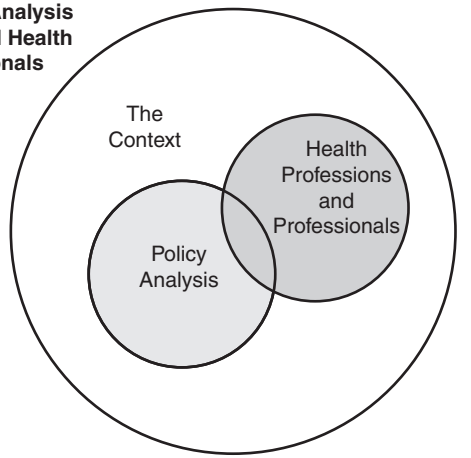
PART I

The Context

The Policy Analysis Process and Health Professionals



Although this book is designed to be valuable to anyone engaged in health policy development, its primary purpose is to enable current and future health professionals to understand and then participate in the health policy process. The figure above shows policy analysis and the work of the health professions taking place within the context of the healthcare system. The first section of this book develops that context. It begins with an explanation of what health policy analysts think about and do (Chapter 1). This is followed by a discussion of the current status of the U.S. healthcare system (Chapter 2) and a review of factors that influenced its development as the decentralized system we have today (Chapter 3). The case accompanying Chapter 3 provides a chance to look at the experiences of other countries and develop some hypotheses about how these countries achieved their current status. Chapter 4 reviews the many and varied objectives for the U.S. healthcare system being expressed by various policy participants. Chapter 5 presents many of the policy choices being suggested. One educational outcome you should try to achieve is to understand these positions, their underlying assumptions, and their strengths and weaknesses.

These chapters provide both the context and vocabulary for moving on to the second part of this book, which outlines available tools for rational policy analysis—one of the circles within a circle in the diagram. The third part of this book looks at the role of the health professions and professionals and, in particular, how they can and should participate in policy analysis.

CHAPTER 1

Introduction

President after president has pushed for an overhaul to our healthcare system and remedies for its access problems. Only Lyndon Johnson and Barack Obama shepherded through dramatic changes. Attempts by Truman, Eisenhower, Nixon, and Clinton were less successful. In the more recent past, the rapid growth of healthcare costs has expanded the policy debate. So has growing recognition of medical errors and other quality problems. In the meantime, policy makers struggle with a highly fragmented system and a divided body politic. At the same time, the rest of the developed world has advanced, used, and institutionalized increasingly sophisticated approaches to policy analysis. Such efforts have supported these countries in doing a better job delivering quality care at less cost.

More recently, United States has faced continuous near-miss attempts to replace the Affordable Care Act (ACA), as well as tax proposals, executive orders, and administrative policy revisions that undermined the act. Uncertainty has dominated the industry and added to costs. This ongoing debate centered on contending definitions of affordability, adequate coverage, consumer choice, and acceptable wealth transfer mechanisms.

The Many Actors

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

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

BOX 1-2 through **BOX 1-7** distributed throughout this chapter provide samples of 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 2016 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. Wide swings 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 how they would have to pay for it.

This chapter describes what healthcare 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 **BOX 1-1**.

BOX 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.

Reproduced from http://www.opm.gov/qualifications/standards/Specialty-Stds/gs-policy.asp; accessed 12/01/12. For more detail see Section IV-A (pp. 33–34) of the Operational Manual for Qualification Standards for General Schedule Positions.

BOX 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?

Health Care: What Is It?

The terms *health* and *health care* are used loosely in the United States. Before exploring the question of meaning, however, a note on style: Most U.S. style manuals have called for health care to be open (two words) as a noun, but hyphenated as an adjective, such as when referring to the *health-care* sector. Writers in the United Kingdom have tended to use health care as a noun and healthcare as an adjective. The style is evolving, however—more and more United States-based publications are using healthcare as an adjective, and healthcare has begun to appear regularly as a noun. This book uses health care as a noun, but healthcare as an adjective.

On the issue of meaning, what people in the United States often 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 healthcare 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 often as the medical care system. The system that promotes health and wellness is actually far more complex. Other health-related 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 our built environment, all shaped by decisions made outside the healthcare 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.

This text focuses mostly on access, cost, and quality issues related to personal medical services. That is because our primary intended audience is healthcare professionals (people who work primarily within the medical care system), and it is also due to the simple fact that the United States is wrestling with so many current policy issues related to medical care access, cost, and quality. Keep that intentional bias in mind. Stop occasionally to think about how a big-picture view of health might change the way problems and solutions are identified.

BOX 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 healthcare system, the mental health system, and public health clinics be merged as healthcare access becomes universal?
- What are intended and unintended consequences of sex education policies on health and health services?
- How do we undertake healthcare 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?

Most of us are clear on what health policy is about in general terms. Simply stated, it addresses questions such as:

- How well are we doing delivering 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. One 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). Readers should come away with a set of tools for interpreting and analyzing events, situations, and alternatives—tools that add to the skills already developed through professional training and experience.

The Policy Analysis Process

The policy analysis process usually involves the following activities:

- **Problem identification.** Why do 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? 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?

BOX 1-4 Illustrative Health Policy Issues for Healthcare 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?

- **Process analysis.** What is happening in practice? How are outputs and outcomes measured? What are interested parties recommending? What are the resource inputs? Are they appropriate? Are the outputs distributed fairly? Process analysis can be approached 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 distribution and perceived fairness 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
    - Status with value-laden issues
  - 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 appropriate alternative(s)?

BOX 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.)?

How do we ensure early implementer and consumer buy-in? How do we mediate conflicting interests?

- **Implementation planning.** What steps do we need to take to ensure the successful implementation of the chosen alternative? 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 policy processes. Prepared professional leadership is extremely important if policies are going to be accepted and effectively implemented.

One reason U.S. healthcare professionals have been relatively uninvolved in policy making has been the very high opportunity cost of time devoted to policy matters. Most countries have a Ministry of Health that oversees the national health system. Their 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 incomes, especially after the introduction of Medicare and Medicaid in 1965, increased the demand for physician services,

BOX 1-6 Illustrative Health Policy Issues for Payer Organizations (Employers and nsurers)

- 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 healthcare costs, and how should we use that knowledge?
- Now that healthcare 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?

but not the supply. Providing care paid so much better than administration that few physicians sought training in health administration. Educational institutions and health agencies again expanded their training programs for health administrators without requiring health profession credentials. As managed care has begun to constrain provider income and consolidation has increased administrator incomes, professionals have 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. Professionals are waking up to the opportunities to participate.

National Systems Differ but Parallels Exist

Every country's healthcare system is unique, 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, to tap into tax revenues available at the regional and local levels and expand private insurance alternatives. Medical care systems in the United Kingdom and Scandinavia provide examples of this. No other developed country, however, spends 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 their population. The results achieved in the United States should be better.

It is important to understand that both developed and less developed countries have taken different routes to more or less successful healthcare systems, leading, in turn, to differences in costs and outcomes. Their 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. 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. The

BOX 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 healthcare 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?

provisions of the ACA went a long way toward meeting those needs. Early attempts to repeal and replace the act ran afoul of the public's desire to not increase the number of uninsured.

Key Policy Categories

The major policy categories in the first column of **TABLE 1-1** relate to quality of care, availability of resources, payment and funding, motivation of patients and providers, volume and price of services, competition, and cost drivers. (McLaughlin, 2014). The other columns represent major disciplines needed by policy analysis teams. 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 the major roles of each discipline in the analysis of that particular issue.

TABLE 1-1 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				

(*continues*)

TABLE 1-1 Matrix of Major Policy Categories versus Major Skills Disciplines (*continued*)

Major Policy Categories	Major Skills Disciplines			
	Medical	Economic/ Financial	Political	Operational/ Managerial
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				

Major Policy Categories	Major Skills Disciplines			
	Medical	**Economic/ Financial**	**Political**	**Operational/ Managerial**
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	

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 healthcare professionals
- Equity in access to services, including affordability, adequacy of coverage, consumer choices available
- Fairness in intergenerational transfers and acceptability of wealth transfer mechanisms
- Professional versus institutional responsibilities for process development and improvement

Relationships Between Healthcare Financing and Employment

Increased 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 insurance for employees and retirees. The proportion of workers receiving health insurance coverage at their place of employment has decreased in recent years. Employers have sought to control costs through the use of managed care organizations. Believing this effort has reaped the bulk of its potential savings, employers now are shifting more of the financial 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 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 which plan option to purchase with the combination of employer, government, and personal funds.

Small employers, the ones most likely to drop their health benefits, were exempt from the requirements of the ACA. There was also concern about whether the penalties in the ACA would be sufficient to change employer behaviors significantly (Wilensky, 2012).

Employment Status, Compensation, and Autonomy of Health Professionals

For many years, physicians and pharmacists were independent business people. 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 healthcare industry, however, prompted states to change these laws and prompted more and more organizations to buy practices and to serve customers that had previously turned to independent practices and 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, healthcare professionals were employed by large organizations and experienced conflicts over 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) 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), and not receiving quality or culturally and linguistically appropriate care when it is accessed. The problem of health disparities is

BOX 1-8 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%.

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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*. **BOX 1-8** shows some of the baselines and the targets displayed in the CDC's *Healthy People 2020 Objectives* (2010).

Fairness in Intergenerational Transfers

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

The individual mandate's shared responsibility penalty payment and the limitation that the older enrollees would pay only three times the premiums of younger enrollees represented a major wealth transfer from the young to the old. When the young did not cooperate as desired, the premiums for individual policies on the exchanges soared.

Professional Versus Institutional Responsibilities for Process Development and Improvement

In the past, when new findings were generated more slowly and there was little concern about cost, we relied on individual professionals to stay abreast of the new developments and decide when and where to adopt them. We relied on continuing professional development to lead to improvements, but change often proved agonizingly slow. Many of the recommendations of management experts now call for reliance on improved learning by provider organizations on top of professional competency. Because the healthcare marketplace is highly fragmented, most provider organizations cannot undertake research and development unless it results in a product that can be patented, providing a legal monopoly. Local providers can only amortize research and 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 support multiple providers. However, vendors are not disinterested parties. Various of provisions of the ACA attempt to deal with this by setting up new institutes and boards to stimulate innovation, but these provisions seemed to lack the support of a broad consensus and have proved difficult to maintain and fund in the face of determined lobbying efforts.

The following new agencies and boards were 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
- Patient-Centered Outcomes Research Institute

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
- Clinical applications
- Testing for efficacy and safety

Impact of Societal Values on Policy Decisions

Healthcare policy does not develop in a vacuum. It is profoundly influenced by value-driven issues that cut across the entire U.S. policy landscape. These include debates over the role of free versus managed market mechanisms and pro-life and right-to-die issues. 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 healthcare issues such as physician-assisted suicide and criminal executions, contraception for minors, morning-after pills, concerns about informed consent, and direct-to-consumer pharmaceutical marketing.

Politicization of Science and Limiting Role of Expertise

Values have always affected the choice of metrics to use in policy analysis. The U.S. Congress placed constraints on the use of quality-adjusted life years for key resource allocation decisions in government programs. Early in the Trump administration, Environmental Protection Agency staff were prevented from attending meetings on climate change. In December 2017, the Washington Post reported that director of the CDC had ordered staff to restrain from using the words: evidence-based or science-based in budget documents. The following was reported to be a suggested substitute: "CDC bases its recommendations on science in consideration with community standards and wishes," (Sun & Eilperin, 2017).

Conclusion

Health policy analysis involves using the many disciplinary skills of team members to reach a recommendation and suggest how best to implement and evaluate it. The role of a policy analyst was discussed and an example given. Several examples were given of the impact of social issues on health policy analysis.