The Professional Transformation of Hospital Administrators: Isn’t It Time for Mandatory Licensing?

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In America, each state licenses or otherwise regulates physicians, nurses, and nearly all other professionals in the healthcare system. Even one class of personnel near the end of the chain of care, nursing home administrators, is licensed in all states. Yet somehow chief executive officers of hospitals have avoided regulation and licensing. In the 5,764 hospitals in the United States in 2003,¹ not one administrator, chief executive officer, president, or executive director is required by law to have a license.

Rather, the quality of hospital administration and administrators has been regulated by the voluntary effort of the American College of Healthcare Executives (ACHE). Presently, the organization has 34,361 listed members² who advance through the designated ranks of Member, Diplomate, and Fellow. Membership is achieved through obtaining an undergraduate or master’s degree and being employed in the field. Advancement is attained through continuing education workshops, after which one takes a competency examination and then submits case studies.³ Yet this effort is soon expected to weaken. In October, 2006, a proposal was made to combine the status of Diplomate and Fellow into a single category to make advancement easier.⁴

Though a commendable effort, the problem with the ACHE organization is that it is voluntary. Only approximately 40 percent of all hospital administrators even belong to the organization.⁵ Most of these executives bear great responsibility for the quality of care, (e.g. patient-to-nurse ratio), the cost of care, (e.g. what new capital equipment and technology may be purchased), and access to care, (e.g., how many clinics are built). The decisions of hospital administrators directly affect 300 million lives in America, and yet most administrators don’t belong to the very professional organization that is the only safeguard for quality in their industry. Compounding this problem, the trend to advance within the organization has been declining.⁶

Without being licensed, critical checks on behavior are eliminated. Administrators need not worry about losing a license that they never had, nor must they worry about being reported to an agency that doesn’t exist. Physicians, nurses and other healthcare professionals cannot practice without their license, and accordingly, they may exercise greater caution in decision-making. Yet hospital administrators can simply make questionable decisions and then, if necessary, relocate to another facility with relative impunity.

⁵ ACHE, 2006 Affiliate Profile, supra note 2.
⁶ Id.
Would mandatory licensing of hospital executives take a Herculean effort or even be expensive? Hardly. Every state in the U.S. has some form of state nursing home board to control that industry; the simple addition of a couple of hospital administrators to this board would make it multi-functional. In addition to formulating educational requirements similar to that required by the ACHE, a formal examination, criminal background check, drug screen and credit check should suffice, complimented by bi-annual continuing education requirements.

Have any states undertaken an effort to license administrators? California has job descriptions that come close, requiring a master’s degree and certain experience to manage a particular size hospital, greater experience is required to manage larger hospitals. In 2003, a Wisconsin state congressional representative introduced legislation to require licensing of hospital administrator’s; however the bill did not succeed.

When polled about a mandatory licensing requirement, I found mixed reactions. Executives and policy makers within the American Hospital Association, American Medical Association, and the American College of Healthcare Executives either took no position or tended to support voluntary efforts. Academicians however supported the idea and thought it was overdue. Indeed, these learned professors active in teaching healthcare administration courses have outlined core competency requirements that should be mandatory for anyone managing a healthcare organization. Those retired executives within the industry tended to consider it a reasonable idea but not one greatly needed.

I also looked to other countries to inquire what is required to be a hospital administrator. In India, one commentator reported that among the government hospitals, administrators tended to be physicians. However in the new up and coming for-profit chains, administrators are often non-physicians with business skills, who have an MBA or an M.S. in Healthcare Administration (MSHA) and often also have western backgrounds. In the Middle East, notably Saudi Arabia, administrators are required to be physicians who have been identified to have leadership skills. Conversely the Joint Commission International standards, modeled after the U.S. standards, only state that the administrator should have the correct education and experience for the job.

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7 Los Angeles County Department of Human Resources, available at [http://dhrdcap.co.la.ca.us/](http://dhrdcap.co.la.ca.us/) (last viewed Nov. 20,2006)
9 Comments gathered from administrators, consultants, academicians, and employees of professional groups, gathered between September 21 and October 14, 2006 for purposes of research. Due to the sensitive nature of the conversations, those providing information asked not to be identified.
10 Id.
12 E-mail exchange with Jamal, Benazir, former student now living in India, October, 2006.
13 E-mail exchange with Radwah, Khalid, Director Quality Assurance and Healthcare Planning, Royal Commission Medical Center, Yanbu, Kingdom of Saudi Arabia, October, 2006.
Hospital administrators are important executives who are critical to today’s hospitals. There currently exists no mandatory licensing system for these individuals. A change to the Medicare/Medicaid laws requiring state licensing, in the same manner as nursing home administrators are licensed, would provide a simple, quick, and inexpensive corrective.

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