CHAPTER 1

Introduction

If everyone is in charge, then no one is in charge. Health policy is a problematic issue 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 the 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. They lived in a world in which one talked of "evil humours" and visited "barbers and churgeons." Summertime yellow fever epidemics frequently disrupted the government in the capitol, Philadelphia. Relatively little was known about medicine when the Constitution was drafted in 1787. Jenner's discovery of inoculation with cowpox to avoid smallpox did not come until 1796, and Pasteur's germ theory and Roentgen's X-rays came almost a lifetime later.

THE MANY ACTORS

Health care policy making in the United States is also very pluralistic. Any discussion of health policy must account for the fact that policy decisions are made at multiple levels of society:

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

The boxed tables randomly distributed throughout this chapter (**Tables 1-2** through **1-7**) provide samples of major health policy questions faced at each of these levels. Like most lists in this book, they are meant to be illustrative, not exhaustive.

In such a decentralized environment, the government may take a hands-on approach, treating health care as a public good, or a hands-off approach, favoring market-driven outcomes. The government's stance and specific policies can also swing dramatically as political power shifts. For example, it may or may not encourage the entry of new institutions into the health sector to generate competition among providers as it did by supporting the introduction of family medicine departments and residency programs in medical schools. Any of these shifts can profoundly affect the professional's work life.

This introductory 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 proceed through the book, you will likely note many parallels between that role description and the organization of this book, even though this book 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. Then we address how certain potentially confusing terms are employed throughout this book and suggest ways to integrate the material that you will be learning with your knowledge from other disciplines.

TABLE 1-1 Excerpts from OPM Operation Manual Qualification Standard for Policy Analysis Positions

The principal requirements for performing policy analysis functions are listed below, as appropriate to the position to be filled:

- Knowledge of a pertinent professional subject-matter field(s). . . .
- Knowledge of economic theories including micro-economics and the effect of proposed policies on production costs and prices, wages, resource allocation, 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 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 decision 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.
- Skills 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 pressure of tight time frames and rigid deadlines.

Source: http://www.opm.gov/qualifications/SEC-IV/A/GS-POLCY.HTM accessed 10/13/06. For more detail see Section IV-A (pp33-34) of the *Operational Manual for Qualification Standards for General Schedule Positions.*

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

- What population groups should receive subsidized coverage from tax revenues?
- How should the federal government participate in supporting health care for all when the Constitution does not include health care as a federal responsibility?
- How should the federal government support quality improvement efforts if state professional licensing and disciplinary boards are not addressing medical error rates effectively?
- The cost of malpractice insurance in some states threatens the supply of providers in some specialties and appears to raise the cost of care. What is the role of the federal government in avoiding the negative effects of these suits and awards?
- Progress in information technology implementation in health care has lagged behind most other information-intensive service sectors. Is this good or bad and what should the federal government do about it?
- What services should be covered under Medicare? Medicaid?
- How many health professionals in a subspecialty are sufficient? Who determines that and how do we respond to such findings?

THE SYSTEM IN THE UNITED STATES IS UNIQUE, BUT NOT UNPARALLELED

Many developed countries struggle with the burden of their social programs, including health care. Even in countries with a national health service, there have been recent 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. Sometimes this transfer of decision-making power carries with it a privatization component. Medical care in the United Kingdom and Scandinavia provides examples of this, as does mental health care in a number of U.S. states. None of the 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 overall results achieved in the United States seemingly should be better, given our relatively high expenditures.

Although this book does not emphasize comparative international health policy, it is important to understand that high-sounding goals such as the World Health Organization's "Health For All by the Year 2000," although promising much on paper, are still far from being achieved. Both developed and less-developed countries have taken rather different routes to more- or

less-successful health care systems, leading in turn to different levels of 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. The case study that follows Chapter 3 compares the health care systems in five industrialized nations.

All countries are aiming at targets that shift as basic science knowledge expands exponentially, new technologies become available, and new diseases and environmental threats emerge. Some countries 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 are concerned about the increasing proportion of the population that lacks health insurance and is forced either to forgo care or to seek some form of public assistance. Even relatively conservative commentators argue 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.

HEALTH CARE: WHAT IS IT?

The terms, *health* and *health care,* are used somewhat loosely in U.S. policy debates. Often, what people mean by health is absence of notable ailments. The World Health Organization, 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. The entire system that promotes health and wellness is actually much more complex. Other health systems, in addition to the system that delivers medical care, 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—that are shaped by policy decisions made completely outside the health care system.

Most health care policy debates revolve around issues of medical care access, cost, and quality; however, there are organizational and individual

proponents (such as The Blue Sky Initiative) of an approach to health policy where the goal is optimal health status. They would like to see a "move from a health care system to a *health system* that provides vertical, horizontal and longitudinal integration" (Peterson, 2006).

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, a lack of physical activity, and alcohol misuse. They argued that some 88% of what we spend on health nationally pays for access to medical care, but in terms of influence on health status, it accounts for a mere 10%. This alternative view attributes 50% of our health status to our behaviors, 20% to genetics, and 20% to environmental factors. Yet only 4% of health spending goes to promoting 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 book draw on material from outside the realm of medical care finance and delivery. The case at the end of Chapter 10 discusses folic acid fortification of foods, an example of a population-based public health intervention, and the case in Chapter 12 looks at evidence-based, community-centered mental health interventions. This book, however, focuses mostly on access, cost, and quality issues related to personal medical services. That is due largely to the fact that the primary intended audience is health care professionals (people who operate primarily from inside the medical care system) and also to the simple fact that the United State is currently facing many salient and immediate 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 get identified. For instance, one of the health care finance reform proposals currently in vogue, and one discussed in several places in this book, is pay for performance, also know 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."

HEALTH POLICY: WHAT IS IT?

Beyond the scope issues just described, most of us are clear on what health policy is about. 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 processes?
- What roles should health professionals and ordinary citizens play in this process?
- How can we become better prepared for such roles?

Can we expect any given set of participants to agree on the answers to those questions? Of course not. Their perspectives vary. Their interests are often in conflict. A goal of this book 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 actors on both sides before reaching individual conclusions. Because of this book's management education approach, you should come away with a set of varied tools for interpreting and analyzing events, situations, and alternatives—tools that you can add to the skills that you have already developed through professional training and experience. You will not be asked to abandon what has worked, but you can probably do a better job with a systematic approach that allows you to use a broader array of methods that fit a greater variety of situations.

THE POLICY ANALYSIS PROCESS

Much of this text is organized around the stages of the policy analysis process, which are as follows:

- Problem identification: Why do we think we need to evaluate and possibly change the way we do things? What kind of actions are

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 assure adequate access to all sections of the state? To all target groups?
- What should be the balance between local governance and state standards and mandates in the provision of public health department functions?
- What should be the state's role in subsidizing care for the uninsured?
- What should be the roles of the state insurance regulations and oversight boards in assuring access to care for the general public and for special populations?
- How separate should the health care system and the mental health system continue to be? What about insurance parity?
- How do we undertake health care emergency planning: responses to floods, earthquakes, pandemics, or terrorism? What is the relationship between the state systems (public health and military) and local first-responders?

people asking for? What are the drivers that require that we commit limited resources to this policy area? What is the intended output? What is the expected result?

- Process definition: What is the current situation, and what is being done about it? What are people citing as the causes of concern? How valid are they? Who are the current actors and what are their roles? Why are the current results unsatisfactory to some? Are people framing the issue effectively? What are reasonable expectations for results over a relevant time horizon?
- Process analysis: What is actually happening in practice? How are outputs and outcomes measured and why? What are the resource inputs? Are they appropriate? Are the outputs distributed fairly? Where, how, and when might new technologies change this process within the relevant time horizon? What are the resource requirements of the really promising alternatives, and what will they cost? What are the impacts of these processes, such as persons served, lives saved, and hospital days avoided?
- Qualitative analysis: Identify and assess the nonquantitative issues related to valuation of benefits, and impacts on quality, equity, and distribution of outcomes.

- Evaluation: Weigh the evidence, quantitative and qualitative, and analyze for the following:
  - Technical feasibility
  - Political feasibility
  - Economic and financial viability
- Recommendation
  - Choice: Consider the value and ethical concerns that must carry weight in your decision and then choose a preferred policy to be recommended.
  - Communication: Prepare to report your findings and conclusions convincingly.

SUPPORTING IMPLEMENTATION

During the design of a health policy study, throughout its conduct, and in its conclusion and reporting stage, the policy process must support its implementation. The objective of policy analysis is not a report but informed choices that lead to an improved health care system. That requires attention to the following:

- Implementation strategy: How do we manage the policy process to gain public, professional, and consumer support for change and backing of the most appropriate alternative(s)? How do we assure that key implementers and consumers buy into the process early enough? How do we mediate conflicting interests?
- Implementation planning: What steps do we need to take to assure successful implementation of the alternative chosen? How will we know that the chosen alternative was an improvement?
- Feedback to our policy processes: Have we been making the right choices? If not, why not? What new understandings should we take away that will lead to better and more efficient policy choices in the future?

HEALTH PROFESSIONALS AND THE POLICY PROCESS

One unusual aspect of health care in the United States is the low level of influence that health professionals generally have on policy formulation. Too often health professionals focus on what policy makers are doing to them, not on what they can contribute to the policy processes. Professionally prepared

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

- How much charitable (uncompensated) care should we provide beyond that which is mandated?
- Should we try to encourage local organizations to participate in a National Health Information Network? Why?
- What efforts should we undertake to encourage local emergency planning?
- How should we go about increasing the proportion of the local population who volunteer as local organ donors?
- How can we rationalize the services provided by local providers, reducing duplication and waste, and still avoid charges of anticompetitive practices?

leadership is extremely important if policies are to be accepted and implemented effectively; therefore, we need to consider how and where professionals can exert leadership in enhancing the delivery of the services that are their work and their calling.

One reason for limited involvement of health care professionals in the United States has been the high opportunity cost of any time they spend on policy matters. In most countries of the world, a ministry of health oversees the national health system. Because government salaries for health professionals are relatively low, there is competition for higher administrative posts that offer better pay and better locations. Health professionals hold most key positions below the political level in the ministry, and physicians are the directors of most divisions, departments, and institutions. At one time, U.S. health department directors, as well as many hospital administrators, were expected to be medical doctors. During and after World War II, when physicians were in short supply, those institutions called on other administrators. The nation's schools of public health trained new cadres of administrators. Rapidly rising physician income, especially after the introduction of Medicare and Medicaid in 1965, increased the demand for but not the supply of physician services. That meant that directly providing care paid so much better than administration that fewer health professionals sought health administration training. Educational institutions and health agencies responded by training health administrators without clinical credentials. As managed care has begun to constrain provider income and consolidation into larger organizations has expanded

management incomes, professionals have taken a stronger interest in managerial roles. This interest has been reinforced by provider dissatisfaction with changes in professional autonomy, incomes, and working conditions that emerged under managed care. Health professionals are waking up to the need to participate in policy making, but their effective participation has been constrained by their lack of skills and confidence and by the other demands on their time.

BIG ISSUES TO KEEP OUR EYES ON

The United States has experienced rapid inflation in health care costs without attendant relative improvements in key health indicators such as infant mortality and life expectancy. One response has been to note that the United States and South Africa were the only two major countries without a national health service. This response, however, does not account for the fact that many highly developed countries with government health services are now struggling with similar and interrelated issues:

- Relationships between health care financing and employment
- Employment status, compensation, and autonomy of health professionals
- Equity in dealing with underserved populations

TABLE 1-5 Illustrative Health Policy Issues for Provider Professionals

- What services should be provided in addition to those normally provided by one's specialty?
- What managed care organizations should I sign contracts with? Avoid?
- What should I do about the state of local emergency preparedness?
- 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 try to make my practice a leader in the adoption of health information technology? A late adopter?
- Should I go into (or stay in) a private practice or should I join a large group that is tied to a dominant delivery network (hospital, HMO, pharmacy chain, etc.)?

- Adequate supplies of trained health personnel
- Democratic political processes for reaching difficult health policy decisions
- Technology development and dissemination
- Impacts of social meta-issues, such as aging and terrorism, on health policy decisions.

Relationship 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 pay for health care for employees and retirees. These costs have been one factor leading international auto manufacturers to select sites in Canada over otherwise lower-cost locations in the southern United States. The proportion of workers covered at their place of employment has been falling in recent years, and this trend is likely to continue. Employers had sought to control costs through the use of managed-care organizations. As this effort seems to have reaped the bulk of its potential savings, more and more the burden is shifting to workers through having high individual premiums, having reduced subsidies for dependents' coverage, moving jobs to independent contractor status, or dropping the benefit altogether under the rubric of consumer-centered health care.

One area where insurance coverage is opposed by many employers is the area of mental health. Many states have passed or tried to pass laws requiring *parity* of coverages for mental illness with coverages for physical illness. Washington State only did so in 2005. There is plenty of evidence that the cost of adding such services would not be all that expensive, but small business organizations have opposed *parity* legislation as costly to them. The existence of publicly funded community mental health centers has complicated the issue. Advocates for the mentally ill have pushed for parity legislation, not only to increase coverage, but also to reinforce the concept that mental illness is a brain disorder that should not be stigmatized and should be handled like any other illness.

Employment Status, Compensation, and Autonomy of Health Professionals

For many years, physicians and pharmacists were almost entirely independent business people. Hospitals employed some specialists (radiologists,

pathologists, anesthesiologists), often under profit-sharing agreements, but medical practice acts in many states prohibited the use of employed physicians. With the movement toward managed care and the consolidation and industrialization taking place within the health care industry, more and more organizations began 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 has forced more and more small operations to sell out. Increasingly, health care professionals are employed by large organizations and are experiencing conflicts involving their professional independence and autonomy. This has led to patient concerns about providers' disinterestedness, a concern that has tended to weaken the status of the health professions.

Equity

Healthy People 2010, the federal strategic plan for improving health status, lists two overarching goals. The first is to increase both the quality and the number of years of life. The second is to reduce health disparities. The term *health disparities* refers to a disproportionate burden of disease, disability, and death among a population or group. Disparities can result from genetics, 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 accessible and available, and not receiving quality or culturally and linguistically appropriate care when it is accessed. Although the problem of health disparities is not unique to the United States—the term for this policy issue in much of the rest of the world is *health equity*—there is a growing recognition that health disparities are a serious national problem. The *National Healthcare Disparities Report,* released by the Agency for Healthcare Research and Quality in December 2003, identified disparities in health care for "priority populations"—women, children, older people, people of minority races, low-income groups, and people with special health care needs.

A report by the Washington State Board of Health cited examples of health disparities among minorities in that state, including the following (Finkbonner et al., 2001):

- The infant mortality rate for American Indians and African-Americans is more than double the rate for whites.
- African-Americans are more than three times as likely as whites to die from HIV/AIDS, whereas Hispanics are more than 1.5 times more likely to die from the virus.

- The rate of tuberculosis for Asian/Pacific Islanders is more than 15 times greater than it is for whites
- African-Americans are more than three times as likely to die from diabetes as whites; the death rate for American Indians/Alaskan Natives is 2.5 times higher, and for Hispanics, it is 1.5 times higher.

Throughout the world, providers tend to congregate where income and educational opportunities are best for them and their families; therefore, medical care has been plentiful in the major cities, especially those with medical education centers, and scarce in rural areas. The United States is no exception. Providers may also choose to direct their efforts toward consumers who have the greatest ability to pay. They gravitate toward more profitable specialties and may emphasize services that are most likely to generate income. All of these factors can contribute to disparities in care.

There have been many governmental and private programs to bring service to special populations, such as underserved rural areas, the posthospitalized mentally ill, American Indian and Alaskan Native villages, and people with AIDS. In these cases, the nation's focus on a market system has been modified to overcome market failures in health care. Phelps (1997) pointed out that government involvement is one of the four features of the economics of health care delivery that differs from the delivery of most professional services. Three other economic differences that Phelps noted are uncertainty, information asymmetry, and externalities. All of these are explored further.

Adequate Supplies of Trained Health Personnel

Much of the cost of educating and training health professionals is borne by the public sector—public colleges and universities and hospitals are all involved in training health professionals. Because professionals tend to be compensated well above the national average and work for private as well as public companies and institutions, the level of government educational support is frequently called into question. Are we training the right number of the right people with the right degree of specialization for the right jobs? This is an issue in just about every other country because of disconnects between the educational system and the health care system. Because the federal government does not operate either system in the United States, we continue to live with the question of who is in charge of determining how many of what type need to be trained.

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

- What options should I offer as health benefits? Given that employees need choices, should I offer medical savings accounts?
- How much money and effort should we be allocating 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 we mine that data and suggest choices of procedures? Providers? Lifestyle changes?

Democratic Political Processes for Reaching Difficult Health Policy Decisions

Time and time again, attempts to rationalize the health care system have been stymied by those who prefer the *status quo ante.* Opposition may be due to self-interest in some cases, but it can also be due to fundamental disagreements about how and where decisions are best made. The debate over the role of central government versus local units split the Founding Fathers and still is ongoing and so is the debate over whether the health care system needs considerable oversight or whether a suitable case can be made instead for relying on market approaches. In thinking about where the nexus for decision making about health care should lie in today's United States, several complex economic, ideological, and managerial issues must be considered:

- Centralization versus decentralization: This is both a strategic and a tactical issue. Often it is considered in an ideological context with one side arguing that management is more responsive when it is closer to the people. The opposing side is likely to argue that local management is much more likely to be captured by local interest groups and is inefficient because of its small scale of operation.
- Unequal power in the markets: There are circumstances in health care that may limit the usual free market conditions of commerce. These include the following:
  - Monopoly power: The ability of the seller to control a market. This is of concern where there are only one or two providers of a specific service in a community. Under federal and most states'

laws, obtaining a true monopoly position is illegal. In rural and other underserved areas, however, a lack of provider interest may allow a monopoly to exist.

- Monopsony power: A counterpart of monopoly in which the buyer rather than the seller has control of the market. Although this is not illegal, it is a market failure. The most common illustration in the United States has been the market power of the federal government. As a purchaser through Medicare, Medicaid, veterans' health care programs such as CHAMPUS/TRICARE, and federal employee health insurance, it has been able to insist on maximum price discounts. In some locales, major managed-care organizations, such as the former Blue Cross and Blue Shield organizations, may also hold such pricing power.
- Collusion: Tacit or explicit agreement by a group (usually of sellers) to follow a common strategy. While joint price fixing is a crime, there are many other legal practices that may limit the supply of services. For example, one hospital in a two-hospital city may decide to stop offering obstetrical services after receiving assurances that the other hospital will in turn stop offering level I trauma care, allowing both to increase occupancy in their respective units and to keep the physicians in the community with those specialties from playing off one hospital against the other.
- Professionalism and information asymmetry: Information asymmetry occurs when one party to a transaction has more or better information about markets and values than the other. One of the underpinnings of professional status is the reality that the professional has information that is not possessed or understood by the client, thereby assuring information asymmetry. The client must then defer in decision making and the delivery of service to the professional.
- Public good vs. competitive market: The conditions of a competitive market require many buyers and many sellers, complete information for both buyers and sellers, and the capacity to make rational decisions on both sides. It can be argued that because of information asymmetry, the provider has a distinct advantage in the health care market, leading to market failure. Because the market is not functioning effectively and health care is a necessity for many, some argue that health care should be considered a public

good to be regulated and perhaps provided by the government. If one assumes that health care is a public good and the market is failing, where and how should the government flex its economic and regulatory muscle? There are those who think that the market or consumer approach is the way to solve our health care national problems. Others argue that health care is not very adaptable to an unmanaged marketplace. That will be an important theme throughout any discussion of health policy analysis. Reagan (1999) referred to this as an aspect of the basic dilemma of health policy.

We in the United States want health care for everyone, and yet we prefer that it delivered through a virtually unregulated marketplace with lots of consumer choice. The unregulated marketplace proves to be a double-edged sword. Those who want to support consumer responsibility and choice believe that careful shopping behavior will reduce costs. Current experience with medical tourism bears that out. On the other hand, the difficulties of those who do shop in gaining access to price and quality information suggest how far we are from suitable market conditions. Although one hears from strong advocates on one side about the need for universal coverage and on the other about consumer-driven markets, the vast bulk of this industry gradually industrializes and continues silently with its current course of growth with disconnectedness, high cost, withheld price and quality information, and dominance of local markets by powerful local actors.

Technology Development and Dissemination

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

TABLE 1-7 Illustrative Health Policy Issues for Individuals

- Should I participate in my employer's health benefit plan and, if so, which option?
- How much should I plan to rely on Medicare when I retire in 2030? What alternative strategies should I be considering?
- 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?

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.

Because the health care marketplace is highly fragmented with mostly local providers, individual providers cannot undertake research and development unless the development can be patented, as is the case with new drugs. Individual providers can only amortize the costs of such development over their own client base, and thus the cost would take too long to recoup. Alternatives are to turn to the federal government or to vendors who have access to multiple providers. Areas of research and development where government already plays some role in the United States include the following:

- 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 takes place in universities that receive grants to conduct proposed 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 areas, such as surgery, which often is not subject to Food and Drug Administration approval, a great deal of individual experimentation goes on and innovation spreads rapidly. In the new drug field, the Food and Drug Administration tightly controls experimentation. This helps assure consumer safety but slows the pace of innovation considerably.
- Testing for efficacy and safety: Here there is joint responsibility of the vendor, the provider, and government regulators, depending 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 has the function of studying "evidence-based medicine" applied to existing treatments and practices, but its funding is not sufficient to do many needed studies.

Impact of Meta-Issues on the Health Policy Decisions

Health care policy making does not occur in a vacuum. It takes place in the context of society at large, and its debates reflect issues in the larger society. 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 the 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 embryos are to be protected. Similarly, 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.

THE ROAD AHEAD

Virtually all of these issues are revisited in the process chapters of this book. As central themes, we have developed brief cases offering 10 health policy examples that accompany their relevant chapters:

- International comparisons of health care systems
- A standard for culturally and linguistically appropriate care
- Subspecialty versus community hospitals
- Global medical coverage
- Marked small area variations in treatments
- The development of the National Health Information Network and regional health information organizations
- The Clinton health plan experience
- Folic acid fortification
- Voluntary versus governmental standards
- Evidence-based medicine and mental health.

These illustrate the types of issues and activities that cluster around health care policy debates and decisions and serve as examples for classroom discussion as we follow the stages of the policy analysis process.

The next five chapters (Part I) review the context in which American policy analysis is likely to take place, the status of our health system, and its apparent performance in recent years. Chapter 2 reviews where we are. Chapter 3 recounts how we in the United States got there, whereas

Chapter 4 discusses what various actors would like to see occur. Chapter 5 outlines some of the government options that are under consideration for the country's future course. Chapter 6 presents some alternative responses and initiatives open to institutions and professions. Discussion case studies are attached to Chapters 3 through 6. Part II presents specific aspects of the policy analysis process. Chapter 7 begins the presentation of this process with issues of process identification and definition. Chapters 8, 9, and 10 deal, respectively, with the three major areas of evaluation in the analysis process: (1) technological, (2) political, and (3) economic. Chapter 11 returns us to the additional value issues that dominate today's headlines, whereas Chapter 12 points out how the policy analysis process must support the implementation of the policy after it is accepted. Discussion cases are attached to each of the six chapters in this part. Part III moves us to a focus on the roles of professions and professionals in the world of health policy. Chapter 13 reviews what is likely to work, given our political processes, and Chapter 14 outlines the ways that professionals can become further involved in the policy process. Chapter 15 wraps things up and suggests some strategies for staying involved with policy issues beyond the completion of this course of study.