Remembering the Strength of Weak Ties

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Healthcare delivery is a networked enterprise. The connections between providers, payers, and purchasers have a profound influence on the quality and value of care patients receive.[1] American sociologist Mark Granovetter has developed a useful typology for understanding how these networks function: through strong and weak ties.[2] Strong ties are relationships between individuals of the same group (eg families, friends, or colleagues) and are small, frequent, intimate, and durable. Weak ties represent the connections between individuals of different groups, and are distributed, sporadic, and often fleeting.

The value of strong ties is intuitive; such connections provide reliable structures for socialization and support. Granovetter argues that weak ties, although more nuanced, are just as important. By bridging different groups, weak ties provide exposure to new people and new ideas. For example, Granovetter's research demonstrates that weak ties are more impactful than strong ties in helping individuals find new opportunities for employment.[2] Ultimately, neither strong nor weak ties are categorically more important, nor is either a substitute for the other. Each has unique benefits, and the most effective individuals and organizations tend to operate in networks enriched by both.

Changing Healthcare Networks

Granovetter's paradigm of strong and weak ties has important implications for healthcare delivery and the ways in which it is changing. If we consider strong ties as the connections between physicians in the same practice, provider group, or hospital, then weak ties are the connections between physicians across organizations, including former colleagues, classmates, or naturally occurring referral networks. As healthcare reform unfolds, the nature of these relationships is changing. For most of American medical history, weak ties have dominated physician networks. Individual and small-group practices were the norm. Physicians had admitting privileges at hospitals, but that was often where their formal connection to other providers and institutions ended. Amidst this climate, informal networks of physicians emerged, based more on shared patients and social connections than on market forces and payment structures.

Over the past 2 decades, network dynamics have shifted from weak to strong ties. Whereas the majority of physicians worked in physician-owned practices in the 1990s, today, most are employed by hospitals.[3] The Affordable Care Act and related private-sector reforms have accelerated these trends, most notably, through the growth of accountable care organizations (ACOs) and continued consolidation in the care delivery market.[4]

ACOs and other high-profile delivery system innovations have been designed to promote coordinated care. To achieve these aims, they create formal networks of physicians and strive to confine care delivery to small networks. New networks created under these models are often substantially different than the organic referral networks they replace.[5] Confidence in the potential of ACOs is grounded in a belief in the power of strong ties and the added control they afford over healthcare utilization. Success is predicated on the notion that formal networks of providers will lead to more coordinated and effective care.

Unintended Consequences

Although a shift toward strong ties promises benefits, there are unintended consequences to the concomitant abandonment of weak ties. A tremendous amount of learning, improvement, and innovation is needed to achieve the national goals of better care, better health, and lower costs. Physician networks are central conduits to these efforts—the means by which information on what works best in healthcare is created and shared.[6] Optimal knowledge gen-

eration and dissemination requires a delicate balance between strong and weak ties.

Strong ties promote learning and diffusion within groups, whereas weak ties foster knowledge transfer between groups. As such, weak ties can help individuals acquire useful knowledge more rapidly, innovate swiftly, and nimbly respond to challenges—a pattern demonstrated empirically in healthcare and other industries.[1,2] Efforts to improve the identification, adoption, and spread of new innovations and best practices will be hamstrung within physician networks dominated by strong ties. Even Granovetter observed that "social systems lacking in weak ties will be become fragmented and incoherent, new ideas will spread slowly, scientific endeavors will be handicapped."[2] Structuring away informal knowledge sharing networks has the potential to create insular nodes of practice, with poor communication among different organizations and groups of physicians.

This may be especially problematic for the care of patients who do not fit neatly into clinical guidelines. Whereas the creation and adoption of clinical guidelines is likely to be accelerated through strong ties, care for complicated patients necessitates weak ties. Physicians have historically managed these nuanced patients through informal consultations and referrals, tapping into networks of friends and colleagues forged during training and clinical practice. In doing so, they learn from the experiences of physicians within and outside of their organization, and adapt their practice accordingly. Within physician networks increasingly dominated by strong ties, these patients may be promptly whisked away to in-system specialists, often through automated referral protocols. Therefore, what is gained by stopping "leakage" is also a lost opportunity for systemwide learning.

Conclusions

Consolidation and strict affiliation risk the endurance of weak ties, as well as the natural innovation and learning that occurs through them. As care delivery models continue to evolve, it will be important to consider strategies to preserve, or reintroduce, weak ties among physicians. Learning networks can help bridge the gaps between clusters of strong ties, and increased clinical data sharing and reporting will allow physicians to see and learn how colleagues at other institutions provide care. Most important will be the need for payers and policy makers to design rules and regulations that, instead of promoting excessive consolidation, allow for independent physician groups to survive, and even thrive, in new delivery models.

Take-Away Points

- According to sociologist Mark Granovetter, connections between individuals can be modeled as either strong or weak ties.
- Over the past several decades, US physicians have become increasingly bound by strong ties rather than weak ones.
- Strong ties promise benefits with regard to care coordination, but the abandonment of weak ties comes with unintended consequences, including a decreased capacity for innovation and the slower spread of new ideas.

Both strong and weak ties have their roles in the organization and structure of healthcare delivery—and the most effective and efficient models will recognize and accentuate the value created by each. Prevailing strategies for delivery reform focus on the power of strong ties by tightening and formalizing relationships among physicians and health systems. Ignoring the importance of weak ties will jeopardize the long-term success of these initiatives. Granovetter urged us to remember the strength of weak ties, so as health reform moves forward, it will behoove policy makers and health system leaders to do the same.

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