Chapter 13


INTRODUCTION

Even though the United States does not have a centrally controlled system of health care delivery, it does have a history of federal, state, and local government involvement in health care and health policy. Americans possess an incredible desire to be healthy. They contend that their individual health contributes to the overall health of the nation and, consequently, to the economy. It is not surprising, therefore, that the government is keenly interested in health policy. This chapter first defines what health policy is and explores the principal features of health policy in the United States. Next, it describes the development of legislative policy and gives examples of critical health policy issues. Finally, an outlook for the future of health policy in the United States is provided.
WHAT IS HEALTH POLICY?

Public policies are authoritative decisions made in the legislative (congressional), executive (presidential), or judicial (court including the Supreme Court) branches of government that are intended to direct or influence the actions, behaviors, or decisions of others (Longest 1994). When public policies pertain to, or influence the pursuit of health, they become health policies. Thus health policy can be defined as "the aggregate of principles, stated or unstated, that...characterize the distribution of resources, services, and political influences that impact on the health of the population" (Miller 1987, p. 15).

Different Forms of Health Policies

Health policies often come as a byproduct of public social policies enacted by the government. A relevant example is the expansion of health care insurance coverage. Policies that excluded fringe benefits from income or Social Security taxes, and a Supreme Court ruling that employee benefits, including health insurance, could be legitimately included in the collective bargaining process, led to important changes in the health care system (see Chapter 3). As a result, employer-provided health insurance benefits grew rapidly in middle decades of the 20th century (HIAA 1992). In 1965, adoption of the Medicare and Medicaid legislation expanded the health sector by providing publicly subsidized health insurance to the elderly and indigent.

The American health care system has developed under extraordinarily favorable public policies. For example, the federally funded National Institutes of Health (NIH) had a budget of about $10 million when the agency was established in the early 1930s. Today, following exponential growth, the NIH annual budget is about $10 billion. Also, encouraged by policies that permit businesses to recoup their investments in research and development from the government, private industry spends a significant amount on biomedical research and development (NIH 1991).

Health policies pertain to health care at all levels, including policies affecting the production, provision, and financing of health care services. Health policies affect groups or classes of individuals, such as physicians, the poor, the elderly, or children. They can also affect types of organizations, such as medical schools, health maintenance organizations (HMOs), nursing homes, producers of medical technology, or employers. In the
United States, each branch and level of government can influence health policy. For example, both the executive and legislative branches at the federal, state, and local levels can establish health policies, and the judicial branch can uphold, strike down, or modify existing laws affecting health and health care at any level.

Statutes or laws, such as the statutory language contained in the 1983 Amendments to the Social Security Act that authorized the prospective payment system (PPS) for reimbursing hospitals for Medicare beneficiaries, are also considered policies. Another example is the certificate-of-need (CON) programs through which many states seek to regulate capital expansion in their health care systems (see Chapters 5 and 12).

**Regulatory Tools**

Health policies can be used as regulatory tools (Longest 1994). They call on the government to prescribe and control the behavior of a particular target group by monitoring the group and imposing sanctions if it fails to comply. Federally funded peer review organizations, for instance, develop and enforce standards concerning appropriate care under the Medicare program (see Chapter 12). State insurance departments across the country regulate health insurance companies in an effort to protect the customers from excessive premiums, mendacious practices, and defaults on coverage in case of financial failure of an insurance company.

Some health policies are self-regulatory. For example, physicians set standards of medical practice, and schools of public health decide which courses should be part of their graduate programs in public health (Weissert and Weissert 1996).

**Allocative Tools**

Health policies can also be used as allocative tools (Longest 1994). They involve the direct provision of income, services, or goods to certain groups of individuals or institutions. Allocative tools in the health care arena are of two main types: distributive and redistributive. *Distributive policies* spread benefits throughout society. Typical distributive policies include funding of medical research through the NIH, the construction of facilities (e.g., hospitals under the Hill–Burton program during the 1950s
and 1960s), and the initiation of new institutions (e.g., HMOs). \textit{Redistributive policies}, on the other hand, take money or power from one group and give it to another. This system often creates visible beneficiaries and payers. For this reason, health policy is often most visible and politically charged when it performs redistributive functions. Redistributive policies include the Medicaid program, which takes tax revenue from the public, and spends it on the poor in the form of free health insurance.

\textbf{PRINCIPAL FEATURES OF US HEALTH POLICY}

Several features characterize US health policy, including government being a subsidiary to the private sector; fragmented, incremental, and piece-meal reform; pluralistic (interest group) politics; a decentralized role for the states; and the impact of presidential leadership. These features often act or interact to influence the development and evolution of health policies.

\textbf{Government as Subsidiary to the Private Sector}

In the United States, health care is not seen as a right of citizenship or a primary responsibility of government. Instead, the private sector plays a dominant role. Similar to many other public policy issues, Americans generally prefer market solutions over government intervention in health care financing and delivery and, for this reason, they have a strong preference for keeping the government’s role in the delivery of health care to a minimum. One result is that Americans have developed social insurance programs far more reluctantly than most industrialized democracies. In addition, public opinion regarding such programs in the US often presumes such programs to be overly generous.

Generally speaking, the role of government in US health care has grown incrementally, mainly in response to perceived problems and negative consequences. Some of the most-cited problems associated with government involvement include escalating costs, bureaucratic inflexibility and red tape, excessive regulation, irrational paperwork, arbitrary and sometimes conflicting public directives, inconsistent enforcement of rules and regulations, fraud and abuse, inadequate reimbursement schedules, arbitrary denial of claims, insensitivity to local needs, consumer and
provider dissatisfaction, and charges that such efforts tend to promote welfare dependence rather than a desire to seek employment (Longest 1994).

The most credible argument for policy intervention begins with the identification of situations in which markets fail or do not function efficiently. Health care in the United States is a big industry, but certain specific characteristics and conditions of the health care market distinguish it from other types of businesses. The market for health care services in the United States violates the conditions of a competitive market in several ways.

The complexity of health care services almost eliminates the ability of the consumer to make informed decisions without guidance from the sellers (providers). The entry of sellers into the health care market is heavily regulated. Widespread insurance coverage also affects the decisions of both buyers and sellers in these markets. These and other factors mean that the markets for health care services do not operate competitively, thus inviting policy intervention.

Government spending for health care has been largely confined to filling the gaps in the private sector. This intervention includes environmental protection, preventive services, communicable disease control, care of special groups, institutional care of the mentally and chronically ill, provision of medical care to the indigent, and support for research and training. With health coverage considered a privilege or even a luxury for those who are offered insurance through their employers, the government is left in a gap-filling role for the most vulnerable of the uninsured population.

Fragmented, Incremental, and Piecemeal Reform

The subsidiary role of the government and the attendant mixture of private and public approaches to the provision of health care also results in a complex and fragmented pattern of health care financing in which: 1) the employed are predominantly covered by voluntary insurance provided through contributions made by themselves and their employers; 2) the aged are insured through a combination of coverage financed out of Social Security tax revenues (Medicare Part A), voluntary insurance for physician and supplementary coverage (Medicare Part B), and voluntary purchase of Medigap plans; 3) the poor are covered through Medicaid via federal, state, and local revenues; and 4) special population groups, such as veterans, Native Americans, and members of the armed forces, have coverage provided directly by the federal government.
Health policies in the United States have been incremental and piecemeal. An example is the gradual reforms in the Medicaid program since its establishment in 1965. In 1984, the first steps were taken to mandate coverage of pregnant women and children in two-parent families who met income eligibility requirements, and also to mandate coverage for all children five years old or younger who met financial eligibility requirements. In 1986, states were given the option of covering pregnant women and children up to five years of age in families with incomes below 100% of federal poverty income guidelines. In 1988, that option was increased to cover families at 185% of federal poverty income. In 1988, as part of the Medicaid Catastrophic Act that remains in effect today, Congress mandated coverage for pregnant women and infants in families with incomes below 100% of federal poverty guidelines. (In 1989, it was expanded to 133% of the poverty income, and coverage of children was expanded to include the age of six years.) In 1988, Congress required that Medicaid coverage be continued for six months for families leaving the Aid to Families with Dependent Children (AFDC) program and allowed states the option of adding six months to that extension. The recently enacted State Children’s Health Insurance Program (SCHIP) allows states to use Medicaid expansion to extend insurance coverage to uninsured children who otherwise are not qualified for existing Medicaid programs.

The above examples illustrate how a program is reformed and/or expanded through successive legislative enactments over several years. In a typical American fashion, the Medicaid program has been reformed through incremental change but without ensuring access to medical care for all of the nation’s uninsured. Among the uninsured are millions of Americans who are not categorically eligible for services. These uninsured consist mostly of adults under age 65 with no dependent children. Congress has demonstrated the desire and political will to address the needs of a small number of the uninsured perceived to be the most vulnerable (e.g., pregnant women and children), but has not developed a consensus on more dramatic steps to move beyond incremental adjustments to existing programs.

The process of legislative health policy development offers another vivid case of institutional fragmentation. Thirty-one different congressional committees and subcommittees try to claim some fragment of jurisdiction over health legislation. The reform proposals that emerge from these committees face a daunting political challenge due to the process of separate consideration and passage in each chamber, negotiations in a joint conference committee to reconcile the bills passed by the two houses, then
back to each chamber for approval. In the Senate, 41 of the 100 members can thwart the whole process at any point.

Once a specific bill has passed in Congress, however, its journey is far from complete. Multiple levels of federal and state bureaucracy must interpret the legislation. Rules and regulations must be written for its implementation. During this process, political actors, interest groups, or project beneficiaries may influence the ultimate design of the program. At times, the final result can differ significantly from the initial intent of its congressional sponsors. This complex and seemingly anarchic process of policy formulation and implementation makes fundamental, comprehensive policy reform extremely difficult. Ideology and the organization of government reinforce the tendency toward a standstill. It usually takes a great political event—a landmark election, a mass popular upheaval, a war, or a domestic crisis—to temporarily shake off the normal tilt toward inaction and the status quo.

**Pluralistic and Interest Group Politics**

Perhaps the most common explanation for health policy outcomes in the United States is one based on the role of interest groups and the incremental policies that result from compromises designed to satisfy their demands. Traditionally, the membership of the policy community has included 1) the legislative committees with jurisdiction in a policy domain, 2) the executive branch agencies responsible for implementing policies in the public domain, and 3) the interest groups in the private domain. The first two categories are the suppliers of the policies demanded by the third category.

Innovative, nonincremental policies are resisted by the established groups because such measures undermine the bargaining practices designed to reduce threats to established interests. The stability of the system is ensured because most groups are satisfied with the benefits they receive; however, the result for any single group is less than optimal.

**Interest Groups**

The most effective demanders of policies are the well-organized interest groups. Interest groups' pluralism affects health policy just as it does any other policy debate in American politics. Powerful interest groups involved
in health care politics are adamant about resisting any major change (Alford 1975). Each group fights hard to protect its best interests.

By combining and concentrating the resources of their members, organized interest groups can dramatically change the ratio between the costs and benefits of participation in the political markets for policy change. Such interest groups represent a variety of individuals and entities, such as physicians in the American Medical Association, senior citizens allied with the AARP (American Association of Retired Persons), institutional providers such as hospitals belonging to the American Hospital Association, nursing homes belonging to the American Health Care Association or the American Association of Homes and Services for the Aging, and the member companies in the Pharmaceutical Research and Manufacturers of America. In recent years, physicians have often found it difficult to establish a unified voice to lobby for their interests because of the many specialty groups that exist among them.

The policy agenda of interest groups is typically reflective of their own interests. For example, the AARP advocates programs to expand financing for long-term care for the elderly. Organized labor was among the staunchest supporters of national health insurance during the 1950s and again in the 1990s. Educational institutions and accrediting bodies have their primary concerns embedded in policies that would enable them to receive higher funding to educate health professionals.

Employers

The health policy concerns of American employers are mostly shaped by the degree to which employers are involved in the provision of health insurance benefits for their employees, their dependents, and their retirees. Many small business owners adamantly oppose health policies that would mandate them to provide coverage for employees because they believe they cannot afford to do so. Health policies that affect the health of workers or the health of the labor-management relations experienced by employers also attract their attention. For example, employers have to comply with federal and state regulations regarding the health and well-being of their employees and to prevent job-related illnesses and injuries. Employers are often subject to inspection by regulatory agencies to ensure that they are adhering to health and safety policies applicable to the workplace.
Consumer Groups

The interests of consumers are not uniform, nor are the policy preferences of their interest groups. Also, consumers often do not have sufficient financial means to organize and advocate for their own best interests.

The health policy concerns of consumers and the groups that represent them reflect the rich diversity of the American people. Blacks, and, more recently, the rapidly growing numbers of Hispanic Americans face special health problems. Both groups are underserved for many health care services and are underrepresented in all of the health professions in the United States. Their health policy interests include getting their unique health problems (e.g., higher infant mortality, higher exposure to violence among adolescents, higher levels of substance abuse among adults, and earlier deaths from cardiovascular disease and various other causes) adequately addressed.

Manufacturers of Technology

The health policy concerns of pharmaceutical and medical technology organizations include discerning changes in health policy areas and exercising influence on the formulation of policies. Health policy concerns regarding medical technology (including pharmaceuticals) are driven by three main factors: 1) medical technology plays an important role in rising health costs, 2) medical technology often provides health benefits to people, although not always, and 3) the utilization of medical technology provides economic benefits aside from its potential to provide health benefits. These factors are likely to remain important determinants of the nation’s policies toward medical technology. Another factor driving the nation’s current medical technology policy is the policymakers’ desire to develop cost-saving technology and to expand access to it. The government is spending an increasing amount of money on technology assessment. The goal is to identify the relative values among alternative technologies, presumably so that the government can support the best values in technology.

Alliances

To overcome pluralistic interests and maximize policy outcome, diverse interest groups form alliances among themselves and with members
of the legislative body to protect and enhance the interests of those receiving benefits from government programs. Each member of the alliance receives benefits from current programs. The legislators are able to demonstrate to their constituencies the economic benefits from government spending in their districts, agencies are able to expand their programs, and interest groups are the direct recipients of benefits bestowed by the government programs.

**Decentralized Role of the States**

In the United States, individual states play a significant role in the development and implementation of health policies. The importance of the role of individual states can be seen in programs involving:

- financial support for the care and treatment of the poor and chronically disabled, which includes the primary responsibility for the administration of the federal/state Medicaid program and the recently enacted SCHIP
- quality assurance and oversight of health care practitioners and facilities (e.g., state licensure and regulation)
- regulation of health care costs and insurance carriers
- health personnel training (states provide the major share of the cost for the training of health care professionals)
- authorization of local government health services

States are vested with broad legal authority to regulate almost every facet of the health care system. They license and regulate health care facilities and health professionals; restrict the content, marketing, and price of health insurance (including professional liability or malpractice insurance); set and enforce environmental quality standards; and enact a variety of controls on health care costs. All states bear a large responsibility for financing health services for the poor, primarily through the Medicaid program, for which financing is shared with the federal government. In addition, most states also help subsidize some of the costs of delivering health services to those without any coverage at all, public or private. Personal health services funded or provided by states, often in cooperation with local government, range from public health nursing and communicable disease control, to family planning and prenatal care, to nutrition counseling and home health services.
Most of the incremental policy actions of recent years originated in state governments. One action, taken by 24 states, was to create a special program called an “insurance risk pool.” These programs are intended to help persons acquire private insurance who are otherwise unable to do so because of the medical risks they pose to insurance companies. Most of these programs are financed by a combination of individual premiums and taxes on insurance carriers.

Other state-initiated programs have addressed additional vulnerable populations. New Jersey developed a program to ensure access to care for all pregnant women. Florida began a program, called Healthy Kids Corporation, that linked health insurance to schools. Massachusetts, Hawaii, and Oregon have experimented with more comprehensive programs designed to provide universal access to care within their jurisdictions.

Arguments have been made against too much state control over health policy decisions. The greater control the states have, the more difficult it becomes to develop a coordinated national strategy. For example, it is difficult to plan a national disease control program if all states do not participate in the program or if they do not collect and report data in the same way. Moreover, some argue that disparities among states may lead to inequalities in access to health services. This might, in turn, lead to migration from states with poor health benefits to those with more generous programs. Finally, states may interpret federal incentives in ways that jeopardize the policy’s original intent. For example, many states took advantage of federal matching grants for Medicaid programs by including a number of formerly state-funded services under an “expanded” Medicaid program. This allowed states to gain increased federal funding while providing exactly the same level of services as before. This phenomenon, called Medicaid maximization, although pursued by only a few states, had an impact outside of those states and may have contributed nationally to rising health care costs in the early 1990s (Coughlin et al. 1999).

Impact of Presidential Leadership

Americans often look to strong presidential leadership in the search for possible sources of major change in health policies, and presidents have important opportunities to influence congressional outcomes through their efforts to develop compromises that allow bills with at least some of their preferred agendas to be passed.

President Lyndon Johnson’s role in the passage of Medicare and Medicaid is often cited as a prime example. Johnson achieved the passage
of Medicare and Medicaid in 1965 in the context of an unusually favorable level of political opportunity, and by effectively using his leadership skills.

Some important health policies have been passed since President Harry Truman's time in office. The major piece of health legislation that passed under Truman was the Hill–Burton Hospital Construction Act. Two major pieces of health legislation were passed during Nixon's presidency: 1) the actions leading to federal support of HMOs in 1973, and 2) the enactment of the National Health Planning and Resources Development Act of 1974. Under President Reagan, new Medicare cost-control approaches for hospitals and physicians were created, and additional Medicare coverage for the elderly was established. Even though President Clinton's comprehensive reform efforts failed, his incremental initiatives succeeded. Examples include the Health Insurance Portability and Accountability Act of 1996 and the SCHIP.

There are many political lessons to be learned from the failure of Clinton's health care reform initiative (Litman and Robins 1997). It should be noted that presidential leadership in achieving landmark changes in health policies can be successful only when a convergence of political opportunity, political skill, and commitment occurs. Opportunities were uniquely abundant for Johnson in 1965, and he effectively handled his legislative role. Presidents Truman, Kennedy, and Carter might have promoted their proposals with greater skill, but they were fundamentally thwarted by the lack of a true window of opportunity. Clinton enjoyed a uniquely high level of public interest in health care reform but failed in part because of other weaknesses in his level of opportunity, especially his failure to act within the first 100 days after his election. The complexity of the ever-changing details of his proposal was another major flaw and ultimately proved too much for the general public to comprehend and too easy for adversaries to distort.

Results of the 2004 presidential election will determine the direction and extent of health care reform in the coming years. A Republican repeat is likely to maintain the current status quo whereas a Democratic victory promises fundamental reforms, as reflected in the campaign speeches.

DEVELOPMENT OF LEGISLATIVE HEALTH POLICY

The making of health policy in the United States is a complex process involving both private and public sectors (including multiple levels of government).
Policy Cycle

The formation and implementation of health policy occurs in a policy cycle comprising five components: 1) issue raising, 2) policy design, 3) building of public support, 4) legislative decision making and building of policy support, and 5) legislative decision making and policy implementation. These activities are likely to be shared with Congress and interest groups in varying degrees.

Issue-raising activities are clearly essential in the policy formation cycle. The enactment of a new policy is generally preceded by a variety of actions that first create a widespread sense that a problem exists and needs to be addressed. The president may form policy concepts from a variety of sources, including campaign information; recommendations from advisers, cabinet members, and agency chiefs; personal interests; expert opinions; and public opinion polls.

The second component of policymaking activity involves the design of specific policy proposals. Presidents have substantial resources at their disposal for developing new policy proposals. They may call on segments of the executive branch of government, such as the Health Care Financing Administration and policy staffs within the US Department of Health and Human Services (DHHS).

In building public support, presidents can choose from a variety of strategies, including major addresses to the nation, and efforts to mobilize their administrations to make public appeals, and organized attempts to increase support among interest groups.

To facilitate legislative decision making and the building of policy support, presidents, key staff, and department officials interact closely with Congress. Presidents generally meet with legislative leaders several mornings each month in an effort to shape the coming legislative agenda and to identify possible problems as bills move through various committees.

Legislative Process

When a bill is introduced in the House of Representatives, it is assigned to an appropriate committee by the Speaker. The committee chair forwards the bill to the appropriate subcommittee. The subcommittee forwards proposed legislation to agencies that will be affected by the legislation, holds hearings ("markup") and receives testimony, and may add amendments. The subcommittee and committee may recommend the bill, not recommend it, or recommend that it be tabled. Diverse interest groups, individuals, experts in the field, and business, labor, and professional associations often
exert influence over the bill through campaign contributions and intense lobbying. The full House then hears the bill and may add amendments. The bill can be approved with or without amendments. The approved bill is sent to the Senate.

In the Senate, the bill is sent to an appropriate committee and next forwarded to an appropriate subcommittee. The subcommittee may send the bill to agencies that will be affected. It also holds hearings and testimonies from all interested parties (e.g., private citizens, business, labor, agencies, experts). The subcommittee votes on and forwards the proposed legislation with appropriate recommendations. Amendments may or may not be added. The full Senate hears the bill and may add amendments. If the bill and House amendments are accepted, then the bill goes to the president. If the Senate adds amendments that have not been voted on by the House, then the bill must go back to the floor of the House for a vote.

If the amendments are minor and noncontroversial, the House may vote to pass the bill. If the amendments are significant and controversial, the House may call for a conference committee to review the amendments. The conference committee consists of members from equivalent committees of the House and Senate. If the recommendations of the conference committee are not accepted, then another conference committee is called.

After the bill has passed both the House and Senate in identical form, it is then forwarded to the president for signature. If the president signs the legislation, it becomes law. If the president does not sign it, at the end of 21 days it becomes law unless the president vetoes it. If less than 21 days are left in the congressional session, then inaction on the part of the president results in a veto. This is called a “pocket veto.” The veto can be overturned by a two thirds majority of the Congress; otherwise the bill is dead.

Once legislation has been signed into law, it is forwarded to the appropriate agency for implementation. The agency publishes proposed regulations in the Federal Register and then holds hearings regarding how the law is to be implemented. A bureaucracy only loosely controlled by either the president or Congress writes (publishes, gathers comments about, and rewrites) regulations. Then the program goes on to the 50 states for enabling legislation, if appropriate. There, organized interests hire local lawyers and lobbyists, and a whole new political cycle begins. Finally, all parties may adjourn to the courts, where long rounds of litigation shape the final outcome.
CRITICAL POLICY ISSUES

Government health policies have been enacted to resolve or prevent perceived deficiencies in health care delivery. Over the last four decades, most health policy initiatives and legislative efforts have focused on access to care (e.g., expanding insurance coverage, outreach programs in rural areas), cost of care (e.g., PPS, resource-based relative-value scale), and quality of care (e.g., creating the Agency for Health Care Policy and Research, later renamed as the Agency for Health Research and Quality, and calling for clinical practice guidelines).

Access to Care

Policies on access are aimed primarily at providers and financing mechanisms, with the purpose of expanding care to the most needy and underserved populations, including the elderly, minorities, rural residents, those with low incomes, and persons with AIDS (see Chapter 11).

Providers

Several groups of providers are involved in delivering health care. Policy issues include ensuring that there is a sufficient number of providers and that their geographic distribution is desirable. The debate over the supply of physicians is an important public policy issue because policy decisions influence the number of persons entering the medical profession, and that number, in turn, has implications on other policies. The number of new entrants into the profession is influenced by programs of government assistance for individual students and by government grants given directly to educational institutions. An increasing supply of physicians may result in increased health care expenditures because of provider-induced demand. An increasing supply of physicians may also help alleviate shortages in certain regions of the country. Policy approaches to expanding access have included the National Health Service Corps, legislation supporting rural health clinics to expand geographic access, student assistance programs to expand the pool of health care workers, legislation to expand a system of emergency medical services, and establishment of community health centers in inner cities and rural areas to extend medical care services to those underserved areas.
Public Financing

Although a national health care program is seen by many people as the best means of ensuring access, the United States focuses instead on the needs of particular groups. Medicare and its companion program Medicaid (care for the poor was added to Medicare in part to compromise with a physician-drafted proposal) established the precedent that government should facilitate access to health care among those unable to secure it for themselves. Over the years, policies have been enacted to provide access to health care for specific groups otherwise unable to pay for and receive care. These groups include the elderly (Medicare), poor children (Medicaid), poor adults (Medicaid and local or state general assistance), the disabled (Medicaid and Medicare), veterans (Veterans Health Administration), Native Americans (Indian Health Service), and patients with end-stage renal disease (Social Security benefits for kidney dialysis and transplants).

Access continues to be a problem in many communities, partly because health policies enacted since 1983 have focused on narrowly defined elements of the delivery system. The fact that many Americans remain uninsured is reason to expect ongoing debate toward a public policy response concerning this issue. However, in policy debates, the need to expand access often overshadows how the expanded access will be financed.

Access and the Elderly

Two main concerns dominate the debate about Medicare policy. First, spending must be restrained to keep the program viable. Second, the program must be made truly comprehensive by adding services not currently covered or covered inadequately (e.g., comprehensive nursing home coverage).

Access and Minorities

Minorities are more likely than whites to face access problems. Hispanics, blacks, Asian Americans, and Native Americans, to name the most prevalent minorities, all experience difficulties accessing the health care delivery system. In some instances, the combination of low income and minority status creates difficulties; in others, the interaction of special cultural habits and minority status causes problems in accessing health care. Resolving the problems confronting these groups would require poli-
cies designed to encourage professional education programs sensitive to the special needs of minorities and programs to expand the delivery of services to areas populated by minorities. Many of these areas have been designated as having shortages of health care workers.

Access in Rural Areas

Delivery of health care services in rural communities has always posed the problems of how to make advanced medical care available to residents of sparsely settled areas. Financing high-tech equipment for a few people is not cost efficient, and finding physicians who want to reside in rural areas is difficult. Thus, specialists and expensive diagnostic equipment are not readily available in rural medical practices. Reimbursement systems based on average costs make it difficult for rural hospitals with few patients to survive financially.

Funding the National Health Service Corps is one step toward redressing the problem of personnel shortages in rural areas. However, the Corps affects only the percentage of graduating physicians practicing in shortage areas, and only for a limited time period for each student. Additional programs that increase the total supply of physicians and create incentives for permanent practice in rural areas are needed.

Access and Low Income

Low-income mothers and their children have problems accessing the health care system, both because they lack insurance and because they generally live in medically underserved areas. Pregnant women in low-income families are far less likely to receive prenatal care than are women in higher income categories. Limited access among children creates problems of untreated chronic health conditions that lead to both increased medical expenditures and loss of productivity in society. The SCHIP, signed into law in 1997, has given states some flexibility in how they spend the $24 billion in federal funds that has been invested in children’s health coverage in five years (States face a welcome dilemma 1997).

Access and Persons with AIDS

Persons with AIDS, those who have progressed from infection with HIV to actually having the disease and therefore needing more expensive
treatment, also have problems obtaining health care. People with AIDS experience difficulty obtaining insurance coverage, and their illness leads to catastrophic health care expenditures. Financial access can be a barrier, particularly for persons without adequate health insurance benefits. The AIDS epidemic presents a special challenge to policymakers committed to universal access to health care services. The services required are expensive, and the population in need is relatively small. Furthermore, the care is directed toward patients who are terminally ill.

Cost Containment

To a large extent, the strengths of the US health care delivery system also contribute to its weaknesses. The United States has the latest developments in medical technology and well-trained specialists, but these advances amount to the most expensive means possible to provide care to patients, making the US health care system the most costly in the world. No other aspect of health care policy has received more attention during the past 20 years than efforts to contain increases in health care costs. Two major policy initiatives enacted by the federal government have targeted first hospitals (PPS), and then physicians’ services (resource-based relative value scale) for price control.

The National Health Planning and Resources Development Act of 1974 became law in 1975. This act marked the transition from improvement of access to cost containment as the principal theme in federal health policy. Health planning, through CON review, was used as a policy tool to contain hospital costs. One major change in the health policy environment was a new system of paying hospitals for Medicare clients, the PPS, enacted in 1983 (Mueller 1988). In lieu of the tight regulation of charges established by individual hospitals, the PPS serves as a general fee schedule and establishes a prospective payment for general categories of treatment (based on diagnosis-related groups) that applies to all short-stay hospitals. PPS has proved to be the most successful tool for controlling hospital expenditures (Wennberg et al. 1984). Government programs, especially Medicare and Medicaid, federal employee benefit programs, and those of the Veterans Health Administration and armed services as well, are under constant pressure from Congress to keep costs down.

Expenditures are a function of the price of services times the quantity of services delivered (see Chapter 12). Most policies enacted, to date, have
focused on the price of services. Policymakers are reluctant to consider restricting the quantity of services, fearful of interpretations that they are sacrificing quality of care for cost containment. Such concerns are warranted because the media fuel the frenzy over denial of services by managed care organizations.

Increased debate over the right to die and the value of life-extending services provides an opportunity to discuss limiting reimbursable services. So far, the federal government has been reluctant to adopt an explicit rationing strategy to contain expenditures, but state governments can be expected to experiment with various means of cost containment.

The private sector also influences the policy focus on cost containment. Major corporations are now aggressively pursuing ways to restrain the escalation of medical costs. These large purchasers are buying medical services in volume, at wholesale prices, and even dictating the terms of service provision. Institutional buyers want to know what they are getting for their money. The answers require detailed data, close scrutiny, and, ultimately, outside judgment of whether the services are worth their value.

**Quality of Care**

Along with access and cost, quality of care is the third main concern of health care policy. The federal government began its actions to relieve the malpractice crisis and devoted greater attention to policing the quality of medical care with the Health Care Quality Act of 1986. This legislation mandated the creation of a national database within the US DHHS to provide data on legal actions against health care providers. This information allows people recruiting physicians in one state to know of actions against those physicians in other states.

In 1989, the federal government embarked on a major effort to sponsor research to establish guidelines for medical practice. In the OBRA of 1989, Congress created a new agency, the National Center for Health Services Research (now called the Agency for Healthcare Research and Quality [AHRQ]), and mandated it to conduct and support research with respect to the outcomes, effectiveness, and appropriateness of health care services and procedures (US House of Representatives 1989). The AHRQ has established funding for patient outcomes research teams (PORTs) that focus on particular medical conditions. The PORTs are part of a broader effort, the medical treatment effectiveness program, which "consists of four elements:
medical treatment effectiveness research, development of databases for such research, development of clinical guidelines, and the dissemination of research findings and clinical guidelines” (Salive et al. 1990).

Research and Policy Development

The research community can influence the making of health policy through documentation, analysis, and prescription (Longest 1994). The first role of research in policymaking is documentation; i.e., the gathering, cataloging, and correlating of facts that depict the state of the world that policymakers face. This process may help define a given public policy problem or raise its political profile.

A second way in which research informs, and thus influences, policymaking is through analysis of what does and does not work. Program evaluation and outcomes research fall under this domain. Often taking the form of demonstration projects intended to provide a factual basis in fact for determining the feasibility, efficacy, or practicality of a possible policy intervention, analysis can help define solutions to health policy problems.

The third way in which research influences policymaking is through prescription. Research that demonstrates that a particular course of action being contemplated by policymakers may (or may not) lead to undesirable or unexpected consequences can make a significant contribution to policymaking.

CONCLUSION

Health policies are developed to serve the public’s interests; however, public interests are diverse. Members of the public often hold conflicting views. Although the public consistently supports the goal of national health insurance, it also rejects the idea of the federal government running the health care delivery system. Similarly, although the public wants the government to control health care costs, it also believes that the federal government already controls too much of Americans’ daily lives. The challenge for policymakers is to find a balance between governmental provisions and control, and the private health care market to improve coverage and affordability of care. Successful health policies are more likely to be couched in terms of cost containment (a market-justice, economic, business, and mid-
dle-class concern) than in improved or expanded access and reducing or eliminating health disparities (a social-justice, liberal, labor, low-income issue). However, cost-related policies are likely to have very little impact on improving the quality of care or reducing health disparities.

REFERENCES


