economy. The provincial government believes that the health system is terribly under-managed and it is their responsibility to correct it (Rachlis & Kushner, 1989). The Health Minister has stated that, because of this lack of management more than 30% of the resources spent on health is wasted. There is also the strong belief that far too many patients are institutionalized in Ontario. Many more people, it is felt should be receiving support in their homes (Statement to the Legislature by the Hon. Ruth Grier, Minister of Health, Ontario, June 6, 1994).

The focus of health care in the 1990s will be to work smarter. The primary challenge facing health care providers in the next decade centres on finding new methods of service

delivery that have lower cost, higher quality and better outcomes. If we are to meet this challenge, we must monitor and evaluate the pursuit of continuing education and professional development of the management staff. Not every health care manager will be able to pursue formal executive development programs, due in part to time constraints and prohibitive costs, but they should be able to follow other management developmental activities. Both Queen's University (Kingston, Ontario, Canada) and the Banff Centre School of Management (Alberta, Canada) offer a management development program with a three-week duration at a cost of approximately $10,000. Executive management programs which offer an academic credential are also very costly. Not all health care managers need the content as offered by those programs, some will need to build on skills that are not offered in the executive development or formal academic programs.

In Ontario, most clinical staff belong to a regulated health profession and there is an mandate that the members of the regulated health professions will have a system to ensure continuing education and/or continued competence (Bill 43, 1991). It seems not unreasonable to make a similar demand of the management staff. There will be some logistical problems in that there is no governing body which has been mandated to monitor health care managers in their continuing education and professional development pursuits. That should not prevent each health care organization from initiating its own monitoring process. One can envisage this becoming the norm in an era of Continuous Quality Improvement and customer focus in the delivery of health care services. An industry-wide system for monitoring professional development for health care managers would be preferred. Such processes would help in the preparation for an evolving future which will demand expertise in the following areas:

- Assessment and understanding of the health status of populations;
- Organization, financing and delivery of health services from multiple perspectives;
- Economic, financial, policy and quantitative analysis;
- Values and ethical issues in health administration practice;
- Positioning and managing organizations for continued effectiveness;

- Development of leadership potential;
- Management of human, capital and information resources; and
- Evaluation methods to assess organizational performance, including quality assessment and assurance (Gelmon et al, 1990).

The Canadian College of Health Service Executives (CCHSE) encourages its members to continue their professional development by pursuing appropriate activities. Membership in the college is voluntary hence there is no accountability on the part of the members to heed the suggestion for professional development. The college offers a certification process for health executives and that certification involves the challenge of a comprehensive examination. The successful challenge to the CCHSE examination offers the designation of Certified Health Executive (C.H.E.) which is becoming an industry standard. At present there is no mandated maintenance of certification requirement but a voluntary reporting of professional development activities; membership renewal is secured by the payment of an annual fee but that could be changed in the near future.

Graduation from one of the Accrediting Commission on Education for Health Services Administration (ACEHSA) accredited programs in Canada, provides prospective employers with an important quality control mechanism, enabling them to know in advance that such a graduate has experienced an academic program that meets quality standards set by the field, and has appropriate preparation for a career in health service administration. That is all that can be assured as there is no mechanism to monitor continued learning and development except perhaps on an individual basis and that might not be a consistent practice by the hiring organizations.

What can/should be done to facilitate, for health care managers, the development and maintenance of leadership and management skills which are consistent with the needs of the individual, the organizations, the communities and the province's interest in high quality, accessible, and affordable health care in a changing health care industry?

It is hoped that question will be answered in the pursuit of the nine areas of interest as outlined in the research questions which can be found later in this chapter. The full survey instrument is presented as Appendix B.

Forty-four percent of business leaders perceive an increase in the value and role of training, education and development throughout the 1990s (National HRD Executive Survey, 1991). Business spends more per capita on the training, education and development of managers and executives than it spends on any other group of employees (Porter, 1988).

By pursuing continuing education and professional developmental activities, the competence and knowledge of practising health care professionals, which will be critical over the next ten (10) years to the success of the health care system, will be enhanced (Carruthers, 1988).

PROBLEM STATEMENT

Health care organizations are very complex and that complexity has been compounded by a number of issues ranging from external changes to management recruitment and promotional practices. In order to remain relevant, a leader must be constantly learning and seeking new ideas, especially where the environment is one of constant change. As mentioned earlier, the health care sector has a history of promoting individuals into managerial positions based on technical/clinical skills and technical/clinical competence. One of the results of such a practice is the plateauing of individuals at the middle management level without any hope of achieving a senior management position. Another area of interest is the fact a 1991 survey found that in one particular segment of health care in metropolitan Toronto, Ontario, only a minority of managers and supervisors had formal training in health and administration (Williams, 1991). Meanwhile, the new trend is to employ, at the senior level, individuals who are academically prepared at the master's level in a health administration program without any regard to their possession

of a clinical background.

For any individual in health care management, the environment is very dynamic and the need for currency of information is becoming a real demand. Even without the changes in the health care environment, it can be seen that there are requirements for the development of health care managers. Whose role is it to assure that the managers are current in health care management information and practices? For Rachlis and Kushner in *Second Opinion*, 1989, their agreement on inadequate management came in the form of a statement which identified widespread inefficiencies within the health care system and which lie at the heart of the problem, "we're so wasteful that virtually no amount of money could ever satisfy our system's proclaimed needs" (p.18).

In what follows are briefs accounts of various aspects of health care in Canada and in Ontario.

The Canadian Health Care System

The Canadian Health Care system is a government-run insurance plan which uses public funds to pay for a private system and the public has come to expect unlimited "free" access to health care services. Patients have free choice of physicians, who in turn are paid by the provincial plan on a fee-for-service basis. Public hospitals receive most of their budget directly from the provincial government which in turn receives revenue from the federal government to partially fund the system. Although national health insurance is among the most popular government programs, in recent years the declining economy and increasing health care cost have produced pressure for cost containment.

Canada as a nation was established in 1867 by the British North America (BNA) Act, and it was that said Act which divided powers between the provincial governments and the federal government, in Ottawa. The Act assigned all matters of national concern, plus those activities likely to be costly, to the federal government, which had the broadest tax

base. Ottawa was given jurisdiction over such items as railways, canals, coinage and, in the health fields, quarantine, marine hospitals and health services for native peoples and the armed forces (Rosenbaum, 1979; Sutherland & Fulton, 1990).

On the other hand, the provinces were given authority for those local concerns which were, at that time, thought unlikely to be costly - including roads, education and the Establishment, Maintenance and Management of Asylums, Charities, and Hospitals other than Marine Hospitals. Health care became a provincial responsibility as it was perceived to be a natural extension of 'hospitals'. Health care in Canada thus became 10 provincial health care systems, plus two in the northern territories. Due to economic inequities, and with some provinces being less able to provide the same level of health care as others, the federal government became involved in financing health services; this opened the door for Ottawa to be able to exert an influence on provincial health policy despite its lack of constitutional authority.

The Canada Health Act

Vayda & Deber reported that in 1983, Canada faced several potential confrontations, one between the federal and provincial governments and a second between the provinces and their health care providers (Vayda & Deber,1984). At the time, the federal government was not only refusing to put more money into the system, but was actually proposing to reduce its contributions to the provinces. At the same time the federal government favoured the elimination of user charges, or the imposition of penalties for user charges; either alternative would increase financial liability at the provincial level. This intent was to discourage a two-tier system which could prove inequitable for the financially disadvantaged.

It was on December 12, 1983, that the Canada Health Act (Bill C-3) was introduced in the House of Commons and it became law in April 1984. It declared the facilitation of access to services without undue financial barriers to be an objective of the national health

policy thus bringing to five the characteristics of the Principles of Medicare as follows:

- The service has to be comprehensive i.e. the provinces have to insure all the services listed in the Act
- The service has to be reasonably accessible to all provincial residents
- The province has to provide universal coverage
- The coverage has to be portable, meaning that a resident of one province had to be covered for services received in any other province.
- The system has to be publicly administered (non-profit) (Rosenbaum & Vance, 1988).

Ontario Health Care Environment

The Canada Health Act (1984) superceeded the Hospital Insurance and Diagnostic Services Act (1958) and the Medical Care Act (1968) thus paving the way for more explicit indication of the conditions required for eligibility of maximum payments to the provinces from the federal government.

In spite of the rapid growth in the provincial economy, the previous provincial government had to resort to higher provincial taxes to balance the provincial budget since government expenditures continued to expand at a rate in excess of the growth in the provincial economy. One of the major components of government expenditures that has grown more rapidly than others is health expenditures. Over a decade ago these expenditures accounted for more than twenty-eight percent of government spending; in 1994, those expenditures accounted for more than thirty-three percent (Ball, 1994).

Fiscal Environment

Ontario's economy has more than doubled in size in nominal terms between 1982 and 1989 - the real provincial economy grew at an average annual rate of almost five percent. While the growth in the well-being of the Ontario economy continued until the second quarter of 1990, a dramatic decline has taken place since then. For the remainder of the 1990s, few observers anticipate real growth to match that achieved in the second half of the 1980s.

Health Cost Trends in Ontario

Just as federal health care expenditures have grown so have expenditures in Ontario. The average rate of growth of nominal health expenditures by the provincial government has been 12.1 percent between fiscal year 1980/1981 and 1990/1991, while the equivalent growth rate in real health expenditures and real health expenditures per capita has been 5.5 percent and 4.1 percent, respectively. Consequently, given the rapid rate of growth of these expenditures, it is not surprising to find that they represent more than one-third of all government expenditures, and have grown from 4.3 percent of Gross Provincial Product in 1980/81 to 5.4 percent in 1990/91 (Ontario Ministry of Health, Annual Report 1992-93).

The most dramatic increase in health expenditures has been in the area of physician services. Expenditures on physician services, after adjusting for inflation, have grown at an average annual rate of more than 10 percent. While a portion of this increase is due to population growth and a higher schedule of benefits for physician services, most of the increase is due to increased utilization (Barer et al., 1988; Rachlis & Kushner, 1989).

The growth in the utilization of physician services has been brought about by an increase in the supply of physicians and an increase in consumerism. Consumer expectations regarding favourable outcome of medical intervention has encouraged more people to seek

medical care. Another reason is that once in the health system patients are now more aggressive in seeking health care services that match their expectations. This aggressive search for medical care sometimes results in requests for diagnostic investigations of minimal utility and in consultations with specialists which may have only a marginal bearing on health outcomes.

Physicians have considerable discretion over the utilization of health care services by their patients. As an example, with substantial increases in malpractice premiums, litigation rates and court awards, the perception of a malpractice "crisis" has created an environment in which physicians may practice more "defensively", and consequently, may recommend more laboratory and radiological procedures for their patients (Coyte and Dewees, 1991).

The lack of health expenditure control has resulted in a dramatically larger share of health expenditures in the provincial budget, a substantial increase in the share of the provincial economy devoted to health.

Issues Facing The Government

The following are some of the issues which have been identified as occupying the agenda of the provincial government:

- Health expenditures represent the largest single funding envelope within the provincial government.
- Health expenditures have grown more rapidly than any other area of government expenditures.
- The relationship between health expenditures and health outcomes is so tenuous at best, that considerable room exists to redirect these expenditures to activities

that are more closely related to a broader view of heath as a resource for daily living.

- While some sectors within the field of health have faced some degree of provincial government restraint, there is a perception that there is room for further economy in health expenditures, either in regard to Ontario Health Insurance Payments (OHIP) to physicians or in acute care facility funding.

- A significant need for health managers who can effectively transform the limited resources for health care services into much needed health outcomes.

- By configuring Ontario's health care system towards services that are elements of the broad view of health as a resource for daily living, the provincial government has the potential to effect significant improvements in well-being for selective socio-economic groups and possibly to reduce long term government expenditures.

Health Goals for Ontario

The prospect of declining revenues, increasing expenditures and the increasing deficit raise doubts about whether the provincial government could afford to finance the health care system in a manner to which it had become accustomed. Considerable efforts have been expended on developing health goals for Ontario. These goals have been articulated in three major provincial government reports (Evans, 1987, Spasoff, 1987, and Podborski, 1987), and have enjoyed a high level of approval to such an extent that the Premier's Council on Health Strategy has used those goals as the basis for the formulation of health policy initiatives.

No mention of the Health Goals for Ontario would be complete without a reiteration of those goals as first proposed in 1990 by the Premier's Council on Health Strategy in *A Vision for Health: Health Goals for Ontario* (p.1), and stated as follows:

- Shift the emphasis to health promotion and disease prevention
- Foster strong and supportive families and communities
- Ensure a safe, high quality physical environment
- Increase the number of years of good health for the citizens of Ontario by reducing illness, disability and premature death.
- Provide accessible, affordable, appropriate health services for all.

The inference here is not that everything has to change. Change may be inevitable in some situations and that change can add vitality to an organization but on the other hand, change involving a complete system could be disruptive and non-productive. What could one say to an organization which changed its management structure twice in as many years before having any objective evaluation results?

In the 1990's, health care organizations are "re-organizing", "downsizing", "rightsizing" and "re-engineering" jobs in an effort to cope with decreased funding and at the same time satisfy client and customer needs and expectations. These activities have caused the health care environment to be one of constant change with demands for new management skills and current knowledge of health care and related issues. Identification of the issues faced by health care managers in their pursuit of continuing education and professional development and documenting their perceptions will help to provide break-throughs in meeting the management needs of the present and future health care industry regarding needed skills and knowledge. Without a clear indication of the needs of the field, managers will be ill-equipped to pursue, in a meaningful way, the required skills and knowledge.

PURPOSE OF THE STUDY

The purpose of the study is to identify and describe, factors which may impact on individual efforts to maintain currency of knowledge and skills while meeting the needs of the future health care environment. This study will seek to contribute both theoretically and practically to the study of professional development of health care managers by documenting the opinions and perceptions of health care managers.

"There are a limited number of national studies of health executives in Canada and the few that do exist are not well known to the average executive". (Storch, 1988, p.1). Even though that sentiment was expressed in 1988, it is still valid. Some of the better known studies have been commissioned to provide data for manpower planning (McLeish & Nightingale, 1973); and to provide comprehensive baseline data on the number of health administrators (Hastings et al., 1981).

Continuing education for health care managers has not been a major topic of inquiry. One study that had a continuing education focus was reported over a decade ago and that study was restricted to managers in Long Term Care institutions (Hastings et al, 1981). In 1991, Williams reported the result of a 1989 survey of the professional characteristics and education needs of 429 managers and supervisors in long-term care institutions and community-based service agencies in greater metropolitan Toronto. The data identified important gaps in the professional training of those administrators and it was identified that there was a widespread support in principle and practice among current administrators in the Toronto region for programs of education which address the particular challenges of long-term care administration (Williams, 1991).

The purpose of continuing education is to build upon one's educational and experiential base for the enhancement of practice, administration, education, or research to the end of maintaining and improving service to the public. (Ferrell, 1988).

Lifelong learning is one way to prepare for handling change. Dolan expressed the opinion that when people do not read, and do not participate in educational programming or professional association activities, they become insulated. He further stated that changes march on, whether individuals know about it or not and that is one situation in which ignorance is not bliss (Dolan, 1993).

SIGNIFICANCE OF THE STUDY

The result of this study would provide invaluable information to individuals, groups and institutions, viz:

- Health care managers who have a desire to be informed about the current and projected changes in the environment and also to have access to tools for assessing their potential for marketability

- Chief Executive Officers who might wish to obtain a comprehensive picture of professional development practices of the industry

- Governmental and other regulatory agencies in setting policy directions for the pursuit of continuing education and professional development for health care managers

- Institutions of higher education for program planning and future policy directions for continuing education for health care managers, and

- Individuals for their career planning in relationship to health care management and those with a research curiosity.

Specific agencies with an interest in the results of the findings would be, the health care industry, institutions of higher education in Ontario, the Canadian College of Health

Service Executives, the Ontario Hospital Association and the Ministry of Health of Ontario.

The topic of this study has not been well/extensively research in Ontario, hence additional data sources will be less well-developed and the research report from this study will make a significant contribution to the related literature.

Studies of this type cannot be based on "hard" data alone. Stakeholders are an invaluable source of information on needs, gaps and preferences. Attention was paid to the qualitative information which was added to the survey responses by individuals. An effort was made to combine the information gained from these sources with quantitative data to develop the most complete understanding of the issues. Data collected from the questionnaires have been analyzed in terms of the study questions and reported in summary data and narrative information formats.

RESEARCH QUESTIONS

The research questions which this study addressed were:

1. What are the perceptions of health care managers regarding the need for continuing education and professional development?

2. What opinions are shared by health care managers on the factors (barriers) which hamper their pursuit of continuing education activities?

3. What benefits are perceived by health care managers in the pursuit of continuing education and professional development activities?

4. What are the opinions of health care managers regarding mandatory vs voluntary pursuit of continuing education and professional development?

5. What are the opinions of health care managers regarding who should assume the role of facilitating their continuing education and professional development?

6. What are the opinions of health care managers as to the factors which would facilitate/drive their pursuit of continuing education and professional development?

7. What are the opinions of health care managers as to what would be a reasonable expectation in their pursuit of continuing education activities?

8. What future skills will be required by the managers of health care in order to function and survive in the face of change?

9. How can the needed skills be developed in the experienced health care manager?

ASSUMPTIONS

It is assumed that a common frame of reference exists for terms and concepts used. It was further assumed that health care managers will provide the time necessary to state their opinions and perceptions in an honest manner. Another assumption is that many individuals, institutions and agencies will be interested in the findings. Last, but not least, is the assumption that health care managers perceive that continuing education activities will enhance their personal growth and professional development.

The individuals surveyed are members of the Canadian College of Health Service Executives and it is assumed that the College will be interested in the views of the members in the area of professional development in general and specifically opinions on mandatory versus voluntary participation. That information could also be used by the College in policy formulation. It was interesting to note that only one fellowship paper has been presented to the College in the area of continuing education in general and that was done about a decade ago, in 1985 (Canadian College of Health Service Executives,

CCHSE Registry 1993).

RELATED LITERATURE

The review of literature relevant to this study is divided into specific segments to address the major areas of interest.

Sample literature from related fields e.g. education and management (general) were used to provide some direction for the study due to the paucity of literature in the specific area of interest in the Canadian context. A useful source was the American literature in health management education and reviews of reports on related studies. Canadian studies on health care management and education, especially in the Ontario context, were examined for relevance. An historical overview of the Canadian Health Care system has been provided and the current health care environment of Ontario has also been examined. The following were the main areas of literature examined:

Training
Changing Nature of Jobs for Managers of Health Care
Skill and Knowledge Needs of Health Care Managers
Training, Education and Development
Mandatory vs Voluntary Continuing Education Pursuits

LIMITATIONS

The current economic climate may influence some of the responses and should be taken into consideration when interpreting the data. Budget constraints might have had an effect on organizational financial support for professional development activities for managers. With the freeze on salaries in health care institutions, it might not be possible for managers to meet the cost of educational activities.

There is always a concern for the interpretation of certain terms and it could be different for individuals based on many factors. The feedback from the panel provided some assistance in lessening the problem.

The collection of information was dependent on the willingness of individuals to complete the questionnaire. There was no way of knowing if the task had been assigned to an assistant. The questionnaire was designed to be self-administered, hence its validity could be affected by the clarity of questions and the honesty of the respondents. The biases of the investigator may have influenced the construction of the questionnaire and the interpretation of the qualitative findings. Assessment by other individuals was sought so as to eliminate or at least decrease any biases.

The findings of this study can only be generalized to health care managers in Ontario and to those who work in hospitals in university cities as outlined earlier. It would have been ideal to survey everyone but one has to consider practicality of such an undertaking.

The study is limited to health care managers who are employed in hospitals in five specific university cities in Ontario and who are members of the CCHSE. Such managers normally occupy relatively senior positions and their opinions may not reflect the views of all levels of management.

The questionnaire was only addressed to a select number of managers. Not every health care manager in the selected cities or in Ontario was polled for his/her opinions, views and comments on continuing education and professional development.

Membership with the CCHSE may influence response rate and even the nature of the responses. The fact that those individuals have chosen to be members of the CCHSE and to pursue recent continuing development are indications of their interest in matters related to continuing education and professional development and members would more likely respond to a survey of this type.

Health care managers who work in hospitals of the larger university cities in Ontario may very well have different perceptions, opinions and needs regarding continuing education and professional development than their counterparts in different work environments and locations.

DEFINITION OF TERMS

Barrier - an obstacle or circumstance that keeps people or things apart; bars access or advance.

Continuing Education is typically viewed in terms of formal programs centered around particular topics and targeted at particular audiences (Gruppen, 1990).

> The process by which an individual participates in professional development activities to prepare for current and future changes in practice.
>
> Education beyond initial professional preparation that is relevant to the type of patient care delivered in the facility, that provides current knowledge relevant to the individual's field of practice, and that is related to findings from quality assurance activities (CCHFA Accreditation Reference Guide 1991, Ottawa).

Education - systematic and sustained learning activities for the purpose of bringing about changes in knowledge, attitudes, values or skills (CCHFA, 1994).

Health Care Executive - All those persons with senior management responsibility in the health care system throughout Canada whose duties involve planning and policy making (Storch, 1988).

Management Development - a series of learning experiences that result in planned and organized training and educational activities; formal or informal (Davidson, 1993).

Mandatory - an official command or instruction; compulsory.

Mentoring - Trusting relationship between an experienced and novice employee for the purpose of providing exemplary support, direction, insight, guidance and advice to the latter with regard to the complexity of their role (CCHFA, 1994).

Motivator - a person or activity that stimulates the interest causing action in a particular way.

Technical - Information specific to the knowledge base of a particular profession.

Vision - an idealized goal which gives direction to organizational action (Kurz, 1991).

ORGANIZATION OF THE DISSERTATION

Chapter 1 includes an introduction to the topic; a snap-shot of the Canadian and Ontario health care environments; a statement of the problem, purpose and significance of the study; a listing of the research questions; definitions of key terms; identification of assumptions; an outline of the limitations; and the layout of the dissertation.

In Chapter 2, the literature related to the study is explored and analyzed. The chapter is divided into several sections so as to capture the major areas of interest which form the study while providing a backdrop against which the health care environment could be understood.

Chapter 3 provides the design and methodology of the study and also includes a description of the population, survey design, information gathering procedures and data analysis.

Chapter 4 contains a presentation and analysis of the findings of the study.

Chapter 5 summarizes the study, presents the conclusions, examines the implications of the findings and provides suggestions for further research.

SUMMARY

An examination of the health care industry reveals a complex environment with managers needing new skill and knowledge and a support system for facilitating and supporting the efforts to that end. In order for health care managers to remain relevant, they must constantly be learning and seeking new ideas. Due to the number of different routes for the preparation of health care management preparation and selection, there is no common body of knowledge nor is there equality in skills.

Although individuals may be promoted based on clinical/technical merit in health care organizations, chances of acquiring a senior management position by those individuals are slim to non-existent as those positions are normally filled by individuals who may or may not have a clinical background but are academically prepared at the master's level in health and other administration disciplines. If the vision is to enhance the opportunity for growth and promotion of middle managers and others in the health care industry then each individual must be perceived as having an equal chance and continuing education may well be necessary to make the vision a reality.

Managers of health administration must be well positioned to take advantage of the tough environment. There are many issues facing health care institutions which must be addressed within the context of the changing environment. In this respect, there is a need for managers to possess a solid understanding of the health care environment, community needs and the demands of the Ministry of Health's policy directions and initiatives. Increased efficiency is required to manage in an environment of decreased resources, increased needs (doing more with less) and increased complexity.

In an environment with an emphasis on quality care provision and a concern for risk management, continuous quality improvement and total quality management, one cannot over-emphasize the need to have individuals of high calibre providing direction for quality service. Those high calibre individuals must be part of a system which ensures continued growth and they must be able to acquire current information to enhance their knowledge while increasing their efficiency.

The literature places a high degree of emphasis on the initial training and education of health care managers as if that were enough for the duration of one's career. This is in direct contradiction to the expectation for the clinical and technical staff of health care. Is the inference that management theory and practices are static while that of the clinical disciplines have a shorter half-life? No one should be under the illusion of static theory and practices. Obsolescence does not escape management theory and practices. The very nature of health care is one of change due to the environmental forces which impact upon it. The mostly high publicized factor is that of a slumping economy which demands new skills of the health care manager as organizations seek new ways of doing business. Another aspect of health care is its high human resource intensity and that adds to the dynamic nature of health care management and the environment.

Leaders must be cautious of the expectations of what can reasonably be achieved by health care managers who pursue continuing education activities. There will be a need for evaluation of continuing education activities with an emphasis on evaluation of behaviour change for any indications of the benefits which have been derived. Overall, there needs to be a determination of what should be done to facilitate, for health care managers, the development and maintenance of leadership and management skills which are consistent with the needs of the individuals, the organizations, the communities and the province's interest in high quality, accessible and affordable health care in a changing health care industry.

Chapter 2 provides a summary and analysis of the literature of interest.

CHAPTER 2

RELATED LITERATURE

This study focuses on the perceptions of health care managers regarding continuing education and professional development as methods of responding to the evolving changes in health care services in Ontario, Canada.

> "A $12-million national forum has been commissioned by the Liberal government to study ways to revolutionize Canada's health-care system." Globe and Mail newspaper, in an article entitled, *National Forum On Health Care Faces Twofold Challenge*, on October 21, 1994.

The above as indicated, was an announcement in one of Canada's national newspapers and it provided an indication of further changes to the Canadian Health Care system. That was not the only indiction of change, worldwide or in health care, as indicated in the following quotations:

> "In a world where the only constant is change, the impact of technological advances, new governmental regulations and economic turmoil have all converged to make life within the organizations complicated, and at time unproductive" (Mezei, 1994, p.19).

> "The world is now in a time of profound turmoil." (Hassen, 1993, p.198).

> "Given the accelerated pace of change....". (Senge, 1990b, p.8).

> "There is no doubt that the health care system of the future will look quite differently than it does today." (Carruthers, 1988, p.1).

> "Even good successful, century-old institutions need to adapt and evolve to survive in a changing health care environment." (Block,

1993, p.16).

> "Across Canada right now health care is changing at a pace far more rapid and far-reaching than the system seems able to withstand." (Hassen, 1993, p.6).

In 1989, Rachlis and Kushner in *Second Opinion*, wrote:

> "By now it should be very clear that we can't expect a significant improvement in Canada's overall health care status without major social and economic reforms". (Rachlis and Kushner, 1989, p.218).

Those thoughts and opinions originated from a range of individuals with an interest in change and in some instances, health care. And those individuals can be categorised as social policy analysts, health care policy analysts, academic educators, health educators and health care managers.

Change in the health care context is perceived as the result of events which have been set in motion by external forces which cause a movement in the direction of health care delivery. Bridges (1991) described change as an external event i.e. external to the individual.

Health Care Organizational Change

According to Mechanic (1988), "change is occurring at a dizzying rate for managers of health care" (Shortell et al., 1988, p.xiii). The health care manager is caught up in a set of forces which are demanding that health care institutions function differently to meet the new expectations and at the same time, tackle, among other major problems, the magnitude of the impact of the aging of the population on health expenditures - the growth of the percentage of the population over sixty-five has been dramatic and an aging population places greater demands on a health care system.

The changes which are demanded are to some extent intentional in that external policy directions are indicating that the health care institutions must respond in a different manner for effective health care delivery. The command has been given but the command is very non-specific. One can use the analogy of being told to get from point A to point B without being given any assistance in the determination of what method of transportation to use or in how to read a map. There is an assumption that one has the ability to obtain the information which is required for planning and decision-making, but those activities must be anchored in policy directives.

Health care organizations cannot afford the luxury of becoming unproductive. The external forces will not allow it - the government will not be hesitant in sending in inspectors to conduct operational reviews on individual institutions that are not meeting expectations. Community organizations which offer financial support are not slow in demanding change when they perceive a lag in progress (Olsen, 1991). On occasion, the changes come with enlightened leadership within the organization as executives have a major responsibility to revitalize organizations for a competitive world (Kilmann, 1977; Zuckerman, 1989).

Health Care Management Change

The health care manager may be perceived as a mini structure within a micro structure (the hospital) which is trying to withstand macro forces (economic, political, and community). The need to change is not a choice for the health care manager but rather a requirement from the external environment (Hudson, 1993).

The challenge of the health care manager is not to try to control the forces of change but to prepare for the future which the change brings. Senge in a 1990 paper entitled, "*The Leader's New Look : Building Learning Organizations*", stated that there was an evolution of new organizations and with any new organization, there would be a demand for new leadership roles which in turn would require new leadership skills (Senge, 1990b, p.13.)

The changes in the health care environment set up other forces of change which occur within the individual manager. The desired individual responses are those that would cause health care managers to prepare themselves for functioning at the appropriate level within their job scope. The situation, then, is a reaction to an external stimulus. It stands to reason that if the health care environment is always in a constant state of change then one can safely assume that the same conditions exist within the worklife and being of the health care manager.

Prybil & Warden in a comment on the *accelerating pace of change* stated that:

> Not long ago, the management concepts learned in graduate school and practised during early work experience could be counted on to maintain their applicability and utility throughout the course of one's career. Today, managers find it necessary on a continuing basis to deal with environmental changes and respond to expectations that could not have been envisioned in earlier years. (Prybil & Warden, 1993, p.157)

Their explanation was that modern organizations have become so complex that the processes involved in their operations are beyond the scope of any individual, including skillful managers, to comprehend fully.

Crighton (1990), advised that hospital managers must not just be passive administrators of funds but proactive planners and organizers of services. He also stated that the last decade had been a difficult period of adjustment in which hospital boards have had to come to terms with the real implications of management, which had been forgotten in the open-ended cost-sharing years. He blamed the dilemma on the fact that there were, as yet, no formal management development system to further the education process into policy analysis and development of practical skills for senior managers.

For an insight into the origin of the problem, Shedden 1993, stated that World War II and its aftermath thrust wholly new management and organizational tasks in the health services upon a diverse groups of health services personnel who had very little training

or background that was relevant to what they had to accomplish (Shedden, 1993).

Dalston & Vaill (1993), upon reflection of the need for management development saw the whole situation as a desperate attempt for keeping up with the pace of change and the challenges that are expected. They further provided another reflection when they stated that one of the assumptions that had run through management education development for decades is that putting an individual through a management training program would make that person a manager, that somehow there will be a convergence of skills and attitudes.

For Prybil & Warden, they were a bit philosophical in stating that the subject of management development had taken on new importance. They also stated that traditional approaches to the basic preparation and continuing education of managers had fallen short of what was needed but, "...there are no obvious or simple answers to the question of what should be done differently". (Prybil & Warden, 1993, p.157).

Loebs (1993), felt that much work needed to be done in identifying the appropriate content for the continuing education of health care executives. He also showed his disgust with some attempts at management development when he stated that there was an unequivocal tendency for many CE programs to respond to the "hot" topics of the moment which did not serve the needs. He further stated that research on continuing management education strongly suggested that the needs were specific for different management levels and different organizations. What Loebs did not say was that there was no uniformity of management job titles across the industry. It is difficult to make suggestion about levels when those levels are very organization specific. In the Ontario health care system, the job of a Director in one institution can prove to be very different from that of a Director in another institution.

It stands to reason that if the policy directives have changed, and the health care institutions are changing the way they do business, then one other important aspect of the change paradigm is change for the managers of the health care system. This change

would include a change in thinking about how managements jobs are performed and how managers prepare for their jobs.

Change must not be perceived as an over-night process; it does not happen instantaneously - it is gradual and often painstaking. Health care managers should understand that as long as the Ministry of Health perceives that benefits will accrue, that there will be changes in the health care environment. The types of benefits that the government would be expecting would be decreased costs, increased benefits to clients with improved care, access and delivery of services.

It is with these premises in mind that this research has set out to document the perceptions of health care managers regarding continuing education and professional development as activities (suitable processes) for maintaining management skills and knowledge currency in an evolving health care environment in Ontario, Canada.

It appears that the managers do not have an option - there is no choice but to change because the health care industry can ill afford, financially or clinically, to entrust the day-to-day responsibilities of the services to the hands of managers who are not adequately qualified or who are not properly motivated for the job. Continuing education will not cure all the ills of health care management but the pursuit of appropriate activities will at least provide managers with the needed skills while increasing motivation levels.

Regarding future management education needs, Dalston (1993), had observed that looking into the 1990s and beyond one can see a very dynamic and changing environment in which graduate education alone quickly becomes inadequate and that more needed to be done.

In the Canadian College of Health Service Executives News Release of May 1994 re *New Certification Program Helps Health Service Executives Prepare for the 21st Century*, Jan Bartkowiak, Chair of CCHSE Board stated the following:

> The complex challenges of reforming the health care system will place increasing demands on the knowledge, skills, and abilities of health service executives.

The rapid pace of organizational change has prompted an increased focus on how organizations learn, or fail to learn, in response to change. In *The Fifth Discipline: The Art and Practice of the Learning Organization*, Senge (1990), issued a challenge to organizations, both in business and in education, to work to build "learning organizations, where people continually expand their capacity to create the results they truly desire, where new and expansive patterns of thinking are nurtured, where collective aspiration is set free, and where people are continually learning how to learn together" (p.3).

This present study is done against a back-drop of *change* as "change" is the one word which aptly describes the Canadian health care system. The system has undergone change, is undergoing change and will continue to undergo change. Finding reasons for the constant change in the Canadian health care system is not a difficult task, one only has to review its history and examine some of the federal and provincial planning activities over the years. A sample of such activities is presented for consideration.

Federal and Provincial Planning Reports

At the national level, a *1969 Task Force on the Costs of Health Services* concluded that increased costs could only be dealt with by reduced standards of care, increased taxes, premiums and/or deterrent fees, or more efficient operation of the system.

In 1972, *the Report of the Community Health Centre Project (Hastings Report)* recommended the large-scale development of community health centres by the provinces as well as reorganization and integration of all health services and reductions in the number of hospital beds.

The Lalonde Report (1974) of the Federal Department of National Health and Welfare

stressed the importance of health promotion, lifestyle modification and greater individual responsibility for health instead of increased provision of medical services.

The Manitoba White Paper on Health in 1972 suggested regionalization of health services and the establishment of community health and social services centres in order to shift from hospital to ambulatory care services.

In Quebec, the Health section of the *Report of the Commission of Inquiry on Health and Social Welfare (the Castonguay Report)* 1970, also suggested decentralization, community clinics and greater consumer input into the organization of health care services.

In 1972, in British Columbia, *the Foulker Report* recommended complete reorganization of the British Columbia health care system with regionalization and rationalization based on Community Health Resource and Health Centres and a de-emphasis on hospital use.

In Ontario, *the Report of the Committee on the Healing Arts in 1970; the 1976 Health Report of the Ontario Economic Council; and the 1974 report of the Health Planning Task Force (the Mustard Report)* all identified increased cost, excessive use of hospital services and the control and deployment of medical and health manpower as key issues, and included rationalization, regionalization and de-institutionalization among their remedies.

A further complication is that there is no national health care system in Canada but a number of health care systems. The Federal government has strong influence in what happens in the provincial systems due to the unique funding and policy arrangements especially in the area of health, education and welfare. With the requirement that the provincial systems meet the five principles of medicare, a change in one province may influence the system in other provinces. It was the province of Saskatchewan which pioneered publicly insured health care in the 1960s, leading to the subsequent adoption

of universality in health care across the Canada during the late 1960s and early 1970s (Hassen, 1993).

Steffan (1994), in commenting on *the significance of change in health care* perceived it as creating an unstable job market for health services managers and posting new issues for career management.

Loebs (1992), provided that all menacing reminder that the traditional method of developing executives primarily by on-the-job experience was no longer adequate:

> The magnitude and speed of change has so many roots in the external environment and the knowledge of these changes is so limited by internal staff, particularly the management development staff, that most organizations do not have the capacity to provide the necessary exposure and learning (Loebs, 1992, p.238).

He goes on to say that continuing management development and education at all levels will be key to any health care organization which desired to succeed in the new era of change. Loebs provided what he called an explicit assumption and stated that the pace of change makes formal degree achievement only a component or a building block in preparation for, and maintaining expertise in, management. The message here seems to be an attempt of motivating health managers to dispel any thoughts of complacency.

In his 1991 book, *"Managing as a Performing Art: New Ideas for a World of Chaotic Change"*, Peter Vaill, provided a graphic description of the health care environment when he stated that organizations were increasingly functioning in a condition of "permanent white water". Vaill contends that there was such a convergence of impelling forces driving organizations in multiple and often contradictory directions, and there was such a rapid pace of change taking place all about executives, that they were less able to employ conventionally effective techniques of problem solving and management. Most will agree that new methods, techniques, and approaches are required in order to operate successfully in the "permanent white water" environment. There is also a need for new

ways of thinking and operating, along with well-honed instincts, highly developed peripheral vision, and skill in repeatedly making the dynamic system work. Vaill was also convinced that the rate of change imposed on the internal structure of organizations and on external relationships is likely to be unprecedented (Vaill, 1991).

In the context of determining responses to the new environment, a fundamental question for health care organizations is what commitment in resources (time, money), and what emphasis should be made to management education and development and by what means should the commitment be fulfilled? More specifically, how will executives learn to understand the new paradigm, the new determinants for success, and the implications for very substantial, even global, external forces and imperatives?

Loebs (1993), posed some interesting questions:

> Can Health Care organizations facilitate development of executives in the "permanent white water" environment and provide stimuli for lifelong learning primarily through internal opportunities and programs?
>
> How can health care organizations prepare both current executives and their successors for successful performance in a much more demanding future?
>
> Will existing mechanism be sufficient in what is arguably a make or break environment?
>
> If current means are not sufficient or not appropriate, then what is needed? p.138.

Those questions lend themselves to forming the basis of several excellent research projects as they contain elements which are of prime concern in a changing health care environment.

Organizations' Response to the Changing Environment

Rachlis and Kushner came back in 1994 in *Strong Medicine* and stated:

> The first step in rebuilding our health care system is to change the rules that govern how it is organized and financed...As the rules change, so will the roles of the various players in the system...new rules, new roles and some new tools - all are needed to make Canada's health care system the best in the world (Rachlis and Kushner, 1994, p.252).

Continued budget pressures are expected to accelerate changes within the hospital sector over the next 2 or 3 years. Senior managers will have to grapple with downsizing programs, restructuring between institutions within a community and reforming the way in which hospitals are managed and operated.

Some of the other pressures which are faced by hospitals are long-term care reform, total system reconfiguration, the incremental integration of health and social services, the realities of consumerism, community empowerment, community-based sector expansion, systems thinking, governance, the changing roles of health professionals, the challenge of managing change, and public policy options of federal and provincial governments.

Some health care institutions are responding to the changing environment with changes to management structures e.g. Program Management; delivery methods; delivery foci. Some Ontario examples are presented later in this chapter.

Program Management

In the 1980s, hospitals began to develop product-line management as a way of controlling cost and responding to the rapidly changing health care environment. Product-line management means redesigning the organizational structure so that products (or services) can be coordinated and managed as separate business entities (Flynn, 1991). Product-line management has been used in business for over 50 years as a management strategy to control cost (Anderson, 1985; Yano-Fong, 1988). There is an assumption that costs can

be managed more effectively when the hospital product is divided into smaller entities and authority for decision making is decentralized to the level where the service is delivered. Another assumption is that timely decisions can be made by those who are closest to the product and have the most knowledge about the product (Bird, 1988).

Instituting product-line management often involves a re-organization of the structure and philosophy of management. Product-line management requires a decentralized organizational structure rather than the hierarchical, bureaucratic structure that has traditionally existed in hospitals (Flynn, 1991).

In their continuing pursuit of quality, effectiveness and efficiency, Canadian hospitals are adopting Program Management, or clinical unit management - a modified form of Program Management - as organizational models. Program Management is similar to and to a very large extent, the same as Product Line Management but appears to be the preferred term in Canadian hospitals. There are several models to choose from but the one which seems to be highly favoured in the Greater Toronto area is the one which decentralizes the traditional clinical structures and shifts responsibility to program managers. Within that structure, all clinical staff working within the program are accountable to the program manager.

Each program has a management team that is responsible for managing all program resources to ensure that an established level of service is maintained for patients and that there is proper utilization and adherence to budgets (Wilson, 1993).

Program Management represents a significant cultural change for those involved and perhaps especially so for medical staff. The success of Program Management is based upon the ability of the hospital to identify and bring together the right players. Program Management also offers employees greater autonomy and empowers staff to collectively make decisions. Staff are more directly involved, in both the provision of service and in the planning and implementation of services. As staff assume new roles at the

planning and committee level, they should receive additional orientation, training, support and encouragement; as professional education often does not address these areas (Wilson, 1993). Training should not stop at the staff level but should also include management personnel to enable key individuals to function effectively in their new roles. One effect of Program Management is the changing of relationships and roles. That has been one of the difficulties when initiated with all the same players form an old (matrix) system. It is difficult for the players to let go and assume new roles. This needs a high degree of preparation and a well orchestrated implementation process.

Selected Ontario Examples

It seems appropriate that some specific Ontario examples be presented at this time to demonstrate what actions have been taken to cope with the new demands of health provision. A variety of institutions have been presented as examples.

Peel Memorial Hospital (Brampton, Ontario)

Bruce Harber, President and Chief Executive Officer of Peel Memorial Hospital in Brampton, Ontario wrote the following in the hospital's Annual Report for fiscal 1993/1994:

> It is anticipated that the future role of acute care hospitals within the health care system to be quite different than is currently the case. Massive reform of the system is under way and it has been a constant challenge to continue to provide a range of services required by a community. It is equally as challenging to inform and educate the public of the appropriate use of health care services and to shape the expectations of what can realistically be provided.

Peel Memorial Hospital adopted Program Management on April 1, 1988 with six programs and was the first hospital in Ontario to reach that level of functioning within the new structure (Harber & Goodwin, 1989). It is the perception of the President of the hospital that the structural barriers to innovation have been removed and that the

organization is far more dynamic (Thomas, 1990).

Sunnybrook Health Science Centre (North York, Ontario)

A feature report in a the *Toronto Star Newspaper* noted that Sunnybrook Health Science Centre was "re-engineering its organization to put customers first; focusing on patient care" (Toronto Star, September 5, 1993, Section G1)

The Chief Executive Officer was reported to have said that the employees will be given more responsibilities and decision making authority and that there will be a reduction in the number of categories of workers. In the opinion of the Chief Executive Officer of the facility, the changes will require strong leadership and the acquisition of a sophisticated information system.

The Acting Chief of Service - Nursing, Jane DeLacy was reported as saying that there will be a need to spend large amounts of money on staff training to teach people the skills needed to make the new system work. There is an implicit inclusion of managers as part of the staff to whom training will be provided. If managers are excluded, then the system is doomed to failure since not many health care managers have experienced an environment of Program Management and much of the guidance is still in the trial-and-error stages.

West Park Hospital

> In April 1992, Toronto's West Park Hospital, a 406-bed continuing care and rehabilitation facility, joined a growing number of Canadian hospitals that implemented Program Management. By restructuring management and the delivery of services, hospitals hope to improve accountability and effectiveness, and better manage their costs (Monaghan et al., 1992, p.33).

It is the belief of the authors, who incidentally were the President and two Vice-Presidents, that program-specific planning and management, guided by a corporate vision

and strategy, had strengthened West Park Hospital's ability to respond to current and future health care challenges, and to design and deliver services to meet the needs of its various communities (Monaghan et al., 1992, p.37).

The Credit Valley Hospital

In a feature entitled, *The Credit Valley Hospital: A Health Facility Success Story*, Special Supplement to *The Globe and Mail Newspaper*, November 23, 1992, the 366-bed facility which was opened on November 5, 1985 joined the ranks of those Canadian hospitals with Program Management as an organizational structure. The facility was referred to as being a modern, dynamic, community hospital providing leadership in the delivery of primary, secondary, and tertiary health care services to the people of Mississauga and surrounding region.

Dean Sane, President and Chief Executive Officer of the facility, had been quoted as saying, "One of the major progressive steps achieved at the Hospital has been the introduction of Programme Management" (p.5). He was further quoted as saying that Programme Management was one of the hallmarks of The Credit Valley Hospital's efficient and effective functioning. Introduced in 1989 on a trial basis, Programme Management was expanded from four to ten programmes in September, 1991.

The President of the hospital also stated that the Programme Management teams were given the complete responsibility and authority for the operation of their programmes; that team work was the essence of Programme Management with each Physician Director, the Nursing Director and the Administrative Director each bringing a unique set of skills and abilities to the effective functioning of the team.

The Credit Valley Hospital places the emphasis on collaboration and cooperation between programmes and department, and even though Programme Management added an additional element of complexity to the hospital structure and management systems, it was

felt that the benefits significantly outweighed the costs.

AMBULATORY SERVICES DEVELOPMENT

Health Care organizations, while initiating new management structures to control costs, are also changing the methods of service delivery and Ambulatory Care is one of the methods gaining prominence in health care services.

The initiatives of the Ministry of Health support the development of an ambulatory mode of delivery of health care services. To take some specific examples, the *Chronic Care Role Study (1993) and the Partnerships in Long-Term Care (1993)*, documents released by the Ontario government, promoted the development of ambulatory care service delivery modes. They recommended the migration of traditional inpatient care delivery to ambulatory settings and a further re-definition of chronic care resources to support rehabilitation and re-activation. In particular, they recommended the provision of ambulatory care and community based supportive living arrangements with the dual goals of either rehabilitating persons back to their community or of maintaining clients in their homes in the community.

West Park Hospital

In the summer of 1993, West Park Hospital conducted an ambulatory services needs assessment to identify client needs and to plan for restructuring to deliver ambulatory care and services. Ambulatory care development would expand the ability of the hospital to meet the special needs of the clients who are physically or psychologically challenged, and who require a range of interdisciplinary services. Developing more ambulatory services would also enable the facility to support clients who are living in the community while supporting the hospital's quest for creating opportunities for personal triumph for individuals (Consultant Report on Ambulatory Care Services, West Park Hospital Library, 1993).

The Credit Valley Hospital

A major part of the future planning within the Medical Staff Organization at The Credit Valley Hospital centres around *ambulatory care services* with an increasing movement away from lengthy inpatient stays. Initiatives at The Credit Valley Hospital included, Surgical Short Stay Unit; Transitional Level of Care; Regional Geriatrics Laboratory; and Regional Renal Services (Globe and Mail Newspaper, Special Supplement November 23, 1992).

WORK TRANSFORMATION

Work Transformation is a carefully orchestrated approach to large scale organizational change, focusing on innovative approaches to the way work is done. It has redefined the way people conduct work and accept accountability for results. It is a focused effort to improve quality, streamline processes and reduce costs. (Hay Consulting, 1993).

Work Transformation initiatives provide major strategic changes in the delivery of quality patient care, the redesign of jobs and work processes, and the development of high-performing interdisciplinary teams. Work transformation offers the possibility of improved effectiveness of care for patients, improved work life for individuals throughout the organization, and improved efficiencies in complex work system.

In 1993, the Hay Consulting Group warned that Work Transformation must not be perceived as an event but rather as an ongoing process that supports continuous improvements and proactive change in the organization's culture. It was designed to complement and support quality improvement initiatives. Work transformation was designed to take a comprehensive view of how work was being conducted and to reassess the dynamics of meeting the needs of customers throughout the organization.

Work transformation, also known as re-engineering, requires far more than shuffling of

positions, a shifting of players, and the creative application of new titles. Although it appears to be about process, work transformation, which is growing in popularity is in reality a people initiative that focuses on the human side of health care (Boston and Vestal, 1994). The long-range goal should be a stable, financially sound organization in which quality - both in terms of employee work life and patient care - continues to grow regardless of the changes in the field.

The process of work transformation fits with the health care industry needs seeing that the provision of health care is a very dynamic undertaking. Creating and motivating employees to be more flexible, to accept new responsibility, and to participate in the work transformation process can be difficult without strong leadership from the top (Boston and Vestal, 1994).

Transforming a health care organization requires both tangible and intangible investments. The cost of such a project, including direct expenditures for project support and indirect costs associated with freeing staff to participate in the process, must be balanced against the desired results. As health care is such a human resource industry, removing individuals for non-patient care activities might result in less care or will require the replacement of the freed-up individuals. This is especially true in a Program Management structures where certain health care professionals are employed in small numbers. In such situations, any decrease in staff at any particular time could be significant effects on patient care.

Changes in organizational structure as in Program Management, new service delivery models as in Ambulatory care and Work Transformation or re-engineering require that all involved understand the goals and objectives of the effort and that the leadership be at a high level. It is not sufficient to change without providing the educational and training support required to inform all the players. It must not be assumed that the "old" players are conversant with the rules of the "new" games. A concerted effort must be made to clarify the rules, roles and provide direction and support.

EVALUATION.....A word to the Wise

In Managing Transition: Making the Most of Change, Bridges (1991) advised that organizations should carefully study the impact of proposed changes and put in place educational programs to help people accommodate feelings of loss of identify, control, meaning, belonging and optimism for the future. Following new directions for health care delivery is commendable but there needs to be an evaluation plan as part of the different change processes to provide objective assessments over time.

Organizations expecting immediate success will be disappointed; the transformation of an organization, including its infrastructure, culture and reward system, takes time. The success and progress of change projects, whether they are cost reductions, improved customer satisfaction or enhanced employee relations, are best measured through sustained results over a longer time, rather than at one point in time.

Maintaining momentum and enthusiasm during the time it takes from design to results can be difficult in today's "results-oriented" environment. It is possible for organizations to meet that challenge by identifying up front, the criteria that will be measured throughout the project and designing a system for monitoring and communicating progress.

The development and use of measures of output and outcome in health care are essential for achieving health service objectives. If deliberate rationing is to be a strategy for cost containment, then cutbacks must be effected in the types of care which have the lowest expected value. Expected value is defined as the probability of improving the clinical outcome multiplied by the value placed on that outcome (Kane-Berman & Taylor, 1990).

On the other hand, it is necessary, as well, to warn against too much reliance on quantification. Frequent measuring can distort organizational efforts because, as a rule, some aspects of output are more measurable than others. Excessive measurement tends to encourage overproduction of highly measurable items and neglect of the less

measurable but highly necessary ones, as is the case in some aspects of the provision of health care.

Detractors

It must be assumed that not everyone was enthusiastic about the changes taking place in health care as can be seen from the expressed feeling of Crighton. In 1990, he stated that the splintering of the administrative group into a whole range of subsections raises a number of questions about boundaries and organizational design.

In the article about Sunnybrook Health Science Centre, the reporter stated that a manager at the centre cautioned that while it was fine for top administrators to study management methods that work well in business, they need to remember that a hospital is a medical centre, not a production line.

Towards the close of 1994, on a local television station, the Ontario health care system was the topic for the nightly presentation and a commentator felt that the Ontario health system was being dismantled rather than being refined in reference to the Ministry of Health's efforts at health care reform in Ontario (CFMT - November 17, 1994 - Dick Smyth).

Training

In the economic literature, education and training are examined in terms of human-capital theory. In order for an individual to undertake education and training, there has to be some return for the investment of time and money which is being used. The money investment is direct, in the form of such expenses as tuition, fees, and books, and the investment is indirect, in terms of the earnings which are forgone while the person is in school (Meltz, 1982).

The fact that employer interests are largely economic cannot be overstated as it has a bearing on policy formulation and practice. Training is assumed to be beneficial to a company in enhancing the goals of the organization (Gutek 1988). What that perception is popular with the organization, managers who build their management training objectives with that philosophy, will gain support, both financial and otherwise. Denora (1979), agreed with the economic basis for training and further stated that business must treat education as an investment, and like any other investment, the value of education will be assessed in terms of its return.

Companies are searching for a payback on money invested in training. "The question of whether employees need more training inevitably comes down to time and money. Will the time and money you invest today in training be repaid - with interest - in the next week, month, year or decade?" was the question asked by Hassett (Hassett, 1992 p.53). By investing in the Human Resource, employers are realizing that it is one of the most dependable ways to solve problems and take advantage of the opportunities as they present themselves. Employers and employees are now beginning to realize that the economy is in transition and as such, plans for education and training must consider skills that enable flexibility and adaptability as well as specific job related skills to meet future demands (Goffee & Scase, 1992; Senge, 1990a).

Changing Nature of Jobs for Managers of Health Care

Managerial jobs are changing and will continue to change even more so over the immediate future. A 1991 survey conducted by The American Society for Training and Development indicated that 38 percent of executives stated that the job of the manager has changed to a great or very great extent over the preceding two years while 72 percent predicted that the manager's job will change over the following two years. (National HRD Executive Survey, 1991; Horton, 1991; Senge, 1990a).

The following provides an indication of reported changes in the job of the manager:

managing more with less; customer focus; working with Total Quality Methods increased management of work teams; increased cross-functional work; managing an increasingly diverse workforce; increased management processes; and global/international management responsibilities (Horton & Reid, 1991; Noble, 1990; Senge, 1990; Taylor, 1989).

If health care facilities are to meet the challenge of maintaining quality and accessibility of services in the present economic environment, significant changes will be required in the way in which health care managers function so that they will be prepared to meet the needs of the community; and provide client centered services in a cost effective manner.

In 1993, Grieshaber wrote that future health care managers will require much stronger skills in managing professionally diverse work group and that the successful manager of the future will also be a transformational leader i.e. leaders with sufficient vision to anticipate demands in their organizations and with leadership qualities to change their organizations.

Grieshaber 1993, sets the tone with the following comment:

> The rapidly changing health-care system will require managers and leaders, as well as caregivers, with new sets of skills. Health-care institutions of the 21st century will require managers with different skills from those at work today. By definition, management practice will still require that resources be acquired and used efficiently to achieve organizational goals. However, the types of resources and the organizational structure themselves will be changed in such a way that the mix of skills required of their managers will change (Grieshaber, 1993, p.25).

The characteristics of the emerging health care organization have been stated as decentralization; an emphasis on caring rather than curing; and by coordination of activities and resources. Grieshaber was convinced that the manager of the future will be so different from the one of the present that if it were possible to construct that future

manager and place him in today's environment he would be less than a success.

If future health care managers will be managing a professionally diverse work group, they will need to speak the language of clinicians and be comfortable with medical terminology. The manager will need to be confident in the ability to evaluate clinical resource needs on an equal footing with clinicians.

The successful manager of the future also will be a transformational leader. The more health care moves into the community, the more responsive it must be to the needs of the community. The industry will need leaders with sufficient vision to anticipate demands on their organizations and with leadership qualities to change their organizations. They will also need to possess the capacity to deal with the uncertainty and constant change of organizational life.

In an exploratory quantitative research project involving health care managers, LLoyd (1994), identified features perceived to be essential for effective health care management. In particular, "key figure" attributes were described as charisma, commitment and drive - all of which received high ratings. Leadership competencies are perceived, not unreasonably, as having significant implications for managerial success. For Lloyd, the important point to consider was that the definition of leadership is heavily influenced by the bureaucratic culture which pervades the health care system and within which the majority of survey respondents operate (Lloyd, 1994).

Loebs (1993), believed that there was a challenge for management development of health care managers as he perceived superior executive performance in the future as requiring a deeper understanding of the social, political, economic and technological forces which are shaping and will continue to shape their operating environment.

Skill and Knowledge Needs of Health Care Managers

Leaders in the private sector receive more formal training than their counterparts in the public sector (National HRD Executive Survey, 1991). By pursuing continuing education and professional developmental activities, the competence and knowledge of practising health care professionals will be critical over the next ten (10) years to the success of the health care system (Carruthers, 1988).

Kazanjian (1993), reported on a study which was concerned with future directions in health management as expressed in terms of skills and knowledge required to fulfil the management role of the future, Findings from the study showed that formal education - entry level and continuing - was generally indicated to be the preferred source of competence for preparing leaders in health care management and that some competencies were acquired from multiple sources including mentors and on-the-job experience (Kazanjian, 1993).

Project TEAMS (1980) and Schaaf (1991) have suggested the following as areas of development for health care managers: management skills re self-awareness, time management, problem-solving and decision making, accounting and budgeting; communications, public relations; recruiting and hiring re labour laws, evaluation of employees and motivation; delegation, personnel management, conflict resolution, stress management, risk management; and management theory, planning, program evaluation, change process management, technological management.

Training of Senior Public Health Administrators: Report of a WHO Working Group (1978), mentioned continuing education for senior public health administrators in the decision-making and managerial policy areas. Eubanks (1991), reported that although 82% of Chief Executive Officers reported that their education had adequately prepared them for their roles as Chief Executive Officers that some cited weaknesses in the area of communication skills.

Based in the foregoing, it can be seen that the needs for management development are many and diverse and there may never be an agreement as to what are the true needs. Davidson (1993), focused his study on the goals of management development and described a variety of techniques that should be considered by health care executives in meeting their personal management development needs as well as the organization-wide needs of their institutions. He found that as health care executives moved through a restructuring of the health delivery system, their ability to focus on service to the community was often hampered by the need to ensure institutional survival. He concluded that managerial obsolescence raised important questions about the priority of management development in today's hospital environment.

Training, Education and Development

Management training has been receiving increasing attention over the past decade. A study by Loo (1992), reported that in Health Care organizations only 36% stated having formal education policies and procedures for management training. He noted that on the positive side, many health care organizations were evolving towards a more articulated and comprehensive approach to management training. He further noted that the constraint of limited funds for training was frequently cited as a hindrance to goal attainment (Loo, 1992). Overall, both health care and other Canadian organizations recognised the importance of management training for achieving organizational goals and they are striving to improve such training (Kazemek & Clarny, 1991).

Hunt (1990), stated that the exponential increase in the cost of management development will lead to much tighter controls on quality and effectiveness of the development process. Even though the reference was one from industry, there is no reason why it will not apply in the health care management field. Career development, like other development functions, is a very complex process. Progress in one's career is undoubtedly stimulated and qualified by the interactive effects of internal and external forces. (Argyris, 1991; Schaaf, 1991; Baldwin, 1990). Simply put, the individual must

be motivated in order to receive any benefit from a developmental program. The source of the motivation could be personal or job related.

Tindel (1979), in a study specific to mental health administrators reported that they had continuing education needs in the areas of management and records; problem resolution; projection of needs; education of the public; outreach; and Philosophy.

The data from Williams' study of 1991 revealed that in many cases, the educational credentials of the respondents were in fields not directly related to the provision or management of health or human services.....less than one-fifth of the survey respondents reported that they were trained in health care or business administration. That led Williams to conclude that if the survey results suggested important gaps in education, they also indicated a substantial degree of individual and institutional support for further education in the field (Williams, 1991). The inference here seems to be that any attempts at improving the gaps will provide benefits to the individual and to the organization.

On the matter of professional development for health care managers, Aylor (1993), expressed the opinion that it was quite apparent that no graduate program of any generation could prepare practitioners for a future containing as much uncertainty and volatility as health care administration. He felt that both the administrator's interest and the demands placed up them by their professional life inevitably change over time and that much more is required of professional education to enable health care executives to be effective throughout their careers as obsolescence was an ever-present danger.

Knowles (1980), believed that if human needs were addressed, the adult learner will be able to climb simultaneously up Maslow's hierarchy of needs as work competencies were being developed. Davidson (1993), believed that the most essential purpose of professional development was to help the organization meet its mission and objectives, and that the purpose was best met when management development activities were tied directly to the organization's need to grow, renew, change and meet with new

environmental challenges and opportunities.

Mandatory vs Voluntary Continuing Education Pursuits

Many U.S. states have initiated mandatory continuing education for re-licensure for nurses. Cannon and Waters felt that mandated continuing education should serve dual purposes: retaining a current and informed body while, at the same time, promoting professionalism? (Cannon & Waters, 1993). As far as Urbano was concerned, "Required learning" has evolved as a method of combating the threat of obsolescence in a rapidly changing nursing profession (Urbano et al., 1988).

In a study done by O'Connor of nurses as reported by Urbano et al. (1988), it was concluded that nurses participated in mandated continuing education for reasons related to professional currency and ability to serve mankind, rather than merely the presence or threat of legislation (Urbano et al., 1988). In Urbano's own study, she found that nurses who participated in mandatory professional continuing education demonstrated the same pattern of motivational orientations as those who voluntarily participated in educational activities - motivated primarily by cognitive interest and a desire for professional advancement and competency (Urbano et al., 1988). In 1992, Thurston stated that the rapid development of technology and expansion of knowledge have made necessary a frequent update of skills.

Urbano said that there were other benefits to a mandated system. It had been suggested that the mandatory requirement had generated a large number of alternate opportunities for participation in professional continuing education (Urbano et al., 1988). Those may have resulted in a large array of professionally relevant, available educational offerings from which nurses could choose than would exist if there were no mandatory requirements.

SUMMARY

For Vaill, his impression of the environment has been presented as a "white water world" which make carrying out of the basic duties of the executive to be a very demanding in terms of energy and time. He reminded us that those individuals have another set of responsibilities and it is to their families. "All of us are constantly torn in trying to keep some semblance of balance in our life - of fulfilling our stewardship responsibilities to our organizational world and fulfilling our responsibilities to our families and to ourselves in the personal world. We are caught within a dilemma" (p.202). He viewed continuing management development as a compounding of the dilemma. He offered, as a solution, that both the individual and the organization should take the point of view that continuing management development was not something to be done outside of the work environment or outside of work duties but as an integral part of them and the time, the expectations, and the environment, "where continually updating ourselves and renewing ourselves in terms of knowledge and skill is part of our basic expectations." (p.202).

There is a strong recognition that the many changes in the health care industry are causing concerns and that has prompted one health care executive to provide some encouragement as follows:

> Change of this magnitude is never easy. But as hard as it may be, it's going to be gratifying. Patients and their families are going to be better served, and employees will face a diversity of challenge that will make their jobs more interesting (Boston & Vestal, 1994).

Davidson (1993), also provided some encouragement when he stated that now was the toughest time in the history of American Health Care delivery to be a hospital executive due to the radical change which was taking place across the entire health delivery system. For him, it was a pace of change never before experienced by health care executives and because of that, he was sympathetic to health care leaders especially if they were feeling disoriented and uncertain of the future.

As a matter of survival, health care managers need to be knowledgeable in order to successfully cope with the increasing numbers of non-traditional workers in the workplace, as well as to maintain a competitive economic position. Future health care managers will require much stronger skills in managing a professionally diverse work group (Grieshaber, 1993). With management structures such as Program Management, unit teams are composed of individuals from many health care disciplines and would not be reporting to a management person of the same discipline as is normally the case in different management structures.

As organizations restructure and re-engineer for increased efficiency and effectiveness, organizational pressure will cause current managers to re-evaluate their own leadership skills. Managers will need assistance in maintaining their required knowledge and skill level and that assistance can be provided in many forms but must have the input of all the players so that the needs of all were met. Those who can find ways to improve their skills will survive and they will be seeking guidance and assistance from established educational institutions which will be forced to respond with programs to stimulate imagination and meet the needs of the stakeholders.

Chapter 3, which follows, provides a description of the design and methodology of the study and also includes a description of the population, survey design, information gathering procedures and data analysis process.

CHAPTER 3

DESIGN AND METHODOLOGY

The intent of the study was to document the opinions and perceptions of health care managers on specific aspects of continuing education and determine how those perceptions and opinions affect the practice of pursuing continuing education and professional development activities in the field of health care management.

This chapter provides detailed information on the research methodology which was used by the researcher in the collection of data.

DESIGN OF STUDY

A survey research methodology was used to collect data. The rationale for using survey research to achieve the purpose of the study was that the researcher did not seek to explain relationships, to test hypotheses, or to make predictions. Instead, the intent was to present the perceptions and opinions of health care managers on some specifics aspects of continuing education and professional development. The plan was to obtain the perceptions and opinions of health care managers regarding perceptions of needs, barriers, perceived benefits, mandatory vs voluntary practise of continuing education, facilitation role, motivators, reasonable expectations, skills for the future health care manager, and suggestions for skill development in the experienced manager. The questions were provided in more detail in Chapter 1 on page 15, and a copy of the questionnaire was provided as Appendix B.

SAMPLE

The sample was taken from a pool of approximately 900 health care managers who were employed by hospitals in major university cities in Ontario, Canada. Managers in major

university cities will probably have different access concerns regarding suitable educational opportunities. There are five Ontario cities (Toronto, London, Hamilton, Kingston and Ottawa) with large universities which offer a medical program and also post-graduate degrees in health administration and/or business administration and/or public administration (M.H.A., M.H.Sc., M.B.A., & M.P.A.). Appendix C is a map of southern Ontario and the cities mentioned in the study can be located thereon. The individuals were selected from *The Members Directory 1993-94 of the Canadian College of Health Service Executives (CCHSE)*. The directory provided full mailing addresses - home or business as selected by the member. Health Care managers tend to be members of the College which offers several membership categories. An attempt was made to have the sample reflect the population regarding male and female proportion but no attempt was made to balance the sample size for each of the five cities. Lemieux-Charles (1994) and Storch (1988) found that the ratio of females to males in health care management was about 3:2. The sample size was one hundred and eighty-nine individuals comprising of ninety males and ninety-nine females. The sample was randomly selected. Distribution for the five cities was as follows:

Hamilton - 8 males and 13 females, totalling 21;
Kingston - 10 males and 5 females, totalling 15;
London - 14 males and 11 females, totalling 25;
Ottawa - 17 males and 15 females, totalling 32; and
Toronto and vicinity - 41 males and 55 females, totalling 96.

A total of nine surveys were returned as undeliverable making the effective survey sample one hundred and eighty. Please refer to Table 3.1 on the following page for more details.

Table 3.3 - QUESTIONNAIRE RECORD

Location (City)	Surveys sent			Undelivered			Delivered			Usable Returns		
	M	F	T	M	F	T	M	F	T	M	F	T
HAMILTON	8	13	21	0	1	1	8	12	20	4	9	13
KINGSTON	10	5	15	0	0	0	10	5	15	7	4	11
LONDON	14	11	25	0	0	0	14	11	25	4	8	12
OTTAWA	17	15	32	0	1	1	17	14	31	6	6	12
TORONTO	41	55	96	2	5	7	39	50	89	13	35	48
Totals	90	99	189	2	7	9	88	92	180	34	62	96

M = Male; F = Female; T = Total

* Fifty-three percent (53%) of the sample responded to the questionnaire.

SURVEY DESIGN

The primary method for collecting data from the health care managers included in the sample was a questionnaire survey. A copy of the full questionnaire can be found in Appendix B.

The self-administered questionnaire was divided into eleven sections to facilitate easy completion, data processing and analysis. Each section was then sub-divided with items ranging from eight to seventeen. The first nine sections of the questionnaire solicited opinions on the statements of interest while the last two sections were designed to collect demographic type information. The rating scale was constant throughout the nine sections where opinions were solicited. A Likert scale, with values from 1 to 5, was utilized for expression of level of agreement/disagreement: 1 = Disagree Strongly; 2 = Disagree; 3 = Neutral; 4 = Agree; and 5 = Agree Strongly. The length of the questionnaire allowed for completion in 15 - 20 minutes. Space was provided at the end of the first nine sections for participants to add comments.

The researcher decided to construct a survey questionnaire after much searching for an appropriate instrument. The investigator did not feel that any of the commercially available or published instruments would have solicited the information needed, especially as this study was not a replication of a previous work. Much effort was put into a literature search and then gleaning from published articles the common areas of interest, especially those areas which were given much attention in the referenced literature. It is the opinion of the investigator that the instrument, as constructed, was the best tool for the topic under investigation.

Every effort was made to construct an instrument that was pleasing to the eye so as to encourage participation. The layout was done in a painstaking matter to avoid small prints and clutter. To assist the process, the rating scale was repeated at the top of each page. The researcher avoided words and phrases which might prove offensive and which

were not considered politically correct, in an effort not to offend anyone. One individual stated some objection to the fact that a demographic item 10.7 requested information on cultural background.

In the Letter of Introduction (Appendix A), participants were assured of anonymity and confidentiality and were asked not to identify themselves on the questionnaire but they were invited to make contact with the researcher if they wished to provide additional information or be contacted for other related reasons. They were to make the request other than on the survey instrument. A telephone contact number and home address were provided on the letter of introduction and on page 1 of the questionnaire.

PRETEST OF SURVEY

The survey instrument was reviewed by a selected panel of experts consisting of psychologists who specialize in measurement and evaluation, and health care managers and educators. Fifteen individuals were involved at this stage. The reviewers were asked to evaluate the survey instrument in relation to understandability of instructions and the clarity and completeness of the questions. The health care managers had the additional task of completing the questionnaire as well as provide feedback on clarity and understandability of the questions. Based on the responses and comments of the reviewers changes were made to the draft questionnaire. The feedback from the expert panel was very helpful in providing suggestions for clarity and some very necessary changes or modifications were made to the instrument before it was sent out in the final form. The responses from the health care managers were analysed for reliability of the items which composed each question.

DATA COLLECTION PROCEDURES

The survey was addressed to one hundred and eighty-nine (189) health care managers who were employed by hospitals in five Ontario cities where there are large universities which offered programs in medicine and post-graduate degrees in health and/or business and/or public administration. Graduates from those programs are known to be employed as health care managers. The researcher, being a certified member of the Canadian College of Health Service Executives had access to a pool of about 900 individuals from which to obtain the randomly selected individuals.

The questionnaire was sent out in early Fall of 1994 with the intent of capturing the attention of potential respondents once they had settled back into their work routine after the summer and before becoming too involved in the holiday break in December. Data were collected over a four-week period.

The respondents were asked to return the completed questionnaire to the researcher in the envelope which was provided with the survey instrument and were instructed to keep their responses anonymous. No one wished to provide additional information by way of personal interviews but the comment sections of the instrument were used and some individuals commented that they found the survey interesting and would be expecting to see the outcomes of the study.

DATA ANALYSIS

Descriptive statistics were used to analyze responses to the survey questions. Comments and additional information provided were analyzed for content and summarized as part of the report. The demographic information was used for discriminant analysis using ANOVA (Analysis of Variance). Investigation was made into the inter-relationships of the demographic variables and the attitudinal scales.

Descriptive analysis was obtained for each statement in each section of the questionnaire. For each attitudinal scale, a reliability analysis was performed in order to determine the Cronback's Coefficient Alpha (internal consistency of the scale). This provided some assurance that each item in the scale was measuring what the entire scale purported to measure. With a reliable scale, there is assurance that there was no analysis of extraneous material.

A factor analysis was also done on each scale to obtain a determination of whether each scale measured only one dimension. The factor score of each scale was used as a dependent variable for further discriminant analysis. Using factor scores as dependent variables allowed for the use of discriminant analyses such as ANOVA and MANOVA (Multivariate ANOVA) and multiple regression to determine group differences e.g. gender difference, education, experience, age, culture, etc. The questionnaire provided for a minimum of 136 data points.

The data collection and analysis from the study was extensive and required extensive data management and statistical analysis. The *MINITAB Statistical Software* package was used for most of the analysis of the data. *MINITAB* is a highly functional, relatively easy-to-use statistical software package that provides a wide range of basic and advanced data analysis capabilities. The *MINITAB Statistical Software* provides a system for organizing and analyzing data, and reporting results in statistical analysis.

The study will provide data which could be applied in decision-making and planning for continuing education for health care managers.

VALIDITY AND RELIABILITY

Ensuring *validity* of the survey instrument was very important to this study. The intent of each question should mean the same things to all respondents and that responses

correspond to what they are supposed to measure or determine (Best and Khan, 1986). In this study, an attempt to assure "face" validity was made through the expert panel. Each member of the panel was asked to comment on the clarity of instructions, the understood meaning or intent of each question and also on coherency and completeness of the survey as a whole.

Reliability is the degree of consistency that the instrument demonstrates (Best & Khan, 1986). It is the extent to which individuals in comparable positions and situations will respond in similar ways. In this type of survey design, good questions are reliable provided that there is consistency in response in comparable situations. In order words, respondents will provide the same answer if the questionnaire were administered at different intervals of time or in different situations. Providing consistent wording and the use of easily understood terms will go a long way in maintaining reliability. That was another area where the expert panel provided some valuable assistance.

Initial return was very encouraging with a receipt of a number of completed questionnaires on a daily basis within a week of mail-out. Some strategically placed telephone calls resulted in about 8 responses after the initial flow was stemmed. The final return of usable responses was 96 of 180 assumed delivered i.e. 53.3 %. (Nine questionnaires were returned undelivered).

As can be imagined with a study of this type, the report consists of tabular presentation of the material with explanatory text and is presented in more detail in Chapter 4 which follows.

CHAPTER 4

ANALYSIS AND INTERPRETATION OF THE DATA

Introduction

This chapter reports the data collected from ninety-six health care managers in five major Ontario cities. The focus of the study was Management in Health Facilities: The Issue of Skill Development for Managers of a Changing Environment and the purpose was to identify and describe factors which may impact on individual efforts to maintain currency of knowledge and skills while meeting the needs of the future health care environment.

Research Questions & Interpretation of Findings

The following nine research questions were identified because they represented the areas of interest of health care managers and researchers in the areas of continuing education and professional development:

Question 1 - What were the perceptions of health care managers regarding the need for continuing education and professional development?

The managers agreed that continuing education and professional development should be a requirement for all health care managers. Senior Managers and CEOs were provided as sub-groups of managers but yet there was a strong indication that they should be part of the group of managers for which continuing education was a requirement. Advantages of continuing education for health care managers were indicated for individuals who had been away from formal academic education for greater than three to five years, so that they would be kept current in management issues. It was also agreed that managers without formal academic credentials in health care management or in general management had a need which could be met via professional development.

A ranking of the data showing response mean for each item of the question regarding perception of need revealed that item 1.10 (4.604) produced the highest level of agreement followed by items 1.9 and 1.1. The item receiving the lowest level of agreement was item 1.7 with a mean score of 3.316 which was just above the neutral rating of 3 (Table 4.1.0). The overall response mean for the question was 3.517 and the number of valid cases was 90. The managers showed some ambivalence in responding to item 1.7 which stated that continuing education should be related to experience level.

TABLE 4.1.0 - Response Mean For Each Item Of Question 1.
PERCEPTION OF NEEDS

Continuing Education for health care managers ...

		Response Mean
1.1	should be a requirement for all health care managers	4.542
1.2	would keep health care managers current in management issues	4.292
1.3	would be advantageous to individuals who have been away from formal education for greater than 5 years	4.232
1.4	would be advantageous to individuals who have been away from formal education for greater than 5 years	4.396
1.5	should be mandatory for managers who do not possess formal academic credentials in health care management	4.083
1.6	should be related to specific levels of job responsibility	3.625
1.7	should be related to experience level	3.316
1.8	should be a mutual understanding between manager and supervisor	3.902
1.9	should be required for Chief Executive Officers	4.394
1.10	should be required for Senior Management	4.604

Rating Scale:
1 - Disagree Strongly; 2 - Disagree; 3 - Neutral; 4 - Agree; 5 - Agree Strongly

Table 4.1.1 - Valid Responses, Response Means and Standard Deviation - Question 1

Question Items & N values	VALID RESPONSES - Percent					Response Mean	Std. Dev.
	1	2	3	4	5		
1.1 (96)	1.0	2.1	3.1	29.2	64.6	4.542	0.753
1.2 (96)	0	1.0	6.3	55.2	37.5	4.292	0.631
1.3 (95)	0	2.1	13.7	43.2	41.1	4.232	0.764
1.4 (96)	1.0	1.0	7.3	38.5	52.1	4.396	0.761
1.5 (96)	5.2	3.1	13.5	34.4	43.8	4.083	1.083
1.6 (96)	5.2	12.5	17.7	43.8	20.8	3.625	1.107
1.7 (95)	5.3	20.0	24.2	38.9	11.6	3.316	1.084
1.8 (91)	2.2	12.1	9.9	54.9	20.9	3.802	0.980
1.9 (96)	0	2.1	6.3	21.9	69.8	4.594	0.705
1.10 (96)	0	2.1	5.2	22.9	69.8	4.604	0.688

Rating Scale:
1 - Disagree Strongly; 2 - Disagree; 3 - Neutral; 4 - Agree; 5 - Agree Strongly

Question 2 - What opinions were shared by health care managers on the factors (barriers) which hampered their pursuit of continuing education activities?

The respondents of the study were able to provide a high level of agreement on which factors negatively impacted on their attempts at continuing education activities. The top choices are presented in Table 4.2.0 which is a record of the Response Mean for each of the ten items of Question 2. The popular choices for barriers were items 2.5 - *cost of courses, conferences and related activities* (3.989); 2.1 - *job work load* (3.965); and 2.7 *personal responsibilities related to home life* (3.667) were the top three barriers chosen from the list of ten provided. The lowest scoring item was 2.8 - *managers perceiving continuing education to be of low personal value* (2.663). The other item scoring less than 3 was item 2.6 - *the perception that continuing education is not valued by employers*. The overall response mean for Question 2 was 3.307 and the number of valid cases was 92. Ambivalence was shown by the managers when choosing items such as inadequate course offerings, distance from home, the low probability of increased financial reward for their efforts at professional development and whether continuing

education was not perceived as an expectation by employers.

It is possible that managers were not sure whether or not courses were available or they had not done enough investigating. Some written comments had indicated a shortage of appropriate course opportunities. Underlying the ambivalence is a need for managers to project a positive image of themselves regarding their willingness to pursue developmental opportunities. The respondents might not have wished to give the indication that some health care organization do not value professional development, even if they felt that way based on the lack of support in some specific situations.

TABLE 4.2.0 - Response Mean For Each Item Of Question 2

BARRIERS

Continuing Education activities by health care managers are negatively impacted by ...

		Response Mean
2.1	job workload	3.865
2.2	inadequate course offerings	3.323
2.3	distance from home	3.344
2.4	distance from work	3.319
2.5	cost of courses, conferences and related activities	3.989
2.6	the perception that continuing education is not valued by employers	2.719
2.7	personal responsibilities related to home life	3.667
2.8	managers perceiving continuing education to be of low personal value	2.663
2.9	the low probability of increased financial reward (pay raises)	3.221
2.10	continuing education not being perceived as an expectation by employers	3.082

Rating Scale:
1 - Disagree Strongly; 2 - Disagree; 3 - Neutral; 4 - Agree; 5 - Agree Strongly

Table 4.2.1 - Valid Responses, Response Means and Standard Deviation - Question 2

Question Items & N values	VALID RESPONSES - Percent					Response Mean	Std. Dev.
	1	2	3	4	5		
2.1 (96)	2.1	11.5	5.2	60.4	20.8	3.865	0.947
2.2 (96)	4.2	19.8	22.9	45.8	7.3	3.323	1.010
2.3 (96)	2.1	17.7	31.3	41.7	7.3	3.344	0.927
2.4 (94)	3.2	18.1	28.7	43.6	6.4	3.319	0.953
2.5 (95)	1.1	3.2	11.6	64.2	20.0	3.989	0.737
2.6 (96)	10.4	39.6	21.9	24.0	4.2	2.719	1.073
2.7 (96)	1.0	7.3	25.0	57.3	9.4	3.667	0.790
2.8 (95)	8.4	42.1	27.4	18.9	3.2	2.663	0.985
2.9 (95)	4.2	23.2	27.4	36.8	8.4	3.221	1.033
2.10 (95)	3.2	33.7	25.3	32.6	5.3	3.032	1.005

Rating Scale:
1 - Disagree Strongly; 2 - Disagree; 3 - Neutral; 4 - Agree; 5 - Agree Strongly

Question 3 - What benefits were perceived by health care managers in the pursuit of continuing education and professional development activities?

The choices for perceived benefits were made from seventeen items. The top five were items 3.3 - *increased opportunities for net-working* (4.253); 3.1 - *currency of information* (4.232); 3.4 - *increased self-esteem* (4.021); 3.12 - *increased job knowledge* (3.979); and 3.7 - *improved management skill* (3.884). The lowest ranked item was 3.2 - *increased promotability (internal)* (3.305). No item received less than a neutral score (Table 4.3.0). The overall response mean for the question was 3.750 and the number of valid cases was 94.

In this question, there were only two items to which the respondents reacted with some neutrality in deciding the value of increased promotability with their organization and increased performance appraisal rating. Increased opportunities for internal promotion

might not be perceived as a possibility due to the decreasing number of management jobs due to downsizing of health care organizations. As far as increased performance ratings go, the perception here was that in situations where performance appraisals were regularly done, the managers have been rewarded for job tasks rather than developmental activities. A mix of both would be valuable in providing some encouragement for the pursuit of professional development. Until employers demonstrate that management development is values, there will always be a level of doubt on the part of the managers.

TABLE 4.3.0 - Response Mean For Each Item Of Question 3

PERCEIVED BENEFITS

Continuing education for health care managers provides for ...

		Response Mean
3.1	currency of information	4.232
3.2	increased promotability (internal)	3.305
3.3	increased opportunities for net-working	4.253
3.4	increased self-esteem	4.021
3.5	increased marketability (external)	3.863
3.6	increased political know-how	3.532
3.7	improved management skills	3.884
3.8	increased morale	3.768
3.9	increased level of job satisfaction	3.758
3.10	increased performance appraisal rating	3.326
3.11	increased productivity	3.432
3.12	increased job knowledge	3.979
3.13	increased decision-making ability	3.779
3.14	improved communication skills	3.811
3.15	increased motivation	3.789
3.16	increased efficiency	3.453
3.17	improved organizational ability	3.611

Rating Scale:
1 - Disagree Strongly; 2 - Disagree; 3 - Neutral; 4 - Agree; 5 - Agree Strongly

Table 4.3.1 - Valid Responses, Response Means and Standard Deviation - Question 3

Question Items & N values	VALID RESPONSES - Percent					Response Mean	Standard Deviation
	1	2	3	4	5		
3.1 (95)	0	1.1	3.2	67.4	28.4	4.232	0.555
3.2 (95)	1.1	17.9	37.9	35.8	7.4	3.305	0.888
3.3 (95)	0	1.1	7.4	56.8	34.7	4.253	0.635
3.4 (95)	2.1	1.1	13.7	58.9	24.2	4.021	0.785
3.5 (95)	0	4.2	24.2	52.6	18.9	3.883	0.766
3.6 (94)	0	13.8	30.9	43.6	11.7	3.532	0.876
3.7 (95)	0	1.1	23.2	62.1	13.7	3.884	0.634
3.8 (95)	0	3.2	31.6	50.5	14.7	3.768	0.736
3.9 (95)	1.1	5.3	25.3	53.7	14.7	3.758	0.808
3.10 (95)	1.1	11.6	46.3	35.8	5.3	3.326	0.791
3.11 (95)	0	8.4	45.3	41.1	5.3	3.432	0.724
3.12 (95)	0	1.1	10.5	77.9	10.5	3.979	0.505
3.13 (95)	0	4.2	25.3	58.9	11.6	3.779	0.702
3.14 (95)	0	2.1	24.2	64.2	9.5	3.811	0.624
3.15 (95)	0	2.1	25.3	64.2	8.4	3.789	0.617
3.16 (95)	1.1	4.2	46.3	45.3	3.2	3.453	0.681
3.17 (95)	0	1.1	40.0	55.8	3.2	3.611	0.570

Rating Scale:
1 - Disagree Strongly; 2 - Disagree; 3 - Neutral; 4 - Agree; 5 - Agree Strongly

Question 4 - What were the opinions of health care managers regarding mandatory vs voluntary pursuit of continuing education and professional development?

Managers were more explicit in the written comments in stating their negative opinions of regulations which mandated continuing education. In the numerical rating of the available choices from the items of the question, the highest rated items of the twelve were 4.5 - *I regularly pursue continuing education and professional development activities* (4.344); 4.3 - *I do not need a mandatory continuing education program to motivate me to pursue continuing education activities* (4.115); and 4.12 - *Continuing education for health care managers is a critical factor in the future success of the organization* (4.000).

The lowest rated item was 4.9 - *Salary increase for health care managers should be based on the pursuit of accredited continuing education* (2.740). There was no other score below the neutral rating. The overall response mean for Question 4 was 3.545 and the number of valid cases was 94.

Four of the twelve items were scored in the neutral range. It would appear that health care managers were not comfortable in supporting the pursuit of formal or accredited programs of continuing education. They indicated some difficulty with endorsing the belief that a mandatory program of continuing education would be beneficial to their own development. The statement that health care organization with mandated continuing education requirements would be assured a competitive edge caused some uneasiness for managers. In general, many managers do not perceive health care as a competitive environment, nor do they wish it to be so. The response would be very different if a different word was chosen to reflect the health care system in a non-competitive manner. Health care managers prefer to project their organizations as being progressive and evaluate how well they are meeting the needs of clients and the community. Organizations would not be competing for clients but be striving to compete for survival in the face of scare resources. The values of health care managers will need to change to adopt some level of competition even if it is not expressed as such.

TABLE 4.4.0 - Response Mean For Each Item Of Question 4

MANDATORY vs VOLUNTARY

		Response Mean
4.1	Health care managers should be required to pursue a formal or an accredited program of continuing education	3.281
4.2	A mandatory program of continuing education for health care managers would be beneficial to my own development	3.115
4.3	I do not need a mandatory continuing education program to motivate me to pursue continuing education activities	4.115
4.4	A mandatory continuing education program will not make any difference in my pursuit of continuing education activities	3.656
4.5	I regularly pursue continuing education and professional development activities	4.344
4.6	Accredited continuing education should be an expectation of health care managers	3.771
4.7	All health care managers should be expected to report their continuing education activities to a governing body on an annual basis	3.084
4.8	Accredited continuing education should be an expectation for health care managers in my organization	3.600
4.9	Salary increases for health care managers should be based on the pursuit of accredited continuing education	2.740
4.10	Health care organizations which mandate continuing education for managers will be assured a competitive edge	3.073
4.11	Health care organizations should have formal policies regarding expectations for managers to pursue continuing education	3.740
4.12	Continuing education for health care managers is a critical factor in the future success of the organization	4.000

Rating Scale:
1 - Disagree Strongly; 2 - Disagree; 3 - Neutral; 4 - Agree; 5 - Agree Strongly

Table 4.4.1 - Valid Responses, Response Means and Standard Deviation - Question 4

Question Items & N values	VALID RESPONSES - Percent					Response Mean	Standard Deviation
	1	2	3	4	5		
4.1 (96)	3.1	25.0	20.8	42.7	8.3	3.281	1.093
4.2 (96)	5.2	29.2	20.8	38.5	6.3	3.115	1.065
4.3 (96)	2.1	10.4	4.2	40.6	42.7	4.115	1.035
4.4 (96)	2.1	22.9	9.4	38.5	27.1	3.656	1.168
4.5 (96)	0	4.2	2.1	49.0	44.8	4.344	0.723
4.6 (96)	2.1	5.2	22.9	53.1	16.7	3.771	0.864
4.7 (95)	8.4	22.1	28.4	34.7	6.3	3.084	1.078
4.8 (95)	1.1	11.6	24.2	52.6	10.5	3.600	0.868
4.9 (96)	12.5	29.2	33.3	21.9	3.1	2.740	1.099
4.10 (96)	6.3	24.0	31.3	33.3	5.2	3.073	1.018
4.11 (96)	1.0	10.4	20.8	49.0	18.8	3.740	0.920
4.12 (96)	0	4.2	13.5	60.4	21.9	4.000	0.725

Rating Scale:
1 - Disagree Strongly; 2 - Disagree; 3 - Neutral; 4 - Agree; 5 - Agree Strongly

Question 5 - What were the opinions of health care managers as to who should assume the role of facilitating their continuing education and professional development?

From the choices provided, health care managers were fairly confident in their choices of responses. For facilitation, the primary role was assigned to *employers for facilitating continuing education activities for health care managers* (item 5.1 with a response mean of 4.400). Next was item 5.6 which stated that *each health care managers had a responsibility to facilitate his/her own continuing education activities* (4.295); The third level was found in item 5.8 which stated that *educational institutions should facilitate continuing education activities for health care managers* (4.289). The lowest rated item was 5.5, which stated that *employers should facilitate continuing education activities by giving bonuses to participants* (2.253). The only item which received a neutral rating was 5.2 which stated that *employers should facilitate continuing education activities for*

health care managers by offering FULL financial support (2.926) (Table 4.5.0).

Health care managers showed a level of discomfort with the idea of full financial support for an activity from which personal benefits would accrue for the participants. The concerns was greater if it was perceived that financial support would provide an inappropriate incentive for health care manager in their pursuit of professional development. There was also a recognition that in times of financial restraints, support for professional development was likely to decrease considerably. The overall response mean for question 5 was 3.736 and the number of valid cases was 83.

TABLE 4.5.0 - Response Mean For Each Item Of Question 5

FACILITATION ROLE

		Response Mean
5.1	Employers should facilitate continuing education activities for health care managers	4.400
5.2	Employers should facilitate continuing education activities for health care managers by offering FULL financial support	2.926
5.3	Employers should facilitate continuing education activities for health care managers by offering PARTIAL financial support	3.842
5.4	Employers should facilitate continuing education activities by providing PAID TIME for attendance	3.895
5.5	Employers should facilitate continuing education activities by giving bonuses to participants	2.253
5.6	Each health care manager has a responsibility for facilitating his/her own continuing education activities	4.295
5.7	The professional body should facilitate continuing education activities by providing appropriate opportunities for managers	4.021
5.8	Educational institutions should facilitate continuing education activities for health care managers	4.289

Rating Scale:
1 - Disagree Strongly; 2 - Disagree; 3 - Neutral; 4 - Agree; 5 - Agree Strongly

Table 4.5.1 - Valid Responses, Response Means and Standard Deviation - Question 5

Question Items & N values	VALID RESPONSES - Percent					Response Mean	Standard Deviation
	1	2	3	4	5		
5.1 (95)	0	0	1.1	57.9	41.1	4.400	0.514
5.2 (95)	7.4	34.7	24.2	25.3	8.4	2.926	1.113
5.3 (95)	0	11.6	12.6	55.8	20.0	3.842	0.879
5.4 (95)	0	9.5	18.9	44.2	27.4	3.895	0.916
5.5 (95)	18.9	44.2	29.5	7.4	0	2.253	0.850
5.6 (95)	1.1	1.1	6.3	50.5	41.1	4.295	0.727
5.7 (95)	2.1	3.2	12.6	54.7	27.4	4.021	0.850
5.8 (83)	0	0	7.2	56.6	36.1	4.289	0.595

Rating Scale:
1 - Disagree Strongly; 2 - Disagree; 3 - Neutral; 4 - Agree; 5 - Agree Strongly

Question 6 - What were the opinions of health care managers as to the factors which would facilitate or drive their pursuit of continuing education and professional development?

Top rated motivators among the choice of thirteen were items 6.4 - *if..I felt my skills would be enhanced* (4.219); 6.8 - *if..I felt the need to increase my marketability* (3.938); and 6.1 - *if..programs were accessible* (3.734). The lowest rated items from the group of 13 were, 6.13 - *if..I felt secure in my position* (3.147) and 6.7 - *if..I felt insecure about my future with my present employer* (Table 4.6.0).

There were no scores below the neutral ranking but there were three items which were rated at that level. The managers did not wish to appear overly confident in assuming lifetime employment of current positions. At the same time, they did wish to expose their insecurities regarding job security nor indicate in any way that they were dependent on organizational policies to motivate them to increase their knowledge. The overall response mean for Question 6 was 3.611 and the number of valid cases was 90.

TABLE 4.6.0 - Response Mean For Each Item Of Question 6

MOTIVATORS

I WOULD INCREASE MY PARTICIPATION IN CONTINUING EDUCATION IF...

		Response Mean
6.1	programs were accessible	3.734
6.2	my employer provided FULL financial support	3.547
6.3	my employer provided PARTIAL financial support	3.442
6.4	I felt my skills would be enhanced	4.219
6.5	I felt that my salary would be increased	3.458
6.6	I felt that my chances for promotion would be enhanced	3.716
6.7	I felt insecure about my future with my present employer	3.358
6.8	I felt the need to increase my marketability	3.938
6.9	I felt that I could increase my chances for secondment	3.552
6.10	there were formal organizational policies in support of the activity	3.323
6.11	educational activities were done on site	3.635
6.12	I could share my knowledge with colleagues	3.558
6.13	I felt secure in my position	3.147

Rating Scale:
1 - Disagree Strongly; 2 - Disagree; 3 - Neutral; 4 - Agree; 5 - Agree Strongly

Table 4.6.1 - Valid Responses, Response Means and Standard Deviation - Question 6

Question Items & N values	VALID RESPONSES - Percent					Response Mean	Standard Deviation
	1	2	3	4	5		
6.1 (94)	1.1	10.6	16.0	58.5	13.8	3.734	0.870
6.2 (95)	3.2	16.8	28.4	25.3	26.3	3.547	1.146
6.3 (95)	5.3	10.5	31.6	40.0	12.6	3.442	1.018
6.4 (96)	1.0	3.1	5.2	54.2	36.5	4.219	0.771
6.5 (96)	4.2	14.6	29.2	35.4	16.7	3.458	1.065
6.6 (95)	1.1	10.5	24.2	44.2	20.0	3.716	0.942
6.7 (95)	4.2	16.8	28.4	40.0	10.5	3.358	1.020
6.8 (96)	1.0	5.2	9.4	67.7	16.7	3.938	0.751
6.9 (96)	2.1	9.4	32.3	43.8	12.5	3.552	0.905
6.10 (96)	4.2	13.5	35.4	39.6	7.3	3.323	0.946
6.11 (96)	1.0	10.4	28.1	44.8	15.6	3.635	0.908
6.12 (95)	1.1	9.5	33.7	44.2	11.6	3.558	0.899
6.13 (95)	6.3	12.6	45.3	31.6	4.2	3.147	0.922

Question 7 - What were the opinions of health care managers as to what would be a reasonable expectation of their pursuit of continuing education activities?

"How much is enough?" would be a question to anticipate in any discussion which preceded any policy setting to plan for professional development. There were ten items forming the choices for reasonable expectations. The highest rated items were 7.2 - *Health care managers should be required to attend at least one professionally related activity per year* (4.234); 7.7 - *Health care managers should be allowed to set their own continuing education goals* (3.915); and 7.8 - *Secondment to another organization should be considered an appropriate educational activity for health care managers* (3.863). The low scoring items were 7.4 - *Health care managers should be required to publish at least one article in a professional journal every year* (2.389); and 7.9 - *Health care managers should be expected to follow educational activities specific to a clinical discipline* (2.642).

There were three other low scoring items and they were all related to research and publication (Items 7.3, 7.5 and 7.6) (Table 4.7.0). Fifty percent of the responses were rated in the neutral zone. This shows a high level of indecision among the respondents. Managers demonstrated a need to project a willingness to decide on levels of activity but there were difficulties in deciding on those levels. The neutral response to the expectation that health care managers pursuing activities which were specific in nature reflect some unresolved conflict for managers with a clinical background. There appears to be a strong allegiance with the clinical training for those managers who were so trained. For individuals direct reports were mostly clinical there could be a desire to be current in matters relating to the discipline. Individuals with a clinical background and who belong to a regulatory college, might have a requirement to pursue professional development activities which are discipline specific. The overall response mean for Question 7 was 3.243 and the number of valid cases was 86.

TABLE 4.7.0 - Response Mean For Each Item Of Question 7

REASONABLE EXPECTATIONS

		Response Mean
7.1	Health care managers should be required to take at least one credit course per year.	3.054
7.2	Health care managers should be required to attend at least one professionally related activity per year.	4.234
7.3	Health care managers should be required to pursue research activities on the job.	2.937
7.4	Health care managers should be required to publish at least one article in a professional journal every year.	2.389
7.5	Health care managers should be required to publish at least one article in a professional journal every 3 years.	2.821
7.6	Health care managers should be required to publish at least one article in a professional journal every 5 years.	2.926
7.7	Health care managers should be allowed to set their own continuing education goals.	3.915
7.8	Secondment to another organization should be considered an appropriate educational activity for health care managers.	3.863
7.9	Health care managers should be expected to follow educational activities specific to a clinical discipline.	2.642
7.10	Health care managers should be expected to follow educational activities related to management.	3.767

Rating Scale:
1 - Disagree Strongly; 2 - Disagree; 3 - Neutral; 4 - Agree; 5 - Agree Strongly

Table 4.7.1 - Valid Responses, Response Means and Standard Deviation - Question 7

Question Items & N values	VALID RESPONSES - Percent					Response Mean	Standard Deviation
	1	2	3	4	5		
7.1 (93)	4.3	28.0	32.3	29.0	6.5	3.054	1.004
7.2 (94)	1.1	3.2	4.3	54.3	37.3	4.234	0.768
7.3 (95)	9.5	21.1	37.9	29.5	2.1	2.937	0.987
7.4 (95)	15.8	40.0	34.7	8.4	1.1	2.389	0.891
7.5 (95)	14.7	22.1	32.6	27.4	3.2	2.821	1.091
7.6 (95)	13.7	22.1	30.5	25.3	8.4	2.926	1.169
7.7 (94)	1.1	8.5	13.8	51.1	25.5	3.915	0.912
7.8 (95)	2.1	3.2	20.0	55.8	18.9	3.863	0.833
7.9 (95)	9.5	41.1	29.5	15.8	4.2	2.642	0.999
7.10 (90)	1.1	12.2	12.2	57.8	16.7	3.767	0.912

Rating Scale:
1 - Disagree Strongly; 2 - Disagree; 3 - Neutral; 4 - Agree; 5 - Agree Strongly

Question 8 - What future skills will be required by the managers of health care in order to function and survive in the face of change?

The response means of the eleven items showed that the managers agreed and agreed strongly with all the suggestions for future skills of the health care environment. For future skills, nine of the items (out of 11) were rated above a 4 (agree to agree strongly) with the top three being 8.2 - *Communication* (4.802); 8.1 - *Leadership* (4.677); and 8.7 - *Results Management* (4.563). The lowest ranked items were 8.9 - *Compliance to Standards* (3.990) and 8.10 -*Teaching/Instructional* (3.969) and they were both close to a 4 rating (Table 4.8.0). The overall response mean for the question was 4.426 and this indicated a high level of managers' confidence in their knowledge of what was expected to manage in the health care industry. Perhaps, there was an indication from managers what skills they would be prepared to develop for themselves and suggest to other individuals with an interest in health care management. The skills chosen would be transferable to other types of management situations thus adding flexibility for managers who might wish to add to their marketability.

There was an awareness that preparation for teaching and providing instructions could be time-consuming. There were indications throughout the responses and the comments that time was a scare commodity in health care management. Health care managers would be willing to concede the teaching role to individuals who possessed the required skill and training. The number of valid cases was 94.

TABLE 4.8.0 - Response Mean For Each Item Of Question 8

FUTURE SKILLS

In order to survive in the face of change, health care managers will require the following skills ...

		Response Mean
8.1	Leadership	4.677
8.2	Communication	4.802
8.3	Lifelong Learning	4.552
8.4	Consumer/Community Relations	4.510
8.5	Health Environment Awareness	4.309
8.6	Conceptual	4.427
8.7	Results Management	4.563
8.8	Resource Management	4.500
8.9	Compliance to Standards	3.990
8.10	Teaching/Instructional	3.969
8.11	Stress management	4.323

Rating Scale:
1 - Disagree Strongly; 2 - Disagree; 3 - Neutral; 4 - Agree; 5 - Agree Strongly

Table 4.8.1 - Valid Responses, Response Means and Standard Deviation - Question 8

Question Items & N values	VALID RESPONSES - Percent					Response Mean	Standard Deviation
	1	2	3	4	5		
8.1 (96)	0	0	0	32.3	67.7	4.677	0.470
8.2 (96)	0	0	0	19.8	80.2	4.802	0.401
8.3 (96)	0	1.0	0	41.7	57.3	4.552	0.580
8.4 (96)	0	0	2.1	44.8	53.1	4.510	0.543
8.5 (94)	1.1	1.1	4.3	53.2	40.4	4.309	0.704
8.6 (96)	0	0	6.3	44.8	49.0	4.427	0.611
8.7 (96)	0	0	1.0	41.7	57.3	4.563	0.519
8.8 (96)	0	0	1.0	47.9	51.0	4.500	0.523
8.9 (96)	0	6.3	18.8	44.8	30.2	3.990	0.864
8.10 (96)	0	3.1	21.9	50.0	25.0	3.969	0.774
8.11 (96)	0	1.0	10.4	43.8	44.8	4.323	0.709

Rating Scale:
1 - Disagree Strongly; 2 - Disagree; 3 - Neutral; 4 - Agree; 5 - Agree Strongly

Question 9 - How can the skills needed by the health care manager in the future organization be developed in the experienced health care manager?

The skills required for the future were identified in the previous section and this section provided the favoured methods for developing those skills. Fourteen suggestions were provided as the basis for the responses for skill development. The top rated items of the 14 were 9.10 - *Attending workshops with a specific focus* (4.263); 9.11 - *Attending short courses - 1-4 days duration* (4.221); 9.1 - *Self-directed individualized programming*; 9.3 - *Pursuit of current health administration programs* (4.000) and; 9.5 - *On the job training WITH a mentor* (4.000). There were two low scoring items viz. 9.13 - *Attending residential programs - 6 weeks or more* (3.500); and 9.2 - *Formal undergraduate courses* (3.526) (Table 4.9.0). These responses reflect the preferences of health care managers to pursue developmental activities that would not take them away from work and personal responsibilities for extended periods of time. Formal undergraduate programs would be not be necessary for the majority of health care managers due to the prevalence of graduate degree holders. From the comments, it was indicated that undergraduate programs do not necessarily meet the professional development needs of practising health care managers. Flexibility and focus were the desired characteristics of professional development programs for health care managers.

Item 9.6 was the only one which achieved a neutral rating viz. *on the job training WITHOUT a mentor* (2.755) (Table 4.9.0). There were some individuals who perceived that it was possible to development professionally through job related activities but that greater benefits could be derived from structured mentorship arrangements. The benefits to mentorship are evident in health care organizations where there are structured mentorship arrangements for students from academic programs. The opportunity needs to be made available to the managers as well. The overall response mean for Question 9 was 3.823 and the number of valid cases was 91.

TABLE 4.9.0 - Response Mean For Each Item Of Question 9

SKILL DEVELOPMENT

Methods for further developing skills of experienced health care managers for the future organization are as follows:

		Response Mean
9.1	Self-directed individualized programming	4.086
9.2	Formal undergraduate courses	3.526
9.3	Pursuit of current health administration programs e.g. MHA, MHSc	4.000
9.4	Pursuit of current management programs, e.g. MBA, MPA, CMA	3.947
9.5	On the job training WITH a mentor	4.000
9.6	On the job training WITHOUT a mentor	2.755
9.7	Paid educational leave	3.660
9.8	Secondment to another organization	3.779
9.9	Reading professional journals	4.084
9.10	Attending workshops with a specific focus	4.263
9.11	Attending short courses (1-4 days duration)	4.221
9.12	Attending intensive courses (1-3 weeks duration)	3.958
9.13	Attending residential programs (6 weeks or more)	3.500
9.14	Presenting at conferences	3.853

Rating Scale:
1 - Disagree Strongly; 2 - Disagree; 3 - Neutral; 4 - Agree; 5 - Agree Strongly

Table 4.9.1 - Valid Responses, Response Means and Standard Deviation - Question 9

Question Items & N values	VALID RESPONSES - Percent					Response Mean	Standard Deviation
	1	2	3	4	5		
9.1 (95)	0	2.2	11.8	61.3	24.7	4.086	0.670
9.2 (95)	4.2	12.6	20.0	52.6	10.6	3.526	0.988
9.3 (95)	0	2.1	14.7	64.1	18.9	4.000	0.652
9.4 (95)	0	0	23.2	58.9	17.9	3.947	0.642
9.5 (95)	0	3.2	12.6	65.3	18.9	4.000	0.668
9.6 (94)	7.4	35.1	33.0	23.4	1.1	2.755	0.935
9.7 (94)	0	13.8	21.3	50.0	14.7	3.660	0.899
9.8 (95)	1.1	4.2	20.0	65.3	9.5	3.779	0.717
9.9 (95)	0	3.2	8.4	65.3	23.2	4.084	0.683
9.10 (95)	0	0	2.1	69.5	28.4	4.263	0.488
9.11 (95)	0	0	2.1	73.7	24.2	4.221	0.465
9.12 (95)	0	4.2	16.8	57.9	21.1	3.958	0.743
9.13 (94)	1.1	13.8	27.7	48.9	8.5	3.500	0.877
9.14 (95)	0	5.3	18.9	61.1	14.7	3.853	0.729

Rating Scale:
1 - Disagree Strongly; 2 - Disagree; 3 - Neutral; 4 - Agree; 5 - Agree Strongly

PROFILE OF RESPONDENTS

Table 4.10.0 provides a summary of responses to the demographic items as requested in Section 10 of the questionnaire. That information has been utilized to compile a profile of the individuals who participated in the study. There were 36.5% males and 63.5% females responding to the survey and they reported that the average time spent in health care was 12.9 years with a minimum of 1 year and a maximum of 30 years. As for the Highest Level of Education Attained, the category showed that 3.2% of individuals reported Community College as their education level while 19.1% possessed at least one Bachelor' Degree. 9.6% reported having pursued some graduate level education while the largest category was in the Master's Degree category at 66%. There were 2.1% of respondents with Doctoral Degrees. Two individuals did not provide information on the highest level of education attained.

Twenty-eight percent (28%) of the respondents were either Chief Executive Officers or one level below. The next level down had 44.1% with level 3 down having 23.7%. There were 4.3% of individuals at level 4. There was no indication from 3 individuals of their level within their organization. 27.7% of the respondents were within the 30-39 age group category which was similar in size to the 50-59 age group which had 28.7%. The majority (42.6%) formed the 40-49 age group. Two individuals did not respond to the request for age classification.

Sixty-four percent (64%) of respondents reported having being trained in a clinical discipline while thirty-eight percent (36%) showed a non-clinical background. There were 7 individuals who did not respond to the category of Professional Background. The mean Time in Health Care was 19.5 years with a minimum of 1 year to a maximum of 40 years. There were 2.2% of the sample who had less than one year with their current employer. Total number of individuals with Less Than Four Years Of Service was 19.6%. Between 4 and 15 years of service there were 66.3% of the individuals and 14.1% in the greater than 15 years category. Four individuals did not respond to the request for the information. The section on Cultural Background revealed that the bulk (92.5%) of the respondents were White/Caucasian. Three individuals did not respond to the question.

As far as income was concerned, the largest category was the $60,001-$70,000 salary group with 22.5%, followed by the $70,001-$80,000 group with 21.3% and the $100,0001 plus group with 20.2%. At the lower end, the $40,001-$50,000 and $50,001-$60,000 groups combined to form 19.1%. Seven individuals did not provide information to this question.

TABLE 4.10.0 - Demographics Of Respondents

10.1	SEX/gender	10.6	PROFESSIONAL BACKGROUND
	35 Male (36.5%) 61 Female (63.5%)		Clinical Discipline 57 (64%) Other 32 (36%) No response 7
10.2	TIME IN E.C. Management	10.7	TIME IN HEALTH CARE
	Mean = 12.9 years Min. 1; Max. 30 years		Mean = 19.5 years Min. 1; Max. 40 years
10.3	EDUCATION (highest level)	10.8	YEARS WITH ORGANIZATION
	0 High School 0 Some Post Secondary 3 Community College (3.2%) 18 Bachelor's Degree (19.1%) 9 Some Graduate Work (9.6%) 62 Master's Degree (66.0%) 2 Doctoral Degree (2.1%) 2 No response		1 Less than 6 months (1.1%) 1 6 months to 1 year (1.1%) 7 1 to 2 years (7.6%) 9 2 to 4 years (9.8%) 26 4 to 6 years (28.3%) 22 6 to 10 years (23.9%) 13 10 to 15 years (14.1%) 13 More than 15 years (14.1%) 4 No response
10.4	ORGANIZATIONAL LEVEL	10.9	CULTURAL BACKGROUND
	Levels between your position & Chief Executive Officer 26 0 (28%) 41 1 (44.1%) 22 2 (23.7%) 4 3 (4.3) 3 No response		4 Asian (4.3%) 2 Black (2.2%) 0 Hispanic 86 White/Caucasian (92.5%) 1 Aboriginal (1.1%) 3 No Response
10.5	AGE	10.10	SALARY (Annual)
	0 20 - 29 26 30 - 39 (27.7%) 40 40 - 49 (42.6%) 27 50 - 59 (28.7%) 1 60 and over (1.1%) 2 No response		5 $40,001 - $50,000 (5.6%) 12 $50,001 - $60,000 (13.5%) 20 $60,001 - $70,000 (22.5%) 19 $70,001 - $80,000 (21.3%) 12 $80,001 - $90,000 (13.5%) 3 $90,001 - $100,000 (3.4%) 18 $100,001 plus (20.2%) 7 No response

TABLE 4.11.0 - Indication Of CE & PD Activity, Clinical And Direct Reports

11.1 *Indication of Continuing Education & Professional Development practice*

Respondents	Activity
41.9%	Credit Courses taken
27.9%	Non-credit courses taken (external)
93%	Workplace courses/seminars taken (non-credit)
100%	Conferences attended
79.1%	Presentations made at Conferences
32.6%	Guest presentations made at colleges or universities
30.2%	Courses delivered at colleges or universities
30.3%	Publications (Author or co-author)
48.8%	Formal mentoring/preceptor occasions

11.2 *Classification of major reporting areas*

60.5% Clinical or 39.5% Non-Clinical

11.3 *Indication of number of direct reports*
Mean 8.4; Min. 1; Max. 20.

SUMMARY

A presentation and analysis of the data appeared in this chapter. The summary was comprised of nine research questions which solicited the perceptions and opinion of health care managers regarding continuing education and professional development for management skill development and maintenance. Section 10 of the questionnaire provided demographic information (Table 4.10.0), while Section 11 provided information which gave some indication of continuing learning activity, span of control and groups (clinical/non-clinical) to which leadership was provided (Table 4.11.0).

It was learned that focus was important in skill development for health care managers and that facilitation was possible by attending short courses which had input from the target audience. Targeted skills for health care management should be *communication* as the top priority. Development should appeal to personal enhancements such as marketability and promotability and that the activity should be facilitated by the employers and should include on-site offerings, mentoring and arrangements for secondments. Personal enhancements should not be interpreted as being of no benefit to the organization. On the contrary, the organization stands to benefit with increased morale of managers and having managers with increased capabilities.

The activities of management development should also provide currency of health care management information. There was no expectation that salary increases would be a natural occurrence following upon skill enhancement but it could be an indirect benefit with increased opportunities. Managers were very aware of cost restraints but the message was that creative ways could be found to sponsor continuing education and professional development for health care managers in the changing industry without adding to the financial burden of the organization.

Professional development was not perceived as a "nice-to-have" but as a necessity based on the needs of a dynamic health care industry. It was also acknowledged that such

values had to be embodied by the Board of Governors of the health care institutions and also by the senior managers.

The overwhelming message was that the pursuit of continuing education and professional development activities was a requirement for every health care manager who wished to play an outstanding role in the dynamic and complex health care environment but should not be mandated by a regulatory external body. Employer expectation for health care management professional development was the preferred route. Given the inevitability of changes in health care and the necessity of making the most of the investment in human capital, efforts at maximising each manager's contribution will pay big dividends to the hiring organization and to the health care industry as a whole.

The next chapter provides more detailed discussion of the findings, conclusions, implications and recommendations for future research.

CHAPTER 5

FINDINGS, CONCLUSIONS, IMPLICATIONS AND RECOMMENDATIONS

The managers of health care institutions work in an environment that is constantly undergoing change. The external environment has caused the health care industry to evaluate its service delivery and re-direct its focus to areas such as community care and patient-centered care. The industry cannot be expected to provide new ways of serving its clients without undergoing some change itself. Some of those changes have resulted in management restructuring for cost effective service delivery models. For health care managers to function effectively in the changed environment, they must possess the skills which are demanded by the new organization and the new external environment. For some managers, this would require a new commitment to professional development but for the majority, the requirement might be a shift in focus to recognize the value of non-traditional methods of professional development.

The purpose of the study was to identify and describe factors which may impact on individual efforts to maintain currency of knowledge and skills while meeting the needs of the future health care environment. To facilitate the task, a questionnaire was developed and mailed to 196 health care managers in five Ontario cities. The source of the population and sample was the *Members Directory 1993 - 94* of the Canadian College of Health Service Executives. It is the opinions of ninety-six respondents (53.3% of delivered questionnaires) which formed the result of this study. Nine questions were developed in order to address the main question which was stated as follows: What can/should be done to facilitate, for health care managers, the development and maintenance of leadership and management skills which are consistent with the needs of the individual, the organization, the communities and the province's interest in high quality accessible, and affordable health care in a changing health care industry? The

responses have provided some answers and direction for assuring that health care managers will be equipped to manage in the future. Excerpts from written comments are interspersed with the narrative.

SUMMARY OF FINDINGS

Perception of Needs - The responses to Question 1 showed that health care managers were in favour of continuing education and professional development regardless of their level of responsibility within the organization. There was a strong agreement that senior managers could also benefit from the pursuit of professional development activities. Most items on the question received a high rating. The responses also indicated a strong commitment to, and support for, continuing education activities for all health care managers.

The findings should not be surprising to anyone who is aware of the demands of the changing health care industry. The new situation demands new skills and different management practices which will only be possible with a new perspective and different values.

Barriers - The top barrier in the pursuit of professional development by health care managers was identified as *cost of courses, conferences and related activities*. That sentiment was supported by individuals indicating in item 6.11 that they would be motivated to increase participation if activities were offered at their work site. This indicated a need to keep cost in check while increasing accessibility to learning opportunities.

Job workload was perceived as another barrier. One respondent articulated his concerns in the following:

> "The hardest thing is getting the time to do additional formal education (graduate level). Work takes up 60 hours a week, and

> with a family which I don't want to suffer, it doesn't leave much time for formal education".

Senge 1990, had stated that individuals cannot be expected to learn when they have so little time to think and reflect. It would appear that having activities on the job premises would assist in decreasing that barrier as well. The same goes for *personal responsibilities at home* which was also named as one of the top barriers. The inference being that it would be easier to participate during work hours. Loebs 1992, warned that the speed of change has so many roots in the external environment and that the knowledge of those changes were so limited by internal staff, particularly the management development staff, that most organizations did not have the capacity to provide the necessary exposure and learning. Senior executives could not be relied upon for assuming the instructional role as they were perceived to be too engrossed in coping with the issues at hand and with multiple demands of constituents.

If there are going to be opportunities for learning on the job, someone has to assume the responsibility to ensure that the learning experience will be beneficial to the individual manager and also to the organization.

Perceived Benefits - Health care managers in their responses displayed an agreement for *increased opportunities for networking* as a benefit to be received from professional development activities along with *being current in health care information*. Other benefits perceived were *positive effects on self-esteem, job knowledge and management skills*. Overall, all seventeen items were perceived as favourable outcomes when pursuing professional development and continuing education activities.

In a constantly changing health care environment one must be concerned with the ability of health care managers to meet the future requirements of the industry in terms of skills and currency of knowledge. There was an indication that health care managers remain in the field for long periods of time and if that is so, there was a further assumption that

skills maintenance and knowledge currency would be concerns to be addressed, even if the manager did not remain with the same employer but did continue to work within the industry. There must be systems of support for individuals whose roles have changed or are changing. The length of time that participants of the study were in health care management ranged from 1 year to 30 years with a mean of 12.9 years. For the time in health care, that ranged from 1 year to 40 years with a mean of 19.5 years. There were several individuals who had been employed by their current organization for over fifteen years. Health care organizations should not be concerned about loss of a manager whose professional development had received financial assistance. More often that not, if the individual leaves the organization, the destination will most likely be another health care organization hence, the training is not lost but redeployed within the health care industry.

Mandatory or voluntary pursuit of professional development - An analysis of the responses to the issues surrounding mandatory vs voluntary continuing education for health care managers indicated that individuals were not supportive of mandated professional development, especially when administered by an external body. They conceded that continuing education activity was a critical factor in the future success of health care organizations but that health care organizations should have formal policies regarding expectations for managers to pursue professional development. Even though the respondents were pursuing continuing education activities on a regular basis, they were not prepared to support the notion of mandated professional development. In comparing this with any directive for compliance, one can draw from an analogy that was made regarding a proposal for the registration of all fire arms owned by private citizens. One media commentator was heard to remark that the legislation was producing a system where the law abiding elements of society were being asked to pay the penalty for the acts of the criminals.

Regarding compulsory continuing education, those health care managers who are motivated to continued professional development will be affected if a mandatory policy were put in place. Even if current individual practices have been effective, they would

have to be modified to meet the policy directives. Mandatory continuing education has always proved to be controversial, especially at the initiation phase. The following four quotes provide a flavour of the comments from health care managers in the study in their opposition to any proposed system of mandated professional development:

> "Personally, mandatory activities are too constraining - expectations lead people into following the norm if not it can be dealt with through the appraisal process".

> "Continuing education is critical, mandatory training while beneficial can be limiting, if people stop taking other programs to focus only on accredited ones; can be too bureaucratic".

> "Mandatory programs disempower the individual and do not motivate those already averse to formal education".

> "I support an environment where managers are motivated to pursue continuing education, rather than being 'forced' to do so".

The issue of mandatory professional continuing education has generated considerable debate among health professionals, educators and legislators. Concerns have been expressed on cost as was noted by one of the Chief Executive Officers in the study when he stated:

> "My concern about mandatory accredited formal education is that as an employer, I would be required to assist in the funding of the continuing education. Many organizations do not have the fiscal resources to provide the appropriate funding".

Balance the comment above with that provided by a non-Chief Executive Officer:

> "In the Regulated (Health) Professions Act - (health) professionals are made responsible for their own continuing competence. Some health care institutions may then back away from financial involvement".

The literature has cited concerns about the impact and effects on learner receptivity. It has been stated that mandatory continuing education does not necessarily ensure either utilization of knowledge or increased competence. Proponents of mandatory continuing

education have stated that it might be the only method of ensuring participation by the majority of practitioners in the field as those most in need would be least likely to participate.

The more generous writers have gone as far as to state that in situations where there is low professional development activity, that the fault might not necessarily lie with the non-participative manager but that the situation might be forced due to lack of accessibility, associated costs, time limitations and constraints and finally, institutional and personal constraints.

Although respondents of the study strongly supported the need for regular professional development, they did not feel that such activity should be financially rewarded. The results did suggest however, support for a system of accountability in that although health care managers will pursue professional development on their own accord, that it should still be an expectation of them. From the U.S. nursing literature, it would appear that after years of resisting the mandated systems, nurses have come to appreciate the need for regular continuing education and professional development. With the changes in the environment and the demands being placed upon the health care sector for services, the choice will soon be gone for health care managers...continue to develop yourself or else!... will be the new directive.

Facilitation Role - The facilitation role has been assigned to individuals, institutions such as employers, educational institutions and professional bodies. In this study the prime responsibility has been given to employers, but there was no expectation for full financial support, although "it would be nice" as one respondent remarked.

> "Employers should try to support continuing education by providing in-house programs with in-house resources to what ever extent possible".

The facilitation by the employer could be in the form of agreeing to be part of a

secondment process. The message has to be communicated to the employers that there was an expectation for them to share some of the responsibility to facilitate professional development. In an age of budget restraints and cost cutting, employers would be less inclined to be budgeting for professional development of managers as a significant financial outlay.

> "Continuing Education by in-house Training and Development is also becoming difficult due to government cuts/budget cuts, little left for staff/management training and development".

If the health care manager perceived the employer as holding the prime responsibility for facilitating continuing education then one can assume that if that expectation failed to be satisfied, it can have a negative impact on professional development pursuits by health care managers. At the same time, health care managers expect to be consulted on the planning of continuing eduction opportunities - a reasonable request which will encourage buy-in.

It must not be assumed that the only responsibility for the employer in the role of facilitation was that of financier. Other roles such as career planning would be useful where individuals are assisted with assessment of abilities, interests, career needs and goals; organization's assessment of employee's abilities and potential; communication of career options opportunities; and career counselling to set realistic goals and plan for their attainment. (Lemieux-Charles, 1994). The health care industry is highly labour intensive and as such, each organization should have a human capital development plan which clearly mandates strategies and tactics for the development of managers, who in turn will develop the staff.

The respondents in this study also assigned a large part of the responsibility to the employee.

> "Employees must buy-in to the need for updating of continuing education and by paying part of costs they are more likely to get value <u>out</u> of continuing education".

The individual manager has a responsibility to improve and develop his or her knowledge and skill, hence all development begins with him or her.

The information from the opinions on facilitation role should be of interest also to educational institutions thus providing them with a perspective on who should take the lead and from whom input should be received.

Motivators - Personal enhancers dominated the choices of motivators and they included *skill enhancement, marketability and promotion possibilities*. There appeared to be a genuine interest in improving one's ability to do the job. The heavy weighting toward personal enhancement of managers should not be negatively interpreted but should be perceived as a willingness to provide greater value to the employer by being more efficient and proficient.

Accessibility of programs including on-site activities would increase participation but that would have to be balanced against work and home life responsibilities. The following two comments identify a plea from managers to the organization to assist their motivation to pursue professional development activities.

> "What is needed is time, release of pressure of day-to-day functions and if possible financial support for education for managers and especially staff".

> "Organizations need to provide for continuing education opportunities (time/money)".

Continuing decreases in the number of health care management positions in Ontario could very well be the signal to managers that the days of health care being a haven were gone. Managers are thus forced to compete for positions either within their present organizations or within another organization. Having current knowledge and required skills will add value to the health care manager who is forced into the competitive job

market. Recently, health care management appointments have been accompanied by contracts with clearly spelled out termination clauses which are easier to administer than the previous system of appointments which were interpreted as lifetime positions.

Reasonable Expectations - Managers in the study showed a preference for a requirement to have health care managers attend at least one professionally related activity per year. The choices could be wide ranging as long as there was "demonstrated improved on-the-job results (outcome measures) for the educational investment made".

> "Activities related to a clinical discipline, management, education or research are all appropriate fields".

> "I think education, in any form with any kind of content (within reason!), is a broadening and challenging experience when met with a receptive mind. If the individual is not motivated themselves (sic), no amount of "requirement" will have any impact on them".

There was strong agreement that *secondment to another organization* should be considered an appropriate educational or developmental activity for health care managers. This is a departure from the view that only credit educational courses were of value in professional development. In the past, individuals pursing credit courses enjoyed stronger approval and financial support than those taking non-credit courses.

At the management level, regardless of clinical background clinical professional development should not be the focus but rather that it should be management related. Management related activities should not be interpreted as credit courses but rather as activities that would enhance the role. There was one comment which did not seem to support the pursuit of activities focusing on management, perhaps that individual was still in the paradigm of credit courses when she stated:

> "If the licensed professionals are having difficulty in establishing these kinds of standards, CME contact hours, publishing volumes, etc, I don't know how we can apply such standards or criteria to something as generic as management".

Little support was offered for carrying out activities of research and publication. It would appear that was due in part to the belief that not many health care managers have the skills and knowledge required for the tasks. Two Chief Executive Officers provided the following comments:

> "Why publish? There is too much nonsense/rubbish, garbage being published as it is at present!"

> "There is too much crap published already - Few managers have the appropriate training to do good research".

Developers of continuing education programs should be aware that research and publication skills and knowledge could be lucrative areas for program development. There was also a strong hint to Chief Executive Officers that there needs to be a focus on those aspects of development for managers. There appeared to be a misconception that publication had to be the result of exhaustive research activities of a quantitative nature. Publication can be the sharing of ideas. With more sharing of ideas via the literature, more joint ventures could be undertaken as articles could be used to identify individuals or organization of like mindedness, while providing increase opportunities for knowledge acquisition.

Future Skills - Respondents provided an extremely high level of agreement with the skills which were identified as being needed for the future health care industry. *Communication skill* was the top rated item among the eleven choices offered. Roberts 1993, stated that a good leader was someone who communicated often and openly. There is no doubt that the health care industry demands a high level of communication skills from its leaders. It needs individuals who can provide information to its constituents and at the same time receive information from them. In an era of client service focus, the manager must be perceived as an individual with whom the client can communicate. Health care managers are also expected to be able to communicate the plans of the organizations to other stakeholders such as funding agencies, especially on matters of

service delivery to meet the guidelines as set by those agencies and also to effectively demonstrate how the proposed plans fit with the overall health delivery strategy of the province. Operating Plans for health care facilities must not only be properly documented but the leaders of the institutions must be able to articulate such plans to the respective District Health Council which will make the appropriate recommendations to the Ministry of Health. In Ontario, the Ministry of Health has expectations of a higher level of cooperation between health care facilities and the community. That directive requires effective communication in various modes.

With the changes taking place in health care organizations, the managers must be able to communicate and present the changes with honesty and integrity, not only to their own staff but also to other interested parties who may be very critical to the survival of the organization.

The next highly rated skill was that of *leadership*. The health care managers must be able to develop a vision for the organization and facilitate the achievement of that vision. Not only will leaders need to anticipate the future but they will be required to anticipate various possibilities and be prepared for them. The health care manager must understand the interdependence of political, technical and cultural aspects of organization decision-making (Grieshaber, 1993). One respondent to the questionnaire referred to the manager with the appropriate skills as a "super person". In her estimation, that is what would be needed to effectively manage the health care organization of the future - a super person.

Roberts 1993, postulated that after the year 2000, the definition of health will be greatly expanded. Hence in seeking educational opportunities for health care managers, the focus should be placed on areas of future needs that are not traditionally a part of health management curricula. This study identified some areas of future skills, as perceived by health care managers. Overall, the study respondents demonstrated an overwhelming agreement on the top rated skills needed for health care managers.

Skill Development - It was fitting and very appropriate that Question 9 dealt with skill development. Having had an indication of the needs, perceived benefits and facilitation role, it was important that health care managers had an opportunity to provide suggestions for methods and activities which would facilitate skill enhancement.

Preference was stated for attending *workshops with a specific focus, short courses of 1 - 4 days duration* and *opportunities for on-the-job development with the assistance of a mentor*, with the manager having had input into planning the program or activity. The short duration focused workshop request support the constant need for new information in a changing health care environment. It also fits with the perception of being over burdened with job tasks. Being away from the job for short periods not only allows the manager to concentrate on the focus of the developmental activity, but it also lessens the anxiety level of a large build-up of job tasks. The 1991 study by Williams of Long-Term Care Administrators in Ontario, showed that the respondents preferred modes of education program delivery that were short, intensive seminars and which were offered as night classes.

In this present study, the top rated items indicated that at the senior levels of health care management there was a necessity or preference for having developmental activities that were focused as opposed to being general. General in this context refers to material which is normally taught in undergraduate courses. The request appears to be for information about new work processes; new methods of service delivery; new organizational structures, e.g. Program Management; new directives from the Ministry of Health; and the results/recommendations of various Ministry of Health Task Forces and Commissions of Inquiry.

Overall, the respondents to the survey were very positive toward skills development and there was a strong indication that many would like to see some form of support from the organization but, at the same time they were very cognisant of financial restraints faced by health care organizations.

> "Unwillingness of employers to grant education leave of absence with pay due to tight budgets".

> "Difficult to find funds for continuing education when budget reductions are so bad, staff being laid off".

Money was not always the issue. As was pointed out in the comment which follows, policy issues and organizational values play a part.

> "A key issue in our organization is Board's (of Governors) expectation about Continuing Education. If it is perceived as 'nicety' and not a 'requirement', there will be little commitment. Expectations concerning the amount, type, and financial support for Continuing Education has not been formalized as part of the Board/Hospital Policy. This is a clear weakness in achieving support for Continuing Education. If there was Board mandate, it would facilitate Senior, Middle Management in moving toward this goal".

There was a concern expressed by one individual which stated that skill development was perceived in some circles, "as an 'extra' when time permits".

> "My opinion (totally unsubstantiated), is that the organizational culture must foster the attitude - it cannot be forced".

CONCLUSIONS

#1 Management development needs of all health care managers must be addressed.

The needs of the industry change with new initiatives and new policy directives hence a co-ordinated approach will be more supportive of managers in their quest for decreasing their deficiencies. Addressing management development needs will provide greater efficiency in managing the changing health care industry.

#2 Health care management job titles should be standardized across the health management field.

This action will lessen the confusion between institutions and provide a better understanding for the public and aspiring health care managers in particular.

#3 Develop a certification process for each health care management position.

This action will provide concrete steps to be taken as one aspires to a particular health care management position. It will take the guess work out of preparation.

#4 Performance Appraisal systems for health care managers should emphasize development.

This will assist health care managers to plan their own professional development but the performance appraisals must be done on a regular (at least annual) basis.

#5 Organize a system to allow academic faculty to spend time in health care organizations for their own professional development.

This will facilitate the building of a relationship which would provide input into the initial and continuing education of health care managers. It would also provide partnerships for management development and other collaborative endeavours.

#6 Pursue partnerships between health care facilities and academic institution for management personnel to be more actively involved in program delivery.

This will assist in the further development of managers while providing

opportunities to share information. Strengths of both sides could be harnessed to improve management development opportunities.

#7 Provide health care managers with opportunities for the development of research and publication skills.

This will facilitate the sharing of health management information on a wide level. High quality research and publication will add to the scholarly literature.

#8 Develop system wide support for managers to pursue management professional development activities and opportunities to utilize the new knowledge and skills.

The busy health care environment was an identified barrier for the pursuit of professional activities hence any support for employers would be welcomed and that support does not have to be purely financial. It could come in the form of time release for attendance at educational opportunities.

#9 Develop and support strong education and professional development services within each facility.

A strong internal service would be able to identify collective and individual needs and positively respond to them in a timely manner.

#10 Each health care facility must facilitate needs assessment services for its management staff.

Not every manager has the skill for needs assessment hence an available service will facilitate future management development. It will also fill those gaps where the senior management staff members are unable to provide the service as part of

performance appraisal - where that is a regular occurrence. Part of this facilitation is the inclusion of personal growth activities.

#11 Management development must be considered an organizational expectation of its managers.

The organization must have policies to support management professional development and recognize its value to the organization. This will send a strong positive message to the managers who in turn will be more motivated to pursue professional development.

#12 Managers must be encouraged to develop lifelong learning skills.

This will allow the managers to plan their own development and will assist them in the development of an appreciation for further learning. Reliance on the education and professional development staff may be lessened.

This study answered some of the questions regarding what skills would be needed for the future health care industry and by what methods those skills could be developed. Respondents were very confident in their responses to Questions 8 & 9 which dealt with those topics. There was no ambivalence manifested in the responses to Question 8 and only for one out of fourteen items for Question 9. However, the study also raised questions regarding the support, especially financial and time release which could be expected from employing organizations. It would appear that support is available but more often than not, is based on job level within the organization which may equate with budget control autonomy of the individual.

The three items, *communication, leadership and results management*, which have been found to be the future skill needs of health care managers would form the basis of sound educational programming for in-house offerings. When offered in-house, there will be

opportunities for evaluation, follow-up and reinforcement. There has to be a commitment from the organization not only to provide opportunities but also, to provide quality opportunities which will be facilitated by competent and qualified individuals.

The data indicated that although health care managers many have a variety of academic backgrounds and that there were a number of levels within management, the skills desired in these individuals should be the same regardless of their academic preparation and position with the organization. This position is destined to generate some heated discussion due to what has been perceived as levels of importance and status of the different health care management jobs. If internal promotion or even external ones were to continue as avenues of upward mobility, then the "lower level" manager must be afforded the opportunity to develop the required management skills while still in the "lower" level position. Having the necessary skill will likely decrease any concerns about opportunities for internal promotion and would give lower level managers a positive feeling about open and fair competition.

The argument that development should be strictly related to level of management position is becoming weak in an age when health care managers are asked to assume more significant roles. Continued perpetuation of that idea will help to keep managers compartmentalized and would not provide opportunities for development and thus offer the opportunity to progress beyond their designated compartment. Development should be based on individual needs and not on job classification needs.

The foregoing shows that everyone has a role in management development and that for the endeavour to be successful, roles will need to change and different opportunities provided for all the key players. Health care managers need to change their perception of the pursuit of professional development to realize that it was an important part of their growth and that it was an expectation. No one's career advancement should be determined by luck and chance as more often than not, luck will favour a particular group. Too often, the basis for selection to higher level jobs in health care seems to have

no quantifiable criteria except for those existing in the minds of the decision-makers. Such a system is riddled with abuse and it was no surprise that there was one dominated racial group in this study. It was found in another study, Storch 1989, that although women made up 60% of health care managers, that the number of women in the position of Chief Executive Officer/President was low (16.7%) and more often than not, the women had superior academic qualifications. The system needs to be reflective of equity and fairness. It was no longer acceptable to reject an applicant without being able to state a plausible reason or to plan the restructuring of an organization so that highly qualified and capable managers were displaced while less qualified and less capable individuals were retained due to kinship with the senior managers.

It is safe to say that the excellence of health care facilities is the excellence of the managers. It is that group which holds the decision-making power. Health care institutions must possess not only the ability to attract top quality managers and managers with potential but they must also be able to retain those currently employed. This is of paramount importance to health care institutions concerned with developing and maintain quality service. That vision could be operationalized by instituting policies which will foster growth and development of managers. In the ideal world, health care managers would be equipped to facilitate their own growth and development but one must remember that the health care environment was not an ideal world. The result of this study will assist in making the search for idealism easier as the struggle by health care managers for readiness continues as they attempt to face the future management roles.

There were some neutral responses to some items of the questions. Those neutral responses suggested that there was some ambivalence on the part of the respondents. The areas with a high neutral response should form other studies. It is possible that the responses were influenced by the level of the respondents within the organization and that there might have been a neutralizing action between the responses for Senior Managers and those of the lower levels.

The findings of this study have proposed some interesting questions.

> Whether the health care environment has changed to modify the perceptions of health care managers regarding the skills needed or were those perceptions always present. In other words, was this new information? I hardly think so. A repeat study will help to provide some clarification.

> Research and publication for health care managers were not positively received. This was not a surprise seeing that only one accredited graduate program in Health Administration (Canadian) has been deemed strong in offering research as part of its academic program. The message appeared to be that research was not important in health care management.

Individuals who have strong management skills and current health care knowledge will do well in managing the health care organizations and might be afforded some level of job security, an elusive commodity in these days of restructuring. It was considered to be elusive because in some instances, the selection of health care managers appeared to be based on kinship as opposed to ability and knowledge - especially when the organization was shielded by employment contracts and have the ability to provide severance payments which meet the minimum requirements of the Employment Standards Act. With documented evidence of possessing and displaying the required skills, the process for retention and selection would be made more transparent and open to scrutiny and there will be more accountability. Having the right person in the right management position would go a long way in improving health care management.

IMPLICATIONS

What do the present findings suggest for the health care industry regarding management development? The findings showed that there was a need for the development of management skills which would improve performance for all health care managers. Professional development of health care managers cannot be done in isolation because, inherent in the health care industry are some management structures, values and procedures which demand examination and change. The required change will range from radical to moderate change if any attempts at management development are to be truly successful and have far-reaching desirable effects.

One very obvious specific action will be to address the management development needs of those managers who do not possess the theoretical knowledge of management and have not experienced formal academic management education. Bridging the gap will increase the likelihood of having a well-informed and creative management staff. But why single out those managers? Not only are they lacking in the required management academic education, they are also the most likely group not to have well developed needs assessment skills. It would not be unusual to find that some of those individuals will have aspirations for further job promotion. Those are the same individuals whose jobs would be in jeopardy with financial cut-backs, without any regard for their length of service with the organization. Career redirection would also present some difficulties for that group due to intensity of the competition from others with the desired academic preparation.

The indications are that health care managers who have pursued a formal academic program in management should not necessarily continue to pursue academic programs per se. The emphasis should be placed on skill development and on those aspects in particular which have been indicated in the survey findings. The three top items selected by respondents as skills needed by future health care managers, are not normally part of academic curricula.

Implications for health care organizations

Position level definitions/classifications will make it easier to compare like job across organizations within the health care industry. Presently, each organization is at liberty to name it management positions without any thought of the effect on the rest of the industry. More often than not, one organization will make changes to job titles and their action may be followed by others. Having common titles which are equivalent across the health care industry will also make research findings more meaningful when management jobs title play a significant part.

Organizations need to re-evaluate their values regarding the importance of the education and professional development department. Greater importance has to be placed on the services which are being offered or should be offered. It must be perceived as an integral part of the organization and not as an area of budget reserve so that in the difficult financial times, that would be the service to disband. On the contrary in difficult times, in times of organizational restructuring and down-sizing, the educational and professional development department should be given an enhanced role especially in preparing surviving managers for expanded and/or new roles.

Education services within health care institutions should be kept centralized in the age of Program Management to avoid fragmentation and compartmentalization of professional development for health care managers. With a centralized service, there will be greater flexibility in meeting needs, both urgent and non-urgent, in a timely manner. The philosophy of Program Management indicates that each program be self-sufficient. That might be desirable for direct service delivery but there are some facets of the organization that should remain corporate and educational and developmental services should be a corporate service.

Using the findings of the survey will provide for more focused in-house programming instead of the potpourri that appears to be common in many institutions. Professional

development must be unique to the organization and the individual and it must not be viewed as an extension of academic management education. At the same time, no one should assume that all managers will receive the same level of benefit or achieve comparable levels of proficiency.

Health care organizations will also need to re-evaluate how they support professional development for managers. "Neighbour-gazing" has got to stop. The needs of one organization are not necessarily those of the other. Any effort at management development must be based on the identified needs of the managers of a particular organization. Once needs have been identified there was no harm in collaborating with neighbouring institutions. The recommendation was for storing, in a central data base (internal), the documented needs of the organizations for management development. That information could then be shared with an external central data base e.g. CCHSE, and the collective information could then be the basis for the planning of management development programs which would be of interest to many health care institutions. The source of the information for the internal data base would be regular performance appraisals with an emphasis on career development. Too often, the emphasis was placed on past achievements which were mostly normal job responsibilities and not enough emphasis on the developmental aspects, which should be the prime focus of a good performance appraisal system.

Implications for educational and management training institutions

Using health care administration as a marketing ploy would need to change. There might be a need for increasing the number of initial management programs but there should be no need to market management programs as meeting the needs of a specific group. There is much to be gained from the interaction of individuals from a variety of backgrounds. It adds depth and value to the networking experience especially for the experienced health care manager. One combined management education programming per academic institution would probably be more cost-effective and stronger. Basic management

training could be perceived as the foundation for a career in health care management. With proper direction and mentoring, the trained managers could be assisted in acquiring competencies in specific areas of health care management.

Providers of education and training should seek out opportunities for alliances and partnerships rather than competition for professional development and continuing education offerings. There needs to be a higher level of co-operation between academic faculty and qualified health care managers in the delivery of management developmental programs. Utilizing the resource of management staff in teaching roles will enhance the theoretical offerings. Academic faculty will be well advised to spend time in the health care environment as part of their own professional development for their role in delivering initial and professional development programs. Academic faculty in the health care environment will have an added opportunity for assessing the instructional capabilities of those health managers who have an interest in presenting programs in the academic environment. The increased interaction will also provide some partnerships for research and publication. This will not only add to the relevant literature but it will also assist health care managers in developing their research and publication skills. Efforts are research and publication would eventually add to the scholarly literature.

Implications for the Health Care Manager

Health care managers need to be skilled and knowledgeable in the principles of adult education since much of the job is involved with the development of others. In any system of management development, managers should be part of the pool of instructors. Proper preparation will make them more effective in teaching opportunities in the formal academic environment. Academic executive development programs expect participants to make formal presentations - the assumption is that all participants will be skilled in oral presentations. Poorly developed or non-existent presentation skills will detract from one's opportunity for growth of self and assisting in the growth of others.

There will be an increased role in gathering information on current health care issues and being part of the dissemination team. Externally, there will be a need for interacting with the media especially when there is a desire to build a strong relationship so that the media will be supportive in presenting information on the institution or programs in a positive manner. Communities have also raised their expectations, due to a higher level of aware, about what was communicated when plans are being made to change services.

Implications for Education and Development Departments

It is without doubt that there should be a strengthened role with increased responsibility for education and professional development services. A crucial ingredient to success would be having the appropriate staff - staff that are highly trained and are knowledgeable, not only in the material of interest but also in adult education principles. Education and development staff must not be selected based on stated interest alone. The individuals must be trained for the task at hand. Developmental services must seek instructional assistance outside of the narrow sphere of its immediate staff and utilize the skills of others, be they managers or university faculty.

More evaluation has to be done regarding canned programs. It is not appropriate to purchase programs with catchy titles and offering them to the managers without any notion of whether or not they are meeting anyone's needs - be they corporate or individual. The situation is compounded when the programs are delivered by individuals who are not trained at the appropriate level and have little or no appreciation for the interest or job role of the customer/clientele. When consultants are utilized, they must also be carefully selected and not selected based on the topics as published in a promotion brochure. Both canned programs and consultant services have a role to play in management education and they must not only be cost-effective but they should also be appropriate in meeting identified needs.

Management education and development jobs must be perceived as full time roles as

opposed to something which is assigned based on availability. The training staff must be aware of a variety of education sources and technologies. They must also be able to eliminate preconceived notions of ideal management development programs and focus on the individual and the situation. This would require that input be received from those individuals for whom the programs are planned. As is the case for managers, education and professional development staff must be current in health care issues and be partly responsible for disseminating that information and be at least able to demonstrate the relevance of the information.

Utilize other qualified and knowledgeable staff from other areas of the institution. Some organizational structure might not foster such a relationship due to the competitive environment which might result from a particular structure. For purposes of education and professional development, the barriers must be removed so that instructional skills of all could be utilized to whatever extent possible for the benefit of the organization.

Implications for Senior Management

Senior managers can no longer be the keeper and sole disseminator of health care information. This would require some shift in thinking for many senior managers because it could prove threatening for those senior managers whose roles might appear modified in a negative way. In such situations, one cannot rule out the display of negative behaviours on the part of the senior managers which could undermine an otherwise effective management development program, especially where cost approval for the program or aspects of the program lies with the senior manager.

The system will require that all senior management personnel be trained presenters and have a working knowledge of adult education principles. Emphasis on the development of individuals will require some very specific knowledge and skill. Senior managers are known to deliver aspects of in-house training and the only qualification for that specific role, in some situations, is their position within the organization, and not necessarily from

a knowledge base or skill level.

The data and my experience in the field of health care management suggest that the administrative head of the department of education and professional development should be a member of Senior Management - not reporting to a Vice-President, especially if that VP has neither the knowledge nor the interest regarding matters of education and professional development. There has to be a high level of autonomy enjoyed by the manager of educational services. Such an arrangement will send the appropriate message to the rest of the organization regarding the commitment of the organization to developmental opportunities.

Provide opportunities for managers for their skill development and for the utilization of those skills. The utilization of those skills can take the form of new job responsibilities or by merely incorporating them into daily activities. It is reasonable to assume that once new skills have been acquired, individuals would welcome opportunities for use of those skills so that expertise could be built and maintained especially where the skills form part of the job requirements.

Opportunities for needs assessment of health care managers could be regularly provided as part of the regular performance appraisal system rather than in a system which might be perceived as diagnostic in which case, co-operation could be threatened. With the performance appraisal system, one's "weaknesses" would be identified in a mutually satisfying manner with a familiar boss, rather than in an environment with a diagnostician who might not be as sensitive to the needs of the managers and would not engender a non-judgemental situation leading to acceptance and co-operation.

Implications for the College (CCHSE)

Generate efforts for breaking down the artificial barriers which have been created between general management and health care management training. There might be a need to

identify what requirements must be met to manage in health care. Reference here is to job requirements and not necessarily College requirements for membership. Adding certification for the different levels of management will be a useful and meaningful contribution to health care management. The College could be assigned the responsibility of certification of the different levels or managers. With a clear delineation of the different management jobs and their required competencies, there should be no confusion surrounding what additional skill development might be required to qualify for a management position in health care. Knowing the requirements for different position levels will also provide some structure for management development. Not only will there be clearer expectations of incumbents but, there will also be clear direction for those aspiring to a particular management job.

The regulatory college should be the focus and source of professional development activity for health care managers. By maintaining the external data base of career development needs of health care managers as identified at performance appraisal, the College can offer programs which will meet the needs of the industry. Such central programming should not necessarily mean central delivery, unless central delivery does not mean a central venue. Central programming and delivery would be possible based on technological capabilities of the individuals and organizations e.g. distance education via interactive computer hook-up. Such systems of program delivery will improve access especially if the interactive system provides for individual pacing of requirements completion and in a work environment where there is strong support of the hiring organizations.

The College should foster interdependence and co-operation between educational institutions, health care organizations, the professional body (College) and the managers. Sharing the data base information will facilitate co-operation. The results of that co-operation will enhance the developmental opportunities for health care managers in various locations.

RECOMMENDATIONS FOR FURTHER STUDY

The following are some suggestions for consideration:

- **Repeat a study of this type at least every three years to identify the needed skills for a dynamic complex health care environment.**

  Such an activity will provide valuable information for continued management development.

- **Repeat this study using managers from a non-health care environment as the population of interest and compare the results with those of this study.**

  I do not anticipate any differences but the results would assist in convincing some individuals that the academic preparation for management in health care organizations is the same as that required for managing in other fields.

- **Conduct a study to identify the health care organizations which are supportive of management development and evaluate their success as determined by customer and manager satisfaction levels.**

  I anticipate that the supportive organizations will be perceived as effective organizations meeting the needs of their communities while having managers who enjoy a high level of job satisfaction.

- **Replicate this study targeting lower level managers and compare their perceptions and opinions with those of the respondents of this study.**

  This recommendation should be carried out by individual organizations so that specific organizational needs could be addressed. If done as a larger study then

it should be planned so that individual results could be separated out so as to allow each organization to know its specific results and thus be able to react to the findings.

Although health care managers have a variety of academic backgrounds, and that the skills desired should be the same regardless of their academic preparation, identified needs existed for needs assessment, for providing direction for skill development, and for on-going support for the pursuit of professional development for managers.

The focus of the study was managing in health care institutions and specifically, the issue of professional development for managers in a changing environment. In the 1990's, health care organizations are "re-organizing", "downsizing", "rightsizing" and "re-engineering" jobs in an effort to cope with decreased funding and at the same time satisfy client and customer needs and expectations. Those activities have caused the health care environment to be one of constant change with demands for different management skills and current knowledge of health care and related issues. Identification of the issues faced by health care managers in their pursuit of continuing education and professional development and documenting their perceptions will help to provide break-throughs in meeting the management needs of the present and future health care industry regarding needed skills and knowledge. Without a clear identification of the needs of the field, managers will be ill-equipped to pursue, in a meaningful way, the acquisition of required skills and knowledge.

APPENDICES

APPENDIX A

Letter of Introduction

8 Morton Way, Brampton, Ontario, L6Y 2R7

Dear Colleague

This questionnaire has been developed for use as a tool to solicit the opinions and perception of health care managers on the topic of **Continuing Education and Professional Development.**

There is no doubt that the health care environment is constantly changing and some health care managers might be wondering how they can maintain the skills required for meeting the future needs of the industry. Continuing education and professional development could very well be the route to maintaining currency. It is my expectation that some very revealing answers would be provided through my research.

There are eleven sections to the questionnaire. ***There are no wrong or right answers, only opinions and perceptions***. The summary data will be used in a dissertation report for my Ph.D. degree. **Your answers are completely confidential and anonymous. Do not put your name anywhere on the questionnaire but in the event that you would like to be contacted for providing more information or to be interviewed please indicate separately.**

The rating scale throughout is the same but is repeated in several spots to facilitate easy completion. Completion of the questionnaire should not take you more than 15 - 20 minutes. Please return in the envelope provided by October 31/1994.

If you have any questions please feel free to contact me at (905) 451 1778 or at the address stated at the top of this page.

Thank you for your kind co-operation.

Yours sincerely

Winston W. Isaac, M.A., M.P.A., C.H.E.

APPENDIX B

CONTINUING EDUCATION QUESTIONNAIRE

Winston W. Isaac, M.A., M.P.A., C.H.E.
8 Morton Way, Brampton, Ontario
L6Y 2R7 (Phone (905) 451 1778)

CONTINUING EDUCATION QUESTIONNAIRE

RATING SCALE	
1 - Disagree Strongly	2 - Disagree
3 - Neutral	4 - Agree
5 - Agree Strongly	

Using the rating scale provided, please indicate your level of agreement/disagreement with the following statements:

1. PERCEPTION OF NEEDS:

Continuing Education for health care managers ...

		1	2	3	4	5
1.1	should be a requirement for all health care managers					
1.2	would keep health care managers current in management issues					
1.3	would be advantageous to individuals who have been away from formal education for greater than 3 years					
1.4	would be advantageous to individuals who have been away from formal education for greater than 5 years					
1.5	should be mandatory for managers who do not possess formal academic credentials in health care management					
1.6	should be related to specific levels of job responsibility					
1.7	should be related to experience level					
1.8	should be a mutual understanding between manager and supervisor					
1.9	should be required for Chief Executive Officers					
1.10	should be required for Senior Management					

CONTINUING EDUCATION QUESTIONNAIRE

RATING SCALE	
1 - Disagree Strongly	2 - Disagree
3 - Neutral	4 - Agree
5 - Agree Strongly	

Using the rating scale provided please indicate your level of agreement/disagreement with the following statements:

2. **BARRIERS:**

Continuing Education activities by health care managers are negatively impacted by ...

		1	2	3	4	5
2.1	job workload					
2.2	inadequate course offerings					
2.3	distance from home					
2.4	distance from work					
2.5	cost of courses, conferences and related activities					
2.6	the perception that continuing education is not valued by employers					
2.7	personal responsibilities related to home life					
2.8	managers perceiving continuing education to be of low personal value					
2.9	the low probability of increased financial reward (pay raises)					
2.10	continuing education not being perceived as an expectation by employers					

CONTINUING EDUCATION QUESTIONNAIRE

RATING SCALE
1 - Disagree Strongly 2 - Disagree
3 - Neutral 4 - Agree
5 - Agree Strongly

2.11	OTHER (Please add suggestions)					

CONTINUING EDUCATION QUESTIONNAIRE

RATING SCALE	
1 - Disagree Strongly	2 - Disagree
3 - Neutral	4 - Agree
5 - Agree Strongly	

Using the rating scale provided, please indicate your level of agreement/disagreement with the following statements:

3. PERCEIVED BENEFITS:

Continuing education for health care managers provides for ...

		1	2	3	4	5
3.1	currency of information					
3.2	increased promotability (internal)					
3.3	increased opportunities for net-working					
3.4	increased self-esteem					
3.5	increased marketability (external)					
3.6	increased political know-how					
3.7	improved management skills					
3.8	increased morale					
3.9	increased level of job satisfaction					
3.10	increased performance appraisal rating					
3.11	increased productivity					
3.12	increased job knowledge					
3.13	increased decision-making ability					
3.14	improved communication skills					
3.15	increased motivation					
3.16	increased efficiency					

CONTINUING EDUCATION QUESTIONNAIRE

RATING SCALE
1 - Disagree Strongly 2 - Disagree
3 - Neutral 4 - Agree
5 - Agree Strongly

3.17	improved organizational ability					
3.18	OTHER (Please add)					

CONTINUING EDUCATION QUESTIONNAIRE

RATING SCALE	
1 - Disagree Strongly	2 - Disagree
3 - Neutral	4 - Agree
5 - Agree Strongly	

Using the rating scale provided, please indicate your level of agreement/disagreement with the following statements:

4. MANDATORY vs VOLUNTARY:

		1	2	3	4	5
4.1	Health care managers should be required to pursue a formal or an accredited program of continuing education					
4.2	A mandatory program of continuing education for health care managers would be beneficial to my own development					
4.3	I do not need a mandatory continuing education program to motivate me to pursue continuing education activities					
4.4	A mandatory continuing education program will not make any difference in my pursuit of continuing education activities					
4.5	I regularly pursue continuing education and professional development activities					
4.6	Accredited continuing education should be an expectation of health care managers					
4.7	All health care managers should be expected to report their continuing education activities to a governing body on an annual basis					
4.8	Accredited continuing education should be an expectation for health care managers in my organization					
4.9	Salary increases for health care managers should be based on the pursuit of accredited continuing education					

CONTINUING EDUCATION QUESTIONNAIRE

RATING SCALE	
1 - Disagree Strongly	2 - Disagree
3 - Neutral	4 - Agree
5 - Agree Strongly	

		1	2	3	4	5
4.10	Health care organizations which mandate continuing education for managers will be assured a competitive edge					
4.11	Health care organizations should have formal policies regarding expectations for managers to pursue continuing education					
4.12	Continuing education for health care managers is a critical factor in the future success of the organization					
4.13	OTHER COMMENTS:					

CONTINUING EDUCATION QUESTIONNAIRE

RATING SCALE	
1 - Disagree Strongly	2 - Disagree
3 - Neutral	4 - Agree
5 - Agree Strongly	

Using the rating scale provided, please indicate your level of agreement/disagreement with the following statements:

5. FACILITATION ROLE:

		1	2	3	4	5
5.1	Employers should facilitate continuing education activities for health care managers					
5.2	Employers should facilitate continuing education activities for health care managers by offering FULL financial support					
5.3	Employers should facilitate continuing education activities for health care managers by offering PARTIAL financial support					
5.4	Employers should facilitate continuing education activities by providing PAID TIME for attendance					
5.5	Employers should facilitate continuing education activities by giving bonuses to participants					
5.6	Each health care manager has a responsibility for facilitating his/her own continuing education activities					
5.7	The professional body should facilitate continuing education activities by providing appropriate opportunities for managers					
5.8	Educational institutions should facilitate continuing education activities for health care managers					

CONTINUING EDUCATION QUESTIONNAIRE

RATING SCALE

1 - Disagree Strongly 2 - Disagree
3 - Neutral 4 - Agree
5 - Agree Strongly

5.9	OTHER (Please list other ideas):					

CONTINUING EDUCATION QUESTIONNAIRE

RATING SCALE	
1 - Disagree Strongly	2 - Disagree
3 - Neutral	4 - Agree
5 - Agree Strongly	

Using the rating scale provided, please indicate your level of agreement/disagreement with the following statements:

6. **MOTIVATORS:**

I WOULD INCREASE MY PARTICIPATION IN CONTINUING EDUCATION IF...

		1	2	3	4	5
6.1	programs were accessible					
6.2	my employer provided FULL financial support					
6.3	my employer provided PARTIAL financial support					
6.4	I felt my skills would be enhanced					
6.5	I felt that my salary would be increased					
6.6	I felt that my chances for promotion would be enhanced					
6.7	I felt **insecure** about my future with my present employer					
6.8	I felt the need to increase my marketability					
6.9	I felt that I could increase my chances for secondment					
6.10	there were formal organizational policies in support of the activity					
6.11	educational activities were done on site					
6.12	I could share my knowledge with colleagues					
6.13	I felt **secure** in my position					

CONTINUING EDUCATION QUESTIONNAIRE

RATING SCALE

1 - Disagree Strongly 2 - Disagree
3 - Neutral 4 - Agree
5 - Agree Strongly

6.14	OTHERS (Please add)					

CONTINUING EDUCATION QUESTIONNAIRE

RATING SCALE	
1 - Disagree Strongly	2 - Disagree
3 - Neutral	4 - Agree
5 - Agree Strongly	

Using the rating scale provided, please indicate your level of agreement/disagreement with the following statements:

7. REASONABLE EXPECTATIONS:

		1	2	3	4	5
7.1	Health care managers should be required to take at least one credit course per year.					
7.2	Health care managers should be required to attend at least one professionally related activity per year.					
7.3	Health care managers should be required to pursue research activities on the job.					
7.4	Health care managers should be required to publish at least one article in a professional journal every year.					
7.5	Health care managers should be required to publish at least one article in a professional journal every 3 years.					
7.6	Health care managers should be required to publish at least one article in a professional journal every 5 years.					
7.7	Health care managers should be allowed to set their own continuing education goals.					
7.8	Secondment to another organization should be considered an appropriate educational activity for health care managers.					
7.9	Health care managers should be expected to follow educational activities specific to a clinical discipline.					
7.10	Health care managers should be expected to follow educational activities related to management.					

CONTINUING EDUCATION QUESTIONNAIRE

RATING SCALE	
1 - Disagree Strongly	2 - Disagree
3 - Neutral	4 - Agree
5 - Agree Strongly	

		1	2	3	4	5
7.11	OTHER (Please add)					

CONTINUING EDUCATION QUESTIONNAIRE

RATING SCALE	
1 - Disagree Strongly	2 - Disagree
3 - Neutral	4 - Agree
5 - Agree Strongly	

Using the rating scale provided, please indicate your level of agreement/disagreement with the following statements:

8. FUTURE SKILLS:

In order to survive in the face of change, health care managers will require the following skills ...

		1	2	3	4	5
8.1	Leadership					
8.2	Communication					
8.3	Lifelong Learning					
8.4	Consumer/Community Relations					
8.5	Health Environment Awareness					
8.6	Conceptual					
8.7	Results Management					
8.8	Resource Management					
8.9	Compliance to Standards					
8.10	Teaching/Instructional					
8.11	Stress management					

CONTINUING EDUCATION QUESTIONNAIRE

RATING SCALE	
1 - Disagree Strongly	2 - Disagree
3 - Neutral	4 - Agree
5 - Agree Strongly	

8.12	OTHER (Please add)					

CONTINUING EDUCATION QUESTIONNAIRE

RATING SCALE

1 - Disagree Strongly 2 - Disagree
3 - Neutral 4 - Agree
5 - Agree Strongly

Using the rating scale provided, please indicate your level of agreement/disagreement with the following statements:

9. SKILL DEVELOPMENT:

Methods for further developing skills of experienced health care managers for the future organization are as follows:

		1	2	3	4	5
9.1	Self-directed individualized programming					
9.2	Formal undergraduate courses					
9.3	Pursuit of current health administration programs e.g. MHA, MHSc					
9.4	Pursuit of current management programs, e.g. MBA, MPA, CMA					
9.5	On the job training WITH a mentor					
9.6	On the job training WITHOUT a mentor					
9.7	Paid educational leave					
9.8	Secondment to another organization					
9.9	Reading professional journals					
9.10	Attending workshops with a specific focus					
9.11	Attending short courses (1-4 days duration)					
9.12	Attending intensive courses (1-3 weeks duration)					
9.13	Attending residential programs (6 weeks or more)					
9.14	Presenting at conferences					

CONTINUING EDUCATION QUESTIONNAIRE

RATING SCALE

1 - Disagree Strongly 2 - Disagree
3 - Neutral 4 - Agree
5 - Agree Strongly

9.15	OTHER (Please add)					

CONTINUING EDUCATION QUESTIONNAIRE

10. DEMOGRAPHICS:

10.1	SEX/gender	10.6	PROFESSIONAL BACKGROUND
	__ Male __ Female		Clinical Discipline_____ Other_____
10.2	TIME IN HEALTH CARE mgmt	10.7	TIME IN HEALTH CARE
	_____years		_____ years
10.3	EDUCATION (highest level)	10.8	YEARS WITH ORGANIZATION
	__ High School __ Some Post Secondary __ Community College __ Bachelor's Degree __ Some Graduate Work __ Master's Degree __ Doctoral Degree OTHER _____		__ Less than 6 months __ 6 months to 1 year __ 1 to 2 years __ 2 to 4 years __ 4 to 6 years __ 6 to 10 years __ 10 to 15 years __ more than 15 years
10.4	ORGANIZATIONAL LEVEL	10.9	CULTURAL BACKGROUND Ethnic/Racial
	Levels between your position & Chief Executive Officer __ 0 __ 1 __ 2 __ 3		__ Asian __ Black __ Hispanic __ White/Caucasian __ Other - Please Specify _____
10.5	AGE	10.10	SALARY (Annual)
	__ 20 - 29 __ 30 - 39 __ 40 - 49 __ 50 - 59 __ 60 and over		__ $40,001 - $50,000 __ $50,001 - $60,000 __ $60,001 - $70,000 __ $70,001 - $80,000 __ $80,001 - $90,000 __ $90,001 - $100,000 __ $100,001 plus

CONTINUING EDUCATION QUESTIONNAIRE

11.0 OTHER

11.1 ***Please indicate your Continuing Education & Professional Development practice - no more than ten years back (approximations acceptable):***

_____ Credit Courses taken

_____ Non-credit courses taken (external)

_____ Workplace courses/seminars taken (non-credit)

_____ Conferences attended

_____ Presentations made at Conferences

_____ Guest presentations made at colleges or universities

_____ Courses delivered at colleges or universities

_____ Publications (____ Author or ____ co-author)

_____ Formal mentoring/preceptor occasions

OTHER: Please add

_____ ----------

_____ ----------

_____ ----------

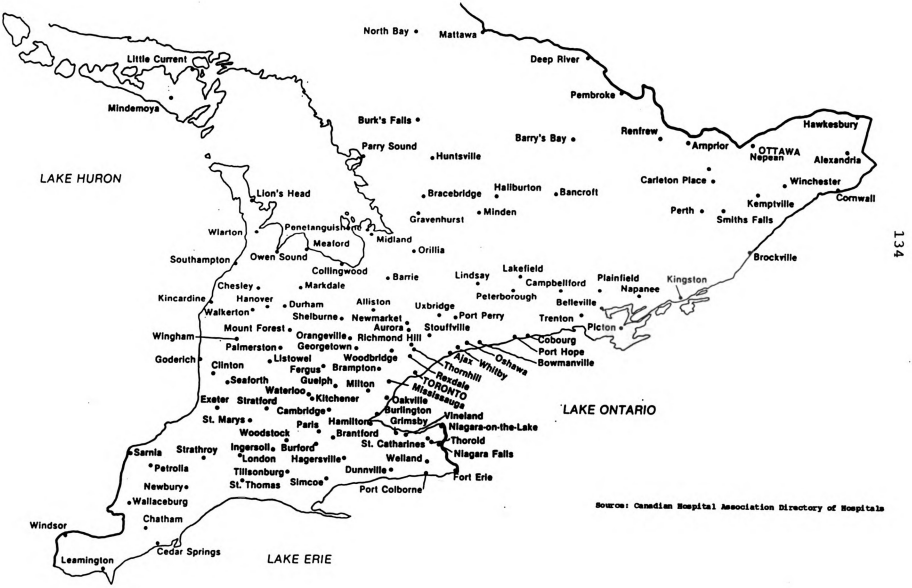
_____ ----------

11.2 ***Please classify your major reporting area:***

____ Clinical **or** ____ Non-Clinical

11.3 ***Please indicate the number of your direct reports:*** _____

APPENDIX C - Map of southern Ontario



Source: Canadian Hospital Association Directory of Hospitals

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