POLITIQUES DE SANTÉ

Idées, Innovations et Illusions

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2015

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HEALTH POLICY AND MANAGEMENT: MIND THE THEORY, POLICY, PRACTICE GAP[1]

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The field of health policy and management (HPAM) tackles "wicked problems" (Rittel and Webber, 1973) that are affected by their unique institutional contexts and whose potential "solutions" are shaped by the ways in which they are formulated. Thus, in contributing to better policy and management decisions, we argue here that it is important for policy analysts and managers to mind the gap between theory, policy and practice.

Leaders in HPAM 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 in HPAM are well adapted to the world of health care organizations and medical practice. Despite decades of efforts aimed at making health systems more effective, efficient and, equitable, little has changed in the basic arrangements within which physicians practice. Prominent analysts state flatly that health care is "stuck" (Porter and Lee, 2013). We continue to have a fragmented health care system that shuns vertical integration across hospitals and community based primary care.

It would be harsh to suggest that HPAM has no positive impact. There are spurts of success in designing financial incentives and new management techniques aimed at improving quality of care and restraining costs. But such interventions are scattered and rarely transformative. We highlight four

1. This paper is a revised and updated version based on two previously published articles: Chinitz and Rodwin (2014; 2015).

interrelated problems that appear to sustain the theory-policy-practice gap and impede attempts to reform health care systems: 1) The dominance of microeconomic thinking in health policy analysis and design; 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 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.

The dominance of microeconomic thinking

Prominent economists, themselves, have noted the over-reach of their discipline in health policy. 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. 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 papers (Klein, 1980). Yet despite these amendments to conventional economic models, and the contributions of behavioral economics to policy thinking (Oliver, 2012; Oliver, 2013), health policy returns cyclically to financial incentives as solutions to health systems that cost too much and provide too little.

An important body of work catalogues the overuse and inappropriate nature of economic models applied to the health care sector (Hsiao, 1994; Oliver and Brown, 2012; 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) emphasizing the apparent success of a significant proportion of participating plans in amassing savings and improving quality (CMS, 2014). 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 HMO 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, so often turns out to be a chimera.

Consider also the case of rewarding quality with financial incentives. 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, there is evidence of 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 don't seem to solve the problem (Moran, 2013).

There are also methodological issues in evaluating the impact of financial incentives on quality improvement. First, despite attempts at risk adjustment for case mix severity, providers receiving low grades on performance measures claim that their case load is more difficult, and respond by trying to avoid patients with complex problems (Farmer *et al.*, 2013; Bevan and Hood, 2006). Moreover, focusing on one measure of quality can distort care as 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 *et al.* 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, it is important to consider 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 who 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 (Cresell, 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. In the U.S., in 2015, the CMS "Hospitals Readmissions Reductions Program" withholds 3 percent of regular reimbursements for hospitals with higher than expected (by CMS) rates of rehospitalization, within 30 days of discharge, due to heart attacks, heart failure and pneumonia. CMS may subsequently expand the list of conditions for which it will penalize rehospitalizations. However, it is readily apparent 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 and complex motives of its diverse actors. 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 "non-rational" behavior deriving from the murky seabed of organizations. The recent rise of behavioral economics even seeks to use non-financial 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 understand part of the picture, but too many HPAM analysts are seduced into overusing them, producing health policy that is simplistic, if not simple-minded. This 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 continue to be dominated by microeconomic concepts that provoke political antibodies among health care providers? One important reason is that despite their knowledge of how health care organizations work, managers have less influence on policy than economists. 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 it is difficult to derive general conclusions from concrete cases because optimal behavior depends on contingency in 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, Porter and 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 (IPU), 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, it is not evident 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, it seems that Porter and Lee 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). EBMd is rooted in comparative studies on the effectiveness of medical interventions, 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 it turns out to be a significant if), 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, 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 of 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. In their analysis of ACOs, Shortell and Casalino (2008) 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 Health Improvement, 2011; 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 White (2013) 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 Frankford (1994) 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," (National Commission on Community Health Services, 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. 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. This 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 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 *et al.*, 2013).

Consider the challenge of assuring patient safety in hospitals (Tucker and colleagues, 2008). Front line staff often find policy guidance on safety irrelevant to the real obstacles preventing improvement. Where policy talks about measurement and incentives, front line 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. Simyeh and colleagues (2012) identify "quality sub-cultures," smaller groups within hospitals that develop their own methods of quality improvement. Typically ignored by higher level policy and management directives, these sub-cultures should be taken into account in developing a unified organizational approach to quality. In managing health care organizations, input from rank and file below 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 towards, for example, the 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, it is not surprising that 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 on the ground. Theory and policy fail to affect practice, which in turn fails to inform policy.

The failure to expose medical students to HPAM

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

too focused 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 that there is a one best way of managing every patient pathway? Why not teach them more about the variety of practice settings in which they may work and the different ways in which financial incentives play out in diverse health care organizations within the U.S., as well as abroad? We agree with Jean de Kervasdoué (2015) that exposing medical students to issues of HPAM is not likely to result in health care reform. But over time, we believe it will strengthen the field of HPAM and better prepare students for the decisions they will surely face in the future.

Recently, the American Medical Association announced an eleven million dollar 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 in which tools such as health information systems (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. There is simply too much to learn about how to treat individual diseases to 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, 2013; NYU Langone Department of Population Health, 2013). 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 health policy and management

A shift in how health policy analysts and managers think about health care systems is long overdue and could narrow the theory-policy-practice gaps we have highlighted. We suggest that the field of HPAM be broadened and deepened so that public policy and management interventions draw more heavility from theory and policy that more closely capture the complexity and conflicts embedded within management and heatlh care practice. 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 and medical students must be introduced to issues of HPAM.

In broadening HPAM, it will be necessary to improve understanding of how financial incentives interact with professional values and organizational cultures. Beyond microeconomics, institutional economics (Chinitz, 2013), organization theory and management, HPAM must embrace (rather than shun) disciplines ranging from sociology, anthropology, epistemology as well as broader perspectives, e.g. ethics, urban health, systems analysis, and cross-national analyses of health care systems. There is a role for microeconomic thinking. But how such tools as ACOs, P4P, HIT are implemented ought to be studied with regard to how they might be adapted in different institutional contexts. And how they interact with professional values and norms should also be assessed so that refinements can be made to avoid crowding out positive behavior rooted in values other than pecuniary incentives.

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, 2012). 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 there is no formula to express (and thereby reduce) 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.

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FROM AN ILLUSION TO CONFUSION: COMMENTS ON THE CONCEPT OF "UNSUSTAINABLE" HEALTH CARE SPENDING

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More than three decades ago, Jean de Kervasdoué and his colleagues, John Kimberly and Victor Rodwin, addressed how national health care systems might address the challenge of paying for the care they promised. "*Though the belief is widely held that health is the most precious thing a person has*," they wrote, "*most of us are loathe to analyze the collective consequences of this belief.*" Seeking to add "realism" to public understanding of health policy choices, they wrote that, "*the notion that the welfare state can provide an abundance of health services for all of its citizens is an illusion.*" They predicted that, "*in the future, social policy is likely to veer from idealism to realism, from opportunity to constraint.*"[1]

In retrospect, an emphasis on budgetary constraints had already become the major concern of executive and legislative participants in the health policy processes of rich democracies, even though providers and consumers of care resisted those constraints.[2] Yet this elite effort to counter any illusion that care can be unlimited goes beyond "realism" in a different way. It has become conventional to say that the health care guarantees in rich democracies are or risk being "unsustainable." In this essay I will argue that this is a

1. Jean de Kervasdoué, John R. Kimberly, and Victor G. Rodwin, "Introduction: The End of an Illusion," in de Kervasdoué, Kimberly and Rodwin eds., 1984, *The End of an Illusion: The Future of Health Policy in Western Industrialized Nations*. Berkeley: University of California Press. Quotes pp. xvii, xviii.
2. The term "rich democracies" is taken from Harold L. Wilensky, 2002, *Rich Democracies: Political Economy, Public Policy, and Performance*. Berkeley: University of California Press. It roughly includes the nations in the Organization for Economic Cooperation and Development, minus some (like Mexico) that do not have the wealth needed to maintain the kinds of systems of social protection that exist in France or Germany, and that could exist in the United States if its political processes chose to create them.