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WHY IS HEALTH POLICY SO HARD TO MAKE?

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The United States has been struggling to develop a comprehensive, national health policy for almost a century. The nation stands almost alone among the industrialized countries of the world in the absence of some form universal health insurance coverage for its citizens. In contrast, it has achieved extraordinary successes in other areas of policy formulation, including monetary and related economic policies.

Why is health policy apparently so hard for us to make? How is it different from other policy objectives and how is the United States different from the other nations of the world? These are the questions I will explore – but not, I am sure, fully answer – in this issue of Health Policy Reports. In the next two issues, I will examine some of the consequences of these problems.

Is It So Hard?

The opening question must be "Is it really hard?" The pragmatic answer from history is "yes, it is hard". Presidents from Woodrow Wilson to Bill Clinton have sought to promote some form of universal health insurance. They have, clearly succeeded to varying degrees. Medicare, Medicaid, and the State Childrens' Health Insurance Plan (SCHIP) are examples of steps toward broadly based, universal coverage. But we remain with over 44 million citizens without coverage, a number than has increased every year up until the past year. And there probably has been no domestic policy issue that raised as much public awareness and concern as did the Clinton health plan.

But Why?

I suggest that the reason health policy is so hard to implement in this country is a complex interaction of several powerful forces. These include certain peculiarities of the American personality and American government combined with important features of health and health care. It is the

synergistic interaction of these two sets of characteristics that has led to a powerful sociopolitical conundrum; either one alone may make things difficult, both together may make them impossible.

THE AMERICAN SCENE

The U.S. public has, as a group, certain characteristics that seem to differ from those of other countries in ways that directly impact health policy making. As described in the introduction to the Clinton health plan, "Health care is a field in which two important American traditions are manifested: the responsibility of each individual for his or her own welfare and the obligations of the community to its members." Thus, for us, there is a powerful innate tension between two countervailing forces – individual responsibility and societal obligations. This tension plays out in most other areas of policy making and commonly is at the root of key differences between political parties and ideologies.

The impact of this conflict may be greater in health policy than in other realms, for health policy *directly* affects everyone all the time – not just the poor, not just during war. Thus, the first, most fundamental and perhaps most difficult question that policy makers must address is whether health care is a basic right of citizenship (that is, a societal obligation to be assured if not provided by the government) or is a market commodity (that is, subject to individual means and initiative).

While this debate continues at the highest levels, the results of a recent poll conducted by the Kaiser/Lehrer News Hour studies (1) shows the sentiment of the people. Eighty-four percent of respondents agreed that "health care should be provided equally to everyone, just as public education is." Only 13% agreed that "health care, like owning a home, should be available only to those who can afford it." In a 2000 poll conducted by the Center for Policy Attitudes (2), 68% of respondents agreed with the statement "The government has a responsibility to expand health insurance to more Americans", while 30% agreed with the statement "Expanding health insurance coverage is another example of the government getting involved in something that is better left to individual initiative."

A second feature of the U.S. populous is a greater distrust of government than is found in other nations. In a recent survey by the Kaiser family Foundation (3), 80% of citizens indicated that the value of what they get for their taxes is only fair or poor; 18% reported good or excellent value. Almost six out of 10 Americans reported that the federal government does what is right only some of the time and one of 10 said that it never what is right. Thus, while we as a population place responsibility for providing health coverage on the government as a right, we do not trust the government to "do it right".

This distrust and the emphasis on personal autonomy leads to what has been described as "the extraordinary reluctance of Americans to yield control of the healthcare system to the government. In part this represents a unique part of the American psyche"(4). Or as stated by Monroe (5), "At the heart of American politics lies a dread and a yearning. The dread is notorious. Americans fear public power as a threat to liberty….The yearning is an alternative faith in direct, communal democracy." It was the accusations by, among others, the insurance industry that the Clinton plan would put "government" in charge of health care that has been credited with a large part of the failure of the plan.

A third distinguishing feature is the difference in expectations that Americans and other nationals have for their health care systems These differences between the citizens of the U.S. and of other nations is perhaps best shown in surveys assessing the satisfaction of citizens of various countries with their own healthcare system (6). For example, Canadians and the British

report greater satisfaction with their healthcare systems than do those in the United States, despite the fact that it is the features of the Canadian and the British systems – greater government control, restricted choice of providers and access to specialists, queues for nonemergency procedures, etc – that Americans reject. Thus, we require a unique solution to meet our expectations and our conflicting view of government.

Another important factor not limited to the United States is the position of the federal government as the largest employer in the land. It has the responsibility, like other employers, to fund much of the health insurance costs of its employees. Thus, when the government makes policies it is affecting its own functions as well as those of the nation as a whole. This may lead to difficult conflicts of interest; what may be good for the people as a whole may have serious fiscal consequences to the government.

THE HEALTH CARE SCENE

Features of health and health care add to this political enigma. A first group of problems relate to the definition of health policy. If we use the common definition of health policy as the set of public policies that influence the health of the public, then what are its bounds? Five of the most common violent crimes add over $10 billion to the national health care costs. Are, then, criminal justice policies part of health policy? Are gun control, drug enforcement and environmental policies all part of health policy because they impact health and because the issues they address raise the costs of health care? Low educational and general socioeconomic levels correlate with poor health status; are educational and general economic policies subsets of health policy? Are foreign policy and immigration policy a part?

If so, then the problem of constructing a fence around what we are considering becomes difficult at best. And as a result, ownership of the problem becomes diffuse or “shared”. Multiple constituencies become core stakeholders, with no clearly identifiable owner of the problem. Each group can claim a piece of the health care pie in an effort to improve the health of the public. This is reflected in the number of Congressional committees and subcommittees that have “jurisdiction” over a health-related bill (4). As summarized by Bryson and Crosby (7), “No one organization is in charge and yet many organizations are affected or have partial responsibility. In such situations, just gaining rough agreement on what the problems are is part of the battle. Then … organizations involved must also engage in political, issue-oriented, and therefore, messy planning and decision making.”

This shared ownership at the policy making level is compounded by the impact that health policies have on everyone. They affect not only health but also taxes, jobs and costs of goods. Thus, almost any group can become a stakeholder and a demander of policy changes because of the direct or indirect impacts of health policy. In one hand are direct costs; a cut in health care spending is, by necessity, a cut in someone’s income. In the other are the opportunity costs related to health care, that is, what other health-related good or other public priority (e.g., education) could we have accomplished with the money we spent on health care? As reflected on by one observer (8), “How many others, I thought to myself, could receive food and education with the resources spent on prolonging one hopeless life by days or years? How many lifeguards or crossing guards could be hired to reduce the odds of similar tragedies?”

A second set of health-related stumbling blocks to effective health policy reflects the number of possible solutions available for any given health problem. For example, do we reduce the death rate from cancer by supporting (a) development of new drug treatment regimens, (b) public screening for early detection, (c) environmental regulation to reduce carcinogen release into the air and water, or (d) commerce regulation limited the distribution of cigarettes? Thus – to use a

mathematical term – health care is an indeterminate problem. And as described above, each option has its own support groups and opposition groups fighting with each other and with groups representing other stakeholders.

And even if we identify a specific issue and the jurisdictional lines around it can be drawn, what type of policies do we want to address it? The options are many. In general, governments can either allocate resources or regulate activities. Allocations may be direct (for example, direct funding of initiatives) or indirect (for example, affecting reimbursement for services). Regulatory approaches include policies that require certain services, preserve or expand markets, etc. The federal approach to reducing cancer deaths in the 1960s was a dramatic increase in funding to the National Cancer Institute, among other agencies and organizations. More recent federal and state regulatory approaches to cancer reduction have included mandating benefits for screening, environmental pollution regulation, restrictions on tobacco sales and, most recently, state and federal lawsuits against the tobacco industry. Other policies – *macro policies* such as those that are designed to balance the federal budget – are designed to have broad impact on all governmental operations, with health policies among the many that are impacted.

A final but critical health-related factor is the difficulty in assessing the effectiveness of any health policy initiative – and hence in justifying more of the same. What do we expect a policy to accomplish and how (and how often) do we measure its success? The relation between inputs to the health care system (for example, dollars) and outputs from it (for example, greater longevity and reduced morbidity) is complex. The plot of output vs. input becomes flatter as input levels rise until minimal gain results from additional investment, that is, putting more and more in leads to less and less out. Policies tend to focus on and measure changes in, to use the model of Donabedian (9), health system structure (e.g., the number of hospital beds or the number of physician specialists) or processes (e.g., the number of hospitalizations, laboratory tests, or prescriptions) rather than on outcomes, i.e., the changes in health status. While structural and process variables are important intermediary outcomes, they are not necessarily causally related to changes in health status (10). Focusing on them may lead to different conclusions as to the efficacy of a policy or program than when actual changes in health are measured. Indeed, policy changes that beneficially impact one set of intermediate goals may be deleterious to the final goal of health status. For example, policies that restrict the number of prescription medications covered by, for example, Medicaid, may reduce drug costs but lead to greater morbidity and hospitalizations – and raise overall health care costs (11).

HEALTH POLICY AND POLITICS

The net result is a complex interaction of conceptual and political hurdles that must all be jumped successfully if effective health policy is to be made. We have to define what we mean by health and health care, determine how we want to approach it, who the stakeholders and constituents are, what policy approach we want to take and how we can assess the results. These intricacies related to health are made much more difficult to manage because of the special aspects of the American political system discussed at the beginning of this column.

A solution based upon the health issues alone must fit within the ambiguous aspirations toward any government involvement and the personal desires of the public. This conflict over the role of government, etc., is, in turn, fueled by the uncertainties of health care. The lack of a clear definition of health, the multiple approaches to any single health care solution and the absence of definitive information defining the effectiveness of programs all provide practical reasons not to proceed while avoiding the more complex underlying issues of, for example, defining the responsibility of society for health care.

We have covered just a few of the impediments that exist in the real world of heath policy making. Others include the important roles of the media in setting agendas; the role of the courts in setting policy; the political aspirations of legislators and the roles of specific interest groups; the complex processes of governmental decision making; and others. As a former Congressman expressed, “the reason that Congress has a hard time solving problems is that the problems it gets to solve are hard.”

REFERENCES

1. Kaiser Family Foundation: News Hour/Kaiser Survey Underscores Difficulties Faced by those Without Health Insurance. http://www.kff.org.
2. Center on Policy Attitudes. American Health Care Policy, August 30, 2000. http://www.policyattitudes.org/OnLineReports Healthcare/introduction.html accessed December 28, 2000.
3. Kaiser Family Foundation/National Public Radio/Harvard University Poll: Americans Distrust Government, But Want It To Do More. http://www.kff.org. Accessed December 29, 2000.
4. Longest BB: “Health Policy Making in the United States.” Chicago: Health Administration Press, 1998.
5. Monroe JA: “The Democratic Wish: Popular Participation and the Limits of American Government.” New York: Basic Books, 1990.
6. Blendon RJ, Leitman R, Morrison I, Donelan K: Satisfaction with health systems in ten nations. Health Aff 1990; 9(2):185-192
7. Bryson JM, Crosby BC: “Leadership for the Common Good.” San Francisco: Josey Bass, 1992.
8. Epstein RA: “Mortal Peril” New York: Addison Wesley, 1997.
9. Donabedian A: The quality of care: how can it be assessed? Arch Pathol Lab Med 1997; 121:1145-1150.
10. Goldratt, EM: The Goal. Great Barrington, MA: North Riven Press, 1992.
11. Soumerai S, Ross-Degnan D, McLaughlin TJ, Choodnoviskiy I: Effects of Medicaid drug-payment limits on admission to hospitals and nursing homes. N Engl J Med 1991; 325:1072-1077.