Part I

Health Policy

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CHAPTER 1: HEALTH POLITICS AND POLITICAL ACTION

This chapter contains six articles that briefly set the factual and conceptual components of health policy, including the various definitions and components of the crises and politics surrounding it.

From the Physicians for a National Health Program (PNHP) comes the lead article, "Health Crisis by the Numbers," written by cofounders David Himmelstein and Steffie Woolhandler and Director of Policy and Programs Ida Hellander. It contains a brief and essential overview of the facts that illustrate key dimensions of the healthcare crisis. Included are discussions on the uninsured as well as on the underinsured, socioeconomic inequality, healthcare costs, Medicaid and Medicare, corporate money and corporate health care, "Big Pharma" and "Hospice, Inc.," and the new healthcare reform law—the Patient Protection and the Affordable Care Act (PPACA). The PPACA (sometimes referenced in a shortened form as the Affordable Care Act, or simply ACA) and the other topics highlighted by this update are addressed, in depth, in articles appearing in subsequent chapters of this book.

Beaufort Longest (1998) offers a definition of *policy* as the "authoritative decisions made in the legislative, executive or judicial branches of government . . . intended to direct or influence the actions, behaviors, or decisions of others" (p. 243). Health policy consists of laws, rules, regulations, and judicial decisions made at all levels of government: federal, state, and local. Policy making, he notes, is deeply *political* throughout all phases, and it is not achieved through a predominantly rational decision-making process. Longest's model emphasizes that factors external to the process itself are influential. In the language of organizational theory, the policy process is part of an "open system" (which is *not* to say that we all have equal access to the system). The phases of the policy process are interactive, interdependent, and interconnected through policy formulation, implementation, and modification, with feedback loops (some might call them backlash loops). Public and private interests are not necessarily balanced through long and strenuous policy debates and changes, sometimes (but more often than not) involving "extremes of excess . . . alongside true deprivation." The results are not likely to be the best, fairest, or most efficient choices to pursue health or to reduce inequalities in access to and outcomes of care.

Vicente Navarro takes our understanding of health policy a step further, arguing that it is much broader than medical care policy alone. Navarro's list of the main components of a national health policy are: (1) the political, economic, social, and cultural determinants of health as most important; (2) the lifestyle determinants as most visible via public interventions; and (3) the socializing and empowering determinants, which link the first and second components of a national health policy. In explicating the individual interventions and the collective interventions, Navarro offers a positive example of a *national health policy plan* such as that developed by the Swedish social democratic government. He then suggests a relevant application, given the current context of health care in the United States.

Nurse, health leader, policy maker, and scholar Catherine Dodd argues that health professionals need to appreciate the import of policy in their practices, as they are becoming increasingly involved in politics and political activities. Participating in the political process requires an understanding of the basic rules of politics. Dodd lays out precepts (her "Ten Universal Commandments of Politics and Reasons to Obey Them") and practical guidelines for successful involvement in politics and advises that: "The personal is political. Each of us is one personal or social injustice away from being involved in politics." Also (for better or worse), while "money is the mother's milk of politics," we achieve visibility by taking credit, and thereby taking control.

Dodd, a former staff director for Nancy Pelosi (first woman speaker of the U.S. House of Representatives), former director of the U.S. Department of Health and Human Services (Region IX), and currently director of health systems in San Francisco City and County, draws her "Ten Commandments" from her deep experience and expertise in the policy process.

Jacob Hacker's article "The New Economic Insecurity—and What Can Be Done About It" makes the case that economic insecurity is inextricably linked with health insecurity and many other forms of insecurity in family and society. He reviews the evidence that Americans are at increased economic risk and outlines a set of principles for restoring economic security. Hacker identifies flaws in traditional policies of risk protection in the United States (e.g., unemployment insurance) that insure employees for short-term exits from the workforce, when it is increasingly evident that long-term job losses and skills obsolescence have become severely problematic for millions of American workers. He offers an agenda for change to help restore job security, health security, and income security, all of which provide the financial foundation that enables every American to invest securely in his or her future. Hacker's proposed new framework of social insurance, which is more suited to today's economy and society, calls for revitalizing the best of the present system and upgrading protections for workers at risk for major job interruptions and for large-scale workforce disruptions in employment, which ultimately place at risk the economic security of families and children. More detail on these proposals are in his books, including *The Great Risk Shift* (2006) and *Winner-Take-All Politics* (2010) with co-author Paul Pierson.

Chapter 1 concludes with Carroll Estes' critical perspective on health policy, politics, and policy. Estes emphasizes two major features of the critical perspective drawn from the larger field of conflict theory: *ideologies* (sets of beliefs and partial perspectives that advance the position of groups in power and those opposing them) and the *role of the state* (the government and nation-state as broadly conceived). Conflict theory posits that society and its structural arrangements are organized and held together by *constraint* rather than consensus across the land. Constraint of the many by the few is a result of the greater power and dominance of certain groups and structural interests over others. Power and dominance emanate from and reflect the disparities (inequalities) in the ability to amass economic, political, and cultural resources around specific problem definitions, ideologies, and policy directions. Paramount is the capacity to construct and impose (by law, regulation, practice—or neglect thereof) what become the leading definitions of "problems and crises" as well as the reigning definitions of the solutions that demand government (or private sector) action (or inaction). The perspective seeks to advance "awareness of the roots of domination, undermine the ideologies and help compel changes in consciousness and action" (Bottomore 1983, p. 183).

CHAPTER 2: HEALTH POLICY AND CORPORATE INFLUENCES

This chapter contains five articles covering a range of corporate practices and influences on health, health care, and health policy. These highlight the tension between the interest and investment in public health versus those of the corporate sectors that comprise the medical–industrial complex.

In the first article, Nicholas Freudenberg and Sandro Galea examine how corporate practices shape health and health behavior. Their case studies of three products (trans fat, a food additive and preservative; Vioxx, a pain killer; and sports utility vehicles, more commonly known as SUVs) show how corporate practices contribute to the production of health and disease. The authors outline the health policy implications of discouraging harmful corporate practices, and thereby increasing opportunities for primary prevention

Jeremy Greene and David Herzberg look at the public health impact of direct-to-consumer (DTC) pharmaceutical advertising. Omnipresent advertisements are part of a long history of corporate self-promotion that includes ghostwriting popular articles and public-relations events. The article ends with a discussion of the public health problems and current significance and dangers of these marketing practices.

Patricia McDaniel and Ruth Malone raise the public health issues residing in what corporations do to ensure their "credibility." This article chronicles how the tobacco industry deploys "credibility-building projects" that enable this corporate sector to continue business as usual. McDaniel and Malone identify how such credibility practices seriously challenge public health.

Arun Mohan and co-authors speak to the relation between health and life insurers' financial investments and the public good. A clear example of the tensions and contradiction between industry financial interests and the public interest is these insurers' major investments of nearly $2 billion in stock in the five leading fast food companies. The authors argue that, since scientific research shows that fast food industry practices negatively impact public health, such insurers should be held to a higher standard of corporate responsibility. How can such standards of corporate responsibility be advanced? Mohan and colleagues offer potential solutions.

A short article by Marion Nestle (food policy expert, food safety advocate, and Paulette Goddard Professor in the Department of Nutrition, Food Studies, and Public Health at New York University) rounds out this chapter about the various corporate influences on U.S. health policy. With increasing frequency, high-profile news stories alert U.S. citizens to the inadequacies and failures of the food safety system that have resulted in numerous cases of foodborne illnesses and even deaths. Such news underscores, as Nestle argues here, that a safe and secure food supply is a matter of public health. Some of the inadequacies and failures in the U.S. food safety system, as Nestle recognizes, are the result of an antiquated and fragmented system of policies and agencies that control food safety oversight. Mainly, archaic federal food safety legislation, dating back to the 1930s, leaves two poorly integrated and understaffed federal agencies, the U.S. Department of Agriculture (USDA) and the U.S. Food and Drug Administration (FDA), to regulate a proliferating (and politically powerful) complex of agricultural and food production industries (including foreign importers). What is more, as Nestle points out, bioterrorism places a safe and secure supply of food at further risk, in light of the tragedy of September 11, 2001. As deadly foodborne illnesses remain newsworthy (most notably in accounts of the 2011 listeria outbreak caused by—no less—contaminated cantaloupes), we can only hope that the newly implemented FDA Food Safety Modernization Act (FSMA), signed into law on January 4, 2011, will provide a way into an era of truly safe, healthy eating. In the revised edition of her book *Safe Food: The Politics of Food Safety* (2010), Marion Nestle details her argument that safe food is political as well as personal. If you access her website, www.foodpolitics.com, you can participate in the food safety debate and get the latest on Nestle's push for continued improvements in food safety oversight, such as her insights into the need for adequate funding that would ensure full implementation of the FSMA and the critical need for combining "the safety functions of the USDA and FDA into a single unit dealing with all foods, from farm to table."

CHAPTER 3: HEALTHCARE REFORM TODAY AND FOR THE FUTURE

John Geyman's book *Hijacked!* is an important analysis of "stolen health care reform." This excerpt from the book dissects the "theft" through the lens of staunch advocates for a single-payer system. Describing the stakeholders (those who benefit from the status quo) and their "quest for the profit grail," Geyman delineates the strategies and gains of the largest private insurers, PhRMA's drug fix, the medical arms race of the hospital and technology industries, and the role of organized medicine. He questions who profits from this corporate "alliance"—the "big four stakeholders" or the public? Investors control the table.

The first of three articles from the Henry J. Kaiser Family Foundation website provides an excellent summary of the coverage provisions in the Patient Protection and Affordable Care Act (PPACA) that President Obama signed in March 2010. This online piece (April 2011) summarizes major health coverage provisions in the law, incorporating changes made to the law by subsequent legislation. The second article (June 2010) contains the timeline for implementation of key provisions of the comprehensive health reform law. The third article, "Medicaid and Children's Health Insurance Program Provisions (CHIP) in the New Health Reform Law," describes the components of the 2010 health reform that relate to expanding the healthcare safety net (through Medicaid and CHIP) to provide seamless, affordable healthcare coverage to at-risk populations of low-income adults and children. Since the law requires individuals to obtain health insurance, it added provisions for Medicaid expansion and for subsidies to help low-income individuals buy coverage through newly established Health Benefit Exchanges.

Joshua Wiener describes how the 2010 healthcare reform legislation addresses long-term and post-acute care, including the inadequacy of financing, the lack of home- and community-based services, the absence of care coordination, and poor-quality care. Wiener describes the CLASS (Community Living Assistance Services and Supports) Act, a voluntary social insurance program for long-term care, that was incorporated in P.L. 111-148.

Wiener's piece is followed by a brief commentary by Carroll Estes that describes the recent and somewhat ignominious takedown of the CLASS Act. This long-term care legislation (initially widely heralded as the achievement of Senator Ted Kennedy's dream of universal health care) became part of health reform in the ACA due to Kennedy's leadership, the extremely effective and prodigious work of his chief staffer, Connie Garner (also a registered nurse and the executive director of Advance CLASS), and deft negotiations that took place over rocky times and across (literally) decades of prior and ongoing advocacy, scholarship, federal commissions, and philanthropic efforts in support of a national policy on long-term care. In an October 2011 letter to Congress, Health and Human Services Secretary Kathleen Sebelius announced that she "did not see a viable path forward" to assuring that the

CLASS program would be fiscally solvent and that the White House would make no further moves at implementation. As of this writing, uncertainty lingers concerning whether or not the CLASS Act might remain on the books (in name only); Republicans have mounted multiple attempts to repeal it, succeeding so far in the U.S. House of Representatives. Although the Democrats and the president oppose repeal of the CLASS Act, much larger issues have diverted focus and diluted efforts to prevent its repeal.

The chapter also includes an article that describes a Senate-passed PPACA bill (P.L. 111-148) that, improved by reconciliation, resulted in the Health Care and Education Reconciliation Act, or HCERA (P.L. 111-152). These two pieces of healthcare reform are designed to expand and reinforce the nation's healthcare workforce through investments in training for doctors, nurses, dentists, and other health professionals. HCERA addresses shortages in primary care and other fields by investing in scholarships, loan repayment, and training grant programs to recruit and train additional primary care, nursing, public health, and other critically needed healthcare professionals.

Chapter 3 culminates with an article by Jill Quadagno, who introduces the major sociological tenet that healthcare organizations and systems reside in and are shaped by larger institutions, historical precedents, and cultural contexts. "Although bound by policy legacies, embedded constituencies, and path dependent processes, healthcare systems are not rigid, static, and impervious to change," as shown by healthcare reform achieved in 2010 (Quadagno, 2010). Quadagno asks how healthcare reform will change the existing network of public and private benefits and the power relationships and their constituencies as she poses questions for future research, post healthcare reform.

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