

BY THE BESTSELLING AUTHOR OF *MANAGING AND REBALANCING SOCIETY*



MANAGING THE MYTHS OF HEALTH CARE

BRIDGING THE SEPARATIONS
BETWEEN CARE, CURE, CONTROL,
AND COMMUNITY

HENRY MINTZBERG

THINKERS50 LIFETIME ACHIEVEMENT AWARD WINNER

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Managing the Myths of Health Care

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OVERVIEW

THIS BOOK IN BRIEF

This book is written for everyone engaged in health care: clinical and other professionals, managers, and policy makers, to be sure, but also the rest of us, as people beyond “patients.” (When I exercise to care for my health, am I a patient?)

I have written this book in an easy style, to make it accessible to specialists and laypeople alike. All of us need to better understand the strengths and shortcomings of this system called health care. We can start by asking ourselves if the labels *system* and *health care* really describe what constitutes mostly a collection of treatments for diseases.

All over the world, people rail on about the failings of their health care. Yet we are living longer, thanks to the many advances in these treatments. In other words, where it focuses its attention, this field is succeeding, not failing, sometimes astonishingly. But it is doing so expensively, and we don’t want to pay for it. So the administrators of our health care, in governments and insurance companies alike, have been intervening to fix it, mostly by cutting costs. And here is where we find a good deal of the failure.

Managing the Myths of Health Care

Is management, therefore, the problem? Many health care professionals believe so. I don't. Health care cannot function without management, but it can certainly function without a form of management that has become too common. I call it *remote-control* management because it is detached from the operations yet determined to control them. It works badly even in business, from where it has come. In health care, it reorganizes relentlessly, measures like mad, promotes a heroic form of leadership, favors competition where there is the need for cooperation, and pretends that this *calling* should be managed like a business. The more of all this we get, the more dysfunctional health care becomes.

All of this is the subject of Part I of this book, called "Myths," to open up perspectives. As you can see, it is somewhat polemical in nature, although most of the conclusions are backed up by evidence and illustrations from experience, a number of these in the supporting footnotes.

Part II, called "Organizing," serves as a bridge between Parts I and III, by considering how we organize in general and for health care in particular. In general, we differentiate work into component parts and then integrate these parts into unified wholes. In health care, however, there tends to be a lot more differentiating than integrating, and this has encouraged all sorts of excessive separations: "consulting" physicians who barely talk with each other; a preoccupation with evidence at the expense of experience; the researching of cures for diseases while failing to investigate their causes; persons reduced to patients and communities reduced to populations. And in the administration of health care, there are those walls and floors that separate managers from each other and from the professionals.

Behind all this lies a particular form of organizing that dominates the delivery of health care services. To understand it, turn on its head much of what you know about conventional

Overview

organizing. For example, here strategy and leadership do not so much descend from some metaphorical “top” as emerge from the base; bigger is not inevitably better; and many of the most successful institutions are neither private nor public.

This *professional* form of organizing is the source of health care’s great strength as well as its debilitating weakness. In its administration as in its operations, it categorizes whatever it can, in order to apply standardized practices whose results can be measured. When the categories fit, this works wonderfully well. The physician diagnoses appendicitis and operates; the government or insurance company ticks the appropriate box and pays. But what happens when the fit fails? For example, who cares for the patient who falls between the categories, say, with some form of autoimmune illness that medicine has yet to prototype? Or how about the patient who fits the category but is ignored as a person, and so does not respond adequately to the treatment? Even more damaging can be the misfit between managers and professionals, as they pass each other like ships in the night, the managers in their hierarchy of authority, the professionals in their hierarchy of status.

This takes us to Part III of the book, called “Reframing,” about how to achieve the necessary integration, so that health care can function more like the system it is thought to be. Its management can be reframed as engagement rather than detachment—or, if you like, as caring more than curing. (Dare I say, like nursing more than medicine?) And it can be seen as distributed beyond just those people called managers. Thus strategies, rather than descending immaculately conceived from some metaphorical top, can be seen to emerge from the base as professionals in the operations learn their way to new forms of care and cure.

The organization of health care can be reframed by encouraging collaboration to transcend competition, culture to transcend control, and what we shall be calling “communityship”

Managing the Myths of Health Care

to transcend leadership. More broadly, the raging battles over public sector versus private sector health care can be reframed with the recognition that the best of our professional services are often delivered by community institutions, in another sector altogether, which we shall be calling *plural*.

Overall, care, cure, control, and community have to collaborate, within the health care institutions and across them, to deliver quantity, quality, and equality simultaneously. To introduce a metaphor that you will read about again, a cow works as a system: all its parts function harmoniously together. So why can't health care?

YET AGAIN?

So here comes yet another outsider who thinks he can help resolve the confusing state of management in health care. Is this book any different?

I hope so. For one thing, I am critical of outsiders who I believe have often made things worse, not better. (Does it take one to know one?) For another, I advocate for the elevation of insiders who know health care on the ground, in their hearts and souls. Administrative intervention alone will not resolve the problems of this field. There are no management problems in health care, separate from medical problems or nursing problems or prevention problems.

In preparing this book, I have consulted colleagues who know better than I do, ones who have devoted their careers to health care. I may have misunderstood some of their advice, so please be prepared to discount some of what you read here, although what that is I cannot say (or else I would have changed it). But don't be too quick to dismiss anything that seems outrageous, because questionable ideas can sometime provoke useful learning.

Like many of these outsiders, my field is management, although health care managers and their organizations have

Overview

figured prominently in my research.¹ Where these outsiders and I part company is in my view of management and leadership. As you will see, I consider leadership the problem more than the solution, especially when it is promoted as being superior to plain old managing.

Likewise, I question conventional ways of developing managers, MBA programs and the like included. Mostly they teach an analytical approach to a job that is primarily practiced as craft with art. Moreover, I am suspicious of measurement too, at least as a panacea, and I believe that strategic planning is an oxymoron: strategies have to be learned on the ground, not deemed in offices.

MANAGEMENT? or management?

Many professionals in health care see management as the enemy. How often have you heard a hospital physician dismissing a colleague who has moved into management as no longer a physician? I understand where these concerns are coming from: all those administrative forms to fill out, all that jerking around by the managerial flavor of the month, etc. “Why can’t we just be left alone?” Because being left alone is a part of the problem.

¹My doctoral thesis on the *Nature of Managerial Work* (Mintzberg, 1973) included the head of the Massachusetts General Hospital among the five chief executives I observed, while my more recent research on this subject (Mintzberg, 2009, 2013; see also 1994 and 2001) has included seven health care managers of all sorts among the 29 managers I observed. I have also published an article about a month I spent on and off studying the management problems of a teaching hospital (Mintzberg, 1997). In my writings on forms of organizations (Mintzberg, 1979, 1983, 1989), the “professional organization” (or “professional bureaucracy”) has attracted particular attention in the field of health care. Other papers of mine in the field include Glouberman and Mintzberg (Parts I and II, 2001) on a framework about care, cure, control, and community in health care, and Mintzberg (2006) on the “Patent Nonsense” of the pharmaceutical industry. See also Mintzberg (2012) for an earlier summary of this book.

Managing the Myths of Health Care

My health and yours is not about a collection of disconnected interventions; it has to be dealt with systemically, in the clinics and the offices together. Professionals, too, must be engaged, with more than their professions.

In 1977, Albert Shapero wrote an article that compared MANAGEMENT with management. MANAGEMENT, essentially the remote-control type, tries to achieve this integration cerebrally, analytically. But who ever got near synthesis by relying on analysis? What we need therefore—within our institutions and across the so-called system of health care—is plain old managing, as a natural human practice, rooted in craft and art (as described in my book *Simply Managing*, 2013).

From a systems perspective, the narrow knowledge of self-serving professionals is hardly better than the broad ignorance of disconnected managers. (Throughout the book, key sentences are highlighted in **boldface** type.) This field needs professionals and managers who see past their jobs, outside their specialties, and beyond their institutions, to the needs of everyone's health.

A FEW CAUTIONS

First caution: This is a book about the management of health care, broadly. It is not about health care in the United States, or Canada (where I come from), or, for that matter, Malta, although all are mentioned. If you are an American interested in Obamacare or whatever, there are other books to read. But before you close this one, let me suggest that we all need to understand what is going on across all of health care. **I can think of no field that is more global in its professional practices yet more parochial in its administrative ones than health care.**

The new professional practices circulate quickly, at least in the developed world, while sensible ideas in management often fail to cross even borders, at least where I live (although nonsensical

Overview

ones do too easily). Canada and the United States are claimed to share the longest unguarded border in the world. Not when it comes to health care! So **this book is about fundamental aspects of health care management that should know no borders.**

Next caution: Books these days are supposed to look terribly up-to-date. In this one you will notice no shortage of references from years ago. Please celebrate them! They are no more out-of-date than is good wine. I have used them because they have likewise stood the test of time, being as insightful today as when they were first written (while too much written today will thankfully be forgotten soon).

Last caution. I use quite a few footnotes in this book, not to make it academic, but to enrich the discussion and support the conclusions. They contain interesting evidence and colorful stories for readers who wish to have more detail.

Donald Hebb, McGill University's renowned psychologist, wrote, "A good theory is one that holds together long enough to get you to a better theory." My hope is that the ideas presented in this book will hold together long enough to help us get to better ideas for managing the care of our health.



PART I: MYTHS

MYTHS ABOUND IN MANAGEMENT—for example, that senior managers sit on “top” (of what?); that they “formulate” strategies for everyone else to “implement” (no feedback? no learning at this top?); that people are “human resources” (I am a human being); and that “if you can’t measure it, you can’t manage it” (whoever measured management, let alone measurement?).

Myths abound, too, in what is called the system of health care, not least that it is a system that is about the care of health. Combine these two sets of myths and you get what we have: a nonsystem that is being managed out of control. Discussed here are these myths: #1 that we have a system of health care; #2 that this system is failing; #3 that it can be fixed with heroic leadership, #4 with more administrative engineering, #5 with more categorizing and commodifying to facilitate more calculating, #6 with increasing its level of competition, #7 by managing it more like a business. These I argue have

Myths

mostly been the problems, not the solutions: fixes such as these have been breaking much of health care. Last comes Myth #8, that health care is rightly left to the private sector for the sake of efficiency and choice, or else Myth #9, that it is rightly controlled by the public sector for the sake of equality and economy. How about greater recognition of what I shall be calling the *plural sector* (civil society, or the nonprofit sector), for the sake of quality and engagement?

1

Myth #1

We have a system of health care.

I haven't noticed. **Mostly we have a collection of disease cures, or at least treatments, often the more acute the better.** Overall, "health care" favors cure over care, acute diseases over chronic ones, and the treatment of diseases in particular over the prevention of illnesses and the promotion of health in general. As for research, development of cure receives much more attention than the investigation of cause.

Calling something a system does not make it a system where it needs to deliver. A system is characterized by natural linkages across its component parts. As we shall discuss later, a cow is a system, since its organs function together naturally. You and I are systems like this, too, at least in how we function physiologically, if not socially. About how much of the field of health care can we say that? What happens when all we individual physiological systems get together in a social context? Even the various medical specialties often have difficulty working with each other, let alone with nursing, community care, and management. As for the inclination to treat diseases instead of preventing them, let alone promoting

Myths

health, see the box on “Health Promotion over the Cliff.” It is not quite an allegory.

Health Promotion over the Cliff

(from Robbins, 1996: 1–2)

Once upon a time, there was a large and rich country where people kept falling over a steep cliff. They’d fall to the bottom and be injured, sometimes quite seriously, and many of them died. The nation’s medical establishment responded to the situation by positioning, at the base of the cliff, the most sophisticated and expensive ambulance fleet ever developed, which could immediately rush those who had fallen to modern hospitals that were equipped with the latest technological wizardry. No expense was too great, they said, when people’s health was at stake.

Now it happened that it occurred to certain people that another possibility would be to erect a fence at the top of the cliff. When they voiced the idea, however, they found themselves ignored. The ambulance drivers were not particularly keen on the idea, nor were the people who manufactured the ambulances, nor those who made their living and enjoyed prestige in the hospital industry. The medical authorities explained patiently that the problem was far more complex than people realized, that while building a fence might seem like an interesting idea it was actually far from practical, and that health was too important to be left in the hands of people who were not experts. . . .

So no fences were built, and as time passed this nation found itself spending an ever-increasing amount of its financial resources on hospitals and high-tech medical equipment. . . . As the costs of treating people kept rising, growing numbers of people could not afford medical care.

Myth #1

The more people kept falling off the cliff, the more a sense of urgency and tension developed, and the more of the country's money was poured into the heroic search for a drug that could be given to those who had fallen, to cure their injuries. When some people . . . questioned whether a cure would ever be found, the research industry answered with a massive public relations campaign showing men in white coats holding the broken bodies of children who had fallen, pleading, "Don't quit on us now, we're almost there."

When a few families who had lost loved ones tried to erect warning signs at the top of the cliff, they were arrested for trespassing. When some of the more enlightened physicians began to say that the medical authorities should publicly warn people that falling off the cliff was dangerous, representatives from powerful industries denounced them as "health police." . . . Finally, after many compromises, the medical establishment [issued] warnings. Anyone, they said, who had already broken both arms and both legs in previous falls should exercise utmost caution when falling.¹

The French word for a surgical operation is *intervention*. Using the word in English, that is significantly what happens in health care: intermittent and disjointed interventions, whether in primary, secondary, tertiary, or so-called alternative medicine, as well as in public and community health. **We need more systemic practices in health care, especially to reconcile the delivery of quantity, quality, and equality.**

¹ Abraham Fuks of the McGill Faculty of Medicine has pointed out how medicine has reconceived some of its practices as preventative: "In the case of non-infectious diseases, preventive medicine has been transformed into a search for disease at its preclinical stages. . . . This strategy is reminiscent of the early warning systems of anti-missile defenses" (2009: 5).

2

Myth #2

The system of health care is failing.

If there is one area of agreement in this field, this may be it: these “systems” are failing, all over the world. Users and providers alike complain bitterly about their health care.

At a party in Montreal a few years ago, I got into a conversation with a young radiologist who went on and on about how bad health care was in Quebec. “You did your residency in the United States,” I finally intervened. “How about that?” She threw her hands in the air: “Don’t get me started on the American system!” Sometime later I was in Italy, with people in the field who were likewise putting down their health care. So how does Italy compare with other countries, I asked. Oh, they replied: in the last ranking by the World Health Organization (2000), Italy ranked second best in the world behind France. Is second best still bad?

SUFFERING FROM SUCCESS

Quite the opposite: I believe that second best and much else is actually rather good—as far as it goes. **In most places in the developed world, the treatment of disease is succeeding, often rather dramatically. The trouble is that it is doing so expensively, and we don't want to pay for it. In other words, where it focuses its attention, health care is suffering from success more than from failure.**

And where it focuses less attention—in preventing illness in the first place—there have still been remarkable improvements, for example, in vaccines and the promotion of better eating and more exercise. It is just that here the pace of improvement is slower, and the efforts and resources expended are less—and no match for the commercial interests that promote poor eating and sedentary living.

On some of the broadest measures of life expectancy, infant mortality and others, performance in most countries has been steadily improving. A World Health Report in 1999 reviewed “the dramatic decline in mortality in the 20th century.” To take one of its examples, Chilean women in 1998 could expect to live to age 79 on average, which was not only 46 years longer than their predecessors of 1910, but also 25 years longer than women of 1910 whose countries had the 1998 Chilean income level. The report attributed a part of the reduction in mortality to “income growth and improved educational levels—and consequent improvements in food intake and sanitation” but concluded that access “to new knowledge, drugs, and vaccines appears to have been substantially more important” (1999: 2).

Don't get me wrong about this claim of health care succeeding rather than failing, as did the head of an ICU who attended our International Masters for Health Leadership program (imhl.org). When he heard me say this, he became angry: he had to live with the errors, the distortions, and the other failures of

Myth #2

health care. I could not argue with him about any of this, only to reply that I use the word *success* to mean getting better, not being perfect. Health care has its problems, to be sure, but it has been making remarkable progress where it focuses.

How about being offered this choice: (1) Health care circa 1960: when you feel chest pains, your GP comes to your home, gets you straight into a hospital, where you get attention from many doctors and nurses, who eventually send you back home to rest and hope for the best. You have received state-of-the-art health care. Or (2) health care now: no doctor comes to your house—you may even have to get yourself to a hospital, there to wait in an overcrowded emergency room until you get to cardiac surgery, where a stent is inserted, so that you can be sent home the next day, in rather good shape. You have received rather ordinary 21st-century health care.

Medicine has been particularly brilliant at developing expensive new treatments. Who among us is prepared to forego one of these to save our life? So we live longer, although sometimes more expensively sicker.

But not always: Consider a 90-year-old man in Vancouver who demanded an expensive hip replacement so that he could keep running. He was intent on maintaining his lifestyle, at the expense of the taxpayers of British Columbia. Could they fault him?

Pharmaceutical companies have had their expensive successes, too, except that these have been far too expensive in those countries disinclined to control the exorbitant pricing by this industry. (Bear in mind that these companies depend on state-granted monopolies—namely, patents—to charge what they do. When in the recent past has any country ever granted monopoly rights on necessities of life, such as electrical power or fixed-line telephone services, without seriously controlling prices? Being allowed to charge “what the market will bear” [a term used in *Businessweek* by Carey and Barrett in 2001] is simply patent nonsense. [See my article by this title, Mintzberg, 2006b.]

MORE FOR LESS?

Of course, while the costs of treatments go up, so too must the budgets to cover them, whether they are paid by taxes, insurance premiums, or personal payments. If we want more, we have to pay more. But in this age of consumptive greed, we want to pay less—or at least not that much more.

For the most part in the field of health care, we are not buying services so much as the possibility of needing services (i.e., insurance). Why, then, should *I* pay for *you*, who is sick, while I am healthy and probably invincible at that? In other words, **while the ill act as a concerted force for spending more locally, the healthy act as a general lobby for spending less nationally. This is not a happy combination: it makes the field of health care sick.**

Reconciling Supply and Demand

Before considering the obvious consequences of this, let me mention two other myths related to this one. The first is that we cannot afford the escalating costs of our health care services. Of course we can: it's a question of choices, individual and collective—really individual *or* collective. When we spend on cars and computers, we get instant gratification. How is health insurance, public or private, to compete with that?¹ It offers no fun! In the case of the United States, while health care costs far exceed those anywhere else, the very rich pay low taxes, and some major corporations hardly any taxes, while many Americans have long suffered for want of basic services.

¹Perhaps this explains a report on the National Health Service of England website that compared patient satisfaction with public satisfaction. “People who have used the NHS tend to be much more positive than the general public.” They speak from experience, while the latter are more inclined to form their opinions from exposure to the media (Edwards, 2009).

Myth #2

The other related myth is that the demand for health services is insatiable: provide more and we shall consume more. I don't know about you, but going to the doctor is not my idea of a good time (although I do like to chat with my particular GP): the waiting room, the needles, the prostate examination—no, thank you. I don't even cherish being admitted to a hospital. “Medical procedures are not hotcakes. People aren't going to line up eagerly demanding heart transplants just because someone else is paying” (CHSRF, 2001, citing Robert Evans of the University of British Columbia).

For every hypochondriac, how many other people avoid health services like the plague (so to speak)? Even that 90-year-old in Vancouver was not being unreasonable. Put yourself in his running shoes: this was truly a question of *health care*. So **excessive demand for health care services is not the problem so much as reasonable demand for services that are in short supply, thanks to our collective reluctance to pay for them.** (An exception can be noted here for the proclivity to order too many tests, especially in the United States, where there is so much litigation.)

Of course, there is a supply side to this issue. Give some physician the time and the fees for some treatment, and he or she may find lots of illness in need of it. Or give some hospital more beds and it will fill them. Is this a bad thing? Only if the added services are unnecessary or, worse, lead to the diagnosis of conditions that are better left untreated.²

²In a striking article, Atul Gawande (2009a) investigated two poor regions of Texas with rather similar health outcomes that had dramatically different costs: for U.S. Medicare in 2006, \$15,000 per enrollee versus \$7500. The reason, in his view: “across-the-board overuse of medicine.” Casual decisions about prescriptions and financial benefits to the prescribers may in fact have increased risks. “Many physicians are remarkably oblivious to the financial implications of their decisions,” while for others, “this is a business, after all.” Recent reports on prostate tests and mammograms have suggested that they may be encouraging dysfunctional surgeries. On the other hand, those

Myths

So what are the consequences of all this? Quite simple: **The field of health care is being squeezed on all sides, by governments and markets, demanders and suppliers. As a result, many users are justified in feeling that they are not getting the services they need—not fast enough, not good enough, or just plain not enough.**

Pervasive Rationing

Rationing is a taboo word in much of health care. In Canada, governments go to great lengths to avoid mentioning the *R* word, let alone facing decisions about it. Yet **rationing is an intrinsic part of health care, everywhere, all the time**—for example, when a night nurse has to decide which of two beeping monitors to attend to first, or a physician has to determine who is to get a kidney that has become available for transplant, or a government or HMO has to specify the age at which people can no longer get some expensive treatment. The only alternative to this rationalizing is that everyone gets everything to cover every possible contingency. That is hardly feasible, at least if you are not Michael Jackson—and look what happened to him.³

people who avoid health care services may just be increasing the costs, since problems caught late can be much more expensive to treat.

³ Peter Goldberg (mentioned earlier as head of that ICU in a Montreal hospital), wrote in his final paper in our IMHL Program entitled *Rationing in the Public Health System in Canada: The Search for an Ethical Construct*:

In thinking about these issues—aided, I must admit by the luxury of time afforded me to do exactly that in the confines of the IMHL—I came to understand that I had become, wittingly or not, an agent of rationing of medical services. While it was clear to me that none of my training or professional experience had prepared me for such a role, it also became clear to me that the public, or certainly those who took the time to consider such issues, would recoil at the arbitrariness with which I had come to occupy such a pivotal role in the allocation of their health care services. Furthermore, and perhaps instructively, I noted that nobody within the public health care system ever mentioned rationing. Nobody ever uttered the “r” word. When spoken of, such

Myth #2

Sometimes medicine strikes back. A surgeon called the executive director of his hospital: “I have a heart. I have a patient. I have an operating room. I have no budget.” What is any manager who has a heart to do? This is rationing reduced to a game of Ping-Pong. Hit the problem back to someone else. Is the “system” failing, or are *we* failing in how we make choices, or refuse to?

We turn now to what have been the main administrative interventions applied to deal with this ostensible failure of health care: heroic leadership; administrative engineering; categorizing, commodifying, and calculating; increasing competition; and running health care like a business. I shall argue that, in some significant ways, much of this has delivered conspicuous failures.

euphemisms as allocation of scarce health care resources would be used so as to spare one’s sensibilities—although it was unclear whose sensibilities were to be spared. (2011: 3)

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