
ACHE MEMBER SURVEY: PERSPECTIVES ON GRADUATE HEALTH MANAGEMENT EDUCATION

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ABSTRACT

This study reports a national survey of American College of Healthcare Executives (ACHE) members and sheds light on preferences for graduate healthcare management education. The study identifies relative preferences for programs that best prepare students to become future healthcare executives. We found equal support for the MHA and a healthcare-focused MBA, with little support for multiple other types of degree programs. Preferences for leadership, creativity, finance, and communication skills were found, as well as support for competency-based education. The importance of accreditation is included, with program-level accreditation favored. This paper also explores institutions in healthcare and provides contextual background emphasizing changing economic conditions and subsequent impact on health management education.

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INTRODUCTION

Institutional context of healthcare and healthcare management education

The history of graduate health management education in the United States has been a natural experiment offering students different academic settings. Programs are commonly found in schools and colleges of public health, business, and health professions. Occasionally, they are found elsewhere. This lack of consistency regarding academic settings arguably reflects the complexity of perspectives about the nature of health services and explains much controversy in the field. The nature of the health sector has long been a provocative subject. Is healthcare merely another service that competitive markets can accommodate, albeit with some public sector intervention? Or are they quite different and not to be left to the avarice of market forces? The subject has resonated for years. The 1938 academy award-nominated film, *The Citadel*, criticized modern medicine and healthcare for lack of attention to public health, greed, and resistance to managed care. Joan Robinson used price discrimination in physician services as an example in her widely recognized *Economics of Imperfect Competition* first published in the 1930s (Robinson, 1969).

Rubin Kessel further developed this in the late 1950s by focusing on the discipline within the medical community necessary to prevent more widespread price competition (Kessel, 1958). As scholars sought to better understand the health sector, Kenneth Arrow published a seminal piece in 1963 arguing that healthcare differed from other parts of the economy in large part because of asymmetric information between consumers and producers (Arrow, 1963; Peterson, 2001). Physicians, for example, have much more knowledge of diagnostic and treatment options than patients. This means that consumers must defer to physicians with a level of trust not commonly found among other purveyors of goods and services. To that end, institutions evolved to help ameliorate at least the perception of exploitation including not-for-profit hospitals and other providers, often with religious affiliations. This, Arrow asserted, helped provide legitimacy to providers and comfort to consumers. The establishment of graduate health management programs in academic health science settings was consistent with this spirit. It helped to distance healthcare managers from the bottom-line orientation of business and further serves to bolster medical control of the industry. It also helps to explain divergence in culture between health science centers and business schools.

Purpose of this paper

Recent work by one of the authors provides a history of the development of MBA and MHA programs in different academic settings, with descriptions of different cultures and economic incentives (Hilsenrath, 2012). It also identifies relative comparative advantage of health science centers vs. business schools but provides no data about preferences of managers in the field. This paper addresses that limitation with a survey of members of the American College of Healthcare Executives (ACHE) about their perspectives on graduate health management education. Questions probe preferences about academic setting, course content, and socio-economic status of respondents.

This is not the first study to survey health managers and ask such questions (Hartman & Crow, 2002; Collins, Matthews, McKinnies, Collins & Jensen, 2009; Frazier, Young & Fuller, 2012). There is a rich literature on related issues, much of it in the *Journal of Health Administration Education* (Levey, Hilsenrath, & Hill, 1998; Shewchuck, O'Connor & Fine, 2006; Broom, Wood, & Sampson, 2013). And the debate about academic settings and appropriate curriculum goes back to at least the Davis Report of 1929 (Davis, 1929). The field of healthcare management is diverse. Managers work in a variety of settings including hospitals and health systems, insurance, ambulatory settings, and long-term care. They also vary functionally from chief executives to operational managers, financial, IT, marketing, human resources, and other managers. This diversity suggests that "one size" education may not best fit all. A survey of healthcare managers with the ability to differentiate preferences by managerial characteristics helps to better understand these nuances. There has been a discernible shift over time with the initial graduate health management program offered in a school of business and most subsequent programs located in academic health science settings. More recently, the business school setting has reemerged. Results of a survey of healthcare executives in Ontario were published in 2012 (Issac, Nippak, Ileda-Douglas, & Pringle, 2012). This survey asked respondents if they preferred the MHA, MBA, or MBA with a healthcare focus. The MBA with a healthcare focus was preferred to the MHA, but the MHA was preferred to a general MBA without a healthcare focus. This study seeks to answer some of these same questions in the United States. It is further differentiated by providing a context rooted in institutional economics.

It was hypothesized that those holding an MHA would prefer to hire MHAs as those who hold the MBA prefer to hire MBAs. Overall, however, there was anticipation of a shift in preference toward the healthcare MBA relative to the MHA as a result of more market-like conditions in the health sector and perceptions of comparative advantage in core management skills

offered in MBA programs (Boissoneau & Kirkman-Liff, 1991). Previous studies found that communications are a key skill that employers seek and this was expected to persist (White & Begun, 2006). Leadership and finance skills were also expected to be a high priority among employers. There was also an expectation of growing dissatisfaction with health management as a career due to the challenges and dislocations confronting practitioners today.

DATA AND METHODS

We constructed our dataset using a survey instrument that we developed for distribution to a target population of current executives within the healthcare industry. The survey consisted of a total of 21 questions that asked participants for their demographic information, academic background, professional background, and preferences on the graduate-level development of future health managers. We assessed survey reliability using a test group of health executives who were not a part of the study sample. Using test/retest methodology, we found a 0.86 average correlation across survey questions, thereby quantifying survey reliability. We assessed content validity using a group of peer reviewers who provided feedback and made suggestions for improvements over multiple revisions to the survey.

The sample of our targeted population consisted of practitioners who maintained ACHE membership. We obtained ACHE chapter information from the national ACHE website. In order to avoid potential regional preferences that might bias the results, we solicited participation from 17 ACHE chapters across the U.S. The chapters were selected to ensure geographic representation throughout the major regions of the country. Additional considerations included ensuring that we had respondents from both heavily and lightly populated states, and states with both urban and rural settings. A total of nine ACHE chapters located in eight states (i.e., California, Florida, Massachusetts, Missouri, Oregon, Texas, Utah, and Washington) agreed to participate, with the remaining eight chapters declining. Since some survey participants lived outside of the state where their chapter was located, a total of 18 states were represented in our sample. Coincidentally, a number of participants resided in the states of nonparticipating chapters.

The method of delivery across the ACHE chapters varied. In some cases, state or regional chapters embedded the survey within a chapter newsletter. In other cases, the chapter posted a link on their website. A handful of chapters chose to distribute the survey directly via email. Overall, this flexibility was necessary to facilitate chapter participation and also helped ensure participant confidentiality. The tradeoff was that we had to estimate our response rate, rather than being able to calculate a precise response rate.

We estimated a response rate of 15%. Of 6,315 possible participants, a figure based on the membership numbers provided by the ACHE chapters, 309 executives responded. This number represents an initial lower bound response rate of 5%. However, two factors reduced how many of those 6,315 members were actually solicited for participation, thereby increasing our estimated response rate. First, the narrative description of the survey, combined with the participation instructions from the chapters, led many potential respondents to voluntarily opt out (for instance, student members who were not “executives”). Second, since the method of delivery varied across the ACHE chapters, we asked the ACHE chapters for feedback on distribution within their active membership. The ACHE chapters provided input regarding traffic patterns to their websites, response rates to surveys embedded in their newsletters, and the accuracy of mailing lists. Chapter input was used to revise our denominator.

We first provide a brief discussion of the healthcare executives and their industry settings within our sample. Next, we offer analysis of the survey results and identify some of the more interesting observations regarding undergraduate and graduate education, as well as knowledge, skills, and competencies required for success in today’s healthcare workplace. We then provide analysis of executive preferences for specific graduate degrees that ACHE respondents deem most appropriate for future health managers.

RESULTS

Our survey sample consisted of healthcare executives who maintained current membership within nine ACHE chapters located across the U.S. The largest setting for survey participants was hospital or health system, comprising 37.2% of the sample. Academic medical centers (19.4%) and government agencies (13.6%) made up the next-largest groups. The most common role identified by participants was an operational role as a health services manager (26.5%). Our sample also had a meaningful number of Chief Executive Officers (CEOs) and Chief Operating Officers (COOs), which together comprised 21.4% of the sample. Other roles of note included consultants, educators, and nursing executives.

Almost half of the sample (44.3%) had over 20 years of experience within the healthcare industry. Regarding the graduate-level development of executives within the sample, more than half (51.5%) had an MHA-type degree (e.g., Master in Health Administration, Health Services Administration, Health Systems Management, etc.). Interestingly, 15.3% of the sample had no graduate degree in any management-related discipline (although most were working towards a graduate degree when they participated in the survey, and a hand-

ful had degrees in non-management fields). Table 1 provides further details about the settings and roles of our sample population, as well as executive backgrounds.

Table 1

Setting, roles, and backgrounds of health executives

Organization Type		Role	
Hospital or Health System	37.2%	Health Services Manager	26.5%
Academic Medical Center	19.4%	CEO or COO	21.4%
Government Agency	13.6%	Other	12.9%
Other	12.0%	Consultant	7.8%
Consulting	7.8%	Educator	6.5%
Educational Institution	4.2%	CNO/Other Nursing	5.8%
Ambulatory Care	3.2%	CFO/Financial	5.5%
Insurance Provider	2.6%	Marketing	4.2%
		IM/IT/Informatics	3.9%
		Quality Manager	3.2%
		Strategic Planning	2.3%

Years of Experience		Graduate Degree	
<1	4.5%	MHA	51.5%
1-5	15.5%	MBA Non-healthcare	12.9%
6-10	14.9%	MBA Healthcare	11.7%
11-20	20.7%	None	10.4%
>20	44.3%	MPA	5.2%
		Other Non-management	4.9%
		MPH	3.6%

Results regarding executive opinions on the most appropriate undergraduate background and optimum amount of work experience in advance of students pursuing graduate education in healthcare management are displayed in Table 2. Our findings indicate that a business degree is preferred at the undergraduate level by 38.4% of the executives, but a substantial portion (28.7%) said that the specific undergraduate discipline does not matter. Interestingly, only minor support existed for clinical or science backgrounds at the undergraduate level. Regarding work experience prior to entering a

graduate program, over 60% of the executives recommended between one and three years of work experience prior to seeking graduate education. The remaining 40% were equally split between little to no work experience and more than three years of work experience. Thus, executives indicated a strong preference for students entering the workforce for at least a year (and preferably for up to a few years) rather than directly beginning graduate school after completing an undergraduate education.

Table 2

Educational preferences of health executives

Preferred Undergraduate Degree		Graduation Education Style	
Business Admin	38.4%	Classroom Setting	9.7%
Does Not Matter	28.7%	Interactive Learning	35.4%
Other	12.6%	External Field Experience	47.4%
Nursing	10.6%	Other	7.5%
Sciences	9.0%		
Arts	0.6%		

Pregraduate Degree Work Experience (Years)		Residency/Internship Length (Months)	
0	12.9%	None	1.6%
<1	8.4%	0-3	9.0%
1-2	34.0%	4-6	34.2%
2-3	26.2%	7-12	31.3%
>3	18.4%	12-24	21.9%
		>24	1.9%

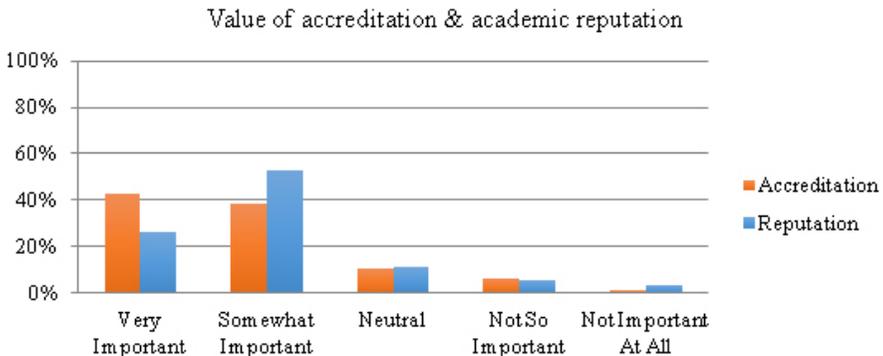
Once students entered into a graduate program in health management, executives indicated little support for the traditional classroom setting. A strikingly low 9.7% of respondents thought this was most important. Instead, emphasis on experience that replicates the more complex environment of the workplace setting was considered more important. Executives strongly preferred external field experiences (47.4%) where students actually work on projects with an external organization, or more interactive learning (35.4%). These executive preferences align closely with the shift by the accrediting body (Commission on Accreditation of Healthcare Management Education) toward

competency-based education. The competency-based approach emphasizes much greater use of higher-level teaching and learning techniques where students learn by doing rather than by listening.

A major component of the interactive and/or experiential learning processes is the field-based integrative experience of the internship or residency. Our survey asked executives for their preferences regarding the length of the internship (typically shorter) or the residency (typically longer). Nearly two thirds of the executives (65.5%) preferred internships and residencies ranging from 4 to 12 months.

We also assessed the perceived value of an academic institution's reputation and the value of accreditation (Figure 1). Roughly 80% of the executives surveyed indicated that reputation (79.6%) and accreditation (81.6%) were either very important or somewhat important. However, they placed more emphasis on accreditation, as evidenced by 42.7% indicating accreditation was very important, compared to only 26.5% for reputation. When accreditation was further broken down into accreditation at university, school/college, or degree level, executives indicated the strongest preference for specialized accreditation at the degree level (CAHME accreditation), and the lowest preference for accreditation at the college/school level (e.g., CEPH, AACSB, etc.). School-level accreditation (AACSB or CEPH) was not considered as important as degree-level accreditation. Only 24% of those with an MHA, 31.3% of those with an MBA in healthcare, and 30% of those with a non-health MBA said it was important (data not shown). That was not the case regarding degree-level accreditation (CAHME). Executives with an MHA (59.5%) are much more likely to place importance on this accreditation than executives with an MBA, including those with a concentration in healthcare (34.4%) or those without a concentration in healthcare (22.5%).

Figure 1
Importance of accreditation and academic reputation



We next looked at the executives' perspectives regarding the current state of competency attainment. Figure 2 provides survey results on the most important competencies for future graduates (participants could select up to three). Three major competency areas clearly stood out as being most important. New graduates should have robust competencies in leadership, operations management, and financial decision-making skills. While a number of other competency areas were deemed important by current healthcare executives, support for the three most important competency areas were identified by two to three times as many survey participants. These competencies closely align with expectations of where many new graduates will find themselves employed after graduation, playing a leadership role in the operational delivery of healthcare, while needing to understand the financial implications their role plays in the overall success of the larger organization. Coincidentally, Figure 3 indicates that leadership and the ability to assess/improve the operational delivery of healthcare were also the knowledge areas deemed most deficient in new graduates. Likewise, communications skills were deemed deficient. Communication skills can be found in all of the major competency models. Our findings indicate that executives may feel that communications skills should be of a higher priority. These results indicate executives feel the current state of graduate healthcare management education may not be sufficiently meeting industry needs.

Figure 2
Most important competencies for new graduates

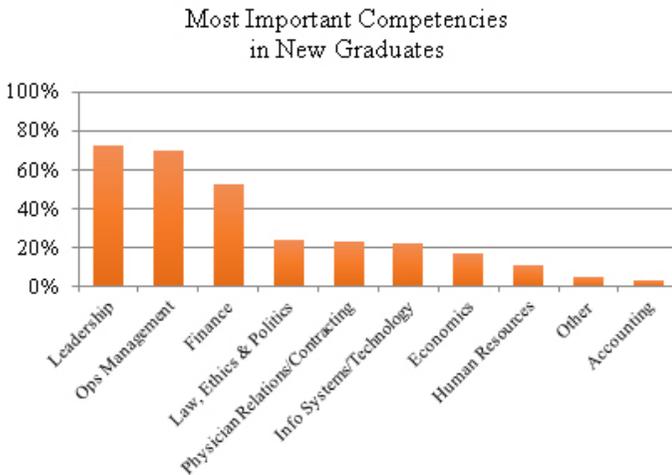
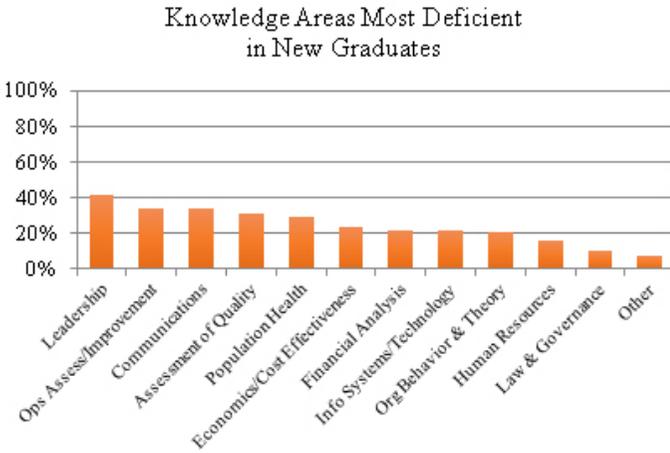


Figure 3

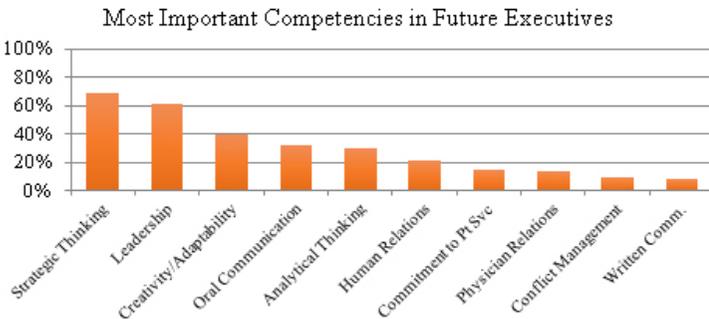
Most deficient knowledge areas for new graduates



We also sought healthcare executive opinions regarding the most important competencies for future leaders who aspire to executive-level positions. The results indicate a shift away from the more technical competencies expected of new entrants toward the strategic competencies expected of those who aspire to lead large healthcare delivery organizations. The two competencies most frequently identified by executives were strategic thinking and leadership, followed by creativity and adaptability to a complex, changing environment. One key message from the survey is that graduate programs should, in the short term, provide a robust set of competencies for graduates to be able to successfully lead at the operational level. However, programs must provide an adequate foundation in strategic thinking, combined with the ability to think creatively, to ensure career success in the long term.

Figure 4

Most important executive competencies



Finally, we sought to determine if any clear patterns existed in the preferences for specific graduate degree programs. In order to conduct this analysis, we chose to reduce the sample population to those executives who had both a graduate degree and sufficient experience to best make a recommendation. We first screened out anyone who did not already have at least a graduate degree. Additionally, we screened out any respondents with five or less years of executive experience in the health industry. Screening out participants on these two characteristics reduced the sample from 309 to 222.

Our analysis is presented in Table 3. Overall, an MHA and an MBA with a healthcare concentration were the most frequently recommended degree options, with roughly equal support (78% and 76%, respectively). The shaded diagonal cells indicate how many executives recommended graduate degrees similar to their own graduate backgrounds. Overall, 95 out of 222 executives (43%) recommended prospective graduate students pursue the same graduate education that the executives had pursued. Of the 78 MHA recommendations, 69 of the 78 executives also had an MHA. Likewise, five of the six non-health MBA recommendations came from executives who also had a non-health MBA. Conversely, support for an MBA with a healthcare concentration was more broadly distributed. Of the 76 recommendations for an MBA with a healthcare concentration, 24 came from executives with an MHA, 20 came from executives who also held an MBA with a healthcare concentration, and 18 came from executives with a non-health MBA.

This analysis indicates two key findings. First, the graduate background of the executive appears to influence preferences for future leaders' graduate degrees. Second, the MBA with a healthcare concentration appears to have broad support within the industry, on par with the MHA. In our sample, 78 executives recommended the MHA and 76 executives recommended the MBA with a healthcare concentration.

Table 3

Recommended graduate degree (health executives with masters and >5 years experience)

Panel A. Numerical Values		Executive recommends an:						Total
		MHA	MBA (HC)	MBA	MPA	MPH	No Pref.	
Executive has an:	MHA	69	24	0	0	1	27	121
	MBA (HC)	4	20	1	0	0	7	32
	MBA	2	18	5	0	1	7	33
	MPA	1	6	0	0	0	9	16
	MPH	0	4	0	0	1	2	7
	Other	2	4	0	0	0	7	13
	Totals	78	76	6	0	3	59	222

DISCUSSION

More than four times as many respondents had MHAs than those with an MBA with a healthcare concentration, yet the two degree types were almost equally preferred (35.1% and 34.2%, respectively). These results suggest that there may be an ongoing shift in convention and preference from the MHA to the MBA with a healthcare concentration. This shift appears to coincide with the growth of MBA programs emphasizing the health industry. The survey also revealed that leadership, finance, strategic planning, creativity, and communication should be fortified in graduate programs. Perhaps the strength of these areas was driven in part by the relatively high percentage of respondents identifying themselves as a CEO or COO (19%). The preference for internships and residencies of 4 to 12 months indicates the market may place less value on summer programs and those with extended residencies beyond one year. In the former, a short internship may not be long enough to adequately prepare students for the healthcare setting. In the latter, time beyond the first 12 months may provide little marginal value.

There were also some surprises. Human resource and information technology competencies received relatively low rankings. Perhaps these areas remain very compartmentalized. Support for traditional didactics was remarkably low, with only 10% of respondents believing it was the most important aspect of educational training. School accreditation was ranked

less important than university-wide or degree-level accreditation. This may be at odds with emphasis on school-level accreditation that many academics are accustomed to. There was an unanticipated preference for undergraduate business preparation. Perhaps this is thought to lay a foundation of core management skills found wanting. Finally, there was a very positive response to the question of choosing the same career in healthcare management. More than three quarters of respondents indicate they would do it again. It is not clear if this is in spite of challenges faced today, or because of them, but it is heartening in either case.

This study sheds light on macro issues in health management education. There are various dimensions that can be used to differentiate academic health science center settings from business school settings. Differing economic incentives in turn help shape comparative advantage as they impact faculty research agendas and curricular areas of expertise. Academic health science centers typically generate substantially higher percentages of revenue from grants and contracts than business schools by aligning research with priorities identified and funded by well-endowed agencies such as the National Institutes of Health (Higher Education Research and Development Survey, 2013). Business schools rely much more on tuition revenue and state support. Unlike health science centers, there is little expectation of grant funding. Curricular areas of expertise in health science centers are influenced by availability of external funding. This drives alignment with the priorities of foundations and government agencies. The relative dearth of government and foundation funding for core management areas undermines the ability of health science centers to recruit and retain well-qualified academics in these fields. For example, new Ph.D.s in accounting typically do not flock to health science centers with expectations of grant funding. Most prefer business schools where external funding is usually retained by faculty. Moreover, accreditation norms and requirements can be broad without reference to core fields of management. For instance, the Council on Education for Public Health (CEPH) accreditation criteria holds only that faculty are “trained and experienced in disciplines appropriate to their instructional, research, and service activities” (Council on Education for Public Health, 2011). The discipline may be regarded as health services administration, not narrower core fields such as accounting, finance or management science. This provides health science centers considerable latitude to appoint people with wide-ranging backgrounds to teach core courses.

The health sector has rapidly evolved in size and institutional complexity (Cuckler et al., 2013). The information asymmetry that Arrow emphasized has eroded as technology has afforded vastly easier access to information and as education levels have increased. The institutions that Arrow argued arose to

accommodate the asymmetry are now no longer as important. Deference to the authority and goodwill of hospitals and physicians is much diminished from what it was half a century ago. Markets and market orientations have displaced much of what previously prevailed and the trend appears set to continue. The advent and rapid growth of consumer-driven health insurance, characterized by high deductible plans and commonly paired with health savings accounts, is generating more consumer discretion (Employee Benefit Research Institute, 2014; Reinhardt, 2013). Providers no longer have the autonomy and leeway once taken for granted.

The occupation of healthcare management has evolved in a parallel fashion. In 1970, the overwhelming majority of healthcare managers in ACHE had an MHA as a graduate qualification. That number has steadily eroded to around half (ACHE Members and Fellows Profile, 2014). The MBA has displaced much of the loss of MHA market share. But so too has the growth of healthcare managers with a clinical degree such as an MD, a masters in nursing, or a PharmD. This includes those with dual degrees consisting of a clinical degree and an MBA or MHA, a development that is occurring in other parts of the world as well (Bhogal & Bhogal, 2009; Chummney, Ragucci, & Jones 2008).

LIMITATIONS

Our study did have a number of limitations that future research can address. As previously mentioned in the Data and Methods section, our estimated response rate initially appears to be somewhat low. However, our response rate is consistent with other studies in survey research. The most recent research on surveys indicates relatively low response rates for executives (Baruch, 1999; Cycyota & Harrison, 2006; Baruch & Holtom, 2008). Our estimated response rate of 15% is within an accepted range (although admittedly on the lower end) for survey research of executives. Future studies on executive preferences in graduate education should seek to improve the response rate.

The primary concern of a low response rate is bias. Bias in our survey includes geographic distribution. The highest response rates in our survey were in Texas, Florida, Massachusetts, Missouri, and Washington. As a result, each of these states is overrepresented in our study. California, the most populous state, is underrepresented. Regarding the health sector setting, approximately 60% of our survey respondents were from hospitals and health systems. This percentage is reasonably consistent with the ACHE membership distribution reported on its website, which shows 53.6% of members being in a hospital setting, but not the wider health sector as a whole. Similarly, our

survey respondents showed a comparable distribution across position types as those reported on the ACHE website. For instance, ACHE reports 21.8% of members filling CEO or COO positions. Our survey consisted of 19% self-reporting as CEO or COO.

Preferences of executives outside of healthcare but still within the broader health industry might not be adequately reflected within the findings. While our study did have some participants within consulting and insurance, other health industry settings such as pharmaceutical manufacturing, durable medical equipment manufacturing, biotech firms, and the health subsector of the finance industry are underrepresented. Future studies should consider gauging graduate degree preferences from outside of healthcare delivery.

Another limitation resulted from the design of our survey instrument. Categorical answers elicited in the survey preclude more precise measurements that could be obtained from using continuous variables. For instance, participants could have been asked to provide the actual number of years of executive experience, rather than asking them to select a range. Additionally, some questions could have afforded participants the option to provide additional insight (e.g., competency choices, knowledge/skill areas, etc.) or better clarity in their answers (e.g., the type of job they fill, their organizational setting, etc.).

CONCLUSION

The distinction between the MBA and MHA is not well defined. There is much heterogeneity and differentiation among the degree programs, as indicated by the number of students who choose to pursue both degrees, and the number of employers who seek graduates with both degrees. Nevertheless, graduate health management education is evolving with growing recognition of the MBA in Healthcare Management. Leadership, operational management skills, and creativity are identified as paramount. Traditional didactic education is not considered of primary importance in spite of its ubiquity. These findings support the shift to competency-based education and invite further innovation and adaptation to rapid change. Finally, challenges faced by today's managers are being embraced and relatively few would choose an alternate career.

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