Chapter 1

Introduction

If everyone is in charge, then no one is in charge. Health policy is problematic throughout the world, but it is particularly challenging in the United States, where there is no consensus about which government agency or social institution, if any, has an accepted, legitimate role of developing or implementing national health policy. The U.S. Constitution is silent on the subject of health and health care. Although its preamble promises "to promote the general Welfare," the Tenth Amendment states, "The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people." Neither education nor health care powers are specifically allotted to the federal government in the Constitution. The omission of health, however, cannot be attributed solely to the framers' intent, despite the presence of three physicians at the Constitutional Convention. They lived in a world of "evil humours" where one visited "barbers and churgeons."

Constitutional issues almost derailed the Patient Protection and Affordable Care Act (ACA) of 2010 before the Supreme Court. In 2012, the Court, by a 5–4 vote, upheld the constitutionality of the "individual mandate" provisions that require most individuals to carry basic health insurance or pay a penalty on their income tax return. At the same time, it overturned a provision requiring states to expand Medicaid access, ruling that it was unconstitutional because it did not provide states enough latitude.

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President after president has pushed for an overhaul to our health care system and remedies to the access problems it creates. Only Lyndon Johnson and Barack Obama have succeeded. Attempts by Truman, Eisenhower, Nixon, and Clinton were less successful. In the more recent past, the rapid growth of health care costs has expanded the policy debate, as has growing recognition of medical errors and other quality problems. In the meantime, policy analysts struggle to make progress with a highly fragmented system and a divided body politic.

THE MANY ACTORS

Policy decisions are made at multiple levels of U.S. society:

- National government
- State and local governments
- Health care institutions
- Provider professionals
- Payer organizations (employers and insurers)
- Employers (meeting the mandate)
- Individuals (consumers)

Tables 1-2 through **1-7**, which are distributed throughout this chapter, provide samples of major health policy questions faced in each of these domains. Like most tables and lists in this text, they are meant to be illustrative, not exhaustive.

In such a decentralized environment, government may take a hands-on approach, treating health care as a public good, as it does transportation and education, or a hands-off approach, favoring market-driven outcomes. Therefore, government's stance and specific policies may swing dramatically as political power shifts. For example, during the 2012 presidential campaign, one side vowed to repeal the ACA if it gained complete control of the political process, undoing a major accomplishment of the Obama administration. Sharp changes in public attitudes are not unknown. The 1988 Medicare Catastrophic Coverage Act had a favorable rating with the public when passed, but was repealed in November 1989 as the public, especially the wealthier elderly, learned more about it.

This chapter describes what health care policy is, how the policy analysis process works, and the different roles health professionals can play in setting and implementing health policy over time. The role of a policy analyst is described quite completely in the excerpt from the U.S. Office of Personnel Management Operating Manual displayed in **Table 1-1**. As you

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Table 1-1 Excerpts from the Office of Personnel Management Qualification Standards for General Schedule Positions—Policy Analysis Positions

- Knowledge of a pertinent professional subject-matter field(s). Typically there is a direct, even critical, relationship between the possession of subject-matter expertise and successful performance of analytical assignments.
- Knowledge of economic theories including micro-economics and the effect of proposed policies on production costs and prices, wages, resource allocations, or consumer behavior; and/or macro-economics and the effect of proposed policies on income and employment, investment, interest rates, and price level.
- Knowledge of public policy issues related to a subject-matter field.
- Knowledge of the executive/legislative decision making process.
- Knowledge of pertinent research and analytical methodology and ability to apply such techniques to policy issues, such as:
  - Qualitative techniques, such as performing extensive inquiry into a wide variety of significant issues, problems, or proposals; determining data sources and relevance of findings and synthesizing information; evaluating tentative study findings and drawing logical conclusions; and identifying omissions, questionable assumptions, or inadequate data in the analytical work of others.
  - Quantitative methods, such as cost benefit analysis, design of computer simulation models and statistical analysis including survey methods and regression analysis.
- Knowledge of the programs or organizations and activities to assess the political and institutional environment in which decisions are made and implemented.
- Skill in dealing with decision makers and their immediate staffs. Skill in interacting with other specialists and experts in the same or related fields.
- Ability to exercise judgment in all phases of analysis, ranging from sorting out the most important problems when dealing with voluminous amounts of information to ensure that the many facets of a policy issue are explored, to sifting evidence and developing feasible options or alternative proposals and anticipating policy consequences.
- Skill in effectively communicating highly complex technical material or highly complex issues that may have controversial findings, or both, using language appropriate to specialists and/or nonspecialists, facilitating the formulation of a decision.
- Skill in written communication to organize ideas and present findings in a logical manner with supporting, as well as adverse, criteria for specific issues, and to prepare material complicated by short deadlines and limited information.
- Skill in effective oral communication techniques to explain, justify, or discuss a variety of public issues requiring a logical presentation of appropriate facts and information or analysis.
- Ability to work effectively under the pressure of tight time frames and rigid deadlines.

Source: Reproduced from: http://www.opm.gov/qualifications/standards/Specialty-Stds/gs-policy.asp; accessed 12/01/12. For more detail see Section IV-A (pp33-34) of the Operational Manual for Qualification Standards for General Schedule Positions.

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Table 1-2 Illustrative Health Policy Issues at the U.S. Federal Level

- How should otherwise healthy people be motivated to participate in health insurance programs, thus lowering the average premium?
- What population groups should receive subsidized coverage from tax revenues?
- Because the Constitution does not include the topic of health care as a federal responsibility, how should the federal government participate in supporting health care for all?
- How should the federal government support quality improvement efforts if state boards are not effectively addressing medical error rates?
- The cost of malpractice insurance in some states threatens the supply of providers in some specialties and appears to raise the cost of care, so what is the role of the federal government in avoiding the negative effects of malpractice lawsuits?
- Progress in information technology implementation in health care has lagged behind most other information-intensive service sectors. Are the provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act sufficient to overcome this problem?
- What services should be covered under Medicare? Medicaid?
- How many health professionals in a subspecialty are sufficient? Armed with the right answer, what should we being doing about any shortages? About any surpluses?

proceed through the text, you will likely note many parallels between that role description and the organization of this text, even though this text is meant to outline health policy analysis for health care professionals rather than cover the full training needs for a career in policy analysis. We then provide an overview of some of the major policy issues facing health care in this country. Finally, we address how certain potentially confusing terms are employed throughout this text and suggest ways to integrate the material that you will be learning with your knowledge from other disciplines.

HEALTH CARE: WHAT IS IT?

The terms *health* and *health care* are used loosely in U.S. policy debates. Often what people mean by health is an absence of notable ailments. The World Health Organization (2005), however, defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”

Similarly, when people utter the phrase *the health care system*, they often are talking about the system for financing and delivering personal medical services—what some refer to as illness care and we will refer to primarily as the medical care system. The entire system that promotes health and wellness is actually much more complex. Other health systems include public

health, mental health, and oral health. Moreover, much of our health is the result of *social determinants*, such as housing, education, social capital, our natural environment, and the way we construct the *built environment* around us. These are shaped by policy decisions made outside the health care system.

Thinking about health in terms of population outcomes can dramatically shift the way problems are defined and addressed. One example is identifying the leading causes of death. Using a disease model, the leading killers are ailments such as heart disease, cancer, stroke, injury, and lung disease, but McGinnis and Foege (1993), using a population-based, prevention-oriented perspective, identified the "real causes of death" as behaviors such as tobacco use, improper diet, lack of physical activity, and alcohol misuse. They argued that 88% of what we spend on health nationally pays for access to medical care, but in terms of influence on health status, medical care accounts for a mere 10%. This view attributes 50% of our health status to our behaviors, 20% to genetics, and 20% to environmental factors. Yet only 4% of health spending has been going to promote healthy behaviors and 8% to all other nonmedical health-related activities (Robert Wood Johnson Foundation, 2000). Since the mid-1960s, public health spending as a percentage of overall spending on health care has fluctuated between 1% and 1.5% (Frist, 2002), and yet 25 years of the 30-year increase in life expectancy between 1900 and 1995 can be attributed to public health interventions.

Some examples used to illustrate points throughout this text draw on material from outside the realm of medical care finance and delivery. One case study discusses folic acid fortification of foods, an example of a population-based public health intervention. This text, however, focuses mostly on access, cost, and quality issues related to personal medical services. That is because the primary intended audience is health care professionals (people who operate primarily from within the medical care system) and also the simple fact that the United States is currently wrestling with many critical issues related to health care access cost and quality. Readers are urged, however, to keep that intentional bias in mind and to think about how a big-picture view of health might change the way problems and solutions are identified. For instance, one reform proposal currently in vogue, and discussed in several places in this text, is pay for performance, also known as pay for quality. Pay-for-performance programs provide financial incentives for providers to meet certain process and outcome measures. Kindig (2006, p. 2611) has proposed a "pay-for-population health performance system" that "would go beyond medical care to include financial incentives for the equally essential nonmedical care determinants of population health."

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Table 1-3 Illustrative Health Policy Issues at State and Local Levels

- What services should be provided and to whom under Medicaid options and waivers?
- How should the professional licensure be conducted so as to encourage quality of care, adequate access, and appropriate competition?
- How should the public university system decide how many professionals to train to ensure adequate access to all sections of the state? To all target groups?
- How aggressive should our state be in implementing and supporting health insurance exchanges?
- What should be the roles of the state insurance regulations and oversight boards in ensuring access to care for the general public and for special populations?
- Should the curative health care system, the mental health system, and public health clinics be merged as health care access becomes universal?
- What are intended and unintended consequences of sex education policies on health and health services?
- How do we undertake health care emergency planning for responses to floods, earthquakes, pandemics, and terrorism? What is the relationship between the state systems (public health and military) and local first responders?

HEALTH POLICY: WHAT IS IT?

Beyond the scope issues just described, most of us are clear on what health policy is about in general terms. Simply stated, health policy addresses questions such as:

- Where are we with our health care?
- How did we get here?
- Where do we want to be?
- What other alternatives are available here and throughout the world?
- What is likely to work in the future given our political process?
- What roles should health professionals and ordinary citizens play in this process?
- How can we become better prepared for such roles?

We cannot expect any representative cross section of participants to agree on the answers to all of these questions because their interests often conflict. A goal of this text is to encourage development of an objective, managerial approach to decision making—one that uses precise definitions of terms and relationships and carefully considers the key issues (and walks in the shoes of key actors) before reaching individual conclusions. Readers should come away with a set of tools for interpreting and analyzing events,

Table 1-4 Illustrative Health Policy Issues for Health Care Institutions

- How much charitable (uncompensated) care should we provide beyond that which is mandated?
- What should be our health information technology strategy?
- Should we undertake joint planning for future services with our local health department?
- How should we go about increasing the proportion of the local population who volunteer as local organ donors?
- Can we rationalize the services provided by local providers, reducing duplication and waste, and still avoid charges of anticompetitive practices?
- What should we be doing to become an effective learning organization?

situations, and alternatives—tools that can add to the skills already developed through professional training and experience. No one need abandon what has worked, but we hope to empower analysts to do a better job using a broader array of methods that fit a greater variety of situations.

THE POLICY ANALYSIS PROCESS

The policy analysis process usually involves the following activities:

- **Problem identification.** Why do we think we need to evaluate and possibly change the way we do things? What kinds of actions are people asking for? What are the drivers that require that scarce resources be devoted to this policy area? What is the intended output? What is the expected result?
- **Process definition.** What is the current situation? What concerns are people citing? Why are current results unsatisfactory to some? What is being done about it? Who are the current actors, and what are their roles? Are people framing the issue effectively? What are reasonable expectations for results over a relevant time horizon?
- **Process analysis.** What is happening in practice? How are outputs and outcomes measured, and why? What are interested parties recommending? What are the resource inputs? Are they appropriate? Are the outputs distributed fairly? Policy analysis can be approached rationally using a consistent set of steps:
  - Map out the existing processes that yield the outputs and outcomes of concern in as much detail as necessary to be operational.
  - Generate a list of solution strategies and narrow it to viable alternatives.

- Map out the best processes for the more promising alternatives.
- Ask where, how, and when new technologies might change each process within the relevant time horizon.
- Determine the resource requirements of the most promising alternatives and then cost them.
- Calculate other process parameters, such as lives saved, hospital days avoided, or persons served.

- **Qualitative analysis.** Identify and assess the nonquantitative issues related to valuation of benefits, quality, equity, and perceived fairness and distribution of outcomes.
- **Evaluation and choice.** Take steps to evaluate the options and make a choice:
    - Weigh the evidence, quantitative and qualitative, and review the conclusions to evaluate for:
        - Technical feasibility (medical evidence and operational effectiveness)
        - Political feasibility
        - Economic viability
    - Choose a preferred policy.
    - Prepare to report your findings and conclusions.
- **Implementation strategy.** How do we gain public, professional, and consumer support for change and backing for the most

Table 1-5 Illustrative Health Policy Issues for Provider Professionals

- Should I accept Medicaid patients?
- What services should I provide in addition to those normally provided by my specialty?
- Should I accept an invitation to join the local consortium for accountable care organizations (ACO)?
- What should I do to help the local populace understand the risks of potential pandemics without arousing unnecessary concerns?
- What positions should I encourage my local, state, and national professional organizations to take on current health policy issues?
- Should I volunteer to serve on local or state committees assessing and advocating on health policy issues? Should I seek or accept a leadership role? How do I prepare for that possibility?
- Should I make my information systems meet current "meaningful use" standards and take the subsidy or forget about it until I'm forced to convert?
- Should I enter (or stay in) private practice, or should I join a large group with ties to a dominant delivery network (hospital, health maintenance organization [HMO], ACO, pharmacy chain, etc.)?

appropriate alternative(s)? How do we ensure early implementer and consumer buy-in and mediate conflicting interests?

- **Implementation planning.** What steps do we need to take to ensure the successful implementation of the alternative chosen? How will we evaluate the level of improvement?
- **Feedback on policy processes.** Have we been making the right choices? If not, why not? What might we do to enable better policy choices in the future?

PROFESSIONALS AND THE POLICY PROCESS

An unusual aspect of health care in the United States is the low level of influence that health professionals have on policy formulation. All too often health professionals refer to what policy makers are doing to them, not on what they are doing to contribute to the policy processes. Professionally prepared leadership is extremely important if policies are going to be accepted and effectively implemented. Later in the text we will point to how and where professionals can exert leadership in enhancing the delivery of services that is their work and their calling.

One reason U.S. health care professionals have been involved so little in policy making has been the very high opportunity cost of any time devoted to policy matters. Most countries have a Ministry of Health that oversees the national health system. Where government pay for health professionals is low, professionals compete for higher administrative posts that offer better salaries, and especially better locations. Most key positions below the political level in the ministry are held by health professionals, and the directors of most divisions, departments, and institutions are physicians. At one time, U.S. health department directors were all expected to be MDs, and so were many hospital administrators. During and after World War II, when physicians were in short supply, other administrators were called on to run those institutions and new cadres of administrators were trained in the nation's schools of public health, public administration, and business administration. Rapidly rising physician income, especially after the introduction of Medicare and Medicaid in 1965, increased the demand for physician services, but not the supply. Providing care paid so much better than administration that few health professionals sought training in health administration. Educational institutions and health agencies again expanded their training programs for health administrators without professional credentials. Only as managed care has begun to constrain provider income and consolidation has begun to increase administrator

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Table 1-6 Illustrative Health Policy Issues for Payer Organizations (Employers and Insurers)

- What kinds of options should I offer as health benefits? Given that employees need choices, should I offer high-deductible insurance policies to go with medical savings accounts?
- How much money and effort should we allocate to prevention? What about the argument that people change plans so often that our investment in prevention won't pay off?
- We have a lot of data on health care utilization. Should I mine that data and suggest choices of procedures? Providers? Lifestyle changes?
- Ethically, how much should we know about our employees' (the insureds') lifestyles that may affect future health care costs, and how should we use that knowledge?
- Now that health care benefits are mandated for most employers, how do we balance competing for the right labor force, avoiding or not avoiding the tax penalties for those employees not covered, and keeping premium costs under control?
- Should we participate in the new insurance exchanges? If so, what should be offered?

incomes have professionals taken a stronger interest in managerial training programs. This interest has been reinforced by provider dissatisfaction with the changes in professional autonomy and working conditions under managed care. At the same time, the incomes and productivity demands on nonphysician professionals have also been rising, dampening their interest in participating in policy processes. Professionals are waking up to the need to participate, but often feel constrained by their lack of skills and confidence to participate effectively in the policy process.

NATIONAL SYSTEMS DIFFER BUT PARALLELS EXIST

Every country's health care system is unique, as a result of culture, history, and happenstance. Yet the issues policy makers face can parallel each other. Many developed countries are struggling with the burden of their social programs, including health care. Even in countries that have long had national health services, there have been many efforts to decentralize them, to make them more responsive to local needs, and to tap into tax revenues available at the regional and local levels. Medical care systems in the United Kingdom and Scandinavia provide examples of this. No other developed countries, however, spend as much per capita or as a percentage of the national income (gross domestic product) as the United States, and many of them have better health outcomes across the population. The results achieved in the United States should be better, given our relatively high expenditures.

Table 1-7 Illustrative Health Policy Issues for Individuals

- Should I purchase health insurance if my employer does not pay for it, or should I pay the tax penalty?
- What should I do about my increasing weight and high blood pressure?
- When I retire, how much should I plan to rely on Medicare to cover my health care costs as I continue to age?
- Certain medical specialties are not available in my area. My county government wants to issue tax-exempt bonds to finance a new doctors' office wing on the county hospital site. Should I support the referendum on the bonds?
- My daughter is 24 years old and waiting tables at the Pizza Palace. The company's health benefits are minimal. Should I keep her on my health insurance policy until she turns 26?

Although this text does not emphasize comparative international health policy, it is important to understand that both developed and less developed countries have taken rather different routes to more or less successful health care systems, leading, in turn, to differences in costs and outcomes. These results have been achieved over decades of adaptation to the cultures and institutions of those countries and may or may not be models for the United States.

All countries are aiming at targets that shift as their populations age, as new technologies become available, and as new diseases and environmental threats emerge. Many, if not most, are experimenting with one or more aspects of a market system for health care delivery, while still maintaining that health care is a basic human right. Although health care is not officially a right in the United States, all levels of government and the body politic have been concerned about the proportion of the population forced either to forgo care or to seek some form of public assistance. Even relatively conservative commentators have argued for universal participation in national or state-level health insurance schemes, partly to disengage health care financing from employment relationships and partly to avoid adverse selection by employees and underwriting discrimination by insurers. The provisions of the ACA, if fully implemented, could go a long way toward meeting those goals. Its impact on costs remains to be seen.

KEY POLICY CATEGORIES

The major policy categories in the first column of **Table 1-8** will be used to structure later discussions. They relate to quality of care, availability of resources, payment and funding, motivation of patients and providers,

Table 1-8 Matrix of Major Policy Categories Versus Major Skills Disciplines

Major Policy Categories	Major Skills Disciplines			
	Medical	Economic/ Financial	Political	Operational/ Managerial
Quality				
Access		X	X	X
Technical management	X	X		X
Interpersonal relationships	X			X
Continuity of care	X		X	
Measurement and reporting	X			X
Resource availability				
Personnel	X	X	X	
Technology				
Evidence-based medicine	X	X		X
Process rationalization	X	X		X
Information systems	X	X		X
Payment				
Insurance/allocation of risk		X	X	
Motivating patients and payers				
Consumer-oriented care		X	X	X
Mandated payments		X	X	
Price transparency			X	X
Motivating providers				
Volume				
Fee-for-service		X	X	X
Capitation/vouchers		X	X	
Bundling	X	X	X	X
Budgets/salaries				
Pay-for-performance	X	X	X	X
Price Competition				
Antitrust		X	X	
Labor substitution	X	X	X	X
Increased buyer power		X	X	
Cost-efficiency and effectiveness				
Malpractice			X	X
Fraud and abuse			X	X
Cost-reduction measures	X	X	X	X
Organizational learning	X			X

volume and price of services, competition, and cost drivers. They are based on a classification of policy interventions developed in McLaughlin (2014). The four other columns represent the major skills disciplines that are needed by the policy analysis team. Each will be the subject of one or more subsequent chapters. Any significant policy analysis is likely to need data and other contributions from experts in medicine, economics (including finance), political science, and services management (including behavioral and operational skills). The Xs identify which of those disciplines seem to have a major role in the analysis of that particular policy category. One could argue that all the boxes need to be checked for all categories. Although expertise and analytical skills across all four domains are relevant for each category, we have chosen to put Xs in a limited number of boxes to highlight the variability in major skill set requirements.

OVERARCHING MEDICO-SOCIAL ISSUES

In addition to these specific policy categories, a number of overarching social issues need to be kept in mind. They include:

- Ongoing relationships between health insurance and employment
- Employment status, compensation, and autonomy of health care professionals
- Equity in access to services
- Fairness in intergenerational transfers
- Allocation of responsibilities among federal, state, and local governments
- Professional versus institutional responsibilities for process development and improvement

Relationships Between Health Care Financing and Employment

Increasing international competition for jobs has highlighted the high costs of U.S. health care and the impact of concentrating those costs onto large employers who purchase health care or health insurance for employees and retirees. These costs have been one factor that has led international auto manufacturers to select sites in Canada over otherwise lower cost locations in the southern United States, resulting in job losses. The proportion of workers receiving health insurance coverage at their place of employment has been falling in recent years. Employers had sought to control costs through the use of managed care organizations. Because this effort seems to have reaped the bulk of its potential savings, employers now

are shifting more of the burden to workers by requiring higher individual premiums, reducing subsidies for dependents' coverage, relying more on independent contractors, or eliminating benefits. This has forced the nation to wrestle with the question of whether health care insurance coverage should be dependent on employer decisions. The response in the ACA was that the employer had to contribute but the employee was to make the decision about what to purchase—how much coverage of what type—with the combination of employer and personal funds.

It remains to be seen whether this will work as planned. Small employers, the ones most likely to drop their health benefits, are initially exempt from the requirements of the ACA. There is also concern about whether the penalties are sufficient to change employer behaviors significantly (Wilensky, 2012) and whether the government subsidies to low-income employees can be offset by other revenue.

Employment Status, Compensation, and Autonomy of Health Professionals

For many years, nearly all physicians and pharmacists were independent businesspeople. Hospitals employed some specialists (e.g., radiologists, pathologists, anesthesiologists), often under profit-sharing agreements, but medical practice acts in many states prohibited the use of employed physicians. Movement toward managed care and the consolidation and industrialization of the health care industry, however, prompted more and more organizations to buy practices and to serve customers that had previously turned to private practices and independent pharmacies. The ability of large organizations to buy and sell goods and services at deep discounts forced more and more small provider groups to sell out. Increasingly, health care professionals are employed by large organizations and are experiencing conflicts around their professional independence and autonomy. This has led to patient concerns about providers' disinterestedness, a concern that tends to weaken the status of the health professions.

Equity in Access to Services

The Centers for Disease Control and Prevention (CDC) has issued a set of targets for *Healthy People 2020*, a federal strategic plan for improving health status and reducing health disparities. Reducing health disparities involves easing the disproportionate burden of disease, disability, and death among a population or group. Disparities can result from cultural factors,

behaviors, social determinants (such as low socioeconomic status), lack of access to care, not seeking or being provided with care when it is available, and not receiving quality or culturally and linguistically appropriate care when it is accessed. The problem of health disparities is not unique to the United States. The equivalent term used in much of the rest of the world, and increasingly in the United States, is *health equity*. **Table 1-9** shows some of the baselines and the targets displayed in the CDC's *Healthy People 2020 Objectives* (2010). More data about the disparities in health status of minorities are presented in Chapter 2.

Fairness in Intergenerational Transfers

Recent debates about the national debt have focused on entitlement reform. Recommended reforms include raising the starting age for full

Table 1-9 Selected Objectives for *Healthy People 2020*

- Increase the proportion of population of all ages with a specific source of ongoing care from 86.4% in 2008 to 95.0%.
- Reduce U.S.-acquired measles cases from 115 in 2008 to 30.
- Reduce age-adjusted deaths from HIV infections in those over 13 from 3.7 per 100,000 population in 2007 to 3.3.
- Reduce age-adjusted smoking rates by persons over 18 from 20.6 in 2008 to 12.0.
- Reduce the rate of infant deaths in the first year of life from 6.7 per 1,000 live births in 2008 to 6.0.
- Increase the age-adjusted rate of adults 18 and older whose hypertension is under control from 43.7 in 2005–2008 to 61.2%.
- Reduce age-adjusted coronary artery disease deaths from 126 per 100,000 populations in 2007 to 100.8.
- Increase the proportion of adults who engage in aerobic physical activity of at least moderate intensity at least 150 minutes/week or 75 minutes of vigorous intensity or an equivalent combination in 2008 from 43.5% to 47.9%.
- Decrease the proportion of adults 18 and over who experienced a major depressive episode in 2008 from 6.8% to 6.1%.
- Decrease age-adjusted death rate due to fatal injuries from 59.2 per 100.000 in 2008 to 53.3.
- Increase the age-adjusted rate of adults receiving colorectal cancer screening according to most recent guidelines from 52.1% in 2008 to 70.1%.
- Increase the proportion of cancer survivors living 5 years of more after diagnosis from 66.2% in 2007 to 72.8%.

Source: Reproduced from: Healthy People 2020, Topics and Objectives - Objectives A-Z. Accessed Dec. 7, 2013 at http://www.healthypeople.gov/2020/topicsobjectives2020/

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Medicare benefits to 67. However, some have objected to the use of the word *entitlement* to refer to Medicare. They prefer the term *earned benefit*. For someone who has been paying into Medicare and Social Security for 20 years but is still relatively young, this represents a loss of expected return on the investment and an intergenerational transfer to the elderly who are already on Medicare. How might we deal with this fairness issue?

Allocation of Responsibilities Among Federal, State, and Local Governments

In the United States, Medicare is a federal program, Medicaid is a joint federal and state program, mental health services are joint state and local programs, and public health services are usually a local program or some blend of local and state. As we try to rationalize our system with a new focus on universal coverage, how will we allocate these responsibilities to achieve integrated and coordinated delivery? Our most expensive and neediest patients tend to have multiple diagnoses and present a special problem. Right now many are dual eligibles under Medicare and Medicaid and have treatment needs in more than one delivery system. All too often their problems are kicked back and forth from one system to the other with less than acceptable results. Who is responsible for the whole patient in such cases?

Professional Versus Institutional Responsibilities for Process Development and Improvement

A key issue in health policy is how to evaluate and rationally adopt new health care technologies. In manufacturing terms, how and when do we deploy the products of our research and development? Much of the recent increase in health care costs has been attributed to the introduction of health care technology, much of which leads to positive improvements in our ability to deal with disease but also costs more to provide.

In the past, when change information was generated more slowly and there was little concern about cost, we relied on the individual professionals to stay abreast of the new developments and decide when and where to adopt them. Many of the recommendations of management experts call for reliance on improved learning by provider organizations on top of professional competency. Because the health care marketplace is highly fragmented, most provider organizations cannot undertake research and development unless it results in a product that can be patented, as is the case with new drugs. Local providers can only amortize research and

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development costs over their own client base, and it would take too long to recoup their investment. Alternatives are to turn to the federal government or to vendors that have access to multiple providers. However, vendors are not disinterested parties. A number of provisions of the ACA attempt to deal with this by setting up new institutes and boards, but these provisions seem to lack the support of a broad consensus and may prove difficult to maintain and fund in the face of determined lobbying efforts.

The following new agencies and boards are included under the ACA:

- Independent Payment Advisory Board
- Center for Medicare & Medicaid Innovation
- National Prevention, Health Promotion, and Public Health Council
- National Health Care Workforce Commission
- Interagency Working Group on Health Care Quality

The role of the Medicaid and CHIP Payment and Access Commission (MACPAC) was also expanded to parallel the functions of the Independent Payment Advisory Board concerning Medicare.

Areas of research and development where government already plays some role in the United States include:

- **Basic science.** Our society has decided to fund basic research in health care through the National Institutes of Health and other government agencies. Much of this research takes place in universities that receive grants to conduct research efforts.
- **Clinical applications.** Some federal funding is available for clinical research, but much of it takes place with the support of vendors or individual or institutional providers. In some areas, a great deal of individual experimentation goes on and innovation spreads rapidly; one example is the field of surgery, which often is not subject to Food and Drug Administration (FDA) approval. In the new drug field, the FDA tightly controls experimentation. This helps to ensure consumer safety but it slows the pace of innovation considerably.
- **Testing for efficacy and safety.** Here responsibilities are shared among the vendor, the provider, and government regulators. Who does what depends on the nature of the innovation. If the technology does not offer a “blockbuster” or high-volume good or service, there is limited support for this type of research. The Agency for Healthcare Research and Quality (AHRQ) has the function of studying how to apply “evidence-based medicine” to existing treatments and practices, but its funding is not sufficient to finance many needed studies.

IMPACT OF SOCIETAL VALUES ON POLICY DECISIONS

Health care policy making does not occur in a vacuum. Health policy is profoundly influenced by value-driven issues that cut across the entire U.S. policy landscape. These include, especially, debates over the role of free versus managed market mechanisms and pro-life and right-to-die ideologies. The battle over embryonic stem cell research is a case in point. The idea of using cells from fertilized eggs that were going to be thrown out anyway might not have attracted attention if it were not for the continuing debate about abortion, much of which turns on the definition of when life begins. If "life" begins at birth, then opposition to early abortion—and the objection to using embryonic stem cells—is greatly weakened. If "life" begins with the union of the egg and sperm, then there is a logic to protecting embryos. Strong clashes among value frameworks affect other health care issues such as physician-assisted suicide or executions, contraception for minors, morning-after pills, concerns of institutional review boards, and direct-to-consumer pharmaceutical marketing.

These issues are largely beyond the scope of this text. However, we are confident that they will be introduced in your classroom discussions as you look at specific policy decisions. Although these values may or may not be subject to study using policy analysis techniques, they exist and must be taken into account.