HEALTH AND HEALTH POLICY

Health and its pursuit are woven tightly into the social and economic fabric of every industrialized nation. Health is essential not only to the physical and mental well-being of people, but also to nations’ economies. The United States is expected to spend more than $2.6 trillion in pursuit of health in 2010, which represents 17.7 percent of the nation’s gross domestic product (GDP), and to spend more than $4.3 trillion annually, or 20.3 percent of GDP, by 2018 (Centers for Medicare & Medicaid Services 2009d). Thus, it is not surprising that government at all levels is keenly interested in health and how it is pursued. This book explores public policymaking—the intricate process through which government influences the pursuit of health. The primary focus is on the policymaking process at the federal level, although much of the information also applies to state and local government.

This chapter discusses the basic definitions of health and health policy and their relationship to each other. Chapter 2 outlines and describes a model of the public policymaking process and specifically applies this model to health policymaking. Subsequent chapters cover in detail the various interconnected parts of the model.

Health Defined

Health is universally important. In 1948, the World Health Organization (WHO; www.who.int) defined health as the “state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity.” Of course, other definitions of health can be found, including “a dynamic state of well-being characterized by a physical and mental potential, which satisfies the demands of life commensurate with age, culture, and personal responsibility” (Bircher 2005). Rodolfo Saracci (1997) defined health as “a condition of well-being, free of disease or infirmity, and a basic and universal human right.” David Byrne (2004), who at the time was European commissioner for health and consumer protection, more recently provided a definition with an important expansion. He views good health as “a state of physical and mental well-being necessary to live a meaningful, pleasant, and productive life. Good health is also an integral part of thriving modern societies, a cornerstone of well performing economies, and a shared principle of European democracies,” a definition which can be extended to all democracies.
In fact, health is a priority in all nations, although the resources available for its pursuit vary widely. Current international health expenditure comparisons for the 30 member countries of the Organisation for Economic Co-operation and Development (OECD), all of which share a commitment to democratic government and market economies, are available at www.oecd.org.

The way a nation defines health reflects its values regarding health, the resources it is prepared to devote to the pursuit of health, and how far it would be willing to go to aid or support the pursuit of health among its citizens. A nation that defines health broadly and in positive terms—as in Byrne’s definition—will make significant efforts to help its members attain desired levels of health. The range of possible interventions in any society’s pursuit of health is enormous, because human health is a function of many variables—or, as they are often called, health determinants.

**Health Determinants**

For individuals and for a population, health determinants include the physical environments in which people live and work, people’s behaviors, their biology (genetic makeup, family history, and acquired physical and mental health problems), social factors (including economic circumstances; socioeconomic position; income distribution; discrimination based on such factors as race/ethnicity, gender, and sexual orientation; and the availability of social networks or social support), and their access to health services (Blum 1983; Evans, Barer, and Marmor 1994; Berkman and Kawachi 2000).

The report *Healthy People 2010* (www.healthypeople.gov), which is currently being revised and updated to *Healthy People 2020*, details comprehensive national health promotion and disease prevention agendas. The following list of health determinants is adapted from its identification and definition of determinants (U.S. Department of Health and Human Services 2000):

- **Biology** refers to the individual’s genetic makeup (those factors with which he or she is born), family history (which may suggest risk for disease), and physical and mental health problems acquired during life. Aging, diet, physical activity, smoking, stress, alcohol or illicit drug abuse, injury or violence, or an infectious or toxic agent may result in illness or disability and can produce a “new” biology for the individual.

- **Behaviors** are individual responses or reactions to internal stimuli and external conditions. Behaviors can have a reciprocal relationship with biology; in other words, each can affect the other. For example, smoking (behavior) can alter cells in the lung and result in shortness of breath, emphysema, or cancer (biology), which then may lead an individual to stop smoking (behavior). Similarly, a family history that
includes heart disease (biology) may motivate an individual to develop good eating habits, avoid tobacco, and maintain an active lifestyle (behaviors), which may prevent his or her own development of heart disease (biology).

An individual’s choices and social and physical environments can shape his or her behaviors. The social and physical environments include all factors that affect the individual’s life—positively or negatively—many of which may be out of his or her immediate or direct control.

- **Social environment** includes interactions with family, friends, coworkers, and others in the community. It encompasses social institutions, such as law enforcement, the workplace, places of worship, and schools. Housing, public transportation, and the presence or absence of violence in the community are components of the social environment. The social environment has a profound effect on individual and community health and is unique for each individual because of cultural customs, language, and personal, religious, or spiritual beliefs. At the same time, individuals and their behaviors contribute to the quality of the social environment.

- **Physical environment** can be thought of as that which can be seen, touched, heard, smelled, and tasted. However, it also contains less tangible elements, such as radiation and ozone. The physical environment can harm individual and community health, especially through exposure to toxic substances, irritants, infectious agents, and physical hazards in homes, schools, and work sites. The physical environment can also promote good health, for example, by providing clean and safe places for people to work, exercise, and play.

- **Policies and interventions** can have a powerful and positive effect on individual and community health. Examples include health promotion campaigns to prevent smoking; policies mandating child restraints and safety belt use in automobiles; disease prevention services, such as immunization of children, adolescents, and adults; and clinical services, such as enhanced mental healthcare. Policies and interventions that promote individual and community health may be implemented by agencies, such as those that oversee transportation, education, energy, housing, labor, and justice, or through places of worship, community-based organizations, civic groups, and businesses.

- **Quality health services** can be vital to the health of individuals and communities. Expanding access to services could eliminate health disparities and increase the quality of life and life expectancy of all people living in the United States. Health services in the broadest sense include not only those received from health services providers but also health information and services received from other venues in the community.
People vary along many dimensions, including their health and health-related needs. The citizenry of the United States is remarkably diverse, varying by age, gender, race/ethnicity, and other factors. Current census data puts the U.S. population at approximately 300 million people; 12.4 percent of them are over 65 years old. By 2020, about 55 million will be older than 65 and about 23 million will be older than 75. Persons of Hispanic or Latino origin make up about 14.8 percent of the population and African Americans constitute approximately 12.8 percent of the population (U.S. Census Bureau 2009). These demographics are important when considering health and its pursuit.

Older people consume relatively more health services, and their health-related needs differ from those of younger people. Older people are more likely to consume long-term-care services and community-based services intended to help them cope with various limitations in the activities of daily living.

African Americans and people of Hispanic or Latino origin are disproportionately underserved for health services and underrepresented in all health professions. They experience discrimination that affects their health and continuing disparities in the burden of illness and death (Krieger 2000; James et al. 2007). “Healthcare disparities” and “health disparities,” although related, are not the same. Healthcare disparities refer to differences in such variables as access, insurance coverage, and quality of services received. Health disparities occur when one population group experiences higher burdens of illness, injury, death, or disability than another group.

In recent years, policymakers have paid greater attention to racial/ethnic disparities in care with notable progress. Congress legislatively mandated the Institute of Medicine (IOM; www.iom.edu) to study healthcare disparities and established the National Center on Minority Health and Health Disparities at the National Institutes of Health. Congress also required the Department of Health and Human Services (DHHS; www.dhhs.gov) to report annually, starting in 2003, on the nation’s progress in reducing healthcare and health disparities (U.S. Department of Health and Human Services 2008). These steps have established the foundation for better addressing disparities in health and healthcare (James et al. 2007).

The IOM (2002c) study’s report, Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care, called for a multilevel strategy to address potential causes of racial/ethnic healthcare disparities, including

- raising public and provider awareness of racial/ethnic disparities in healthcare,
- expanding health insurance coverage,
- improving the capacity and quantity of providers in underserved communities, and
- increasing understanding of the causes and interventions to reduce disparities.
Although the population is diverse, the values that directly affect the basic approach to healthcare in the United States are homogeneous. Many Americans place a high value on individual autonomy, self-determination, and personal privacy and maintain a widespread, although not universal, commitment to justice. Other societal characteristics that have influenced the pursuit of health in the United States include a deep-seated belief in the potential of technological rescue and, although this may be changing, an obsession with prolonging life regardless of the costs. These values shape the private and public sectors’ efforts related to health, including the elaboration of public policies germane to health and its pursuit.

**Health Policy Defined**

Health policy is but a particular version of public policy. There are many definitions of public policy and no universal agreement on which is best. For example, B. Guy Peters (2003) defines public policy as the “sum of government activities, whether acting directly or through agents, as it has an influence on the life of citizens.” Thomas A. Birkland (2001, 132) defines it as “a statement by government of what it intends to do or not to do, such as a law, regulation, ruling, decision, or order, or a combination of these.” Charles Cochran and Eloise Malone (1999) propose yet another definition: “political decisions for implementing programs to achieve societal goals.” Drawing on these and many other definitions, we define public policy in this book as *authoritative decisions made in the legislative, executive, or judicial branches of government that are intended to direct or influence the actions, behaviors, or decisions of others.*

The phrase *authoritative decisions* is crucial. It specifies decisions made anywhere within the three branches of government—and at any level of government—that are within the legitimate purview (i.e., within the official roles, responsibilities, and authorities) of those making the decisions. The decision makers can be legislators, executives of government (presidents, governors, mayors), or judges. Part of these roles is the legitimate right—indeed, the responsibility—to make certain decisions. Legislators are entitled to decide on laws, executives to decide on rules to implement laws, and judges to review and interpret decisions made by others. Exhibit 1.1 illustrates these relationships. A useful source of information about all three branches of the federal government and about state and local governments is www.USA.gov.

In the United States, public policies, whether they pertain to health or to defense, education, transportation, or commerce, are made through a dynamic *public policymaking process.* This process, which is modeled in Chapter 2, involves interaction among many participants in three interconnected phases.
Public policies that pertain to health or influence the pursuit of health are health policies. Health policies are established at federal, state, and local levels of government, although usually for different purposes. Generally, a health policy affects or influences a group or class of individuals (e.g., physicians, the poor, the elderly, children) or a type or category of organization (e.g., medical schools, health plans, integrated healthcare systems, pharmaceutical manufacturers, employers).

At any given time, the entire set of health-related policies made at any level of government constitutes that level’s health policy. Thus, health policy is a large set of decisions reached through the public policymaking process. Throughout this book, we will say much more about the decisions that form health policy and the process through which these decisions are made. It should be noted at the outset, however, that these decisions can be misguided and can have unintended consequences. Some policies fail by worsening the problems they are intended to address or by fostering other problems. For
example, through policy changes implemented in 2004, California became
the first state to establish nurse staffing ratios in acute care hospitals. The central
desired outcome of the policy was improvement in patient outcomes, but
there is no evidence that this resulted from the change (Spetz et al. 2009).
Although the process of making the decision to impose staffing ratios was
contentious, insufficient attention was given to the effect on nurses’ wages.
In fact, two separate studies designed to estimate the costs of imposing
staffing ratios assumed that nurses’ wages would be unaffected by the change
(Kravitz et al. 2002; Spetz et al. 2000). Implementation of this policy, however,
led to significant growth in nurses’ wages and in the use of RNs in
California hospitals. One study concluded that “wage growth for RNs in
California following the implementation of minimum-nurse-staffing legisla-
tion outstripped RN wage growth in other states not subject to such legisla-
tion” (Mark, Harless, and Spetz 2009). The differences between metropolitan
areas inside and outside California were as high as 12 percent. This policy not
only failed to achieve its intended purpose, it also generated some surprising
and challenging results.

Evidence-based learning can improve policies and minimize such prob-
lems, “but learning in complex systems is often weak and slow. Complexity
hinders our ability to discover the delayed and distal impacts of interventions,
generating unintended ‘side effects’” (Sterman 2006, 505). The healthcare
system may well be the most complex system in the United States.

Some countries, most notably Canada and Great Britain, have developed
expansive, well-integrated policies to fundamentally shape their societies’ pursuit of health (Sanders 2002). The United States has a few large
health-related policies, including its Medicare program and its regulation of
pharmaceuticals, but the U.S. government takes a more incremental or piec-
meal approach to health policy. The net result is a very large number of poli-
cies, few of which deal with the pursuit of health in a broad, comprehensive,
or integrated way. The current efforts to reform the healthcare system may
lead to a more comprehensive and integrated health policy. However, as
Gawande (2009) has observed, reform has not occurred in one dramatic step
in any Western democracy.

Popular opinion holds that the United States is entering a period of major
national health reform. The healthcare system is described as “unsustain-
able” and “flawed.” Those making this claim cite uncontrolled costs, variable
quality, and millions of uninsured and underinsured people as evidence.
Few now contradict these conclusions. However, views on what to do about
the problems widely diverge. Furthermore, this is not the first time these
problems have stimulated efforts to address them in a comprehensive way. As
Hoffman (2009, 1) notes, “The country has been on the verge of national
health reform many times before.” But the United States has not yet managed
the large-scale, comprehensive reforms that would systematically address the
cost, quality, and access problems that now characterize its healthcare system.

Policies made through the public policymaking process differ from poli-
cies established in the private sector. Authoritative decisions made in the pri-
vate sector by executives of healthcare organizations about such issues as their
product lines, pricing, and marketing strategies, for example, are private-sector
policies. Authoritative decisions made within such organizations as The Joint
Commission (www.jointcommission.org), a private accrediting body for
health-related organizations, and the National Committee for Quality Assurance
(NCQA; www.ncqa.org), a private organization involved in assessing and re-
porting on the quality of managed care plans, are also private-sector health
policies. This book focuses on the public policymaking process and the public-
sector health policies that result from this process. Private-sector health poli-
cies, however, also play a vital role in the ways society pursues health.

Despite government’s substantive role in health policy, which is ex-
plored further in subsequent chapters, and its role as a provider of health ser-
VICES in government facilities, most of the resources used in the pursuit of
health in the United States are controlled by the private sector. When govern-
ment is involved in health affairs, it often seeks broader access to health ser-
VICES that are provided predominantly through the private sector. The
Medicare and Medicaid programs provide clear examples of this approach.
Public dollars purchase services in the private sector for the beneficiaries of
these programs. Appendixes 1 and 2, respectively, provide overviews of
Medicare and Medicaid. These programs and the policies that guide them are
so important to understanding health policy and its effect on health that you
may wish to read the overviews now; the information provided will be help-
ful throughout the book.

Forms of Health Policies

Health policies, which we defined earlier as authoritative decisions, take several
basic forms (see Exhibit 1.2). Some policies are decisions made by legislators that
are codified in the statutory language of specific pieces of enacted legislation—
in other words, laws. Federal public laws are given a number that designates the
enacting Congress and the sequence in which the law was enacted. P.L. 89-97,
for example, means that this law was enacted by the 89th Congress and was the
97th law passed by that Congress. A briefly annotated chronological list of im-
portant federal laws pertaining to health can be found in Appendix 3.

Other policies are the rules and regulations established to implement
laws or to operate government and its programs. Still others are the judicial
branch’s decisions related to health. Examples of health policies include

- the 1965 federal public law P.L. 89-97, which established the Medicare
and Medicaid programs;


an executive order regarding operation of federally funded health centers;
• a federal court’s ruling that an integrated delivery system’s acquisition of yet another hospital violates federal antitrust laws;
• a state government’s procedures for licensing physicians;
• a county health department’s procedures for inspecting restaurants; and
• a city government’s ordinance banning smoking in public places within its borders.

Laws

Laws enacted at any level of government are policies. One example of a federal law is the Food and Drug Administration Amendments Act of 2007 (P.L. 110-85), which amended the Federal Food, Drug, and Cosmetic Act to revise and extend the user-fee programs for prescription drugs and medical devices. Another example is the Breast and Cervical Cancer Prevention and Treatment Act of 2000 (P.L. 106-354), which created an optional Medicaid category for low-income women diagnosed with cancer through the Centers for Disease Control and Prevention’s (CDC; www.cdc.gov) breast and cervical cancer early detection screening program. State examples include laws that govern the licensure of health-related practitioners and institutions. When laws trigger elaborate efforts and activities aimed at implementing the law, the whole endeavor is called a program. The Medicare program is a federal-level example. Many laws, most of which are amendments to prior laws, govern this vast program.

Appendix 4 provides an example of a complete federal law, the National Institute of Biomedical Imaging and Bioengineering Establishment Act of 2000. This law established the National Institute of Biomedical Imaging and Bioengineering (NIBIB; www.nibib.nih.gov) to accelerate the development and application of biomedical technologies. Electronic versions of this and other federal laws dating back to 1973, the 93rd Congress, can be found at thomas.loc.gov, a website maintained by the Library of Congress that provides access to federal and other legislative information.

Rules and Regulations

Another form policies can take is that of rules and regulations (the terms are used interchangeably in the policy context) established by agencies responsible
for implementing laws. The Administrative Procedures Act of 1946 defined “rule” as “the whole or part of an agency statement of general or particular applicability and future effect designed to implement, interpret, or prescribe law,” a definition that still stands. Because such rules are authoritative decisions made in the executive branch of government by the organizations and agencies responsible for implementing laws, they fit the definition of public policies. The rules associated with the implementation of complex laws routinely fill hundreds and sometimes thousands of pages. Rulemaking, the processes through which executive branch agencies write the rules to guide law implementation, is an important activity in policymaking and is discussed in detail in Chapter 5.

Rules, in proposed form (for review and comment by those who will be affected by them) and in final form, are published in the Federal Register (FR; www.gpoaccess.gov/fr), the official daily publication for proposed and final rules, notices of federal agencies, and executive orders and other presidential documents. The FR is published by the Office of the Federal Register, National Archives and Records Administration. Appendix 5 contains the summaries of a proposed rule which would revise parts of the Medicare hospital inpatient prospective payment system and a final rule that modifies and updates certain elements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The entire proposed rule and the final rule can be read in the FR at www.gpoaccess.gov/fr.

**Operational Decisions**

When organizations or agencies in the executive branch of any level of government implement laws, they must make operational decisions. These decisions, authoritatively made in the implementing agencies, although different from the formal rules that influence implementation, are policies as well. For example, effectively managing Medicare requires the federal government to undertake a complex and diverse set of management tasks, among them (Gluck and Sorian 2004, 15)

- determining eligibility for Medicare;
- collecting Part B premiums from beneficiaries;
- educating and informing Medicare beneficiaries about their benefits, rights, and options;
- processing and paying Medicare claims;
- implementing Medicare payment policies (i.e., developing and implementing payment methodologies and setting and updating Medicare payment rates)
- administering private Medicare plans;
- selecting and managing Medicare contractors;
- rendering coverage determinations for medical services, procedures, and technologies;
• combating fraud and abuse in Medicare;
• ensuring the quality of services provided to Medicare beneficiaries (i.e., setting standards for healthcare facilities and other providers to participate in Medicare and overseeing quality improvement efforts); and
• supporting Medicare research and demonstration projects.

In carrying out these tasks, the Centers for Medicare & Medicaid Services (CMS; www.cms.gov), the agency responsible for implementing the Medicare and Medicaid programs, must make frequent operational decisions. Again, because they are authoritative, these decisions are policies. Examples of operational decisions can be found in all implementing agencies. For example, the several federal agencies with implementation responsibilities for the Water Quality Improvement Act (P.L. 91-224) establish operational protocols and procedures for dealing with those affected by the provisions of this law. These protocols and procedures are a form of policy because they are authoritative decisions. Appendix 6 provides another example by illustrating ongoing operational decisions made within the federal Food and Drug Administration (FDA; www.fda.gov).

Judicial Decisions
Judicial decisions are another form of policy. An example is the U.S. Supreme Court’s ruling in 2000 (by a 5–4 vote) that the FDA cannot regulate tobacco. Another example is the Supreme Court’s 2005 decision not to hear an appeal filed by six health insurers in a bid to stop a class-action lawsuit brought by more than 600,000 doctors who claimed the companies underpaid them for treating patients. This decision allowed a lower court’s ruling to stand, meaning that a class-action suit could proceed in federal court. A third example is the Supreme Court’s 2008 MetLife v. Glenn decision regarding how federal courts reviewing claims denials by plan administrators under the Employee Retirement Income Security Act (ERISA) “should take into account the fact that plan administrators (insurers and self-insured plans) face a conflict of interest because they pay claims out of their own pockets and arguably stand to profit by denying claims” (Jost 2008, w430). All three decisions are policies because they are authoritative decisions that direct or influence the actions, behaviors, or decisions of others.

Categories of Health Policies

Another way to consider health policies is to recognize that any type of policy, whether law, rule or regulation, operational decision, or judicial decision, fits into one of several broad categories. Public policies are typically divided into distributive, redistributive, and regulatory categories (Birkland 2001).
Sometimes the distributive and redistributive categories are combined into an allocative category; sometimes the regulatory category is subdivided into competitive regulatory and protective regulatory categories. For our purposes, all of the various forms of health policies fit into two basic categories—allocative or regulatory.

In market economies, such as that of the United States, the presumption is that private markets best determine the production and consumption of goods and services, including health services. Of course, when markets fail, as the financial markets in the United States and worldwide began to do in 2008, government intervention becomes essential. In market economies, government generally intrudes with policies only when private markets fail to achieve desired public objectives. The most credible arguments for policy intervention in the nation’s domestic activities begin with the identification of situations in which markets are not functioning properly.

The health sector is especially prone to situations in which markets function poorly. Theoretically perfect (i.e., freely competitive) markets, which do not exist in reality but provide a standard against which real markets can be assessed, require that

- buyers and sellers have sufficient information to make informed decisions,
- a large number of buyers and sellers participate,
- additional sellers can easily enter the market,
- each seller’s products or services are satisfactory substitutes for those of their competitors, and
- the quantity of products or services available in the market does not swing the balance of power toward either buyers or sellers.

The markets for health services in the United States violate these requirements. The complexity of health services reduces the consumer’s ability to make informed decisions without guidance from the sellers or other advisors. Entry of sellers in the markets for health services is heavily regulated, and widespread insurance coverage affects the decisions of buyers and sellers. These and other factors mean that markets for health services frequently do not function competitively, thus inviting policy intervention.

Furthermore, the potential for private markets on their own to fail to meet public objectives is not limited to production and consumption. For example, markets on their own might not stimulate sufficient socially desirable medical research or the education of enough physicians or nurses without policies that subsidize certain costs associated with these ends. These and similar situations provide the philosophical basis for the establishment of public policies to correct market-related problems or shortcomings.

The nature of the market problems or shortcomings directly shapes the health policies intended to overcome or ameliorate them. Based on their
primary purposes, health policies fit broadly into allocative or regulatory categories, although the potential for overlap between the two categories is considerable.

**Allocative Policies**

Allocative policies provide net benefits to some distinct group or class of individuals or organizations at the expense of others to meet public objectives. Such policies are in essence subsidies through which policymakers seek to alter demand for or supply of particular products and services or guarantee certain people access to them. For example, government has heavily subsidized the medical education system on the basis that without subsidies to medical schools, markets would undersupply physicians. Similarly, government subsidized the construction of hospitals for many years on the basis that markets would undersupply hospitals in sparsely populated or low-income areas.

Other subsidies have been used to ensure that certain people have access to health services. The most important examples of such policies, based on the magnitude of expenditures, are the Medicare and Medicaid programs. Medicare expenditures will be approximately $531 billion in 2010 (making up almost 20 percent of the nation’s health expenditures) and could reach $884 billion by 2017; Medicaid expenditures will exceed $417 billion in 2010 and could reach $717 billion by 2017 (Centers for Medicare & Medicaid Services 2009).

Federal funding to support access to health services for Native Americans, veterans, and migrant farm workers and state funding for mental institutions are other examples of allocative policies that are intended to help individuals gain access to needed services. Some believe subsidies are reserved for those people who are most impoverished. However, subsidies such as those that support medical education, the Medicare program (the benefits of which are not based primarily on the financial need of the recipients), and the exclusion of employer-provided health insurance benefits from taxable income illustrate that poverty is not necessarily a requirement.

Some of the provisions of the American Recovery and Reinvestment Act of 2009 (P.L. 111-5) provide examples of allocative policy. This law, enacted in response to the global financial crisis that emerged in 2008, contains many health-related subsidies. Exhibit 1.3 lists some examples.
**Exhibit 1.3** Examples of Health-Related Subsidies Included in the American Recovery and Reinvestment Act of 2009

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continuation of health insurance coverage for unemployed workers</td>
<td>$24.7 billion to provide a 65% federal subsidy for up to 9 months of premiums under the Consolidated Omnibus Budget Reconciliation Act. The subsidy will help workers who lose their jobs to continue coverage for themselves and their families.</td>
</tr>
<tr>
<td>Health Resources and Services Administration</td>
<td>$2.5 billion, including $1.5 billion for construction, equipment, and health information technology at community health centers; $500 million for services at these centers; $300 million for the National Health Service Corps (NHSC); and $200 million for other health professions training programs.</td>
</tr>
<tr>
<td>Medicare</td>
<td>$338 million for payments to teaching hospitals, hospice programs, and long-term care hospitals.</td>
</tr>
<tr>
<td>Medicaid and other state health programs</td>
<td>$87 billion for additional federal matching payments for state Medicaid programs for a 27-month period that began October 1, 2008, and $3.2 billion for additional state fiscal relief related to Medicaid and other health programs.</td>
</tr>
<tr>
<td>Prevention and wellness</td>
<td>$1 billion, including $650 million for clinical and community-based prevention activities that will address rates of chronic diseases, as determined by the secretary of health and human services; $300 million to the Centers for Disease Control and Prevention for immunizations for low-income children and adults; and $50 million to states to reduce healthcare–associated infections.</td>
</tr>
</tbody>
</table>

**Source:** Reprinted with permission from Steinbrook (2009).

**Regulatory Policies**

Policies designed to influence the actions, behaviors, and decisions of others by directive are regulatory policies. All levels of government establish regulatory policies. As with allocative policies, government establishes such policies to ensure that public objectives are met. The five basic categories of regulatory health policies are

1. market-entry restrictions,
2. rate- or price-setting controls on health services providers,
3. quality controls on the provision of health services,
4. market-preserving controls, and
5. social regulation.

The first four categories are variations of economic regulation; the fifth seeks to achieve such socially desired ends as safe workplaces, nondiscriminatory provision of health services, and reduction in the negative externalities (side effects) associated with the production or consumption of products and services.

Market-entry-restricting regulations include licensing of health-related practitioners and organizations. Planning programs, through which preapproval for new capital projects by health services providers must be obtained, are also market-entry-restricting regulations.

Although price-setting regulation is generally out of favor, some aspects of the pursuit of health are subject to price regulations. The federal government’s control of the rates at which it reimburses hospitals for care provided to Medicare patients and its establishment of a fee schedule for reimbursing physicians who care for Medicare patients are examples.

A third class of regulations are those intended to ensure that health services providers adhere to acceptable levels of quality in the services they provide and that producers of health-related products such as imaging equipment and pharmaceuticals meet safety and efficacy standards. For example, the FDA is charged with ensuring that new pharmaceuticals meet these standards. In addition, the Medical Devices Amendments (P.L. 94-295) to the Food, Drug and Cosmetic Act (P.L. 75-717) placed all medical devices under a comprehensive regulatory framework administered by FDA.

Because the markets for health services do not behave in truly competitive ways, government establishes and enforces rules of conduct for participants. These rules form a fourth class of regulation, market-preserving controls. Antitrust laws—such as the Sherman Antitrust Act, the Clayton Act, and the Robinson-Patman Act—which are intended to maintain conditions that permit markets to work well and fairly, are good examples of this type of regulation.

These four classes of regulations are all variations of economic regulation. The primary purpose of social regulation, the fifth class, is to achieve such socially desirable outcomes as workplace safety and fair employment practices and to reduce such socially undesirable outcomes as environmental pollution and the spread of sexually transmitted diseases. Social regulation usually has an economic effect, but this is not the primary purpose. Federal and state laws pertaining to environmental protection, disposal of medical wastes, childhood immunization, and the mandatory reporting of communicable diseases are examples of social regulations at work in the pursuit of health.

Whether public policies take the form of laws, rules and regulations, operational decisions, or judicial decisions, they are created through a complex process, which is described in Chapter 2. The policymaking model, within which the authoritative decisions that form policies are made, applies at federal and state levels of government, and elements of the model apply at
all levels of government. Before examining this model, however, it will be useful to consider how health policies affect health and its pursuit.

The Impact of Health Policy on Health Determinants and Health

From government’s perspective, the central purpose of health policy is to enhance health or facilitate its pursuit. Of course, other purposes may be served through specific health policies, including economic advantages for certain individuals and organizations. But the defining purpose of health policy, so far as government is concerned, is to support the people in their quest for health.

Health policies affect health through an intervening set of variables, or health determinants (see Exhibit 1.4). Health determinants, in turn, directly affect health. When examining how it can affect health, consider the role of health policy in the following health determinants:

- physical environments in which people live and work
- behavioral choices and biology
- social factors that affect health, including economic circumstances; socioeconomic position; income distribution within the society; discrimination based on factors such as race/ethnicity, gender, or sexual orientation; and the availability of social networks or social support
- availability of and access to health services

Health Policies and Physical Environments

When people are exposed to harmful agents such as asbestos, dioxin, excessive noise, ionizing radiation, or toxic chemical and biological substances, their health is directly affected. Exposure risks pervade the physical environments of many people. Some of the exposure is through such agents as synthetic compounds that are by-products of technological growth and development. Some exposure is through wastes that result from the manufacture, use, and disposal of a vast range of products. And some of the exposure is through naturally

**Exhibit 1.4** The Impact of Policy on Health Determinants and Health

<table>
<thead>
<tr>
<th>Health Policy</th>
<th>Health Determinants</th>
<th>Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical environment</td>
<td>Behavior and biology</td>
<td>Social factors</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Health services</td>
</tr>
</tbody>
</table>
occurring agents such as carcinogenic ultraviolet radiation from the sun or naturally occurring radon gas in the soil.

The hazardous effects of naturally occurring agents are often exacerbated by combination with agents introduced by human activities. For example, before its ban, the widespread use of freon in air conditioning systems and other chlorofluorocarbons in aerosolized products reduced the protective ozone layer in Earth’s upper atmosphere. This allowed an increased level of ultraviolet radiation from the sun to penetrate to Earth’s surface. Similarly, exposure to naturally occurring radon appears to act synergistically with cigarette smoke as a carcinogen.

The health effects of exposure to hazardous agents, whether natural or manmade, are well understood. Air, polluted by certain agents, has a direct, measurable effect on such diseases as asthma, emphysema, and lung cancer and aggravates cardiovascular disease. Asbestos, which can still be found in buildings constructed before it was banned, causes pulmonary disease. Lead-based paint, when ingested, causes permanent neurological damage in infants and young children. This paint is still found in older buildings and is especially concentrated in poorer urban communities.

Over many decades, government has made efforts to exorcise environmental health hazards through public policies. Examples of federal policies include the Clean Air Act (P.L. 88-206), the Flammable Fabrics Act (P.L. 90-189), the Occupational Safety and Health Act (P.L. 91-596), the Consumer Product Safety Act (P.L. 92-573), the Noise Control Act (P.L. 92-574), and the Safe Drinking Water Act (P.L. 93-523).

Health policies that mitigate environmental hazards or take advantage of positive environmental conditions are important aspects of any society’s ability to help its members achieve better health. Other determinants provide additional avenues to improved health.

**Health Policies and Human Behavior and Biology**

As Rene Dubos (1959, 110) observed a half-century ago, “To ward off disease or recover health, men [as well as women and children] as a rule find it easier to depend on the healers than to attempt the more difficult task of living wisely.” The price of this attitude is partially reflected in the major causes of death in the United States. Ranked from highest to lowest by the Centers for Disease Control and Prevention (2006), the ten leading causes are heart disease, cancer, stroke, chronic lower respiratory diseases, accidents, diabetes, Alzheimer’s disease, influenza/pneumonia, nephritis/nephritic syndrome/nephrosis, and septicemia.

Behaviors—including choices about the use of tobacco and alcohol, diet and exercise, illicit drug use, sexual behavior, and violence—and genetic predispositions influence many of these causes of death and help explain the pattern. Furthermore, underlying the behavioral factors are such root factors as stress, depression, and feelings of anger, hopelessness, and emptiness, which
are exacerbated by economic and social conditions. In short, behaviors are heavily reflected in the diseases that kill and debilitate Americans.

Changes in behaviors can change the pattern of causes of death. The death rate from heart disease, for example, has declined dramatically in recent decades. Although aggressive early treatment has played a role in reducing this rate, better control of several behavioral risk factors—including cigarette smoking, elevated blood pressure, elevated levels of cholesterol, poor diet, lack of exercise, and elevated stress—explain much of the decline. Even with this impressive improvement, however, heart disease remains the most common cause of death and will continue to be a significant cause. Cancer death rates continue to grow, with much of the increase attributable to lung cancer, which is strongly correlated with behavior. Appendix 7 describes the extent of state, commonwealth, and local municipality laws intended to restrict where smoking is allowed.

**Health Policies and Social Factors**

In addition to their physical environments, behaviors, and genetics, a number of social factors can affect health. Chronic unemployment, the absence of a supportive family structure, poverty, homelessness, and discrimination, among other social factors, affect people’s health as surely—and often as dramatically—as harmful viruses or carcinogens.

People who live in poverty experience measurably worse health status (more frequent and more severe health problems) than those who are more affluent (Do and Finch 2008; Phipps 2003). African Americans, Hispanics, and Native Americans, who are disproportionately represented below the poverty line, experience worse health than the white majority (National Center for Health Statistics 2007).

The poor also typically obtain their health services in a different manner. Instead of receiving care that is coordinated, continuing, and comprehensive, the poor are far more likely to receive a patchwork of services, often provided by public hospitals, clinics, and local health departments. In addition, poor people are more often treated episodically, with one provider intervening in one episode of illness and another provider handling the next episode.

The effect of economic conditions on the health of children is especially dramatic (Henry J. Kaiser Family Foundation 2009a; Wood 2003). Impoverished children, on average, have lower birth weights and more conditions that limit school activity than other children. These children are more likely to become ill and to have more serious illnesses than other children because of increased exposure to harmful environments, inadequate preventive services, and limited access to health services.

Economic circumstances are part of a larger set of social factors that unequally affect people in their quest for health. Living in an inner-city or rural setting often increases the challenge of finding health services, because many
such locations have too few providers. Lack of adequate information about health and health services is a significant disadvantage, one compounded by language barriers, functional illiteracy, or marginal mental retardation. Cultural backgrounds and ties, especially among many Native Americans, Latinos, and Asian immigrants, for all the support they can provide, can also create a formidable barrier between people and the mainline healthcare system.

An example of health policy intended to address social factors is P.L. 105-33, the Balanced Budget Act of 1997. This policy provided for expanded health insurance coverage of children by establishing the State Children’s Health Insurance Program (SCHIP). In 2009, President Obama signed a renewal of this program into law as the Children’s Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3). The reauthorization significantly expands coverage to include an additional 4 million children and, for the first time, allows the spending of federal money to cover children and pregnant women who are legal immigrants. This policy, with many others, has addressed some of the social factors that affect health. However, a great deal remains to be done.

**Health Policies and Health Services**

As shown in Exhibit 1.4, another important determinant of health is availability of and access to health services, which are any of a host of “specific activities undertaken to maintain or improve health or to prevent decrements of health” (Longest and Darr 2008, 232). Health services can be preventive (e.g., blood pressure screening, mammography), acute (e.g., surgical procedures, antibiotics to fight an infection), chronic (e.g., control of diabetes or hypertension), restorative (e.g., physical rehabilitation of a stroke or trauma patient), or palliative (e.g., pain relief or comfort in terminal stages of disease).

The production and distribution of health services require a vast set of resources, including money, human resources, and technology, all of which are heavily influenced by health policies. The organizations and networks that transform these resources into health services and distribute them to consumers are collectively known as the healthcare system. The system itself is also influenced by health policies. Health policies determine the nature of health services through their effect on the resources required to produce the services and on the healthcare system through which the services are organized, delivered, and paid for. Policies’ effect on the resources used to provide health services are examined in the next sections.

As Exhibit 1.5 shows, growth of national health expenditures is expected to continue. They may exceed $4.3 trillion by 2018. These expenditures, representing about 17.6 percent of the GDP in 2009, could rise to more than 20 percent of the GDP by 2018 (Sisko et al. 2009). The United States spends more on health than does any other country, in total and on a per capita basis (Organisation for Economic Cooperation and Development 2008; Henry J. Kaiser Family Foundation 2009; International Labour Organization 2009; Organisation for Economic Cooperation and Development 2009b; Organisation for Economic Cooperation and Development 2008).

**Money**
Foundation 2009b). Other countries have been far more likely to adopt policies such as global budgets for their healthcare systems or to impose restrictive limitations on the supplies of health services (Anderson et al. 2005; Reinhardt, Hussey, and Anderson 2004).

Current health expenditures and projected future increases have significant implications. The increasing expenditures, in part, reflect higher prices.

### Exhibit 1.5 National Health Expenditures (NHE), Aggregate and per Capita Amounts, and Share of Gross Domestic Product (GDP) for Selected Calendar Years 1993–2018

<table>
<thead>
<tr>
<th>Spending category</th>
<th>1993</th>
<th>2006</th>
<th>2007</th>
<th>2008a</th>
<th>2009a</th>
<th>2013a</th>
<th>2018a</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHE (billions)</td>
<td>$912.5</td>
<td>$2,112.7</td>
<td>$2,241.2</td>
<td>$2,378.6</td>
<td>$2,509.5</td>
<td>$3,110.9</td>
<td>$4,353.2</td>
</tr>
<tr>
<td>Health services and supplies</td>
<td>853.1</td>
<td>1,976.1</td>
<td>2,098.1</td>
<td>2,226.6</td>
<td>2,350.1</td>
<td>2,915.8</td>
<td>4,086.2</td>
</tr>
<tr>
<td>Personal health care</td>
<td>773.6</td>
<td>1,765.5</td>
<td>1,878.3</td>
<td>1,992.6</td>
<td>2,099.0</td>
<td>2,598.3</td>
<td>3,639.2</td>
</tr>
<tr>
<td>Hospital care</td>
<td>317.1</td>
<td>649.3</td>
<td>696.5</td>
<td>746.5</td>
<td>789.4</td>
<td>992.6</td>
<td>1,374.1</td>
</tr>
<tr>
<td>Professional services</td>
<td>280.8</td>
<td>661.4</td>
<td>702.1</td>
<td>744.7</td>
<td>785.8</td>
<td>953.7</td>
<td>1,338.1</td>
</tr>
<tr>
<td>Physician and clinical services</td>
<td>201.2</td>
<td>449.7</td>
<td>478.8</td>
<td>508.5</td>
<td>539.1</td>
<td>636.1</td>
<td>865.2</td>
</tr>
<tr>
<td>Other prof. services</td>
<td>24.5</td>
<td>58.7</td>
<td>62.0</td>
<td>65.8</td>
<td>68.7</td>
<td>84.1</td>
<td>116.8</td>
</tr>
<tr>
<td>Dental services</td>
<td>38.9</td>
<td>90.5</td>
<td>95.2</td>
<td>99.9</td>
<td>101.9</td>
<td>121.4</td>
<td>161.4</td>
</tr>
<tr>
<td>Other PHC</td>
<td>16.2</td>
<td>62.5</td>
<td>66.2</td>
<td>70.5</td>
<td>76.1</td>
<td>112.0</td>
<td>194.7</td>
</tr>
<tr>
<td>Nursing home and home health care</td>
<td>87.3</td>
<td>178.4</td>
<td>190.4</td>
<td>201.8</td>
<td>213.6</td>
<td>269.8</td>
<td>375.8</td>
</tr>
<tr>
<td>Home health careb</td>
<td>21.9</td>
<td>53.0</td>
<td>59.0</td>
<td>64.4</td>
<td>69.7</td>
<td>92.4</td>
<td>134.9</td>
</tr>
<tr>
<td>Nursing home careb</td>
<td>65.4</td>
<td>125.4</td>
<td>131.3</td>
<td>137.4</td>
<td>143.9</td>
<td>177.4</td>
<td>240.9</td>
</tr>
<tr>
<td>Retail outlet sales of medical products</td>
<td>88.4</td>
<td>276.4</td>
<td>289.3</td>
<td>299.6</td>
<td>310.2</td>
<td>382.1</td>
<td>551.3</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>51.0</td>
<td>216.8</td>
<td>227.5</td>
<td>235.4</td>
<td>244.8</td>
<td>307.8</td>
<td>453.7</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>13.5</td>
<td>24.2</td>
<td>24.5</td>
<td>25.2</td>
<td>25.2</td>
<td>29.0</td>
<td>38.1</td>
</tr>
<tr>
<td>Nondurable medical products</td>
<td>23.9</td>
<td>35.3</td>
<td>37.4</td>
<td>39.0</td>
<td>40.2</td>
<td>45.4</td>
<td>59.5</td>
</tr>
</tbody>
</table>
These higher prices have reduced access to health services by making it more difficult for many people to purchase the services or the insurance needed to cover those services. Increases in health expenditures have absorbed much of the growth of many workers’ real compensation, meaning that as employers spend more to provide health insurance benefits, wages decrease. Some employers have dropped health insurance altogether. With the nation working its way through the worst economic downturn since the Great Depression, declining employment is dramatically affecting the number of uninsured. A 1 percent rise in unemployment has been estimated to increase the number of uninsured by 1.1 million and to drive another 1 million people onto the Medicaid rolls (Henry J. Kaiser Family Foundation 2009c). The number of people without health insurance in the United States grew from about 40 million in
2000 to about 46 million, or 18 percent of the population under the age of 65, in 2007 (DeNavas-Walt, Proctor, and Smith 2008).

Because federal and state governments now spend so much on health, rising health expenditures have put substantial pressures on their budgets. As health expenditures consume a growing portion of government resources, it becomes more difficult for government to support other priorities such as education or homeland security (Congressional Budget Office 2009). Appendix 8 reproduces a brief perspective on this issue from the director of the Congressional Budget Office (CBO; www.cbo.gov).

### Human Resources

The talents and abilities of a large and diverse workforce make up another basic resource used to provide health services. Human resources are directly affected by health policies. There are more than 14 million healthcare workers in the United States, the largest number in any industry, and 7 of the 20 occupations projected to grow the fastest over the next several years are concentrated in healthcare. Healthcare will generate about 3 million new jobs between 2006 and 2016, again leading all industries (U.S. Department of Labor 2009). The effect of policies on health-related human resources can be seen clearly in the nation’s supply of physicians and registered nurses.

There are about 817,000 active physicians in the United States. Slightly more than one third are generalists (family practice, general pediatrics, or general internal medicine); the remaining two thirds are specialists (National Center for Health Workforce Analysis 2006). The number of physicians doubled from the mid-1960s to the mid-1990s. To a considerable extent, this was due to federal policies intended to increase their supply, including the Health Professions Educational Assistance Act of 1963 (P.L. 88-129) and its amendments of 1965, 1968, and 1971.

Studies by the National Center for Health Workforce Analysis demonstrate a serious shortage in the supply of RNs and project the shortage to increase in future years. As Exhibit 1.6 shows, “by 2020 the national shortage is projected to increase to more than 1 million FTE RNs if current trends continue, suggesting that only 64 percent of projected demand will be met” (National Center for Health Workforce Analysis 2009, 26).

Concerted efforts have and will continue to be made to alleviate the shortage. The main federal response to date is the Nurse Reinvestment Act of 2002 (PL 107-205), which authorized the following provisions:

- loan repayment programs and scholarships for nursing students
- public service announcements to encourage more people to enter the nursing profession
- career ladder programs for those who wish to advance within the profession
- best practice grants for nursing administration
long-term care training grants to develop and incorporate gerontology curriculum into nursing programs

a fast-track faculty loan repayment program for nursing students who agree to teach at a school of nursing

In addition to federal policy, some states have enacted laws requiring minimum patient-to-nurse staffing ratios and prohibiting mandatory overtime to ensure safer working conditions for nurses. Such conditions help retain current nurses and attract those who left nursing careers back to the workforce. As federal and state policymakers continue to address this problem, their efforts to establish effective policies will require consideration of the following questions (Henry J. Kaiser Family Foundation 2008):

- How and why is this current nursing shortage different from previous shortages? Do the policy options address the current problems, or are they responding to historical problems?
- How does the nursing shortage affect the quality of patient care?
- Is ensuring an adequate nurse workforce a federal responsibility? What is the correlation, if any, between the availability of nurses in the health workforce and the nature and funding of federal discretionary nursing programs?
- What other federal policies affect the demand for and supply of nurses?
- What is the nature of states’ “safe staffing” legislation? Why are states addressing the nursing shortage this way? Does this policy have potential unintended consequences? Will an inability to find enough qualified RNs force hospitals to eliminate beds and reduce access to care?
- Do state nursing policies affect the supply of nurses from state to state? If so, how?

A third type of resource that health policies significantly affect is health-related technology (Longest and Darr 2008). Broadly defined, technology is the application of science to the pursuit of health. Technological advances result in better pharmaceuticals, devices, and procedures. A major influence on the

<table>
<thead>
<tr>
<th>Year</th>
<th>Supply</th>
<th>Demand</th>
<th>Shortage</th>
<th>Supply/Demand</th>
<th>Demand shortfall</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>1,942,500</td>
<td>2,161,300</td>
<td>(218,800)</td>
<td>90%</td>
<td>10%</td>
</tr>
<tr>
<td>2010</td>
<td>1,941,200</td>
<td>2,347,000</td>
<td>(405,800)</td>
<td>83%</td>
<td>17%</td>
</tr>
<tr>
<td>2015</td>
<td>1,886,100</td>
<td>2,569,800</td>
<td>(683,700)</td>
<td>73%</td>
<td>27%</td>
</tr>
<tr>
<td>2020</td>
<td>1,808,000</td>
<td>2,824,900</td>
<td>(1,016,900)</td>
<td>64%</td>
<td>36%</td>
</tr>
</tbody>
</table>

SOURCE: Adapted from National Center for Health Workforce Analysis (2009, 27).
pursuit of health in the United States, technology has helped eradicate some diseases and has greatly improved diagnoses and treatment for others. Diseases that once were not even diagnosed are now routinely and effectively treated. Advancing technology has brought medical science to the early stages of understanding disease at the molecular level and intervening in diseases at the genetic level.

The United States produces and consumes more health-related technology than does any other nation, and it spends far more on it. It has provided technology with a uniquely favorable economic and political environment. As a result, health-related technology is widely available in the United States.

Health policy provides funding for the research and development (R&D) that leads to new technology, although the private sector also pays for a great deal of R&D. The United States has a long history of support for the development of health-related technology through policies that support biomedical research and encourage private investment in such research. The National Institutes of Health (NIH; www.nih.gov) invests more than $29 billion annually in medical research. About 80 percent of the NIH’s funding is awarded through almost 50,000 competitive grants to more than 325,000 researchers at over 3,000 universities, medical schools, and other research institutions in every state and around the world. About 10 percent of the NIH’s budget supports projects conducted by nearly 6,000 scientists in its own laboratories, most of which are on the NIH campus in Bethesda, Maryland (National Institutes of Health 2009).

Encouraged by policies that permit firms to recoup their investments, private industry also spends heavily on biomedical R&D. In fact, the Pharmaceutical Research and Manufacturers of America (PhRMA; www.phrma.org), which represents the nation’s leading pharmaceutical research and biotechnology companies, reports that industry-wide research investment was $58.8 billion in 2007 (Pharmaceutical Research and Manufacturers of America 2009).

Health policy also affects technology through the application of regulatory policies, such as those promulgated by the FDA to ensure technology’s safety and efficacy. The FDA is responsible for protecting the public health by assuring the safety, efficacy, and security of human and veterinary drugs, biological products, medical devices, the food supply, cosmetics, and products that emit radiation (U.S. Food and Drug Administration 2009). The following are laws the FDA is responsible for, or partially responsible for, implementing, including writing rules for implementation:

- Food, Drug, and Cosmetic Act of 1938 (P.L. 75-717)
- Infant Formula Act of 1980 (P.L. 96-359)
Advances in technology have caused the costs of health services to rise as the new technology is used and paid for. One paradox of advancing health-related technology is that as people live longer because of these advances, they then may need additional health services. The net effect drives up health expenditures for the new technology and for other services consumed over a longer life span. The costs associated with use of technology generate policy issues of their own. An example of this is how Medicare policies guide the determination of whether it will pay for new services, treatments, and technologies. Using a complex process, consideration is given to whether the item is safe, effective, and appropriate; whether it leads to improved health outcomes; and
the quality of available evidence (Neumann, Kamae, and Palmer 2008). An overview of this decision-making process can be found in “An Introduction to How Medicare Makes Coverage Decisions” (Medicare Payment Advisory Commission 2003, 245-50). Hlatky, Sanders, and Owens (2005) provide a specific example with their discussion of Medicare’s decision to cover implantable cardioverter defibrillators (ICDs).

The Role and Importance of Policy Competence in the Pursuit of Health

Because there is a powerful connection between health policy and health, anyone professionally involved in the pursuit of health through any of the determinants shown in Exhibit 1.4 has a vested interest in understanding how health policy is made at all levels of government. An understanding of the context and the decision-making process leads to a higher degree of policy competence.

DeBuono, Gonzalez, and Rosenbaum (2008, 206) state the challenge and importance of engagement in the policymaking arena as follows:

Many public health practitioners fear getting involved with the policy world. There is no question that public health practice is valuable and fulfilling when the task is to gather data, issue reports, and find solutions that modify individual behavior. However, if the nation is ever to achieve optimal population health, then the public health dialogue must include the policy dimension. To advance the health of the population, the public health system must train a work force capable of, and ready to embrace, policy leadership as an inherent and critical element of the profession.

Similar conclusions apply to healthcare managers, physicians, nurses, and other health professionals. It is entirely possible that, with sufficient policy competence, these professionals can contribute as much or more to improving health through their efforts to improve and enhance the nation’s health policy as they do through the more routine practice of their professions.

In many ways, this book is about enhancing the policy competence of healthcare managers and other health professionals. We discuss policy competence more thoroughly in the final chapter, but in this chapter it is sufficient to say that policy competence is made up of the dual abilities to (1) analyze the impact of public policies on one’s domain of interest or responsibility and (2) exert influence in the public policymaking process.

The single most important factor in policy competence—including the ability to analyze the impact of public policies or to exert influence in the policymaking process—is to understand the public policymaking process as a decision-making process. Public policies, including health policies, are decisions, albeit decisions made in a particular way by particular people. Thus,
understanding policymaking means understanding a particular type of decision making, including its context, participants, and processes.

As we discuss throughout the book, the public policymaking process includes three tightly interwoven and interdependent phases: formulation, implementation, and modification. The phases do not unfold in neat sequence. Instead, they blend together in a gestalt of actors, actions, and, sometimes, inactions that yield policies. Exhibit 1.7 illustrates the relationships among the phases of policymaking.

This illustration of the policymaking process emphasizes the cyclical character of public policymaking and shows it as an ongoing phenomenon, one without a definitive beginning or end. In this view of public policymaking, policy formulation (making the decisions that are policies) is inextricably connected to policy implementation (taking actions and making additional decisions, which are themselves policies, necessary to implement policies). Neither phase is complete without the other. Because neither formulation nor implementation achieves perfection or exists in a static world, policy modification is vital. Modifications to previously formulated and implemented policies can range from minor alterations in implementation, to new rules and regulations for implementation, to modest amendments to existing legislation, to fundamental policy changes reflected in new public laws.

Policy competence is increasingly important to those who wish to be effectively involved in the pursuit of health. Many participants in the political marketplace seek to further their objectives by influencing the outcomes of this process and by more accurately predicting those outcomes. An adequate degree of policy competence is necessary to understand what effect the policymaking process might have on a vital interest. Through competent participation, one can influence future health policies and, thus, the determinants of health and ultimately health itself.
Summary

Good health is “a state of physical and mental well-being necessary to live a meaningful, pleasant and productive life. Good health is also an integral part of thriving modern societies, a cornerstone of well performing economies, and a shared principle of European democracies,” a definition that can readily be extended to all democracies (Byrne 2004). Considering health in this way emphasizes the need to address many health determinants: the physical environments in which people live and work; their behaviors and genetics; social factors, including economic circumstances, socioeconomic position, income distribution, discrimination based on factors such as race/ethnicity, gender, or sexual orientation, and the availability of social networks or social support; and the type, quality, and timing of health services that people receive.

Health policies are authoritative decisions made within government that are intended to direct or influence the actions, behaviors, or decisions of others pertaining to health and its determinants. These policies are the principal means through which government in a developed society helps shape the pursuit of health. These decisions can take the form of laws, rules, and operational decisions made in the context of implementing laws and judicial decisions. Health policies, like other public policies, can fit into broad allocative or regulatory categories.

Policy competence is made up of the dual abilities to analyze the impact of public policies on one’s domain of interest or responsibility and exert influence in the public policymaking process. This competence begins with an understanding of the public policymaking process and the context in which it takes place. Policy competence can be valuable to healthcare managers and other health professionals, who can use it to affect health by affecting the determinants of health.

Review Questions

1. Define health. What are the determinants of health in humans?
2. Define public policies and health policies.
3. What forms do health policies take? Give an example of each.
4. Compare and contrast the two basic categories of health policies.
5. Discuss the connection between health policies, health determinants, and health.
6. What is policy competence? Why is it important to anyone who is interested in being involved in the pursuit of health?