Managing the myths of health care

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ABSTRACT: Myths impede the effective management of health care, for example that the system is failing (indeed, that is a system), and can be fixed by detached social engineering and heroic leadership, or treating it more like a business. This field needs to reframe its management, as distributed beyond the "top"; its strategy as venturing, not planning; its organizing as collaboration beyond control, and especially itself, as a system beyond its parts.

Myths abound in management, for example that senior managers sit on "top" (of what?), that leaders are more important than managers (try leading without managing), and that people are human resources (I am a human being).

Myths abound in what is called the system of health care too, not least that it is a system, and is about the care of health (mostly it is a collection of treatments for disease). Combine these two sets of myths, as is increasingly common these days, and you end up with the mess we now face in the world of health care.

Let us begin with the myths of managing now prevalent in health care and then turn to some reframing that may help to escape this mess.

Myth #1: The health care system is failing. Speak to people almost anywhere in the world and they will tell you how their system of health care is failing. The truth is quite the opposite: In most places in the developed world, health care is succeeding – expensively. In other words, success is the problem, not failure.

Consult almost any statistic. We are living longer, losing fewer infants, and so on, in large part because of advances in treatments. The trouble is that many of these are expensive, and we don't want to pay for them – certainly not as healthy people through our insurance premiums or taxes. So health care services get squeezed, and it looks like the system is failing. In fact, as we shall discuss below, the problems are not in the health care services themselves so much as in the consequences of our interventions to fix this ostensible failure. We consider three interventions in particular: social engineering, leadership, and business practice.

Myth #2: The health care system can be fixed by clever social engineering. The system is broken so the "experts" have to fix it: usually not people on the ground, who understand the problems viscerally, but specialists in the air, such as economists, system analysts, and consultants, who believe they understand them conceptually. Thanks to them, in health care we measure and merge like mad, reorganize constantly, apply the management technique of the month, "reinvent" health care every few years, and drive change from the "top" for the sake of participation at the bottom.

Do all this and all will be well, we are told. But is it ever? In particular, at this so-called bottom, the real experts struggle to cope with the pressures, not least from these very "solutions," most of which seem to make things increasingly convoluted.

What if, instead, we came to appreciate that effective change in health care has to come largely out of the operations, and diffuse across them rather than forced down into them? Consider, for example, the changes in recent times that have made the greatest differences, not only in cutting costs – that's the easy part – but also in improving quality. Day surgeries have to be near the top of that list. This idea came from engaged clinicians, not detached social engineers.

Myth #3: Health care institutions as well as the overall system can be fixed by bringing in the heroic leader. New leadership can certainly help, at least when it replaces a leadership that was worse. But what does effective leadership mean in a field where the professionals have so much of the power? In hospitals, for example, physicians are usually far more responsive to their own hierarchies of professional status than the managerial hierarchies of formal authority. Hence what can be called "heroic leadership", so fashionable now in business (witness the whole system of bonuses), can be bad for health care, let alone for business itself. Far more necessary is what can be called engaging management: managers who are deeply and personally engaged so as to be able to help engage others.

Myth #4: The health care system can be fixed by treating it more as a business. This is a particularly popular prescription in the United States. Perhaps no country on earth treats health care more as a business, or is more encouraging of competition in this field. But given America's current state of performance – far more expensive than anywhere else, with overall quality rankings that are mediocre – shall we take this as testimonial to the wonders of competition and business practices in the field of health care?

The United States spends about 31¢ of every health care dollar on administration; Canada, with much less competition and far less of a business orientation in health care, spends about 17¢, and achieves better measures of quality. To quote from an article in the *New York Times*: "Duplicate processing of claims, large numbers of insurance products, complicated bill paying systems

and high marketing costs [plus all the "paperwork required of American doctors and hospitals that simply do not exist in countries like Canada or Britain"] add up to high administrative expenses" (Bernasek 2007). In the name of competition, American health care in fact suffers from individualization: every professional and every institution for his, her, or itself.

So again, let's try it differently: Health care functions best as a calling, not a business; as such, it needs greater cooperation, not competition, among its many players and institutions. Physicians may be well paid, but these are smart people capable of earning large incomes elsewhere. What keeps many, if not most, of them in health care is the sense of service. This applies equally, if not more so, to the nurses, who don't earn that kind of money, and many of the managers too. What happens to health care as a calling when it is seen as "one-stop shopping", hospitals as "focused factories", patients as "customers" and "consumers", and physicians as "industry players" (as described by Herzlinger 2006)?

Myth #5 and 6: Health care is rightly left to the private sector, for the sake of efficiency. Health care is rightly controlled by the public sector, for the sake of equality. Take your choice, according to the country in which you live. In fact, if you live where the services are largely public, you hear a great deal about the private sector (as in Canada now). And if you live where they are largely private, then you hear a great deal about the public sector (as in the recent debates in the United States Congress). That is because nowhere in the world today can the field of health care function without serious involvement of both government controls and market forces.

Many Americans, and not only on talk radio shows, are sharply critical of the role of the state in health care. In two influential publications, Porter and Teisberg were highly dismissive of the state as a player in this field. Their book *Reforming Health Care* (2006) referred to government-controlled regulations as "never a real solution" (although it certainly is in most developed countries). Concerning the unsatisfactory performance of American health care over many years, they claimed in their related *Harvard Business Review* article (2004) that "while this may be expected in a state-controlled sector, it is nearly unimaginable in a competitive market." (Again, the facts suggest exactly the opposite.)

Of particular importance is that many of the most important services in health care come from neither the public nor the private sector. Canada and the United States sit near the two extremes on this issue, yet the vast majority of hospitals in both countries are in the plural sector, namely in the form of organizations that are owned by no-one (so called "voluntary" in the United States), and that includes the most prestigious. Efficiency and equality certainly matter in health care, but hardly more so than quality, which often seems to be delivered best by organizations that are autonomous – controlled neither by the state nor owned by private shareholders. Presumably this helps to reinforce the engagement of their professionals with regard to their sense of calling.

Of course, all the sectors have a role to play in health care: the public sector, largely to maintain a certain level of equality (as in the new American legislation) as well as in regulation; the private sector, significantly to provide supplies and equipment as well as some of the more routine services; and the plural sector, for the delivery of many of the key professional services, including research. (And the latter might well include pharmaceuticals. In the twentieth century, arguably the three most significant pharmaceutical developments – penicillin, insulin, and Salk vaccine – all came out of not-for-profit laboratories.)

The Myths of Measurement and of Scale Measurement is a fine idea, as long as it does not mesmerize the user. Unfortunately, it so often does: both managers who rely on it for control and physicians who believe that being "evidence-based" always has to trump being "experienced-based." Management and medicine alike have to balance these two in order to be effective. Unfortunately, too much of health care at both the administrative and clinical levels has been thrown out of balance by their obsessions with measurement.

In the management of health care, the frustration of trying to control rather autonomous professionals has led the administrators and social engineers to a reliance on measurement. And this, it should be noted, is no less prevalent in private sector control by insurance companies and HMOs, etc, than in public sector control by government agencies.

The problem with measurement is that, while the treatments exist in standard categories – certain medications for manic-depression, particular forms of angioplasty for various heart conditions, etc. – their outcomes are often not standard, and therefore can be tricky to pin down by measurement. That is because we as individual patients are not standardized, and so our treatments have to be tailored to our individual needs and conditions.

It is often said that "If you can't measure it, you can't manage it." Well, who has ever adequately measured the performance of management? (Don't tell me it can be done by looking at a stock price.) In fact, who has ever even tried to measure the performance of measurement itself? I guess we must conclude therefore that neither management nor measurement can be managed.

So what can be done if we cannot rely wholly on measurement? That's easy: use judgment. Remember judgment? Can you imagine medicine without judgment? Well, then, I suggest that you not try to imagine management without judgment either.

Measurement favors large scale; in fact scale is measurement. So a society mesmerized by measurement is a society obsessed with large scale. Hence the small hospitals are the ones that get closed. Herzlinger wrote in her 2006 *Harvard Business Review* article that "Health care is still an astonishingly fragmented industry. More than half of the US physicians work in practices of three or fewer doctors; a quarter of the nation's 5,000 community hospitals and nearly half of its 17,000 nursing homes are independent." But what is wrong with that? She added that "You can roll a number of independent players into a single organization…to generate economies of scale". Picture that!

Notice the term: economies of scale. Not effectiveness of scale but economies of scale. Too much of the management of health care has come to be about using scale to reduce measurable costs at the expense of difficult-to-measure benefits.

I am not trying to make the case that smaller is always more beautiful, only to plead that bigger is not always better. Scale, too, has to be judged, especially for its impact on performance. Health care as a calling works best in units that are as humanly small as the best of technology allows. This, in fact, seems to hold true even in pharmaceutical research. To quote Roger Gilmartin when he was chief executive of Merck: "Scale has been no indication of

the ability to discover breakthrough drugs. In fact, it has been the other way – you get bogged down" (Clifford, 2000).

All of this suggests that it is time for some reframing in the management of health care. What follows is not social engineering so much as a suggested set of guidelines.

Reframing management: As distributed beyond the "top"

As noted at the outset, management on "top" is a myth. Aside from that ubiquitous chart, and those famous bonuses, what is management on top of exactly? Indeed, in hospitals, "top" managers often sit on the ground floor (perhaps to be able to make a quick getaway). Seeing yourself on top of an organization all too often means not being on top of what is going on in that organization.

Should these top managers have the power to make decisions about the purchase of expensive equipment, independent of the physicians who use them? That hardly makes more sense than leaving those decisions to the physicians themselves. These are not financial decisions or technical decisions but hospital decisions, and so require collaboration on the part of managers and physicians. And, make no mistake about it, involvement in such decision making places the physicians squarely in the realm of management – as soon as we get past the notion that management is something practiced only by people called managers. Many health care organizations require "distributed management", which means that managerial activities be performed by whoever has the necessary skills, knowledge, and perspective to carry them out most effectively – and that often means collaboratively.

Reframing strategy: As venturing, not planning

If you want to understand what strategy means in a professional organization such as a hospital, stay away from almost all the strategy books. They tell you about strategic planning from the top; recognize instead strategic venturing at the base.

If strategy concerns the positioning of products and services for users, then in a hospital the services are specific kinds of treatments for specific diseases. And where do these come from? Rarely from any "top" management and rarely in any planning process. They come mostly from the venturing activities of professionals: concern about a new disease here, championing of a new treatment there. In other words, the strategy of a hospital is largely the sum total of the many ventures of its professional staff. So here, especially, is where we see distributed management: Professionals on the ground, who are not managers, are responsible for most of the strategic initiatives in health care.

Sure there are other, more conventional strategies determined at large – for example about what services to offer and where to locate them. But much of that is built into the structure and history of the institution.

Hospitals may engage in strategic planning, but a great deal of this, in my experience, doesn't amount to much. Too often it is just another indication of what can be called "the administrative gap" – the disconnect between the machinations of management and the operations of clinicians (Mintzberg 1994, 2007).

Reframing organization: As collaboration beyond control, communityship beyond leadership

With management as distributed and the strategy process as venturing, the nature of most health care organizations can be better understood. The prevailing model in business is what can be called the "machine organization": top-down, hierarchically-focused, control-oriented, numbers-driven, and outputs-standardized. Managers rule. But a very different model, that can be called the "professional organization", is more common in health care: expert-driven, skills-oriented, and highly oriented to pigeonholing, which means getting the client into the right box (mania, hernia, etc.) so that the most appropriate intervention can be applied.

Such pigeonholing describes the great strength of the professional organization as well as its debilitating weakness. The professionals get used to operating in their own pigeonholes, as free as possible of the influence of their own colleagues, let alone the controls of the managers.

Unfortunately, as human patients we are sometimes square pegs forced into these round holes. Some of us have this habit of getting illnesses that cut across the disease categories, or worse still, that don't fit them well (as in auto-immune diseases). Then we require interventions that cut across the pigeonholes, which are often resisted by medical specialists used to operating within them. In other words, we need collaboration from people who are mostly inclined to avoid it.

How to organize around this problem? The inclination has been to use solutions designed for the machine organization – centrally-imposed control systems, performance measures, financial incentives and the like, or else expecting managers up the hierarchy to force the professionals to collaborate. But these hardly work well with independent professionals. Resistance to collaboration in the professional organization will more likely be overcome by drawing on the professionals' sense of calling, and enhancing their organization as a community of service. Put differently, when people are committed to their organization, and not just to their own profession, they are more likely to collaborate effectively. A good sense of this can be had from some comments made by Atul Gawande in one of his *New Yorker* articles on health care:

> The Mayo Clinic… is among the highest-quality, lowest-cost health-care systems in the country. A couple of years ago, I spent several days there as a visiting surgeon. Among the things that stand out from that visit was how much time the doctors spent with patients. There was no churn – no shuttling patients in and out of rooms while the doctor bounces from one to the other…
>
> The core tenant of the Mayo Clinic is "The need of the patient first" – not the convenience of the doctors, not their revenues. The doctors and nurses, and even the janitors, sat in meetings almost weekly, working on ideas to make the service and the care better, not to get more money out of patients. …decades ago Mayo recognized that the first thing it needed to do was eliminate the financial barriers. It pooled all the money the doctors and the hospital system received and began paying everyone a salary, so that the doctors' goal in patient care couldn't be increasing their income. …almost by happenstance, the result has been lower costs (2009: 14–15).

Reframing scale: As human beyond economic

None of the guidelines suggested above are helped by large scale – not community, not engagement, not collaboration, not closing the gap between administration and operations. Nor does large

scale help to humanize the practice of medicine.

There can, of course, be technical reasons to favor large scale, for example, in order to purchase necessary expensive equipment. This suggests that we should no more reject large scale than embrace it. But the unfortunate fact is that, because of our mesmerization with measurement, far too often we embrace large scale, conveniently forgetting the human factors.

Imagine if we made small scale the default position, so to speak – in other words put the onus on the proponents of large scale, in health care institutions as well as in health authorities, to make their case for scale on social grounds, judgmentally as well as numerically, beyond the technical and economic grounds.

Reframing managing style: As caring more than curing

Nursing, focused on care, may be a more appropriate model for managing than medicine, focused on cure. Our health care institutions, in other words, require care more than cure: the engagement of their managers to help them function more smoothly, rather than having the power of heroic leaders to run around fixing things.

There was a cartoon once that showed a group of surgeons around a patient on an operation table, with the line "Who opens?" In medicine, we know who opens; in management often we do not – not even if someone should open. That is why management has to be a fundamentally cooperative practice, of a style far from heroic leadership. Managing in health care should be about devoted, continuous, holistic and preemptive care more than interventionist, episodic, narrow and radical cures.

Reframing health care itself: As a system beyond its parts

I opened this article with the claim that we do not have a system of health care so much as a collection of disease treatments. Even my own examples have come largely from the latter. (Hospitals, it should be remembered, account for only about 30 percent of health care expenditures.) Especially the promotion of health, but also the prevention of disease, are muscled aside by our focus on the treatment of disease, even though investment in the former can be far more cost-effective.

An ad appeared some years ago for SAP Canada, headed "This is not a cow." It showed a picture of a cow, with lines drawn where it would be quartered, with the text: "This is an organizational chart that shows the different parts of a cow. In a real cow the parts are not aware that they are parts. They do not have trouble sharing information. They smoothly and naturally work together, as one unit. As a cow. And you have only one question to answer. "Do you want your organization to work like a chart? Or a cow?"

Why can't health care work like a cow: why can it not be a true system of cooperation and collaboration? Note that the parts of a cow are not "seamless." They are distinct, necessarily so. But in a healthy cow, they work together harmoniously. Can this happen in health care? I believe so, and have been working with colleagues for some years to that end. Our management and medical schools at McGill University have teamed up to create a masters program for health leadership that seeks to encourage all of these guidelines (www.mcgill.ca/imhl). It brings practicing managers from all over the world in all aspects of health care – hospitals, community care, public health, government ministries, etc., most of them with clinical backgrounds – together in an ongoing forum that meets periodically over a year and a half to address the major issues of health care. These include:

- The Gap Issue: How to bring the administration of health care closer to the operations, connecting it for support beyond control?
- The Collaboration Issue: How to get the different parts of health care working in greater cooperative harmony?
- The Engagement Issue: How to enhance engagement through the promotion of human scale beyond economic scale?
- The Sector Issue: What are the appropriate roles of the three sectors, especially the plural sector that sits between the now dominant public and private sectors?
- The Performance Issue: How to balance the intrinsic needs for efficiency, equality, and quality in health care?

We have been especially struck by the natural propensity of managers in such a program to work together on such issues, reaching out beyond their own personal needs and those of their institutions, into their local communities and out to the needs of health care in general. On a number of occasions, groups in the class have brought into our forum key issues of concern in their communities, to enable the class to address them in a process we call "friendly consulting".

A group of managers from Quebec, for example, invited the three commissioners of a major government health care commission into the class for a workshop on some of these issues. And two physician managers from Uganda brought our classroom to a conference they organized in Kampala for 60 health care managers from seven African countries, on the subject of how to scale up their management infrastructures.

What this has made clear is that an immense amount of energy and goodwill exists in the field of health care, to work collaboratively to render it more effective, on both the local and the global levels. We just need to get past the myths. ❑

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