Editor's Note

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Institutions—including national, state, and local governments; regulatory agencies; hospitals; and the medical profession itself—play a central role in health care. Health care institutions shape the interactions between patients and physicians, payers and providers, and privileged insiders and disadvantaged outsiders. Institutions create rights and duties, preserve organizational memory, and establish standard operating procedures. Institutions thus promote stability, producing health care outcomes that remain constant even as the economic, political, and social world around them changes.

Yet institutions can also be a source of dynamism in health care. New institutions can emerge from struggles among actors to acquire power or to solve problems. As Karen Orren and Stephen Skowronek (2004) argue, new institutions typically do not eliminate or displace old institutions but are simply layered atop them, creating frictions that are themselves an engine for political development and change. Moreover, the function and goals of institutions may evolve in response to external pressure. Rather than standing outside of politics, institutions are affected by the sociopolitical context. As Kathleen Thelen and Sven Steinmo (1992: 16–17) observe, "Exogenous changes can produce a shift in the goals or strategies being pursued within existing institutions—that is, changes in outcomes as old actors adopt new goals within the old institutions."

The articles in this issue explore the development of several key health care institutions, focusing on their respective missions, bases of support, and evolution over time. In the first article, Simon F. Haeder draws on both

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event history analysis and qualitative research to trace the development of the vital institution of public hospitals in California. Haeder shows that by the early 20th century all but the smallest counties in California were direct providers of comprehensive health care through public hospitals. These institutions provided extensive benefits to essentially all comers from their communities, including vaccinations and services for the blind, the deaf, the disabled, the aged, and the mentally ill. Haeder found strong evidence that various coverage expansions by state and federal governments, such as Medicaid and Medicare—intended to make medical services more accessible to Americans—had the ironic downstream consequence of undercutting the rationale for local governments to offer comprehensive medical care, leading to many hospital closures. Public hospitals became a matter of targeted redistribution for local governments and no longer a matter of broad community responsibility. While more affluent counties possessed the fiscal capacity to maintain hospitals, poorer, needier counties closed their doors. An important take away is that local health care institutions are critically important to their residents, but the fate of such institutions is often shaped by decisions made outside their respective communities.

One of the most important tasks for any institution in democratic politics is to build a constituency that will defend it against attack. In the second article in this issue, Ann C. Keller, Robin Flagg, Justin Keller, and Suhasini Ravi explore the political mobilization efforts of the Patient-Centered Outcomes Research Institute (PCORI), an agency established by the Affordable Care Act to fund comparative effectiveness research on what treatments and care options work best. Many analysts hoped that the evidence-based information generated through this research would incentivize the use of effective medical services, which would improve the quality of care and reduce wasteful spending. Many industry groups and provider associations are concerned, however, that comparative effectiveness research will be used to lay the foundation for reimbursement cuts and government rationing of health care. A key question is whether PCORI can cultivate a robust constituency in order to gain protection from a hostile political environment. Drawing on stakeholder interviews, content analysis of public comments, congressional hearings, and media and Internet content about PCORI, the authors found that PCORI's leaders have successfully mobilized patients and researchers in support of the organization's mission, but patients groups are tending to mobilize within rather than across disease categories, limiting their collective impact. Further, PCORI has produced few practice-changing findings, which leaves it open to the criticism that it has had little impact. The PCORI case highlights

the difficult challenge of building a powerful clientele for institutions that produce outcomes with general rather than concentrated benefits.

In the third research article, Sarah Staszak examines the subterranean politics of institutional change with respect to the promotion of arbitration within the medical malpractice system. Proposals to use mandatory, binding arbitration in lieu of litigation initially found support from liberals (seeking to provide justice to parties unable to find it in courts), but more recently medical malpractice arbitration has won endorsement from conservatives (seeking to reduce "unnecessary" lawsuits and curb "defensive medicine"). Staszak examines this little-understood transition through three periods of institutional change: partisan conversation, judicialization, and privatization. She argues that this shift in the aims and function of arbitration has produced a situation that privileges powerful institutional defendants like hospitals and corporations and other "repeat players" over the interests of individual patients.

As one form of malpractice, many experts argue that some proportion of surgical procedures performed in the United States is "unnecessary" in the sense that the interventions are either not indicated or not based on evidence demonstrating that they will benefit the patient more than conservative treatment options. Unlike drugs, surgical innovations are not subject to Food and Drug Administration review and may diffuse into general use without rigorous documentation of their safety and efficacy. In theory, patients are protected against unnecessary surgeries by oversight of state medical boards, payer denials of reimbursement, the threat of malpractice suits, and physician self-regulation, but how well do these protections really work, and what happens when a controversy develops over the appropriateness of a particular operation?

David Barton Smith examines these questions in a Beneath the Surface case study, which focuses on a surgeon (Dr. A.) who believed that existing criteria for diagnosing Chiari malformation (a rare congenital skull malformation) should be expanded and that patients who complained of chronic pain and fatigue could be treated through a surgical intervention. When Dr. A. was sued for unnecessary surgeries by 4 patients, 14 local physicians signed a letter expressing concerns about the rates of the practice. Yet the system of peer protection against unnecessary surgery is only as strong as its weakest link. Dr. A was able to obtain privileges at another hospital, his practice generated millions of dollars in revenue (the cost per procedure was $30,000) over several years, and he successfully fought off most attempts to limit his practice. While this is a single case study, it illustrates that the failure to prevent unnecessary

surgery cannot be ascribed to a lack of individual leadership (some of Dr. A's peers took steps on their own initiative to contain his practice) but reflects deeper institutional failures in medical governance.

The final essay is a Politics and Policy of Health Reform report on state innovation waiver activity. Section 1332 of the Affordable Care Act allows states to waive certain requirements of the law, provided that insurance coverage remains comparable to that offered by the Affordable Care Act with respect to affordability, benefit design, and other elements. Brad Wright, Anna Porter, Phillip M. Singer, and David K. Jones analyze thirteen 1332 wavier applications since January 2017 and report on the status of waiver applications in other states. They found that most states are using or considering waivers to implement reinsurance programs, rather than to pursue broader reforms, and consider this trend likely to continue.

References

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