Improving Quality as a Solution to the Health Care Cost Problem? Health Policy Experts and the Promotion of a Controversial Idea

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Abstract

Context: In the late 2000s, the contention that quality improvements achieved by reforms in the delivery of care would slow the growth of costs throughout the US health care system became the predominant strategy for cost containment in the discourses and programs of all the 2008 presidential candidates. The question that this paper addresses is why, despite all of the critiques of this idea (especially those of the Congressional Budget Office), what the author terms the *quality solution* has remained credible enough to be a possible argument in policy makers' discourses and programs. To answer this question, the article explores the role of health policy experts—who are expected to provide credibility and legitimacy to proposals defended by policy makers—in supporting and diffusing this quality solution.

Methods: The empirical research combines written sources with evidence from 78 interviews.

Findings: This article highlights the political factors that explain the rise and growing prominence of the quality solution in the community of policy analysts: the political support for delivery reform–oriented research since the 1980s and also the importance of political calculations for prominent health policy experts.

Conclusions: This policy history contributes to works that underscore the political dimension of policy analysis.

Keywords American cost-containment policies, policy analysis, health care policy experts, clinical epidemiology, quality solution

Delivery system reform has long been a particular focus of cost-containment proposals in the United States. Its hold on US health policy was temporarily weakened by the backlash against managed care in the late 1990s. But in the next decade delivery system reform gained renewed force thanks to its reformulation in a new political frame that would have an enduring

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influence on US health policy: the rhetoric of quality. According to this rhetoric, changes in medical practices to improve the quality of care were presented as not only necessary but also almost sufficient to control costs. What I call the *quality solution* became the predominant cost-containment strategy of all the major candidates for the presidency in 2008. According to them, billions of dollars—perhaps as much as 30% of total health care spending—could be saved by cutting unnecessary and inefficient care (Hillary for President 2007; John Edwards08 2007; McCain 2008 2008; Obama '08 n.d.; Obama 2008).

There were strong critiques of the rationale for the quality solution (Marmor, Oberlander, and White 2009; Oliver and Sorenson 2009; Russell 2009), the most important being that of the Congressional Budget Office, which found little evidence that delivery-system changes would reduce growth in health care spending (CBO 2010). Thus the final provisions related to the quality solution in the Affordable Care Act (ACA), though presented as significant by their proponents, were relatively marginal in terms of budget forecasts (Elmendorf 2010). Yet those forecasts did not dampen proponents' enthusiasm for the potential of delivery-system reforms to transform US medical care and curb spending.

The aim of this article is not to understand why policy makers made the quality solution important in their cost-containment strategies. There are convincing answers to this question (Gusmano 2011; Oberlander 2011): The quality rhetoric was a way to talk about cost-containment without alienating stakeholders, while avoiding the idea of care restriction previously associated with managed care. The question that this essay addresses is why, in spite of all the criticism, and especially that leveled by the Congressional Budget Office, the quality solution remained credible enough to be a viable argument in policy makers' discourses and programs.

To answer this question, the article explores the role of health policy experts (Brint 1994; Fischer 1990) in supporting and diffusing the quality solution. Indeed, as noted by Joseph White (2018), this idea was supported by many prominent health policy experts in Washington. Thus, tracing the path traveled by the quality solution in the discourses of health policy experts, this article contributes to scholarship about the relationship between policy analysis and politics (Fischer 2003; Stone 2012; White 2018). Cumulative research spanning several decades about the role of policy analysis in policy making has dissuaded most social scientists from claiming a linear and instrumental use of research in politics as well as the strict dichotomy between reason and power (Peterson 2018; Stone 2012). Even John Kingdon ([1984] 2002: 131), who elaborated the model

of separated policy and political streams, acknowledged that policy specialists have to take into account political events and "anticipate what might happen should the proposal be advanced in the larger political arena." However, while many political scientists focus on the influence of policy analysis in the policy-making process, this article instead explores which policy analysis is influential and why (Parsons 2002; White 2018).[1] The ambition is to reveal the political dimension of policy analysis. This political dimension is active at two levels.

The first level refers to the daily professional activity of policy analysts, who constantly take into account the political context—at least as they interpret it—and adapt to it as a determinant of their positions. This attitude is assumed by policy professionals in the name of the search for political feasibility, relevance, and usefulness. It is also essential to reach prominent positions as experts and stay "in the game."

The second level revolves around research funding. Such funding frequently has a political dimension. An oft-cited case is the support for behavioralist and microeconomics research during the MacCarthy era because of potentially less-critical and socially subversive orientations than institutionalist approaches (Bernstein 2001; Fourcade 2009). In an applied field such as health services research that is even more dependent for its funding on federal agencies and foundations we can expect an even stronger effect (Lepont 2017). Thus we cannot consider, as does John Kingdon ([1984] 2002) and many other policy scholars (e.g., Cohen, March, and Olsen 1972; Sabatier 1988), that an infinite range of ideas "float" in the community. Instead, we need to ask why some policy research is prominent in the policy analysis community and some is not.

The empirical research on which this article rests derives from a research project that initially aimed at identifying the most consulted health policy experts in the United States from the 1970s to the Affordable Care Act, that is, those most called on by US decision makers to advise them, develop programs and policies for health care reform, and sometimes fill managerial positions in the administration. These experts were identified with the aid of an original database built by the author that includes individuals on the basis of two criteria: (1) consultations as experts (testimonies before Congress, political appointments in government, nomination to expert commissions of the government and Congress on health care policy such as PPRC, ProPAC, MedPAC, and CBO Health Advisory Panel); and

1. This question joins the general one suggested by policy-idea specialists at the more general level of policy ideas (Schmidt 2010; Major 2010): not whether ideas are influential but which are and why.

(2) publications in *Health Affairs* or the Perspective section of the *New England Journal of Medicine*.[2] Then, a qualitative study was conducted with two elements:

1. A sociographic analysis of the most-consulted experts, centering around their training, the organizations they belonged to, their careers (data gathered from their CVs and from specialized databases) and their opinions (deduced from their publications—articles, reports, policy briefs).
2. A comprehensive analysis of their policy positions and interpretations based on in-depth interviews (78 in total) conducted in person during spring 2010 and fall 2011. Two-thirds of these interviews were with "most-consulted experts," and one third was with less engaged experts and individuals working in contact with health policy experts (officials in the executive branch of the federal government, congressional staffers, and employees of AcademyHealth [previously the Association of Health Services Research]).

The article proceeds as follows. It first analyzes how the quality issue was reformulated at the beginning of the 2000s and how the quality solution was disseminated during the decade. It stresses the role not only of Dartmouth researchers but also of the organizations that supported them. The second part focuses on the rallying of prominent health policy experts—mostly health economists—to this solution in the mid-2000s.

From a Health Care Quality Concern to the "Quality Solution"

Quality as a Public Problem (1990s and early 2000s)

Traditionally, health care quality per se was considered to be the prerogative of medical professionals and, despite the efforts of public health leaders (Rosen 1958), was hardly recognized as a problem by American policy makers. However, public scandals have periodically triggered politicization of the issue. This was the case in the second half of the 1990s, when, following a number of medical scandals, a growing distrust of how medicine was practiced in managed care plans spread among both patients and providers and gave the quality issue a new visibility (Blendon et al. 1998; Peterson 1999). Managed care, which had become the norm in most private plans (Hacker and Marmor 1999), was alleged to encourage poor

2. For more details about this database, see Lepont 2016a.

quality of care by restricting patient-physician time, information to patients about their treatment options and access to needed care, and the clinical autonomy of physicians (Mechanic 2001). Public and media attention turned to medical errors, malpractice, rationing of care, and "gag rules" that insurance plans imposed on physicians.

This social pressure induced policy makers to react. Republicans and Democrats formulated proposals for a patient's bill of rights (Mechanic 2001). President Clinton appointed an Advisory Commission on Consumer Protection and Quality in the Health Care Industry, which recommended among other things the prohibition of gag rules (Advisory Commission on Consumer Protection and Quality in the Health Care Industry 1998). A National Quality Forum was established in 1999, based on recommendations by the Advisory Commission, with the purpose of establishing and diffusing health care quality measurements. Finally, lawmakers at the state and federal levels passed legislation to regulate managed care organizations and limit their power over providers, by enforcing, for example, prompt payment for physicians, direct patient access to specialists, external reviews of patient complaints, and provisions to assure the financial solvency of managed care organizations (Brown and Eagan 2004).

In this context, the focus on quality was quickly adopted by institutions that fund health policy research. The Agency for Health Care Policy and Research—renamed the Agency for Healthcare Research and Quality in 1999—reoriented its funding toward research on the delivery system (Gray, Gusmano, and Collins 2003). The Institute of Medicine (IOM) created several commissions devoted to the quality of care.[3] These groups published important findings about disturbing gaps in quality (Hewitt and Simone 1999). One report in particular, *To Err Is Human* (IOM 2000), was quoted extensively in the media and had a major impact on public opinion. Its first author, Donald Berwick, a physician and prominent health services researcher who had founded the Institute for Healthcare Improvement, became a leading figure in the movement to improve health care quality. His key recommendation was to take inspiration from industrial quality processes so as to standardize medicine based on more efficient practices (Robelet 2002).

Foundations, too, took increased notice of quality (Fox 2010). Thus the Commonwealth Fund, at the beginning of the 2000s, started funding research led by Donald Berwick (Berwick 2002; Berwick et al. 2003).

3. These included the Committee on Quality of Health Care in America, formed soon after the report of a less formal IOM-sponsored National Roundtable on Health Care Quality.

At this time, the efforts needed to improve quality, by means of encouraging prevention, primary care, and new information technologies, were widely viewed as very costly, requiring a large additional national investment in the health system (IOM 2000; Davis 2001, 2002b). The proposition that health care quality merited such a national investment was less daunting in the second half of the 1990s, however, in part because the US economy was relatively strong (annual growth exceeding 4% and the federal budget in surplus). Moreover, US health spending rates had slowed substantially between 1993 and 1997 during the height of managed care.

Reframing the Quality Issue: A New Vocabulary for an Old Program

At the beginning of the 2000s, though, economic growth began to slow, health expenditures increased again, and the cost issue reemerged (Oberlander 2003). In this context, a group of researchers from Dartmouth University who promoted a fresh conception of quality received attention from the Bush administration. The Dartmouth researchers criticized the vast sums wasted by ineffective medical practices and organization, contended that improved quality was not necessarily costly, and indeed proposed quality improvement as a way to lower health care spending (Fischer 2003; Skinner 2011). They argued not only that "more [medical care] was not better" but also that "more may be worse" (Fischer 2003). Their reasoning redefined quality as not only a medical safety issue but also one that centers on the performance of the delivery system and incorporates an economic dimension.

The argument in this article is that this expansion of the dimensions and connections of quality was a rhetorical reformulation of a long-standing research agenda of some clinical epidemiologists (Berkowitz 1999), and especially John Wennberg, the founder and leader of the Dartmouth team (Tanenbaum 2013), concentrated on the search for efficiency in the delivery system. This reformulation was made strategically in the context of the managed care backlash and the focus on the quality issue.

Diffusion in Washington of the Quality Solution

Activism of Dartmouth Researchers in Washington, DC. By the end of the 1980s, Wennberg and the Dartmouth variations research had become influential in US health policy making. The transformation of the Center

for Health Services Research (relabeled the Agency for Health Care Policy and Research, AHCPR, in 1989) and the doubling of its funding were largely due to Wennberg's success in convincing policy makers in both parties of the promise of variations research in terms of cost savings (Gray, Gusmano, and Collins 2003). Unlike other solutions promoted by reformers, delivery reforms promised to reduce health care spending without directly regulating fees or costs. In short, as White (2011) explains, this type of reform disconnected the spending issue from the price issue. For this reason, it enjoyed the support of some influential interest groups, such as the American Medical Association and the American Hospital Association (Tanenbaum 2013), and prestigious official institutions of the medical profession, such as the Institute of Medicine.[4]

However, Wennberg's activism in Washington initially focused mainly at winning more funds for clinical and outcome research (Tanenbaum 2013). He believed that rationalization of the delivery system would probably save money but viewed the research results then in hand as insufficient to prove that point, and he did not promote specific cost-containment proposals. That changed at the beginning of the 2000s, when Wennberg concluded that enough supportive evidence had accumulated. He contacted Vermont senator Jim Jeffords (Republican until 2001; then Independent) in the spring of 2001 and suggested that the senator introduce a bill that would allow an experimental program to test a new delivery system in Medicare.[5] The senator was interested, and Wennberg and his staff wrote legislation, introduced in December 2001 (S. 1756, *Medical Excellence Demonstration Program Act*), to implement a demonstration project of a new kind of integrated care organization (Harrington 2004). The bill got the attention of the White House, which convened several meetings between Wennberg, White House staff, and the leaders of two agencies of the Department of Health and Human Services (CMS and AHRQ). In May 2003, a revised version of the bill was introduced by Senator Jeffords, with the support of a bipartisan group of senators, as a section in the Medicare Modernization Act (Harrington 2004; *Medicare Health Care Quality Demonstration Programs*, Section 646).

During this collaboration with the George W. Bush administration, the Dartmouth researchers worked closely with Mark McClellan, the head of

4. Another reason for the support of physicians may be that, as with evidence-based medicine, rationalizing the delivery system does not affect the whole medical profession equally, and some segments of it—generally those who already have powerful positions—can even find in it a source of increased power (Castel and Friedberg 2010).

5. Interview with John Wennberg, December 2011.

the Centers for Medicare and Medicaid Services (CMS), who enthusiastically supported this approach. As CMS administrator, he was in a strong position to spread their ideas. After leaving the administration in 2006, McClellan also helped them sell the ideas to Democrats when he joined the Brookings Institution to run its health policy center.

Growing Support: From the Health Services Research Community to Policy Institutions. Crucially, the diffusion of the quality solution resulted not only from direct contacts with politicians and political appointees but also from the growing support during the 1990s of prominent institutions dedicated to funding and disseminating delivery-system research, and especially variations research. Private foundations were enthusiastic about the approach and became its first source of financing in the late 1980s (Fox 2010). The Dartmouth Atlas was entirely financed by the Robert Wood Johnson Foundation (RWJF) during the 1990s. Since the 1930s, foundations had downplayed broad reform of the American health care system because it was too highly politicized (Fox 2010). The support of both parties and leading interest groups put delivery reform on a much more consensual basis. This allowed these foundations to protect their legal status and reputation for "neutrality" (Fox 2010: 136). Moreover, in many cases—for example, that of the RWJF, the most important in volume of funding (Knickman and Isaacs 2010)—this absence of conflict aligned better with the preferences of their boards' members, some of whom were stakeholders themselves.

As recognized by Elliot Fisher, who progressively took the lead for the Dartmouth team in Washington during the 2000s, organizations such as the RWJF and the IOM were crucial bridges to the administration: "Something important was to get to know all these people in the Health Service Research Community. It helped to serve in the IOM or the RWJF. I got to know for instance John Eisenberg, who was the head of the AHRQ, who was really interested in my work. To get to the policy world, the science helped!"[6]

These organizations stage events (meetings, conferences, seminars, etc.) to which they invite policy makers and "policy VIPs"—for instance, the above-mentioned director of the AHRQ or the chair of the expert congressional commission on Medicare issues, MedPAC. The support by these institutions is therefore a means to penetrate policy institutions.

6. Interview with Elliott Fisher, December 2011.

In particular, delivery-system reform became a renewed focus for AHRQ following a political crisis that jeopardized the agency's existence (it was then called the Agency for Healthcare Policy and Research). After the Clinton administration's failed effort at health reform, Republicans accused the agency of favoring Democrats' policies and threatened to cut its funding. To save the organization, the head of the agency reoriented the funding policy to research on delivery reforms, which enjoyed bipartisan support. Its relabeling as the Agency of Healthcare Research and Quality in 1999 was done in this context. Additionally, MedPAC was searching for an approach to physician payment that would avoid cutting their Medicare fees under the Sustainable Growth Rate formula, which medical associations strongly opposed.

Charged with providing expertise on health care issues for the administration or Congress, these federal institutions are often involved in the elaboration of policy instruments when policy makers plan a reform. In this sense they can be considered "policy forums," that is, places that connect experts, professionals, and policy makers and are involved in the designing of policy approaches (Fouilleux 2000; Jobert 1994). This is exactly how Elliott Fisher portrayed the development of Accountable Care Organizations (ACOs): "In 2007, I presented this work to the Medicare panel of advisers [MedPAC], and that is where the idea of ACOs really was born. When Glenn Hackbarth, the chair of the commission, said, 'The name must be changed; why don't you call these organizations accountable organizations?' And I said, 'Accountable care organization.'"[7]

This meeting was part of a series that started in 2004 and continued until 2009. Their recurring presence in MedPAC, an institution with strong credibility that played a central role in writing many details of the ACA (White 2018), helped the Dartmouth team to connect to other crucial individuals and institutions, such as the Congressional Budget Office, whose director in 2007, Peter R. Orszag, became a strong supporter of the quality solution (Orszag and Ellis 2007) and then, once he was appointed chief of the Office of Management and Budget in 2009, brought it to the White House when the ACA was being designed.

Simultaneously, Elliott Fisher became a member of several expert national commissions, including the National Advisory Council for Health Care Research and Quality of the AHRQ. The support of these expert institutions helped to make the Dartmouth team's ideas familiar to policy makers (White 2018)—and also gave them such strong legitimacy and credibility that they were becoming part of the conventional wisdom.

7. Interview with Elliott Fisher, December 2011.

The Way to the Democrats. From 2004, when Democrats began reviving health care reform on their agenda (Beaussier 2012), they quickly became familiar with the quality solution as expounded in myriad policy forums, think tanks, and foundations. For them, too, a powerful argument in its favor was its bipartisanship, which, since the failure of the Clinton health plan, Democrats had come to view as crucial to the passage of any reform plan. The influence of the Massachusetts reform, which was enacted with broad support from both parties, on their proposals after 2006 reflected this conviction (Lepont 2016b; McDonough 2011; Oberlander 2007). The Massachusetts plan, however, did not offer a strategy to reduce costs, a goal the state intended to address in subsequent policies.

The quality solution had the additional advantage that it catered to different political factions within the Democratic Party. The consensus around it rested heavily on the ambiguity of the solution, which different sides could interpret as they pleased (Stone 2012). Liberals liked it because it avoided emphasizing patients' responsibility (cost sharing) and competition, did not threaten public programs, and did not entail quick, draconian cuts in spending. Conservatives liked it because it sought to change practice patterns and operated by means of economic incentives rather than coercion (in contrast to cuts in fees).

From Controversy to Consensus

The diffusion of the quality solution during the 2000s demands explanation because the strategy had been far from consensual at the beginning of that decade. As Elliot Fisher acknowledged, "In the policy sphere, there were a lot of health services researchers who didn't believe in the idea. For instance, Stuart Butler [of the Heritage Foundation] thought that you would never be able to decrease spending like that. [Democratic Congressman Henry] Waxman was worried that it would hurt the poor."[8]

Many prominent health policy experts explicitly criticized the rationale at this time.[9] These critiques quickly disappeared, however, and the rising consensus among experts built legitimacy, credibility, and, in time, success for the quality solution. Why did many experts shift direction and rally to it?

8. Interview with Elliott Fisher, December 2011.

9. I have defined and identified prominent health policy experts on the basis of my database by the frequency of their consultation as experts and their publications (for more details, see Lepont 2016a).

Criticism of the Quality Solution

At the beginning of the 2000s, many of the most consulted health policy experts were critical of the quality solution. One doubt concerned the methodology used by the Dartmouth team to prove the existence of waste and estimate the extent of possible savings. The main criticism was that the data were too amalgamated to support conclusions on the quality of care received by patients at the individual level (Tanenbaum 2013). Bruce C. Vladeck (2004), for instance, former administrator of the Health Care Finance Administration during the Clinton administration, argued that the geographical variations in spending and quality shown by Dartmouth researchers did not prove any causal connection between them because of the scale of the data, and therefore could not be of much help in policy making.

Others noted that improving quality was a laudable goal but one that implied increasing, rather than decreasing, health spending. Under the leadership of Karen Davis, the Commonwealth Fund, a historically progressive foundation, supported at the beginning of the 2000s efforts by Donald Berwick and his collaborators to improve quality[10] but did not embrace the quality solution. On the contrary, as illustrated in the introduction to its 2001 Annual Report, the Commonwealth Fund asserted the priority of increasing access to health care over decreased spending: "The best modern medicine has to offer is not available to all Americans today, and the future quality of health care may be jeopardized by forces that place too great an emphasis on reducing costs" (Davis 2002: 15).

Other analysts did not critique the quality solution per se, but contended that the source of high health care spending was not poor-quality care. Two health economists who had worked in the Clinton administration, David Cutler and Mark McClellan (2001a, 2001b), argued that increasing costs in the health sector, far from necessarily indicating inefficiency and bad quality, were mainly caused by technological advances that tended to improve quality and health outcomes. Two other prominent health economists, Uwe Reinhardt and Gerard Anderson (and colleagues), argued in several articles that appeared in the early 2000s that the real cause of high health costs in the United States was the level of prices (Anderson et al. 2003; Reinhardt, Hussey, and Anderson 2004; Anderson et al. 2006).

10. Don Berwick's (2002) famous book *Escape Fire* was financed by the Commonwealth Fund.

Rallying to the Quality Solution

By the mid-2000s, criticisms of the quality solution were progressively disappearing from the public debate. Some mentioned above as notable skeptics of the quality solution joined its most passionate proponents. For instance, while the reports of the Commonwealth Fund (led by Karen Davis) had treated improving quality as a necessary but costly goal, in 2004 they started revising, even reversing, the argument (Davis 2004), as a new vocabulary was introduced. Terms such as *performance*, *efficiency*, and *transformation of the delivery system*, which were rare in previous reports, became ubiquitous. In 2005, the foundation created a Commission on a High Performance Health System, which supported all the stratagems promoted by the quality solution (Mongan 2006; Commonwealth Fund 2007; Schoenbaum et al. 2008) and, in a first report, foresaw savings of more than $1.5 trillion over 10 years—rising in a later report to $3 trillion by the end of the next decade (Schoen et al. 2007; Commonwealth Fund 2009). Berwick, too, started changing his discourse and became among the most optimistic and engaged experts in promoting the quality solution (Birnbaum 2012; Fisher, Berwick, and Davis 2009; Swensen et al. 2010).

Around 2005, David Cutler increasingly joined the worried discourse on costs (Chernew, Hirth, and Cutler 2009; Cutler 2005; Cutler 2006) and became an ardent supporter of the quality solution, arguing, for example, that "the Patient Protection and Affordable Care Act [had] several features . . . [that] could spark a productivity revolution in health care [and] make it much more affordable and simultaneously increase the quality of care" (Cutler 2010, Cutler and Ghosh 2012). After the adoption of the ACA, he continued to spread this optimistic vision of the quality solution—for instance, in his 2014 book *The Quality Cure: How Focusing on Health Care Quality Can Save Your Life and Lower Spending Too*. By 2011, he was the economist to whom Elliot Fisher from Dartmouth said he now felt closest:

> **Q.** Who's the economist whom you feel closest to, from an intellectual point of view?
>
> **A.** I would say David Cutler, if I think at a national level. I think we converged. I learned from him and he learned from me.[11]

Some health policy experts, though, continued to express their skepticism about the ability of the instruments associated with the quality

11. Interview with Elliott Fisher, December 2011.

solution to reduce costs. Several contended that the ACA did not include effective measures to contain costs and echoed the widespread view that the White House had decided to avoid centralized cost controls in an effort to not alienate interest groups (Daschle, Greenberger, and Lambrew 2008; Gusmano 2011; Oberlander 2011). However, very few of those interviewed for this study—and especially among the "most consulted"—stated their reservations publicly in articles, testimony, or political briefs. Most did not state the contrary either; rather, they sat on the fence.

How, then, is one to understand these expert attitudes that oscillated so dramatically between caution toward and enthusiasm for the quality solution? The explanation lies in the political context of policy expertise, which includes how policy experts see their work as well as their individual and professional interests. Answering this question requires attention to how health policy experts' circles are structured and work in Washington.

Understanding the Rallying of Health Policy Experts

Political Considerations. As I have shown in other articles (Lepont 2020, 2017), the health policy experts who are regularly consulted by policy makers in the United States are far removed from the traditional expert figure who relies on the objectivity of scientific knowledge to assert the neutrality of a position and establish legitimacy. What was striking during interviews with those I have called "most consulted" and "prominent health policy experts" is that they always recognized and accepted the political dimension of their activity, situated on the border between policy and politics. Defining themselves as policy analysts (deLeon 2006), their priority is to propose politically feasible solutions to achieve goals, and they know that they must take into account the political context in designing their recommendations. These experts judge feasibility by electoral results, by the state of power relations between the different currents within parties, by the events that are currently making news, and by the supposed state of public opinion, as evaluated by polls. The evaluation also takes into account the position of interest groups, which are recognized as having strong blocking power. Conversely, the support of interest groups is judged as a very positive element in political feasibility. The professional contexts in which they operate (think tanks, foundations, university-based centers) foster this attitude since these organizations encourage and expect experts to exert influence on the legislative process.

Another striking element of the interviews was that most of the experts I met presented themselves as personally committed to the achievement

of a major reform that would significantly improve the access of Americans to health insurance. As expressed by Len Nichols, who was part of the Clinton administration team designing health reform, they had worked for years to advance this goal and saw Barack Obama's election as a historic opportunity:

> I was not part of the political team but I watched the political team do their disaster! And because I was so close to them, it hurt me. I was ashamed, I was embarrassed, I was like "America should do better," "oh my god." So, the loss hurt me until this March. It's like losing a war, then you get another chance. After the Clinton debacle, I decided not to go back to academia and to stay in Washington. I knew that Washington needed help. I knew that I was so committed to try to make a reform happen, I could do far more here than back in academia.[12]

Partly because, like Nichols, many of them had been involved in the Clinton reform, the prominent health policy experts were constantly referring—in interviews and in their publications—to its failure and the lessons to draw from it (see also Donnelly and Rochefort 2012). One lesson was that the constraints on health care spending the bill proposed were too tight and triggered the opposition of interest groups (Daschle, Greenberger, and Lambrew 2008; see also Gusmano 2011; Laugesen 2011; Oberlander 2011). As Jonathan Oberlander (2011: 478) put it, "The greater a health reform plan's capacity to limit medical inflation, the smaller its chances of political adoption" (see also Oberlander 2003; Quadagno 2005). Some observers even thought that, as Medicare and Medicaid were enacted without cost controls (Oberlander 2003), achieving the two goals of better access and cost containment together in the same reform was impossible in the United States (Kingsdale 2009). At the same time, it was politically necessary for policy makers to have a plan to control costs (which the CBO would scrutinize in "scoring" any proposal). During the reform debate, President Obama claimed, "If we do not control these costs, we will not be able to control our deficit" (*Washington Times* 2009) and Secretary of Health and Human Services Kathleen Sebelius contended that "every cost-cutting idea that every health economist has brought to the table is in this bill" (Sebelius 2010). In this context many welcomed the quality solution as, in the words of Judith Feder, "something that may or may not work but at least, it gave a way to talk about cost containment

12. Interview with Len Nichols, May 2010.

in a less scary fashion."[13] It is noticeable here that anticipation of interest-group power led prominent health policy experts to adjust their proposals in light of political feasibility. Thus interest groups indirectly influenced health policy analysts.

The quality solution promoted unity among policy experts around an ambiguous consensus: liberal experts like Karen Davis saw it as a means to avert the excesses of cost sharing and patient "responsibility," while others such as Mark McClellan, Katherine Baicker, David Cutler, and Jonathan Gruber applauded its avoidance of federal price regulation (Antos et al. 2009). This addressed another lesson of the Clinton failure shared by the experts: reformers had to stay unified.

In sum, the shift in many experts' perspective on the quality solution shows that political considerations are intrinsic to, not separate from, policy analysis (Stone 2012; Medvetz 2012; Wildavsky 1979).

Individual and Professional Interests at Stake. Health policy experts also had compelling personal and professional incentives to support the quality solution. Indeed, the political attractiveness of the idea made allegiance to it a kind of necessary condition for experts who aspired to be regularly consulted by Congress or the White House. Those who attained positions in campaign teams, government, or congressional commissions embraced the idea. This was the case for some experts mentioned above (David Cutler, Donald Berwick, Karen Davis) and also for others such as Peter Orszag and Rahm Emanuel (2010); Henry Aaron, David Cutler, and Alice Rivlin (2010); and Jon Gruber (Brownstein 2009). Conversely, experts risked becoming persona non grata by publicly expressing doubts about the quality solution. As health economist Mark Pauly noted, "Politicians want that [reducing costs by improving quality] to be possible; that's why I am not usually so welcome at these gatherings. Because I don't agree to agree! When they say, 'Professor, can you tell me how to cut costs and improve quality?' I just say, 'There are just a few things to do and it's not nearly enough. If you want to cut cost, you have at least to reduce the rate at which we improve quality.' That is why I am usually not invited!"[14]

13. Interview with Judith Feder, December 2011.

14. Interview with Mark Pauly, November 2011. It is interesting to note that Pauly's attitude seems to be less intransigent than the quotation suggests. He is, for instance, among ten experts who in 2009 signed the report of the Engelberg Center for Health Care Reform, *Bending the Curve: Effective Steps to Address Long-Term Health Care Spending Growth* (Antos et al. 2009). In this report, the method Pauly favors (reducing coverage by cutting overly generous health plans) is mentioned, but the "quality solution" holds a more central position.

Two main types of experts persisted in publicly stating their skepticism about the quality solution. Unsurprisingly, neither type was found among central actors in Washington. The first type consisted of academics for whom access to Washington was not a high priority. The second type, mostly political scientists, were often allied with liberal Democrats and sometimes worked closely with think tanks such as the Institute for America's Future, the Economic Policy Institute, and the New Labor Forum. Jacob Hacker and Helen Halpin, the two most visible health policy experts in advocating the public option, are cases in point, as are Theodore Marmor, Jonathan Oberlander, and Joseph White (2009). These experts emphasized the centrality of price regulation to cost containment.

Finally, the quality solution assisted health services researchers and their association in arguing for more funding, especially for cost and comparative effectiveness research, which is a key element of the quality solution and requires sizable resources. According to the former director of AcademyHealth, the choice to focus on cost-effectiveness research was deliberate: "We tried regulation, we tried promoting competition, that didn't work. We believe that cost-effectiveness research was what policy-makers wanted to limit costs. So AcademyHealth is now dedicated to improving the delivery system."[15] In 2009, Congress voted for $1.1 billion for comparative effectiveness research in the American Recovery and Reinvestment Act and then, with the creation of the ACA, made further investments via the Patient-Centered Outcomes Research Institute and the Innovation Center in CMS.

Conclusion

This article has traced the political evolution of the quality solution in US health policy making. At first glance, Dartmouth researchers' advocacy of the idea seems perfectly to exemplify Kingdon's (1984 [2002]) account of policy entrepreneurs, who adapted their policy ideas to a specific political context and advocated for it effectively in Washington. Thanks to long-term promotion of their research inside the health policy community, Dartmouth researchers were broadly recognized as credible experts with a persistent commitment to this idea. Moreover, they took advantage of a political context—which can be considered a window of opportunity—marked by revived concern about health care spending. But following the managed care backlash, the political context was also shaped by worries

15. Interview with David Helms, November 2011.

about the quality of care in US medicine. Dartmouth researchers displayed great political skill in reshaping the familiar calls for "rationalization" of care into a discourse about quality, thus transforming a sensitive issue, containing health spending (which is often associated with rationing care), into a positive promise. They also enjoyed the support of interest groups, which saw in this agenda a strategy to avoid direct regulation of fees and prices. These components of the quality solution explain its appeal to policy makers of both parties. This bipartisan aura, rare in an increasingly polarized political environment, was especially valuable to Democrats as they constructed their health care reform agenda.

However, this interpretation, which focuses on the role of a few key individuals, gives too little weight to the political factors that explain the rise and growing prominence of a particular idea in the community of policy analysts. The success of the Dartmouth researchers was heavily intertwined with the enormous growth of delivery-reform-oriented research within the health services research community since the 1980s. This development derived importantly from political support for this research. The institutions that fund and disseminate health services research in the United States, most importantly private foundations (especially the RWJF, the Agency for Healthcare Research and Quality, and the Institute of Medicine) appreciated its bipartisan appeal, an element these institutions valued highly. To the extent that bipartisan support was in large part the consequence of the support of the stakeholders, this was also an indirect influence of the interest groups on policy analysis.

This article also shows the importance of political calculations for prominent health policy experts. This political dimension of expertise fits well with the image of policy analysts sketched by Aaron B. Wildavsky (1979) and Giandomenico Majone (1989) but runs contrary to what literature on expertise often asserts (Brint 1994). The rallying of health policy experts, many of whom were initially skeptical, reflected political perceptions of what was politically attractive and so "doable" in a given political context. Perceptions of political appeal and feasibility also had much to do with the stance of stakeholders, who favored the quality solution over other reforms because they saw it as less threatening to their revenues. The quality solution seemed to be a way to talk about cost containment that did not trigger stakeholders' ire and therefore did not (seem to) jeopardize the bill. Their motivation to respect the boundaries of feasibility was partly grounded in their personal commitment to see reform happen.

Moreover, because of the attractiveness of the quality solution to many policy makers, their support for the idea won them invitations to and warm welcomes in health policy forums connected to policy makers and held

out the prospect of generous funding for the professionals in the health services research community. Positions in campaign teams, government, and congressional commissions came to those who embraced and ardently defended the quality solution. This consensus among prominent experts overwhelmed the critiques made by the CBO and others and conferred a legitimacy that came to enshrine the quality solution as a centerpiece of policy makers' conventional wisdom.

The quality solution has had an enduring influence on US health policy. A decade after the ACA's enactment, much of the US health policy community continues to believe that delivery-system reform is central to controlling medical care spending. Meanwhile, American medical care remains the most expensive in the world.

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