Behind the Jargon

What Passes and Fails as Health Policy and Management

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Abstract The field of health policy and management (HPAM) faces a gap between theory, policy, and practice. Despite decades of efforts at reforming health policy and health care systems, prominent analysts state that the health system is "stuck" and that models for change remain "aspirational." We discuss four reasons for the failure of current ideas and models for redesigning health care: (1) the dominance of micro-economic thinking; (2) the lack of comparative studies of health care organizations and the limits of health management theory in recognizing the importance of local contexts; (3) the separation of HPAM from the rank and file of health care, particularly physicians; and (4) the failure to expose medical students to issues of HPAM. We conclude with suggestions for rethinking how the field of HPAM might generate more-promising policies for health care providers and managers by abandoning the illusion of context-free theories and, instead, seeking to facilitate the processes by which organizations can learn to improve their own performance.

The field of health policy and management (HPAM) faces a gap between theory, policy, and practice. Leaders in the field inundate managers and physicians with ideas about accountable care organizations (ACOs), value-based health care (VBHC), pay for performance (P4P), and more. These ideas are not arbitrary; they grow out of current policy initiatives, which are, in turn, influenced by widely accepted theories of how to reform the health care system. But neither the theories nor the dominant ideas

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in HPAM are well adapted to the world of health care organizations and medical practice.

What passes for HPAM typically fails in practice. To suggest that HPAM has no positive impact would be harsh. Spurts of success occur in designing financial incentives and new management techniques aimed at improving quality of care and restraining costs. But such interventions are scattered and rarely sustained. We highlight four interrelated problems that appear to sustain the theory-policy-practice gap: (1) the dominance of microeconomic thinking; (2) the lack of comparative studies of health care organizations; (3) the separation of HPAM from the rank and file of health care, particularly physicians; and (4) the failure to link medical education with HPAM. We conclude with suggestions for rethinking how the field of HPAM might generate more promising policies for health care providers and managers.

The Dominance of Microeconomic Thinking

Prominent economists themselves have noted the overreach of their discipline in health policy. Kenneth J. Arrow's (1963) classic article on health care notes the information asymmetries leading to market failure and the critical importance of trust in health care transactions. Albert O. Hirschman's (1970) analysis of organizations highlights the limits of conventional market models that rely on "exit" and the importance of nurturing "voice" and "loyalty" to avoid the corrosive effects of market behavior. The implications of these models for the health sector have spawned incisive articles (e.g., Klein 1980). Yet despite these amendments to conventional economic models, and the contributions of behavioral economics to policy thinking (Oliver 2012, 2013), health policy returns cyclically to financial incentives as solutions to perceived health system problems.

An important body of work catalogs the overuse and inappropriate nature of economic models applied to the health care sector (Hsiao 1994; Oliver and Brown 2011; White 2007). Policies inspired by conventional neoclassical economic theory, such as the diffusion of health savings accounts, the extension of capitated payment, and the promotion of managed competition, are repackaged as consumer-driven health care, ACOs, P4P, VBHC, and bundled payments. The renaming overlooks the limited success of these approaches and enables their recycling in a kind of policy maelstrom where economists assume that with renewed effort the intervention will work, thus crowding out consideration of alternatives.

As a contemporary example, early evidence on the performance of Medicare ACOs and shared savings plans is mixed, with the Centers for Medicare and Medicaid Services (CMS 2014) emphasizing the apparent success of a significant proportion of participating plans in amassing savings and improving quality. But other observers question this view and express concerns about issues of self-selection, inequality, and the sustainability of early cost savings, patterns that plagued earlier efforts such as Medicare health maintenance organizations (HMOs) and Physician Group Practice Demonstrations (Epstein et al. 2014; Goldsmith 2013). What appears to be a "no-brainer" from the standpoint of microeconomics, and even shows signs of early success, usually turns out to be a chimera.

Consider also the case of rewarding quality with financial incentives. Bruce C. Vladeck (2003) argued long ago that despite the consensus on the virtues of paying for quality, it is actually a "bad idea" supported by scant evidence. Recent experience indicates that little has changed. Even after significant efforts to develop quality measures and apply them in hospitals, often accompanied with financial incentives, evidence shows disappointing results (Landrigan et al. 2010). Even policy innovations based on good evidence, such as surgical checklists and hand washing in hospitals, face an uphill battle in crossing the theory-policy-practice gap, and financial incentives do not seem to solve the problem (Moran and Scanlon 2013; Gawande 2010; Kupfer 2013).

Methodological issues also arise in evaluating the impact of financial incentives on quality improvement. For example, despite attempts at risk adjustment for case-mix severity, providers receiving low grades on performance measures claim that their caseload is more difficult and respond by trying to avoid patients with complex problems (Farmer, Black, and Bonow 2013; Bevan and Hood 2006). Moreover, focusing on one measure of quality can distort care, since it encourages "treating to the test." The proliferation of quality measures and practice guidelines for treating different diseases and conditions has not resulted in greater integration of care and gains in population health (Bishop 2013; Berenson, Pronovost, and Krumholz 2013). Reducing medical errors, avoidable hospital admissions, and readmissions are all vital goals, but piecemeal consideration of each supported by increasingly sophisticated measurement tools may run counter to integration across the vast number of silos in health care practice (Bishop 2013). Moreover, as Vladeck (2003) argues, important to consider is whether aggressive implementation of such fashionable policy ideas corrodes notions of "professionalism" and society's underlying trust in the norms and behaviors to which physicians are supposed to pledge allegiance.

To conventional neoclassical economists, the answer to these conundrums is provision of better and more detailed information. For example, health information technology (HIT) and electronic medical records, often envisioned as melding into integrated universal data systems, are intuitively compelling as engines of health care improvement. But health policy analysts steeped in microeconomic thinking seek to stimulate these developments through financial incentives, rather than to engage physicians and managers (Chinitz 2011). Thus, in response to funding "meaningful use" of HIT, multiple vendors sell diverse information systems that go in the opposite direction of health care integration. The concept of "meaningful use" becomes a cat-and-mouse game between government regulators that produce volumes of specifications and an alliance of vendors and health care organizations eager to cash in on the latest government incentives. Even if some of the resulting projects are worthy, one wonders about the magnitude of waste generated by such a process (Creswell 2013).

Another example of how microeconomic thinking has dominated HPAM is the notion of bundled payment. When HPAM analysts seek to price episodes of care, they are likely reacting to the carving up of medical care induced by highly targeted performance measures accompanied with financial incentives. Starting this year, the CMS Hospitals Readmissions Reductions Program withholds up to 1 percent of regular reimbursements for hospitals with higher than expected (by CMS) rates of rehospitalization, within thirty days of discharge, because of heart attacks, heart failure, and pneumonia. In 2014 and 2015, CMS will raise this figure to 2 percent and 3 percent, respectively, and may subsequently expand the list of conditions for which it will penalize rehospitalizations. However, what is readily apparent is that without better coordination of services following discharge, hospitals alone can hardly be held accountable for rehospitalization.

In summary, microeconomic concepts and tools, while ostensibly passing as the foundation of HPAM, are not sufficient for understanding the context of health care systems. In-depth understanding of health care organizations relies on analysis of many more variables than those typically used in microeconomic models that assume financial incentives can neutralize "nonrational" behavior deriving from the murky seabed of organizations. The recent rise of behavioral economics even seeks to use nonfinancial incentives, "nudges," to overcome irrational behavior of citizens, patients, and providers; yet this trend seems to follow microeconomics in lacking attention to institutional considerations (Oliver 2012; Chinitz 2013). Microeconomic concepts help analysts understand part of the picture, but

too many HPAM analysts are seduced into overusing them, producing health policy that is simplistic, if not simpleminded. This outcome is not surprising, since the health care management literature has not provided strong competition, for reasons to which we now turn.

The Lack of Comparative Studies of Health Care Organizations

Why does the field of HPAM, as well as most policies that government seeks to implement, continue to be dominated by microeconomic concepts that provoke political antibodies among health care providers? One important reason is that despite knowledge of how health care organizations work, managers have less influence on policy than economists have. Much health care management knowledge grows out of case studies of so-called high-performing health care systems, such as Geisinger, Kaiser Permanente, or the Mayo Clinic (Song and Lee 2013; Bodenheimer and West 2010). Yet to derive general conclusions from concrete cases is difficult because optimal behavior depends on local conditions. Trying to turn all health care systems into high-performing integrated models is akin to Aneurin Bevan's motto about "generalizing the best" in England's National Health Service. The unique traditions and cultures of population-oriented care, which characterize integrated health systems, are too often forgotten. Under the weight of policies inspired by microeconomic thinking and the pressure to produce short-term payoffs, slow knowledge accumulation through case studies has little influence.

Consider, for example, Michael E. Porter and Thomas H. Lee's (2013) argument that market conditions will compel health care organizations to transform themselves and achieve the "clear" goal of "value for patients." In their view, unless health care systems design integrated practice units (IPUs), provide good information about outcomes and costs, and bundle payments, they will be unlikely to survive. Examples of "successful" organizations are invoked to support the argument. To their credit, Porter and Lee recognize that there are no "silver bullets" and that change will take time. Nonetheless, not evident is why IPUs will spread any more than prepaid group practice did in the past. The "value added" by integrated organizations does not explain how wisdom accumulated in successful health systems will diffuse more widely, particularly if stakeholders working within existing organizational arrangements typically do not view alternative organizations as increasing their professional autonomy or income. Rather, Porter and Lee seem to assume that health care systems *will* evolve into IPUs because that is what they believe should happen.

Another example of research drawing on case studies is the rise of evidence-based management (EBMg), inspired by evidence-based medicine (EBMd). Rooted in comparative studies on the effectiveness of medical interventions, EBMd is often based on randomized clinical trials. Despite the fact that EBMd has encountered dilemmas that complicate its implementation, leaders in HPAM hastened to appear scientific; thus EBMg was born (Kovner and Rundall 2006; Dopson et al. 2013). Even if (and the if turns out to be significant) optimal treatment can be based on cost-effectiveness studies and the resulting practice guidelines can be used across health care organizations, EBMg is more complicated to implement than EBMd (Pfeffer and Sutton 2006). While EBMd relies on information that cuts across organizations, EBMg requires attention to what is going on inside particular organizations, as well as outside them—the institutional context of each organization (Kahan et al. 2009; Mintzberg 1989).

These examples illustrate a large number of health care management approaches that focus on case studies and emphasize the importance of "culture" as if this black box were easily transferable. Stephen M. Shortell and Lawrence P. Casalino (2008), in their analysis of ACOs, note that their successful implementation will require a melding of cultures between hospitals and physicians. Much is written about integrated care and "teamwork," and examples of "high-performing" health systems are often invoked (Institute for Healthcare Improvement 2007; Commonwealth Fund 2013). Often the methods and financial incentives of integrated care and teamwork are even transferred to other settings, but the impact of such models on dominant forms of fee-for-service medical practice has mostly taken the form of what Joseph White (2013: S24) calls "aspirational initiatives" that have succeeded in specific local contexts, but have not spread across the nation.

The struggle to generalize across institutional contexts reminds us of the methodological tension between quantitative and qualitative research. While the latter has become more accepted in the field of HPAM, especially in the study of organization and management, its role in policy and decision making remains suspect in the eyes of those looking for "evidence-based" solutions to complex managerial challenges. What David M. Frankford (1994: 784) has called "data-driven" health services research in the name of "scientism and economism" serves the desire of policy makers to make broad-brush claims. Yet such claims often run counter to the need for managers to respond to local contingencies. To the extent that health care is a "community affair" (Rosen 1967), it can derail and distort the intended outcomes of well-intentioned policy interventions and bottom-line-oriented metrics against which to measure health care system performance.

Given the rich diversity of health care organizations, policy appropriately adapted to the world of health care organizations will require better understanding of how such organizations learn from so-called best practices, as well as from interesting failures. Organizational learning is likely to require that improved understanding be filtered through the sieve of each health care organization's specific institutional context. Eugene Bardach (2012) suggests replacing the term *best practice* with *smart practice*, to avoid misplaced mimicry and the "not invented here" syndrome. But the current state of EBMg is manifested by a resort to vague terms such as *culture* and *trust*, on the one hand, and in-depth case studies of *high-performing* health care organizations, on the other. What is missing is generalized agreement on the criteria to assess what constitutes high performance and efforts to promote the comparative analysis of health care organizations, including the role of EBMg and other approaches for turning health care systems into "learning organizations" (Dopson et al. 2013; IOM 2012).

The Separation of HPAM from the Rank and File of Health Care

Beyond the dominance of microeconomic thinking and the lack of comparative studies of health care organizations, another problem that sustains the theory-policy-practice gap is the separation of HPAM from the rank and file of health care. Health care delivery organizations are often designed without sufficient participation from the rank and file, especially physicians. Their limited participation strikes us as inappropriate given their critical role in the provision of quality health care (Emanuel and Steinmetz 2013; Audet et al. 2005; Porter and Teisberg 2007) but is not surprising, since, as we discuss below, the training and socialization of medical professionals is distant from considerations of cost, quality, and access. Although prevailing opinion in the field of HPAM suggests that targeted financial incentives and regulation will eventually make key stakeholders come around (Dixon, Chantler, and Billings 2007), this approach has not worked so well (Berenson, Pronovost, and Krumholz 2013). Despite decades of policy and management interventions to make health care organizations more effective, efficient, and equitable, ebbs and flows in managed care, and grouping and regroupings of hospitals and physicians, little has changed in the basic arrangements within which physicians practice.

Consider the challenge of ensuring patient safety in hospitals (Tucker et al. 2008). Frontline staff often find policy guidance on safety irrelevant

to the real obstacles preventing improvement. Where policy talks about measurement and incentives, frontline staff are more concerned with the lack of proper equipment that leads to safety breakdowns. Rather than focus on narrowly defined clinical improvements, from a staff perspective improvement occurs and is sustained better when addressing overall hospital processes. Reema Sirriyeh and colleagues (2012) identify "quality subcultures," smaller groups within hospitals that develop their own methods of quality improvement. Typically ignored by higher-level policy and management directives, these subcultures should be taken into account in developing a unified organizational approach to quality. In managing health care organizations, input from rank and file is at least as important as directives from on high, yet HPAM has disproportionately emphasized the latter.

While policy commentaries and perspective pieces in health economics journals, the *Journal of the American Medical Association* (*JAMA*) and the *New England Journal of Medicine* (*NEJM*), promote ideas from the field of HPAM, rank-and-file medical professionals often find them removed from an understanding of what clinicians and managers face in the world of practice. While few surveys take the pulse of physician attitudes toward, for example, the Patient Protection and Affordable Care Act, existing evidence suggests limited understanding and dissatisfaction with government health policy (Tilburt et al. 2013). Clinicians have a difficult time just keeping up with the clinical articles in *JAMA* and *NEJM*, let alone becoming acquainted with the field of HPAM. Thus, not surprisingly, dominant HPAM approaches focus on financial incentives and regulatory constraints to alter behavior and leave the complex internal workings of health care systems unexplored. As we have suggested, such an approach leads to a cycle of organizational dysfunction in which past failures are interpreted as calling for more intensive and refined interventions—better capitation formulas, better measurement of medical care, better information systems. The result is to drive a wedge between the HPAM discussions going on in the intellectual and policy stratosphere and what is actually happening at the level of the rank and file. Theory and policy fail to affect practice, which in turn fails to inform theory, the precise opposite of the recursive looping that should exist.

The Failure to Link Medical Education with HPAM

At the end of the top-down, nonrecursive HPAM food chain lies the socialization of the medical workforce, particularly physicians. Medical education has given short shrift to the field of HPAM. Just as most health

policy interventions are biased toward short-term gains, thereby pushing away long-term problems, leaders in the field of HPAM have neglected to make the field relevant for the next generation of health care professionals. Proponents of social medicine argue that medical education is focused too much on the clinical treatment of patients, not enough on community health. Medical students will continue, of course, to be trained to treat individual patients. With regard to ethics, they will continue to focus on doctor-patient relationships (Beauchamp and Childress 1994). But they could also be introduced to the analysis of ethical issues in public policy (Sandel 2009) and management (Darr 2005) and to studies of variations in medical practice (Wennberg 1984). Why not expose medical students to case studies of integrated team care without suggesting a one best way to manage every patient pathway? Why not teach them more about the variety of practice settings in which they may work and the different ways that financial incentives play out in diverse health care organizations within the United States, as well as abroad?

Recently, the American Medical Association announced an $11 million program of medical school grants to develop the "physician of the future" (AMA 2013). While such funding might loom large in one medical school's budget, this is the exception that proves the rule. Clinicians, as well as health policy analysts and managers, must learn more about the variety of organizational cultures in the health sector. What are the contextual characteristics of Geisinger, Intermountain, Kaiser, Mayo, and, for that matter, innovative organizational arrangements in other countries? What are the different, as opposed to the standardized, ways that tools such as HIT, P4P, and bundled payments play out in health care organizations, and what are their effects beyond what they are targeted to do? What conditions have seen such interventions lead to successful organizational learning, and where have they led to perverse outcomes? Does the language of organizational change focus on issues of cost and community health, as well as on individual care?

Medical education resists change and perhaps for good reason. With simply too much to learn about how to treat individual diseases, why divert medical students' attention to population health? Medical school professors are rewarded for their research and teaching in medical therapies and new diagnostic and treatment interventions. Several medical schools have created departments of population health, but these seem to be parallel add-ons to the core medical curriculum and not integrated with the training of physicians (Jefferson School of Population Health, n.d.; NYU Langone Medical Center, n.d.). Research on the human genome and new developments in personalized medicine will only increase this orientation and

continue to challenge the field of HPAM, which remains driven by the quest to achieve value for money, understand organizational complexity, and improve population health.

Rethinking HPAM

Given the theory-policy-practice gaps we have highlighted, what currently passes as HPAM has a negligible effect on practice. Prominent analysts state flatly that health care is "stuck" (Porter and Lee 2013), and so is HPAM. What now passes as HPAM is incapable of altering a fragmented health care system that shuns vertical integration across hospitals and community-based primary care. Because theory and policy are disconnected from practice, and because practice, likewise, is so removed from theory and policy, each is reciprocally stuck.

While reforming medical education may be too much to expect, a shift in how health policy analysts and managers think about health systems is long overdue and could narrow the theory-policy-practice gap. The dominance of microeconomic theory must be challenged, comparative studies of health care organizations must be encouraged, and participation of rank-and-file health care providers must be extended. In broadening HPAM, improved understanding of how financial incentives interact with professional values and organizational cultures will also be necessary. Beyond microeconomics, institutional economics (Chinitz 2013), organization theory, and management, HPAM must embrace (rather than shun) disciplines ranging from sociology to anthropology and epistemology as well as broader perspectives, for example, ethics, urban health, systems analysis, and cross-national analyses of health care systems.

Perhaps most challenging for narrowing the theory-policy-practice gap is how to allow for flexible responses by diverse health care delivery organizations. With regard to quality assurance, for example, the field of HPAM typically promotes well-defined "care-centered" standards (Degos and Rodwin 2011). The challenge is that delivering health care, while involving many activities that can be standardized, also relies on professional judgment, discretion, and complex organizations. While no formula expresses (and thereby reduces) the requisite interaction between professional norms and financial incentives, we urge emerging leaders in HPAM to supplement the strong influence of microeconomics with the insights of other disciplines and professional perspectives.

What currently passes as HPAM is likely to continue to fail in the world of professional practice. What we suggest is that the field of HPAM must

be broadened and deepened so that public policy and management interventions draw more heavily from theory and policy that more closely capture the complexity and conflicts embedded within management and health care practices.

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