Books

Review

Ezekiel J. Emanuel. ***Prescription for the Future: The Twelve Transformational Practices of Highly Effective Medical Organizations.*** New York: PublicAffairs, 2017. 272 pages. $18.99 cloth.

Ezekiel J. Emanuel has been an exemplary American health policy leader for decades. His CV could hardly be better designed to show his centrality in American health debates: Harvard-degreed oncologist and political philosopher, vice-provost and department chair at the University of Pennsylvania, founding head of the National Institutes of Health Department of Bioethics, widely published writer with a slot at the *New York Times*, fellow at the Center for American Progress, member of the Obama administration during passage of the Affordable Care Act (ACA) (and brother of Obama's first chief of staff), star of a massive open online course (MOOC), and now involved in venture capital.

It is worth reading his previous beautifully written book (Emanuel 2014), because it is indicative of the views of Democratic policy elites on the ACA and evidence of his centrality in that community. If his new book is any guide to where Democratic policy elites' thought is going, then American health policy is in trouble. Emanuel's book is sloppy in the manner of any airport business book, but its sloppiness is strategic. The book points

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in a direction that is not just willfully naive but also runs a real risk of misdirecting reformist energy.

Emanuel believes in the inevitability of health care transformation. Transformation will come because of the scale of the problems in US health care: "Two fundamental problems plague the American healthcare system: (1) it underperforms on almost every conceivable metric, and (2) the public, small businesses, corporations and governments all find it unaffordable" (Emanuel 2014: 1). Uncertainty caused by the Trump administration's opposition to the ACA

> is ultimately transitory. The system's underperformance and excessive costs are fundamental and structural. . . . Rather than focusing on the latest rumor about repeal and replace or the ups and downs of Washington political maneuvering, it is prudent to aim for what will be necessarily be important both 5 and 10 years from now. For healthcare, that means achieving high-value care. That is where the system is ultimately headed. And that is where the smart money, lots of it from venture capital and private equity, is investing. . . . The transformational practices, and lessons in this book will help position medical organizations for the future regardless of the momentary vicissitudes created by the 2016 election. (3)

The causal argument here is not spelled out well, but it may not please readers of this journal. When he writes on page 3 that "fundamentals provide the surest foundation to weather the vicissitudes of uncertainty," or claims here and there that the scale of the two US health care problems will lead the future he maps out, we recognize a functionalist argument, essentially claiming that problems call forth their solutions. Health care reformers have been making this argument in the United States for a long time, but actual changes such as the ACA were quite clearly political and driven by very powerful actors. The scale of the problems mattered only insofar as they mobilized political interests.

The ACA and the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) occupy a rather awkward spot in the argument since it seems that for him they are simultaneously critical catalysts and mere way stations in a broader inevitable movement. In the chapter on these he says they are as important as the Flexner Report was. "Regardless of whether these laws remain on the books, they mark an irreversible turning point in American health policy" (19). This is because they address the two "consensus" reasons for American health policy underperformance: fee-for-service payment and payment systems that discourage systematic collection and use of data (20).

To a comparative health policy specialist, this is just another case of American exceptionalism. The reasons for the failures of the American health care system clearly lie in its political structure. Every other system has the buck stop somewhere, with price controls and de facto monopsony (White 2013). The result is that somebody is responsible for controlling health care expenditure's share of the economy and, consequently, responsible for trying to promote quality and efficiency within that budget envelope. Data and payment systems are part of what Joseph White (2013) calls the "aspirational agenda" in these systems. Ironically, readers in the United States likely would find Emanuel's book less useful than those in countries like the United Kingdom or Sweden. Elsewhere, policy makers can use the tools of the aspirational agenda laid out by Emanuel because they can use them to squeeze more efficiency or quality out of systems that are already universal, effective, under financial control, and reasonably efficient. The data/payment aspirational agenda is the frosting on the cake of monopsony and price controls. It is distinctively American to make the entire cake out of frosting.

The two most interesting arguments of the book are unrelated to Emanuel's central argument. One is the assumption that the United States will continue its "buck stops nowhere" approach. This includes approaching essentially every problem with the only two really strong tools for system change that Americans agree on: payment systems, which Emanuel likes, and litigation, which he gives no attention. This makes some sense, since the ACA marks a bigger advance in the world of payment systems than it does in the centralization of power. Policy elites who focus insistently on payment systems are, in a sense, well-socialized creatures of a system whose basic politics make other countries' policy instruments unusable.

The other argument is that we should focus on the causal power of ideas: the "ACA's most important legacy is not any particular provision but rather how it changes the psychology of the people involved in the provision of health care . . . the change in attitude is permanent" (22). Put more practically later:

> Everyone in healthcare—whether a physician, a hospital administrator, a nurse, a payer, a device or drug manufacturer, or even a medical equipment supplier—has begun speaking a new language. They are all now comfortable including in their standard pitches, slide decks of talking points the vocabulary of transformation: the "triple aim," "value-based care" and "value-based payment methods," "capitation," "population health" and "patient-centric care." (33)

Buzzwords from the standard slide decks of pharmaceutical companies are a limited form of evidence for systemic transformation. Emanuel is probably right about the popularity of these ideas, though. There is a great deal of momentum around the notion of moving from fee for service to some kind of bundled payment system that produces better "value" and quality. It amounts to an effort by payers to extract more knowledge about what they have bought from the system, and ideally some better outcomes, coupled with an effort by provider organization leaders to both adapt to their future and get some control over their notoriously difficult workforces. Health system managers have to anticipate even the most inscrutable future, and anticipating value-based care at least responds to an intelligible agenda that is popular with many policy makers. This is no different from the way they rebuilt the system in anticipation of the ACA's implementation even when the 2012 election and Supreme Court posed dire threats to its survival. In neither case was the bet necessarily a safe one, but they had to bet on *something*.

Emanuel's book points to a gap in our understanding of why and how different policy, academic, and business elites converged around this agenda. It merits a study reminiscent of Lawrence D. Brown's (1983) work on an earlier moment in this movement's history. It also would be interesting to test whether the advocates have the political power (vs. lobbies) and the organizational power on the ground in hospitals and insurers' and doctors' offices to produce anything like the scale of change they discuss. Other, rigorous research suggests the answer is no (Laugesen 2016). Likewise, quite a lot of health services research finds disappointing results from payment system reforms such as the readmissions penalties that Emanuel regards so highly (Doran, Maurer, and Ryan 2017).

After moving rapidly through the inevitability of the transformation, the next question the reader might ask is, what methods will Emanuel use to identify the transformation? Neither his methods nor his reporting of methods will satisfy social scientists. He calls it a "qualitative book based on case studies" (16). That naturally directs the reader to two further questions. The first is, how did he select his cases? The answer: "In a somewhat haphazard way. I heard about one great practice or healthcare system and decided to see if it had transformational practices that others could learn from. I attended a lecture by someone who transformed some aspect of his or her practice, and then I studied those changes. I was asked to speak somewhere and determined that their processes of care were worth examining" (15–16).

He then goes on to stress that none of the clinical settings he describes have all twelve of his key practices in operation, with all short of the final destination, a design flaw that further erodes the credibility of his case selection. Fortunately, a short discussion is usefully supplemented by a reading of the acknowledgments and disclaimer sections, which illuminate some of the personal and financial relationships between Emanuel and the cases he studies.

In reading about this case selection, one is reminded of the way medical innovation often diffuses: a doctor hears through the grapevine about something interesting and spends a few weeks in the place where it's being done in order to learn. As a way to do health services research, it is wanting. While Emanuel's cases might interest his readers by highlighting innovations to imitate, the book is not really designed to produce knowledge about what the health sector does. Emanuel's cases will almost by definition fail to support his functionalist approach, since focusing on a particular kind of outlier will not produce knowledge that is easily generalizable to the rest of the health care system.

The second question we should ask of his methods is, what qualitative research did he do? The answer: "Much of the book is based on what qualitative researchers call 'saturation'—carefully observing and ascribing significance when various diverse groups and organizations, in many different geographic locations, are independently reporting similar things" (16). That is it—the methods discussion tells us only that the author conflates saturation as a component of qualitative research (it is not a method!) with the concept of simultaneous discovery. Presumably he means that he spent enough time in interesting places to feel confident in his argument. It would be good practice to make it clear that this is not, in itself, a qualitative method.

Put together, the weakness of these answers allows us to stop and reflect on the status and quality of qualitative research in America's elite medical academic institutions, including the bioethics establishment. If qualitative case study research is understood to mean going to some places that interest you and talking to people you find interesting, then no wonder it is not well regarded. Social scientists should be clear: this is not qualitative research methods. Even if his "haphazard . . . saturation" approach is actually bad reporting of good methods, reporting good methods badly is tantamount to bad methods.

What did this approach teach him? The book presents most of its findings in a very large set of tables at the back. It finds six conditions that lead organizations to adopt some of twelve practices:

- A catalyzing crisis
- Leadership
- Culture, governance, and physician engagement
- Data
- Physician-management alignment
- Financial incentives

Without these six causal factors, there will be no transformation in the right direction.

The "twelve transformational practices of highly effective medical organizations" of the subtitle are listed, explained, and justified, with lots of examples from his favored cases. In some cases they are practices, and in others, domains of health care organization where he sees transformational changes:

- Scheduling patient appointments
- Registering and rooming patients
- Measuring physician performance
- Standardizing patient care
- Chronic care coordination
- Shared decision making
- Site of services and referrals—centers of excellence
- Deinstitutionalization of care
- Behavioral health interventions
- Home and palliative care
- Community interventions
- Lifestyle interventions

The informed reader can probably fill in the contents of these eighteen headings relatively well, though the details are often interesting. How we are to get system-wide transformative change when the six catalytic factors might not be in operation across the system is not discussed. Nor does he explain why these twelve factors should necessarily result from the six factors.

For a book that says so much about payment systems, these central chapters recurrently raise and fail to answer the question, what finances these models? Emanuel is very keen on primary care providers who focus on Medicaid populations with multiple comorbidities and provide high-touch customized care. From the patients' point of view, and he includes a number of vignettes about patients, it sounds better than the fragmented system of today. But from what he tells us, these systems often involve

more resources and more time and are not set up to reap the savings from fewer acute episodes later.

In the Scottish National Health Service, we could see why there would be demand and money for high-touch primary care that prevents later acute episodes, since they come out of one budget. In the American system, it is still not clear how our primary care payments will fund this kind of approach, regardless of the savings later for Medicare or an insurer. One might worry that these firms, spending more on primary and secondary prevention and case management in order to save on acute and emergency episodes, will be little more than a bubble if we do not change payment systems beyond the ACA and MACRA. This reader suspects that the underlying politics of the US health care system mean no such radical payment change will happen. Right now the buck stops nowhere, and that is an agreeable situation for most powerful actors.

Moreover, the incentives point more to mergers and oligopolies, and one of the cases in the book Emanuel admires is a cautionary tale. The Advocate Health Care system in Illinois, which receives admiring attention from Emanuel, is now merging with Wisconsin's Aurora Health Care. There is no particular reason to believe that the practices he admires at Advocate, or any particular practices, will survive a merger. Perhaps transformation is good, but becoming an oligopolist is better.

In short, Emanuel has moved from thinking about policy to thinking about how individual medical organizations can be more successful. It would be tempting to see this as a sort of privatization of public concern. The turn inward is a common phenomenon in politics, common enough to have a German word: *insichgehen*. It was coined by Hegel and refers to the inward flight into poetry and art of Germans whose beliefs in the French Revolution were dashed by Napoleon. People who are frustrated, or just exhausted, by political engagement turn to private action with social goals that overlap their political goals, from setting up a farm shop to working in corporate social responsibility. In this case, Washington is so frustrating as to drive Emanuel into the arms of the venture capital groups he refers to as "smart money" (3). They will probably be attentive readers of this book. Indeed, they appear in his conflict of interest statement. What we see as a conflict of interest they might see as a sensible willingness by the author to put his money where his mouth is.

Though not a guide to actual transformation, the book is probably more useful as a sort of primary source document, not just for the concerns and thinking of a certain kind of mainstream Democratic health policy analyst, who is proud of the ACA and interested in turning to more technocratic

ways to "bend the cost curve," but also as the latest in a very long lineage of medical elites who seek above all to centralize, standardize, and manage medicine (see Fox 1986). Other than as a primary source for future historians, this book has little use. It certainly should not be assigned in courses of study or influence serious health policy debates.

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