REPORT OF STUDY TRIP

# TRAINING OF MANAGERS IN HEALTH CARE: AN APPROACH IN THE U.S.A.

# REPORT OF STUDY TRIP

# TRAINING OF MANAGERS IN HEALTH CARE: AN APPROACH IN THE U.S.A.

ROY GREENHALGH

APRIL 1988

# Contents

1. Purpose of Study Trip

I am now in the fifth year of organising a semester long ( 4 months ) practicum for an American undergraduate from the Univers--ity of New Hampshire, U.S.A. . Throughout this period I have also been preceptor for either National or Regional trainees, as well as being involved in other, less formal types of training. In working with students and trainee managers I became interested in the differences between the approaches in the two countries. More specifically, my imagination was caught by the idea that N.H.S. training had been able to rely for many years on a common vocabulary relating to manage--ment structures which general management was now rapidly breaking down. If what is now called Griffiths 1 was to fulfil its purpose, perhaps the N.H.S. would acquire some of the diversity of the U.S. system.I knew from a previous study trip to Sweden that visiting another health care system has a surprisingly profound effect upon one's understanding of ones own system, but a management training perspective would give my visit direction and concentration. In any case receiving transatlantic telephone calls for five years without being able to visualise their origin or originator produces its own curiosity and I was keen to meet Dick Lewis, the Professor who organi--ses the U.N.H., and the University.

Having picked the theme for my visit, my intention was speci--fically to zone in on the organisation of the practicum; its prepara--tion and monitoring. I also hoped to be able to gain a better unders--tanding of the links between the U.N.H. course in Health Management and Policy and the local health service environment. Although the G.M.T.S. 1 course is a formal management training rather than a course for undergraduates, I intended to use my experience of it to provide contrasts with what I found in the U.S.. I was especially fortunate in that Julie Wratten, the G.M.T.S. 1 trainee to whom I am currently mentor, was able to spend her elective in an amended U.N.H. practicum. Julie had already spent 2 months in the U.S. when I arrived and I found discussions with her invaluable in ensuring that I bore in mind the perspective of someone who had experienced both systems.

My trip was made possible by the generous grants made by the King's Fund and the Special Trustees of Westminster and Roehampton Hospitals. The latter grant enabled me to attend the New England Health Assembly held in Boston. This report is not intended to be an academic study but is rather a pragmatic view by a practitioner. Nevertheless, 1 hope it will be of interest as an account of a study visit which has certainly benefited me as a trainer - and provided that unlikely combination of an intellectually challenging and person--ally very pleasurable experience.

## 2 Background

It is easy to emphasise system differences between the U.S. and G.B. health care industries which may then be considered to be the implicit basis of differences between training approaches in the two countries. There are also many contrasts between the educa--tional systems in the two countries which may be used in a similar way. More fundamentally, however, the contrasts are a result of basic differences in the philosophy adopted by society in each case. Thus in the U.S. the needs of the individual have been seen as pre-eminent, whereas in G.B. an inconsistent, but possibly pragmatic, melange of individualism and socialism co-existed as the basis for society's consensus until 1979.

A particular problem in describing the U.S. health care industry is that it does not easily accept the label of a system as appropiate. Very early in my visit to U.N.H. Dick Lewis, the Profe--ssor responsible for the organisation of the internships it was my primary interest to study, made clear that no answer to a question about the U.S. health care system would receive a clear "Yes" or unequivocal "No".

"So Medicaid is the safety net to provide health care for the poor?"

'Well, Yes, but Medicaid does not provide health care for all poor people- some do not qualify, and each State defines the poverty level at which Medicaid is appropriate. Medicare also provides some care for the indigent and even with these programmes hospitals still provide uncompensated care for the indigent.'

In this diversity and confusion lies the origin of my interest in looking at management training in the U.S.. Management training in G.B. has always had a common N.H.S. structure as a basic plank for orientation for management trainees. Every District prior to the implementation of the 1983 Griffiths Report had the same senior management team and Authority structure. There was always diversity between Districts but within a clearly defined proforma. U.S. managem--ent training programmes, or educational courses, have not had this advantage and have to cope with a far higher diversity than exists in the N.H.S., which provides some 95% of health care in the country. In the month prior to my study trip the media in G.B. devoted conside--rable efforts to describing and analysing the financial crisis in the N.H.S.. I believe there to be consensus that there is a crisis, but none regarding the solution or solutions. However, the Prime Minister is even now reviewing the N.H.S. with the intention of provi--ding a solution. My belief is that virtually any action she undertak--es over and above a cosmetic holding operation will dramatically increase diversity in the N.H.S.. Barbara Young, a senior N.H.S. manager, has expressed the view that the Prime Ministerial review will be like human life in mediaeval times; "Nasty, brutal and short." We may both be right, and as the N.H.S. becomes at the same time less dominant and less monolithic, British approaches to training have much to learn from the American experience.

Going from the 'Old World' to the 'New World' to look at the most 'advanced' and certainly the most expensive health care system in the world, I was unprepared for the constant reminders of history which were a feature of my visit to New England. I arrived on St. Patrick's Day - assuming that the origin of it being such an important cause for celebration in Boston and New England was the large number of Irish Immigrants. It took me some days to realise that St. Patricks Day was the day that the British were forced, uncer--emoniously, to evacuate Boston following the eruption of the Revolut--ion in 1776. My visit was based on the University of New Hampshire, located in the State ( motto 'Live Free, or Die') which was the first to declare independence. The emphasis on democracy which was at the heart of the Revolution has resulted today in active mechanisms for local democracy. New Hampshire has the largest State legislature in the U.S. in relation to population. Lengthy town meetings are a feature of N.H. life. In Durham, where U.N.H. is located, towm meetings for this 6000 population small town often go on until midnig--ht - Durham was the location for hiding gunpowder for the opening of the Revolutionary War. The N.H. Primary is an important early stage of the U.S. presidential election machinery - I heard that one elector from N.H. said 'I haven't decided between the candidates yet - I've only met them once.' (!). This emphasis on individualism and discussion is very much an important part of the New England scene which was clearly reflected in my visit. Fortunately, the origi--nal anti-British feelings have long since disappeared.

The persistence of the local democratic tradition of discussion may be a particular New England phenomenon, but the emphasis on individua--lism is very much a central plank for the U.S. approach to health care as well as society in general. The primacy of the wishes of the individual rather than the community as a whole is the driving force behind the demand-led approach in the U.S., with the Federal Government and other parts of the government scene, controlling exces--ses indirectly and frequently in a self-conscious and inconsistent way.

Having been a preceptor for interns from U.N.H. for the last five years, the natural focus for my study visit was the university. U.N.H. is a 'land grant' university - a state university - started in 1866. Its 188 acre campus and 10000 students totally dominate the small town of Durham. Its large size is unusual by English standa--rds, as is the fact that it is surrounded by nearly 4000 acres of U.N.H. owned woods, fields and farms. Features more immediately notic--eable to the English eye, however, are the way that university build--ings are often within feet of trees of forest dimensions and there are frequent attractive outcrops of granite in what is , afterall, called the 'Granite State'.

The U.S. educational system makes a first degree a far broader educat--ional experience than is usual in England. Students are required to take general courses so that the first degree lays the foundation for a specialisation, whereas in England it is much more common to provide a sharp focus on a subject, together with an emphasis on thinking and studying techniques. Perhaps not surprisingly in a socie--ty where employment is even more of a key than in England, U.N.H. is anxious to build bridges so as to ease the way of students into employment in the future. Having taken such a general first degree many students go on to take a masters programme, possibly after a few years work experience, or go on to acquire a professional educati--on - for example, in the law. As a reflection of the importance of the 'real world' to students, even in a State like N.H. where employment is high, U.N.H. has a programme termed 'U.N.H. Field Exper--ience'. This involves more than 400 students in over 40 majors each

year. Students are placed in appropriate positions and are supervised by faculty sponsors. Many majors have work experience or internship either as a requirement or as an elective. Interestingly, even the Fine Arts major has a practicum programme - one of whose internships is to a dental prosthetics laboratory.

4 Department of Health Management and Policy

U.N.H. is organised into 6 colleges and schools, one of which is the School of Health Studies. In addition to health manageme--nt and policy this school includes nursing, communication disorders, occupational therapy, physical education and perhaps curiously, leisu--re management and tourism. Field experiences are a part of each curriculum in this school.

Part of the School for Health Studies, the Department of Health Management and Policy (H.M.P.) was started in 1975 as the Department of Health Administration and Planning. Its graduates are now employed in various aspects of the health field across the U.S., with most graduates having remained in New England. The Department is a full member of the Association of University Programs in Health Administration ( A.U.P.H.A. ), which is a North American consortium of 143 graduate and undergraduate academic programmes at 132 colleges and universities. Full membership is only gained through an external review of curriculum and faculty and the Department is 1 of only 20 of the more than 700 undergraduate programmes in the U.S. to have achieved this status.

The major programme offered by H.M.P. is a 4 year B.Sc. course. The curriculum involves generic ( ie not health specific) coursework in administration, selected social sciences, courses in health management, and a 16 week field internship. In addition to the main programmes offered, the faculty periodically offer contin--uing education seminars and short courses for current health profess--ionals many of whom regularly need to aquire continuing education credits to maintain their licensure or the accreditation of their facility. The Department, therefore, attempts to maintain close relat--ions with practitioners partly to facilitate internship sites and to assist graduates in 'networking' to achieve their first jobs but also for marketing reasons. I was fortunate whilst at U.N.H. to attend a Faculty meeting where one of the subjects under discussion was a graduate programme which is being developed. The content of the course had already been determined but the location ( U.N.H. has a campus in Manchester,N.H. ) and the timing of the part-time progra--mme were discussed carefully. The role of Dick Lewis as the practic--um instructor who had during March visited over 30 internship sites in New England was of key importance. Whilst visiting internship sites with Professor Lewis, I noticed how he used the opportunity, not only to deal with the overt agenda of assessing the intern and practicum, but also used it as an opportunity to keep in touch with alumni and preceptors as a potential market for additional courses in general and the masters programme in particular.

At U.N.H. I was able to have a number of detailed discussions with Dick Lewis, and also John Seavey, the Chairperson of the H.M.P. Depar--tment. I met the remaining members of the Faculty at the Faculty meeting mentioned above. I was also able to meet the Dean of the School, Roger Ritvo. I was allowed to sit in on a variety of classes in order to gain a better understanding of the way the U.N.H.programme works.

I sat in on H.M.P. 401, U.S. Health Care Systems, a course mainly attended by freshman students who will not necessarily major in H.M.P.. The particular class I attended was dealing with current issues in health care, the role of Medicare and Medicaid and the emergence of health maintenance organisations. I also sat in on a class designed primarily for sophomores, H.M.P. 501 Epidemiology and Community Medicine, both in the classroom and the computer labora--tory.The former was dealing with controlled trials and the latter with probability factors in a food poisoning outbreak.

I attended a course for senior students, the Strategic Management H.M.P. 742 Course. This is what is termed a 'cap-stone' course which

requires the students to draw on all of the courses they have attended up to that point. Most of the course is structured to comprise studen--ts working in groups and presenting their projects which are based on the mythical town of 'Lewisville'. One of the differences between the taining in G.B. and the U.S. which struck me many times was the way that the very diversity of the U.S. health care system and , in particular its enormous overhead of monitoring and third party providers, reduces the overwhelming significance in G.B. of direct health care delivery as a career. This was reflected in the breadth of projects which student groups undertake in the Strategic Manageme--nt course:

Nursing Home Management ( ie long term care )
Insurance Product Development ( eg health maintenance organ--isations, preferred provider organisations )
Health Care Advertising
Human Resources Management
Public/Governmental Affairs
Business Health/ Managed Systems

The evening I attended was atypical. I was asked to speak on issues affecting the N.H.S., which I did for 15-20 minutes, and then faced a barrage of questions for a further 20-25 minutes - a level of interest which I believe reflects the anxieties of Americans about the direction of their own system, and other possibilities, rather than the intrinsic fascination of my own presentation. The session then continued with a discussion of the course so far, in which it became apparent that some of the students felt that the professors had far higher expectations of them than had been set so far in the course and felt that they had been left unprepared for the change of gear of resultant increased pressure at a time when the final grade of their degree would be sensitive to the professors tougher approach. Professor Seidel completed the evening with a discussion on issues in marketing. The course is run jointly by professors Seidel and Seavey.

Finally I attended a class in Cost Accounting run by Dick Lewis for part time students. This particular class was dealing with proble--ms of assessing fixed and variable costs and then deriving pricing decisions.

5 Practicum Organisation

It can be seen from the above sections that attachments to gain experience in the field are both an important emphasis within U.N.H. as a whole, and within the School of Health Studies in particu--lar. Within the H.M.P. programme, the practicum is seen by faculty as a key stage in the development of students. Prior to the practicum, the requirements of the university mean that students undertake a wide range of courses and will have only taken a relatively small number of specific health subject courses. Following the practicum, the H.M.P. courses are deliberately more advanced and faculty expecta--tions of the students rise markedly.

The general courses undertaken by students before the practic--um are, however, seen as an important foundation. Thus courses in English are seen as a foundation for the development of technical writing skills, and courses in organisational behaviour, economics, accounting and statistics will provide a theoretical framework for experiences on the practicum. The H.M.P. courses will also give the student a basic vocabulary and theoretical reference points to prepare them for what can be a rather bracing transition from the academic environment to that of the health care industry.

Inevitably, comparisons in this paper between the English and American systems of university education must be subjective, and in terms of my own experience of the English university system potentially 15 years out of date! However, I was also able to discuss comparisons with Julie Wratten who, as I have mentioned, was undertak--ing a modified internship at the time of my visit. As a Law graduate of only 2 years ago, her confirmation of my impressions was helpful. A marked impression which is relevant to the practicum is the careful attention given by the H.M.P. department - possibly as part of U.N.H. policy - to written guidance for students. I was able to obtain course descriptions for the majority of courses run by the Department and was struck by the highly structured approach. A case in point was the written work expected of students, where commonly the detailed structure and approach required in the paper are set out for students. In some ways this may be a reflection of a contrast between the U.S. and G.B. ways of working in general. On my visits to U.S. facilities it was clear that it is common practice to have comprehensive sets of job structures and procedures in a way that does not exist in the more pragmatic institutions of my G.B. experience. Often, in health care in the U.S., the documentation is needed in order to gain and retain accreditation and again is a reflection of the U.S. approach of encouraging individualism and diversity but then using accreditation mechanisms to ensure some consistency. Given this cultu--re, it was not surprising to find that there is comprehensive docume--ntation for the practicum, and a clear structure for its control and evaluation.

In the H.M.P. major, the junior year (ie 3rd) is dominated by the practicum experience. The pre-practicum seminar ( H.M.P. 621) is held during the Fall Term and the practicum itself takes the whole of the Spring Term (H.M.P. 622 ). The practicum itself merits 16 credits as it takes an entire semester, whereas the pre-practicum seminar is taken with other courses and awards 2 credits.

The aim of the pre-practicum seminar, H.M.P. 621, are to ensure that students enter the practicum in a position to gain the maximum benefit from it. This is especially important as it has been found that the most successful model for the practicum is a total commitment to work for the 16 weeks of the semester. As a matter of deliberate policy the support for the student is at arms length so that the student is seen as being there full time and as part of the organisation.

H.M.P. 621, therefore, aims to prepare the students for

the transition from the familiar classroom environment to the workpla-ce. The aims are listed as to enable students to:

a) understand how the practicum fits into the course as a whole
b) to match the interests of students to the most appropria-te internship
c) to understand the link between theory and practice
d) to increase personal competencies
e) to understand basic concepts of financial management, terminology and statistical analysis.

The pre-practicum seminar and practicum are seen by the H.M.P. Department as an integrated learning process, with a Guided Learning Manual ( G.L.M. ) issued to students which is an important aid in both stages. The G.L.M. is a 135 page document which details procedur-al matters with regard to the practicum, together with a good deal of practical advice. It includes a description of the main types of facilities in which practicums may be based, to assist students in choosing. The choice by the student regarding the type of practicum is of key importance as the interns often obtain their first post at the site of their practicum. The U.S. system is so diverse that changing from the management of long stay facilities to acute hospital management, or from a third party provider is by no means easy.

The processes adopted in H.M.P. 621 are as follows:

a) to assess individually with students their goals
b) to develop student skills ( eg in interviewing )
c) to prepare a professional resume ( c.v. )
d) to understand the relevance of the practicum
e) to understand the expectations of H.M.P.

Thus the intention is to heighten the self awareness of students and start the process of clarifying with them the kind of job they wish to have after graduation. By spending some time on practical issues such as how to take the minutes of meetings, time management, the complexities of financial management and so on, the potentially difficult transition to work is eased. Finally, the work on preparing a resume and the process whereby students are 'interviewed' for the practicum develops practical skills which will assist students in gaining jobs in the future. The H.M.P. expectations of the students are that they should be conscious of the pressures on their preceptors, that they should see themselves as representatives of U.N.H., and that they should return prepared for work at a more advanced level.

The objectives of the practicum itself are that the student, on completion of the internship, should be able to:

a) describe, analyse and interpret the relationship of health management theories to the practical setting
b) understand and be able to analyse the impact that outside forces have on the institution. This includes such things as federal regulation changes, local economic problems, state agencies, etc
c) apply, at an elementary level, skills of health management to the tasks that they are assigned to perform
d) understand and be able to work with the administrative strategies for the delivery of health services in total. This includes understanding the interaction, cooperation, and competition between all the providers in the market
e) investigate, in depth, a specific problem or problems, recommend alternative courses of action, or undertake a significant project which also requires utilisation of decision-making skills and , to the extent possible,

participate in the implementation of the desired course of action.

In order to achieve these objectives, the practicum is required to have some structure although this is a general format which has to be applicable to the wide range of organisations on which practicu--ms are based. The intention of providing a structure is to ensure some uniformity of experience, to stop instant specialisation, with the student zoning in too early onto a particular department within the organisation, and to provide some means of measurement by requiri--ng some common tasks and papers.

a) the student should receive an orientation to every depar--tment, both clinical and non-clinical ( 3-5 weeks ).
b) the student should perioodically meet with his or her preceptor (initially not less than once a week )
c) the student should be allowed to sit in on as many commi--ttees and other meetings as possible
d) in the mid third of the practicum, the student should be gaining in depth exposure to the administrative depar--tments of the facility
e) in the last third of the practicum, the student should be gaining some kind of specialisation of experience.

During the practicum the student is expected to work a 40 hour week and to undertake assessments required by U.N.H. outside working hours. The student has 3 written assignments to complete:

a) Agency Assignmement
Due at the end of the orientation period, this is a descriptive account of the institution and how it intera--cts with its environment
b) Journal
This is handwritten (all other U.N.H. papers must be typewritten ) made daily, with weekly summaries
c) Project(s)
The student has to submit copies of any project undertaken, with appropriate explanation.

The grading of the practicum reflects the importance of these assignments. The agency assessment and daily journal are the basis for the Field Practicum Organisational Analysis ( H.M.P. 622a ) which merits 4 credits. Project work, as important work experience is given a particular emphasis and merits 8 credits as H.M.P. 622c., Field Practicum Project Analysis. Finally, the assessment of the Practicum Supervisor and Preceptor is taken into account in H.M.P. 622b, the Field Practicum Management Skills Development ( 4 credits ). This assesses the level of development of students in the areas of communi--cation, human relations and the management of time and resources. The importance of the roles of the Practicum Supervisor and Preceptor is explained below.

The role of Practicum Supervisor is performed by Dick Lewis. Dick is an Assistant Professor in the faculty. He joined the Departme--nt in 1982 following a career as a hospital administrator in the U.S.A.F.. His specialty within the faculty is financial management. Each year he arranges practicums for approximately 35 students. in order to do this he has to maintain a wide range of contacts in the health care industry in New England. This network provides the basis of the kind of network students will need to develop when they gradua--te in order to gain promotion. It also provides a wide range of internships which can be matched to student interests and future

career hopes. I visited a number of internship sites and will describe them below, however, it should be noted at this point that they are very varied. The structure of the practicum and its written assignmen--ts are deliberately formulated so as to be applicable to a wide range of health care facilities. The learning and experience provided by these facilities is also very disparate so the assignments concent--rate on general themes and disciplines which can be applied by the intern to the facility.

Between the fifth and ninth weeks of the sixteen week practicum, all students will receive an on site visit from Dick Lewis. These vi--sits usually last about 2 hours and allow for an open exchange between Dick Lewis and the student about the positive and negative aspects of the internship. Dick also sees the preceptor alone on the visit. I was fortunate in being able to accompany Dick on 5 of his visits and saw a wide range of facilities - listed in the section below.

The visits serve the vital function of providing the practic--um supervisor with the opportunity to assess initial progress and competencies of students and to provide an input into the areas to be pursued in the latter part of the practicum experience. a normal part of the visit would be a tour of the facility provided by the intern, during which Dick was able to assess how comfortable the student was as well as how much knowledge and experience he or she had gained.

The role of Dick Lewis provides a major contrast with my experience of English training programmes. I have been visited by training staff from Region or the King's Fund with regard to trainees, and this seems a standard part of the English as well as the American approach. Often the format also seems very similar, with joint and individual discussions and tour by the trainee. However, the role of Dick Lewis differs markedly in scale and additional objectives. Whilst trainers at Region and the King's Fund no doubt gain networki--ng and 'real world' briefing during visits, Dick Lewis emphasises far more the marketing opportunities of his visits, both in terms of keeping practitioners aware of H.M.P. courses and keeping in touch with alumni. These issues are explained in more detail in a later section. In addition, the sheer scale of Dick Lewis' operati--on dwarfs my experience of English training systems. The English trainers I have encountered seem to handle no more than a handful of trainees at a time so that the opportunities for networking and marketing are significantly reduced. Dick Lewis in keeping control of 35 interns is dealing with something like two thirds of the annual intake of G.M.T.S. 1 in England and Wales and yet is incomparably more visible than the Regional, education centre trainers or than the national coordinator of G.M.T.S.-George Kempton. There are no doubt many reasons for this difference. These include the fact that George Kempton is dealing with employed trainees, mainly graduates who may be more independent, he is handling a larger intake at appro--ximately 50 per year, the national nature of the scheme means that the different educational centres are contracted for the theoretical and educational input, the financing of the programme gives Regions a role ( which is sometimes uncertain ), and probably most significa--ntly, he is dealing with 3 cohorts at a time - those being recruited, those in Year 1, and those in Year 2. Nevertheless, there is little evidence that he, or anyone else, has a clear 'building bridges' role in the way that Dick Lewis has in faculty. Whatever the reasons for the differences, undoubtedly major benefits accrue from having one practicum supervisor who controls, and visits such a substantial number of interns and their preceptors. The network of preceptors and the way they are linked into the system are described below.

In 1988 there were 35 preceptors, of whom 2 were in England (myself and Caroline Fowles at Kingston Hospital ), 1 in Switzerland

( a one-off because of a students family connection ), and the remaining 32 in New England. Although the majority were in New Hampshire, a significant number were in Maine and Massachusetts. Looking at the list in total 16 were hospitals, 4 were nursing homes ( which embraces long stay hospitals in N.H.S. terminology ) and the remaining 15 were a very varied mix, including H.M.O.s, government agencies. clinics and insurance companies. Even the hospitals and nursing homes were very varied and included state run, not for profit, and profit making, as well as a U.S.A.F. hospital as a tribute to Dick Lewis' former career.

Dick Lewis provides each preceptor with a 'Preceptors Guide' which sets out the objectives and format of the practicum. It also explains the overall organisation of the H.M.P. major so that precep--tors can understand the background of the intern, Preceptors are also asked to an annual seminar for preceptors at U.N.H. which gives an opportunity to exchange experiences.

Preceptors are encouraged to meet interns regularly - initially not less than once per week and interns are asked to show preceptors their agency assignment although not their daily journal. Clearly, preceptors will see the projects prepared by interns, which are intended to be meaningful work exercises. As previously noted, Dick Lewis visits each ( U.S.) practicum site and will have a private session with each preceptor. At the end of the practicum, preceptors are asked to complete an evaluation of the student. This evaluation is intended to assess the abilities and skills of students and their growth during the practicum. The evaluation falls under the following headings:

a) Intellectual Abilities
b) Initiative and Responsibility
c) Assessment Skills
d) Interpersonal Skills
e) Communication Skills
f) Attitude
g) Job Potential
h) Recommended Grade

Following my study trip I now understand the key significance given to g) Job Potential. The aim of the H.M.P. Department is to produce graduates who have been prepared effectively for an entry level post in the health care industry. the practicum is seen as a critical stage in this process - and the practical, market-orienta--ted view of the preceptor is a key indicator of potential success.

At the end of the practicum, interns ( with the exception normally of the overseas interns ) return to U.N.H. to undertake a de-briefing day, which ends with an examination paper designed to test their knowledge of the organisation to which they have been attached. This paper covers basically the ground of the agency asses--sment but checks whether they have actually absorbed the important dynamics of the organisation. When the students return in the Fall, the courses are more advanced, and the Faculty expectations of the students much higher now that the student is deemed to have gained experience in the field, and added maturity.

6. Practicum Visits

The timing of my visit was dictated partly by the weather - I was told that in January and February it can be appalling - and partly by the New England Health Assembly, which is the venue for the annual U.N.H. H.M.P.alumni gathering. I was able to visit 5 practicum sites with Dick Lewis. At each site I met the intern and the preceptor and was given a tour of the facility.

Exeter Hospital was the practicum site for a U.N.H. intern but had also been the practicum site for Julie Wratten. It is a 100 bed acute community hospital. Exeter Hospital is 'not for profit' although it did make a profit of $3M last year - clearly this profit must be invested in the enterprise rather than paid out to shareholders. Despite the fact that Boston was only 1½ hours drive away, and must have one of the largest concentrations of health care facilities in the world, Exeter Hospital is superbly well equipped. Its facilities included a gamma camera, cardiac catheterisation laboratory, and C.T. scanner. N.M.R. ( M.R.I.) and lithotripsy were available as a weekly mobile service. Queen Mary's as a 430 bed D.G.H. with a number of specialist regional units and teaching obligations to medical students amongst others can only boast a gamma camera aquired in the last year out of this list of facilities. I was struck by the high involvement of volunteers in Exeter, as well as its bright, modern and efficient image., I was also startled by the heavy investment in utilisation review and D.R.G. costing staff, the latter being qualified to degree level in their subject.

Rockingham County Nursing Home, N.H., is a 290 bed long stay hospital - mainly for geriatric patients. This was very much the U.S. safety net in operation. The county nursing home is in the same complex as the county farm and the county jail. Prisoners from the latter help in the nursing home, for example in the kitchens. I was relieved to see that they no longer wear striped uniforms. Although the administrator was proud of what he felt was a 'progressive facility' which had access to services and equipment which many others did not, I was surprised at the out dated approach in a number of areas. The nursing home still uses cotton 'diapers' for patients and is so emphatically moving away from disposables as to still be installing new autoclaves on the wards - clearly no central sterile supply was in operation. The nursing home ran its own free-standing store, with no central purchasing organisation, and its own laundry - which appeared not to have the kind of special treatment facilities for foul or infected linen which is mandatory in G.B.. Most surprising of all, the bed pan washers on the ward did not incorporate sterilisation, and foul linen was sluiced on the ward and put through a mangle - a practice I believe disappeared from even the most obscure N.H.S. hospital at least 15 years ago.

The training of nursing home administrators is entirely separate from that of acute hospital administrators. It is very practically orientated and 'hands on' experience is considered of supreme importance. The administrator I met undertakes daily rounds and was proud of his attention to the paperwork in patients medical records. It is probably an unfair comment as well as an unfair sample, but all the trained nurses I saw on our tour of the wards seemed to be undertaking paperwork, with the exception of the one I saw admiring a new autoclave!

Ninety five per cent of the patients in the nursing home were Medicaid patients, with only five percent paying. It was explained to me that the New Hampshire State defined the poverty level as $2500 which meant that if patients accumulated more than this they had to 'spend down' until they were eligible for Medicaid again. But despite the outmoded practices and frequent smell of faeces on the wards, the patients at least seemed happy and well cared

for.

Healthsource, New Hampshire, is an H.M.O. which was started only 2½ years ago and is growing fast. The preceptor is an alumni of the H.M.P. programme at U.N.H. and we met 4 other alumni in a young and female dominated 90 strong staff. Of the total staff, 5 are computer programmers - which reflects how critical an effective computer system is to such a company. There are 2 basic types of H.M.O.; one where the physicians are employed and the H.M.O. owns the facilities from which they work. The other is an 'independent practitioners association' (I.P.A.) which consists of a pool of doctors who work together and no facilities are owned. The capitalisation is thus relatively modest and growth can be very fast. Healthsource are of the latter type, with 20,000 subscribers (45,000 members in all, including families ). H.M.O.s tend to be organised on a state basis as so many of the regulat--ions within which they operate are determined on a state level. H.M.O.s have been boosted both by cocerns about escalating costs of health care and also, more cynically, by an overprovision of physicians. They operate in a highly competitive environment and a Blue Cross/Blue Shield H.M.O. in New Hampshire went bankrupt in 1987.

Region 1 of the U.S. Public Health Service is located in the J.F. Kennedy building , a skyscraper in downtown Boston. The Federal Government does not provide health services directly for the population in general, but has a role in providing a disease monitoring and control service together with other centrally determined but locally executed policies relating to priority areas such as maternity and child health, migrant workers, the homeless, deployment of physicians to deprived areas - and now A.I.D.S..

Under the 8 years of Reagan government the Region, which embraces the 13-14M people in New England, has seen its staff reduce from 150 to 50 as Federal functions are progressively passed to the state governm--ents to implement. The perception, not only of the Federal employees I met, but also of other people I spoke to in New England, is that Federal health programmes have taken disproportionate cuts because of the budget protection given to defence. Although I saw no relevant statistics, the allegation was that health statistics were showing a deterioration as a result of this policy, for example, child health statistics.

I visited the information section in Brigham and Womens Hospital, an 800 bed Boston teaching hospital. This hospital is part of an enormo--us complex of teaching hospitals close to Boston's poor inner city area. This hospital boasts 400 departments and a sophisticated informat--ion system. Most memorable was a new entrance hall which would not have disgraced a new airport terminal, and an example of the importance of voluntary donations whereby a plaque dedicated a lift lobby to the memory of a benefactor. As a an inner city teaching hospital, a signifi--cant proportion of the patients were indigent, but there was little evidence of what the N.H.S. would consider to be resource constraint.

7. Alumni

One of my personal objectives in visiting the U.S. was to keep in touch with my own alumni, that is the U.N.H. students who have been interns with me. Following a week of visits to practicum sites and sitting in on classes at U.N.H., I was able to attend the New England Health Assembly in Boston. Not only did this enable me to attend lectu--res and seminars on issues of current concern in the U.S. but I was also able to attend the annual U.N.H. H.M.P. alumni gathering at the Assembly, which is held in association with the Assembly.

This gathering is one of a number of mechanisms U.N.H. uses for keeping in touch with alumni. Others include the practicum visits undertaken by Dick Lewis, an alumni newsletter and occasional free courses offered by the faculty. The objectives of this effort seem to lie in the key importance of the faculty staying in contact with the health care industry in New England. This is partly no doubt in order to retain a state of the art knowledge of the practicalities of their subject, but probably more critically to assist the senior U.N.H. students in 'networking' and also to enable the faculty to market their own products - for example the impending masters programme. ' 'Networking', that is making contacts in the hope of obtaining job opportunities, is even more important than in England. The basis for this is almost certainly the diffuse and decentralised nature of U.S. health care - whereas in England the monopolistic structure of the N.H.S. aids the job search, particularly in urban areas.

I was fortunate in meeting at the alumni gathering, all of my own alumni. Stephen Cairns was the first (1984). He works for Blue Cross/Blue Shield of Massachusetts and is currently working on a major new computerisation project although he hopes to leave soon to join a consultancy firm. Jane Pitcher (1985) also works for the same 'not for profit' health insurance company but works in the section which provides management information for major companies which subscribe to their plans. She hopes to start a masters course in Public Health in the Fall. Jeanette Clark (1986) now works for a health employment agency, and finally Allison York (1987) is a senior student, who hopes to go on to study law. Jill Bradley (1988). was, of course, in the middle of her practicum in England.

To an English eye, the lack of alumni undertaking basic hospital management is surprising, particularly at such an early stage in their careers. To a certain extent this is not a random group in that those students wishing to ensure a smooth path into hospital or other health care institutional post would tend to have their practicum at a New England site. However, the Association of University Programs in Health Administration (A.U.P.H.A.) 1985 survey of H.M.P. graduates from U.N.H. showed that the largest number of graduates found employment in H.M.O.s followed by hospitals and ambulatory care clinics. Some students elect to go direct to graduate school in areas of study such as public health health economics or law.

## 8. New England Health Care Environment

Boston is a very important conference centre in the U.S. so it was appropriate that I was able to time my visit so that I could attend the New England Health Care Assembly which was held between 27th March and 1st April. The Assembly was held in the massive John B. Hynes Memor--ial Convention Center - which was still under construction. The Assemb--ly followed a familiar format in having open lectures and exhibition stands, but was less so in its large size and the wide range of produc--ts exhibited. Another unfamiliar feature was the significant part played in the Assembly by seminars held at an additional charge, at which attendance counted for continuing education credits for those administrators and others who need to acquire credits in order to maint--ain licensure or to keep their organisation's accreditation. My aim in attending was to familiarise myself further with some of the current concerns in U.S. health care.

### William L. Kissick: D.R.G.'s and Health Care Rationing in the 21st Century

It is not exagerating to suggest that the concept of D.R.G.'s has dominated U.S. health care in the 1980's. They were developed by John D. Thompson of Yale, and the lecture I attended was dedicated to him. Dr Kissick pointed out that, although the American medical profession had opposed President Johnson's Medicare and Medicaid legis--lation, a significant result had been to take the average physician's salary to four times the national average, compared with twice the national average in 1965. Over the same period, health care expenditure has risen from 6.2% of G.N.P. to 11.2% in 1987. In this environment D.R.G.'s were seized on by Congress as a way to control health care costs and the cosy retrospective payment system has now been moved to a prospective payments system.

The introduction of D.R.G.'s has had an enormous impact on a health care system based on principles of 'free choice,fee for service, and solo practice'. Although health care costs are still spiralling upwards, the health care industry is feeling itself in a much more competitive environment than ever before. However, Dr Kissick quoted the aphorism 'the hand of the American health care market is all thumbs' to exprees some scepticism about the application of 'pure' economics to health care. Nevertheless the pressure on the industry is reflected in frequent corporate restructuring and the development of different ways of organising, such as H.M.O.s; where physicians may be directly employed.

Dr Kissick noted that rationing is an alien concept to Americans but suggested that although the N.H.S. has rationing 'up front', in the U.S. it is achieved by ignoring equity for 30M Americans. He saw a reduction in emphasis on D.R.G.s in the future and an increasing trend towards capitation payments.

### John Nunelly: Case Based Budgeting

This seminar was put forward as being on the 'leading edge' of budgeting development. John Nunelly saw a development from fixed budgets which did not reflect volume, to flexible budgets and finally to case based budgets. Such a system would reflect case mix and would be highly dependent on computing and detailed costing. He suggested that case based budgeting had to be founded on a 'product line approach'- an alien concept to someone from the N.H.S.! He saw the acute sector as a 'mature product line' where the annual rise in bed days had finally stopped, so that additional profit could only be gained by containing costs and looking for new product lines. Interestingly, he compared a hospital to a car repair shop where case costs are difficult to predi--ct, in contrast to a factory production line where costs were much more predictable.

The key to case based budgeting is predicting case mix - with the answer to this problem being to but a computer package sold by Mr Nunel--ly's firm! It was quite clear, however, that implementing C.B.B. would force hospitals to define procedures and protocols, in a system where the emphasis on choice has already led to an enormous overhead in utili--sation review staff and accreditation agencies. C.B.B. also raises the issue of accountabl ity; if a projected product mix does not material--ise, then who could be held accountable when the physician was not employed by the hospital. This is a familiar problem in the N.H.S. but is even more florid in the U.S., where the hospital is seen as the ' physicians workshop'.

Dr Martin D. Merry: Practical Approaches for Implementing Outcome Orientated Quality Assessment in Your Hospital

Quality Assurance is burgeoning in the U.S., this seems to be partly a result of the competitive environment, and also somewhat curiously, the rising costs of health care increase the pressure to improve qualit--y. Dr Merry pointed out that physicians were unhappy ( 'mad as hell') about the increasing scrutiny under which their practice was placed and that traditional, cosmetic, peer group reviews will no longer be adequate in the future. Where medical peer group review has concentr--ated on individual cases it has always been easy to explain away probl--ems by suggesting an unusual case load. Dr Merry noted that as large employers become more concerned about health care costs they are applyi-ng industrial Q.A. analysis to health care and are finding little evide--nce of abnormal case mixes explaining differences in behaviour by physicians. Industry is , therefore, applying an outcome orientated approach rather than one which is process orientated and in which there is frequently a lack of clarity about clinical outcomes.

## 9. General Management Training Scheme

I have been a preceptor ( or mentor, the terminology changes ) for various types of National Health Service management training scheme over the last 5 years. Before that I was frequently a part of the train--ing programme of these young managers in training. I am currently the mentor for Julie Wratten, a G.M.T.S. 1 trainee who was in the U.S. on a 4 month elective during the period I was able to visit New England. G.M.T.S. 1 is an elitist management training scheme which sets out to recruit recent graduates and young people who have some experience in the N.H.S., who are believed to have the potential to rise to the most senior N.H.S. management positions. It is a scheme which is intend--ed to be the first in a series of training programmes for aspiring general managers, although acceptance on the scheme does not guarantee progression to G.M.T.S. 2 or 3 , the latter being the immediately pre-U.G.M. programme.

The majority of G.M.T.S. 1 recruits are graduates and the scheme lasts 22 months, of which 12 months is spent gaining practical experien--ce in an accredited junior management post under the supervision of a specially selected senior manager. During the scheme formal training courses are held in one of a number of academic centres in the country. So there are many contrsats with the U.S. system which I examined. The trainees are older and more experienced, but arrive with much less preparation than the U.N.H. students. The emphasis of the G.M.T.S. scheme is to attach trainees to a particular District in order to obvia--te problems with previous schemes whose peripatetic nature often incre--ased stress and and disorientation of trainees. In addition to the formal training input and work experience, the scheme aims to provide a comprehensive orientation to the N.H.S. - which as the recruitment brochure points out is the largest employer in Europe with a total budget which dwarfs many commercial enterprises. As a recent Sunday Times article made clear Roy Griffiths ( now Sir...) reported on an organisation of which any of the 13 English Regions would on turnover make the list of Britains top 30 companies. Sainsburys at the time was 23rd on that list. THis comprhensive understanding of the N.H.S. is plainly not at a profound level, but has under previous training schemes provided such an effective common language and network for trainees as to be accused by some people as being a Mafia. The national structure and jargon of the N.H.S. has made this orientation of traine--es a relatively straightforward task. The N.H.S. is a long way from the disparate confusion of the U.S. system, which Dick Lewis described to me as being like an eco-system where links between parts are not always clear, but if one part of the system is changed the ramifications tend to be very wide ranging. However, the days of the monolithic N.H.S. where the job titles of senior officers in all 200 Districts were the same are now over. Whilst tight central controls are still being mainta--ined on many, semmingly peripheral, parts of the managerial scene there can be no doubt that G.M.T.S. is going to have to provide a very robust programme for trainees in the future. The firm attachment of the trainee to one District is in many ways of assistance in this proce--ss in providing a firm anchorage whilst the trainees gain experience and make that key transition - rcognised clearly by U.N.H. - from the educational scene to working life and attitudes. However, the U.N.H. experience shows, in my view, the need for the overrall system's divers--ity to be handled carefully by some central organisation in the traini--ng scheme. In the same way that U.N.H. makes the practicum an experien--ce which can take place in a hospital, long stay nursing home, or insurance company, educational organisations such as the Kings Fund and Warwick University which are involved in G.M.T.S. 1 will need to ensure that the education/training they provide can cope easily with Districts which are rapidly dispersing from the relatively tight cluster of style and approach of a few years ago.

The growing diversity of N.H.S. Districts will also place increasi-

-ng strain on a training scheme which recruits 50 people a year, alloca-
-tes them to 50 Districts, in 13 Regions, and then groups them again into 4 educational centres. One result of this system is that there is no-one with the comprehensive network of preceptors/mentors of Dick Lewis. Thus there is no-one who has as an integral part of their role, keeping close links with the fast moving 'real world'. Not only is the marketing role of the people running G.M.T.S. 1 in relation to education and training unclear in relation to the N.H.S., presumably because they are directed towards a recruitment market for the scheme. But also, there remains the danger that the lack of emphasis on relating to the N.H.S. leads to a lack of clarity about the environment which the trainees are being trained to survive, and indeed thrive, in. This is demonstrated nicely by asking the question 'If my G.M.T.S. 1 trainee has a problem - who will help to solve it?' In U.N.H., with 35 interns the answer is simple, either the preceptor or Dick Lewis. In England, with 50 trainees per annum, the answer is either the mentor, or the Regional Link, or the educational centre tutor, or the National Coordinator of the scheme employed by the N.H.S.T.A.. As indicated at the beginning of this project, perhaps one should bear in mind that there are 3 cohorts of G.M.T.S.1 trainees at any one time. But as a mentor I believe that more cohesion, and concentration on working at keeping in touch with mentors would make G.M.T.S. 1 a more powerful training scheme.

## 10. Endpiece

The reader who has reached this far does not need reminding that this did not set out to be an academic study of training in 2 continents. I am both a pragmatic manager and trainer and, although stimulated by concepts, the major origin of my enthusiasm is working with people who have so much to learn about and also from the management of health services. My experience in training, side by side, interns from U.N.H. and English management trainees raised questions in my mind which sugge--sted the need for a study trip to the U.S.. The trip has proved to be a very valuable experience - not only in terms of looking at training systems but also thinking carefully about U.S. and G.B. health care whilst released briefly from the gruelling treadmill of an Acute U.G.M.s job. Having been back now for several weeks I have been surprised and somewhat shocked at the way the Prime Ministerial Review of the N.H.S. has encouraged an amazing array of half digested analyses of what may be transferred over from the U.S. system. Perhaps we should bear in mind Dick Lewis' analogy of health care as an eco-system. The ecologists would then warn us to research most carefully the possible introduction of alien species to control 'pests' within our own system. The problems of predicting accurately what will then happen are enormous and there is a great danger that species which are not considered to be 'pests' will also be affected.

Whilst in the U.S. I was given far more courtesy, hospitality and time than I could possibly have expected from Dick Lewis and John Seavey. I was delighted to see all 4 of my own alumni and also owe a special debt to Julie Wratten, who with the benefit of her additional 2 months in the U.S. gave me a crash course in how to speak American.

**********

RG/RG April 1988