

## **CHAPTER 2**

# Public Policy, Public Health, and Health Policy

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## **Introduction**

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The world of public policy is fascinating, complex, and essential for all those interested in any facet of health policy. To work effectively within health policy arenas, policy stakeholders, including individuals and organizations, must understand certain tenets and structures of public policy. Effectively analyzing and changing health policies also requires knowledge of certain key public health principles and issues.

This chapter (a) provides an overview of the policy process, including a brief summary of two policy frameworks, (b) discusses major issues in public health and health policy, and (c) offers suggestions for getting involved in health policy.

## **Overview of the Policy Process**

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Policy competency requires knowledge of certain core principles. This section will define policy and explain core public policy structures, discuss the policy process, and summarize two major policy models. Discussion will focus on the national level of government, with reference to states and localities as needed.

## **Defining Policy and Policy Structures**

Definitions of public policy abound. One policy scholar defined it as “authoritative decisions made in the legislative, executive, or judicial branches of government that are intended to direct or influence the actions, behav-

iors, or decisions of others” (Longest, 2006, p. 7). Health policy comprises the subset of these decisions dealing with health.

Although this definition of health policy focuses on government policies, many health policies are created in the private sector (although these too may be influenced by government policy). For example, a grocery store might choose to display low-fat milk more prominently than whole or chocolate milk; a convenience store might decide to add a large fresh produce section; or a health insurance plan might offer incentives for enrollees to participate in physical activities. All of these represent nongovernmental policy decisions to promote health and healthy lifestyles.

Furthermore, each level of government—local, state, and federal—develops health policies. The outcomes (laws, regulations, or court decisions) are often the result of collaboration, negotiation, and bargaining among individuals at different levels of government. For example, each state makes policy decisions for its Medicaid program, but significant changes require approval of the federal government. As another example, the Centers for Disease Control and Prevention (CDC) works collaboratively through funding grants with state and local governments to address public health issues. Although CDC sets program guidelines, each grant recipient implements programs and policy that make sense in the local environment. Thus, organizations in the private sector and all levels of government are involved with health policies. Moreover, health policies must be examined within the context of socioeconomic conditions, political environments, and different ideologic and philosophical perspectives.

Politics are an important component of any policy analysis. Harold Lasswell’s classic definition of politics has endured for nearly a century. According to Lasswell, politics is “the process by which society determines who gets what, when they get it, and how they get it” (Lasswell, 1958, as cited in Birkland, 2011, p. 42). Building on Lasswell’s definition, it is important for those engaged in health policy to be mindful of the politics of issues in order to understand power dynamics and bargaining outcomes, regardless of the setting or clinical focus.

## Stages of the Policy Process

Typically, when we discuss the policy process, we envision it as a linear sequence of stages. But as most people who work in national health and other policy domains know, it is actually a cyclical process (Longest, 2006) with modification and feedback loops throughout. The classic stages of the policy process are agenda setting, policy formation, policy implementation, and policy evaluation. Sometimes, agenda setting is considered part of policy formation, and implementation and evaluation often are linked together. Consider how key players in each stage described in the following text also influence other stages of the process through informal or for-

mal mechanisms, thereby demonstrating the cyclical nature of the policy process.

**Agenda setting:** Problems and issues can rise to the attention of policy makers in a number of ways. The news media may report on a new problem, or a constituent may raise a novel concern. Alternatively, emerging scientific research or successful local or pilot programs may suggest potential solutions to long-standing problems.

Important to note is that a clinical problem does not usually translate to a policy problem for lawmakers. Therefore, knowing how to define a problem or frame policy for policy audiences is the first key step to the policy process.

If an issue is particularly compelling, or if it resonates with a legislator's personal priorities, legislators and their staff may take the initiative to introduce legislation. Other times, interested stakeholders, often led by professional or special interest associations, provide the driving force to craft legislation. In these cases, the individuals or groups seeking to spur the creation of a new bill must first do their homework to learn as much as possible about both the issues and the legislators. The most compelling arguments often comprise scientific evidence, demographic data, and personal stories or anecdotes. Communication should focus on only one problem or issue at a time to prevent distracting lawmakers and constituents from the priority at hand.

Given the bargaining nature of politics, it is always best to have a backup or contingency solution in case one's first choice is not politically feasible. It is wise to indicate whether there is support for a given proposal among other interest groups, the lawmaker's constituents, and other legislators and executive branch officials. And, it is also wise to acknowledge what one's opponents or critics of the solution might say and to suggest possible responses.

**Policy formation:** Once a legislator (or group of legislators) has decided to introduce a bill, the next goal is to gain adequate support from other lawmakers to pass the bill and from the president to sign it. Savvy advocates know how to work with the media by providing compelling facts and narratives. Individual constituents can communicate with their elected officials to describe anticipated effects of the proposed legislation and to express support for or opposition to the bill; special interest groups will do likewise.

Constituents have more leverage than advocates who are not from that lawmaker's district. One can advocate for a position to legislators by telephone calls or emails, as face-to-face interactions with lawmakers or their staff may be most effective but may not be feasible. Working with the legislator's district offices, one can attempt to either schedule a time to meet when the legislator is in the home office or arrange an appointment in Washington, DC, with staff, and the legislator if she or he is available. Advocates should focus on talking with the staff, who generally carry tremendous influence with lawmakers. A very important rule of thumb is to establish ongoing communications with staff and legislators. It is not sufficient to com-

ment only once when advocating for legislative action. Rather, one should be a regular source of knowledge and expertise.

**Policy implementation:** After members of Congress pass a bill and the president signs it into law, it goes to the relevant executive branch agency for implementation through rule making. However, less than 10% of all proposed bills become law. The 113th Congress (2013–2014) has been one of the least productive in terms of number of bills enacted (125 as of September 10, 2014). But assessing congressional productivity is difficult because of the many different measures that one can use, such as number of pages or words per law or the ratio of introduced to enacted bills (Tauberer, 2014). Rules are established to guide implementation of the law at state or local levels, or in delivery systems where Medicare, Medicaid, and other federal beneficiaries, such as veterans, receive care. Rule making usually provides details or specifics of a law that the lawmakers, perhaps intentionally, omitted in the policy formation stage. It can be difficult for executive and legislative branch officials, interest group representatives, and others to agree on the intent of the law. That is one reason why rule making can be so politically challenging, yet important.

Usually, healthcare bills are referred to an agency in the Department of Health and Human Services (DHHS), but some go to other agencies, such as the Department of Veterans Affairs, Department of Defense, or Department of Agriculture.

The rulemaking process differs significantly from the legislative process. First, it occurs within the executive branch, often with legislative oversight. Second, it tends to be a more closed process than lawmaking because access to the executive branch is not as easy as to the legislative branch, where elected officials are eager to work with members of their district and organizations with expertise in a designated area.

Nevertheless, an important—and often overlooked—means of influencing health policy is to comment on proposed rules. This pertains to both those who supported the enacted law and those who opposed the legislation. Most often, there are sections of the law that legislators, organizations, or individuals oppose. Comments to the executive branch regarding proposed rules usually address specific sections of the law in an attempt to mitigate what interested parties consider the law's adverse effects or to revise a proposed rule.

It is important to watch for proposed rules relevant to one's area of interest. One way to do this is by being a member of or supporting a professional organization or other group that is following the rulemaking process. Its government affairs staff will likely send members notices that explain rules, the organization's position, and how to respond or communicate with executive branch officials.

**Policy evaluation:** Once a policy is implemented at the federal, state, or local level (or a combination of them), executive branch officials often seek

evaluation information to determine the policy's effectiveness and the extent to which it has reached the intended populations. Executive branch officials may also want to know about any unintended outcomes, such as undue enrollment burdens on target populations, and whether federal funds were used efficiently. Did bureaucratic obstacles make implementation an unwieldy and unnecessarily difficult process?

Interagency coordination is also an area for evaluation. How well did federal and state administrators from different agencies responsible for implementation work together? What systems might be needed to enhance such coordination for the good of improving population outcomes? With this type of evidence, lawmakers, interest group representatives, and individual citizens can advocate for changes in laws or rules or the introduction of new bills, thereby demonstrating the cyclical nature of the policy process.

## Policy Frameworks

Policy frameworks are useful for enhancing understanding of and planning how to attain policy change. The summaries of the two frameworks described here, multiple streams and punctuated equilibrium, are not meant to be complete descriptions. Readers are referred to the original works (Baumgartner & Jones, 2009; Kingdon, 2010; Sabatier, 2007) for more detailed explanations.

### *Kingdon's Framework*

John W. Kingdon (2010) developed one of the most well-known policy frameworks, focusing on agenda setting, or how issues catch the attention of lawmakers. His model is based on decades of research on federal agenda setting for several issues, including health care. Kingdon posited that three "streams" are needed for issues to land on the national agenda. According to Kingdon, each stream is independent of the others. The three streams pertain to a different aspect of agenda setting: problems, policies, and politics. At critical and often unpredictable junctures, a "window of opportunity" opens when two or more streams overlap. This open window, which is short-lived, enables lawmakers to push an issue onto the legislative agenda.

**Problem stream:** Kingdon distinguished between *conditions*, which people may know about and discuss, and *problems*, which catch the attention of lawmakers and then prompt them to act. The successful transformation of a condition to a policy problem is a main characteristic and process of the problem stream.

Kingdon also specified that interest groups are mainly responsible for pushing an issue onto the national agenda. They do this by forming coalitions with each other and with legislators who might be interested in introducing a bill, developing succinct ways of conveying evidence to legislators, and bringing to congressional hearings and meetings with legislators indi-

viduals who can tell compelling stories that might convince legislators to support a bill. Interest groups also can develop model legislation for congressional staff to use in drafting an official bill.

**Policy stream:** The policy stream consists of a mix of ideas that are “generated by specialists in policy communities (networks that include bureaucrats, congressional staff members, academics, and researchers in think tanks)” (Zahariadas, 2007, p. 72). Although many ideas float within the policy stream, only a few will endure. Those that are technically and politically feasible have the most likelihood of success.

Individuals and organizations in the policy stream are continually developing ideas and policy solutions for different conditions or problems. That way, when a problem lands on the government agenda, members of the policy stream are ready to offer a policy solution.

**Politics stream:** The politics stream has three major components: national mood, interest group campaigns, and legislative or executive branch turnover. Changes in national mood, usually detected by public opinion polls, can create changes in the problem stream. An example is the ideologic shifts of the 1980s when the national mood became increasingly conservative. This meant that policy solutions that were left of center were unlikely to be feasible. National mood changes also can be the result of sudden or dramatic shifts in the economy or economic indicators, such as increases in inflation or unemployment rates, which can lower people’s trust in government and national policies.

Major public campaigns on behalf of interest groups or coalitions can generate changes in the political stream. An example is Mothers Against Drunk Driving (known as MADD), whose members drew attention to the dangers of driving while under the influence of alcohol and set into action a new type of awareness among the public at large and especially among teens.

Last, changes in the party in control of the White House or Congress, swings in ideology, and turnover in the presidency or an influx of a new cohort in Congress can prompt changes in the politics stream. These partisan or political shifts can be sudden or occur gradually over years. Nonetheless, they can contribute to action on the national government agenda.

**Policy entrepreneurs:** For a problem to land on the government agenda, two or more streams need to couple, and a policy entrepreneur, or broker, needs to make use of a window of opportunity to push the problem through to the agenda. Policy entrepreneurs have keen policy and political bargaining skills, persevering until their issue lands on the agenda.

It often takes more than one attempt for an issue to land on the government agenda. In the process, actors in each stream—problem, policy, and politics—can strategize how to work the coupling of the streams to their advantage. For example, actors in the policy stream might interact in the political stream by campaigning for the election of a president or legislator who supports their policy goals.

A major limitation of Kingdon's framework is the assumption that the streams are independent. To the contrary, the policy and political actors often interact with each other in more than one stream. Moreover, sometimes Kingdon's model blurs the line between agenda setting and policy formation. Nonetheless, it is a well-known and useful model for health policy analysts and activists—including clinicians, researchers, and academicians—seeking to get their proposed problem solutions on the government agenda.

### ***Punctuated-Equilibrium Framework***

Another useful public policy model is the punctuated-equilibrium theory, which Bryan Jones and Frank Baumgartner developed (Baumgartner & Jones, 2009). This theory offers a way of understanding how and why policy change occurs. It claims that political processes are characterized by periods of rapid change followed by periods of “stability and incrementalism” (True, Jones, & Baumgartner, 2007, p. 155).

Baumgartner and Jones were interested in what caused these waves of policy change and the subsequent periods of relative stasis, characterized by issues and actors settling into a state of equilibrium. They claimed that periods of equilibrium are also reinforced by American political institutions, such as Congress, that “were conservatively designed to resist many efforts at change and thus to make mobilizations necessary if established interests are to be overcome” (True et al., 2007, p. 157).

Interest groups are important in the punctuated-equilibrium framework. They are necessary for mobilization of individual actors and organizations, changes in issue definition, agenda setting, and subsequent policy change. In analyzing the rise and fall of issues on the agenda, Baumgartner and Jones (2009) identified positive and negative feedback effects. Policy feedback effects occur when several events coalesce to enhance the visibility and rise of an issue on a government agenda; they resemble Kingdon's policy windows. Negative feedback effects function as brakes on rapid policy change.

The value of the punctuated-equilibrium theory for those interested in health policy is that it offers ways of conceptualizing policy structures, players, and events. It also provides ways of strategizing how to prompt policy change. Specifically, if a policy issue is in a lull or state of relative equilibrium, then one might plan how to work with interest groups and members of Congress to revise a problem definition, widen an issue network, and accelerate policy change.

## **Major Issues in Public Health and Health Policy**

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Health policy is complex and dynamic—constantly changing. Clinicians and policy makers can analyze health policy through many different and

overlapping perspectives. For example, those engaged in policies for children and youth aim to ensure that all children get screening for chronic or acute conditions that can impair their development. Those working with older adults know that events and patterns of childhood affect adult lifestyles and health. From another perspective, studying access to care necessarily involves understanding the financing of care. Similarly, quality of care entails understanding patient safety, health literacy, relationships between patients and clinicians, and more recently, electronic health records.

Policy stakeholders bring different perspectives to health policy. The politics of health policy making reflect the interactions, alliances, and negotiations among individuals and groups in a particular health policy arena. Understanding the politics of a particular health policy can enhance one's appreciation of why certain policy outcomes (e.g., laws, regulations, and court decisions) prevail over others.

Different ways of categorizing health policy abound, and none is better than another. The following section will discuss public health, access, financing, and quality. We chose these topics because they span most areas of health policy and encompass diverse populations, delivery settings, and clinical specialty areas.

## Public Health

Public health encompasses many aspects of public and health policy, not just issues assigned to public health agencies. The Institute of Medicine (IOM) defined the mission of public health as “fulfilling society’s interest in assuring conditions in which people can be healthy” (IOM Committee for the Study of the Future of Public Health, 1988, p. 7). The work required to carry out this mission is broad and includes forming and implementing policies aimed at preventing infection and illness, ensuring access to safe food and water, developing healthcare delivery infrastructures, improving healthcare systems, and preparing for threats to health (Turnock, 2012).

In 1999, CDC released a list of the 10 greatest achievements of public health in the 20th century. Among them were vaccination and control of infectious diseases, motor vehicle and workplace safety, and recognition of tobacco as a health hazard. As a result of these and other initiatives, public health has been credited with 25 of the 30-year increase in Americans’ life expectancy during the 20th century (CDC, 1999).

A major impetus for many public health policies is the Healthy People plan. In 1979, Surgeon General Julius B. Richmond released *Healthy People: The Surgeon General’s Report on Health Promotion and Disease Prevention*, which identified specific population health goals that the nation was to achieve by the end of the next decade. In 1980, U.S. DHHS (2014) operationalized this under *Healthy People 1990: Promoting Health/Preventing Disease: Objectives for the Nation*. Each decade since then, DHHS has revised *Healthy People* in response



to changes in society's health needs and priorities and progress in attaining previous Healthy People goals. In 2010, DHHS released the most current version, *Healthy People 2020: Objectives for Improving Health*. Many states and localities develop similar plans specific to their jurisdiction.

One of the most important indicators of population health is infant mortality. It is “associated with a variety of factors such as maternal health, quality and access to medical care, socioeconomic conditions, and public health practices” (MacDorman & Mathews, 2008, p. 1). In 1900, the United States had an infant mortality rate of 100 per 1,000 live births, meaning that 10% of infants died before their first birthday. By 2000, the rate had improved and dropped to 7 deaths for every 1,000 live births. Yet, closer analysis reveals disparities among infant mortality rates for different populations. The largest infant mortality disparities were between non-Hispanic Black populations and other groups. Non-Hispanic Black infants are two to three times more likely to die by one year of age than White infants. Maternal child health specialists and practitioners have a dual goal: to reduce the national infant mortality rate and eliminate the disparities so that babies of all racial and ethnic groups have the opportunity to thrive (Health Resources and Services Administration [HRSA], 2012).

In the aftermath of the terrorist attacks of September 11, 2001, and the subsequent anthrax threats, “bioterrorism preparedness and emergency response [rose] to the top of the national agenda” (Turnock, 2012, p. 424). Since 2001, enhanced federal funding has strengthened the infrastructure for public health preparedness for any health crisis, whether a disease outbreak, natural disaster, or act of terrorism. Under this all-hazards strategy, public health officials assess risk and plan to prevent or mitigate disaster.

## Access to Coverage and Care

Access to care is a complex issue with no single definition (Medicare Payment Advisory Commission, 2003). IOM has defined access to care as “the timely use of personal health services to achieve the best possible health outcomes” (Millman, 1993, p. 4). Access to care includes both availability of services and their actual use. Although coverage is an important component of access, the two are not the same. One can have coverage but lack access to appropriate care due to rurality, lack of culturally congruent care, or other structural barriers. Similarly, one can lack coverage and still access care through safety net providers.

Some covered individuals report that they delay or forgo care because of cost concerns (Kaiser Commission on Medicaid and the Uninsured, 2012). Also, providers may opt not to work with specific payers (Borchgrevink, Snyder, & Gehshan, 2008). Provider shortages can also create access problems. By increasing the number of people who may have access to health insurance, the Patient Protection and Affordable Care Act (ACA) in 2010 in-

creased the need for primary care clinicians. In response, many states have increased the funding for physician, nurse practitioner, and physician assistant training, but lack of available providers in rural and certain inner-city areas are likely to represent ongoing access policy challenges.

The United States has historically had a combination of private and public coverage policies. In 2011 (prior to implementation of the ACA), almost 50% of Americans had employer-provided insurance coverage, and an additional 5% purchased health insurance through the individual market (Kaiser Family Foundation, n.d.). Virtually all of the older adults in America have coverage through Medicare (Kaiser Commission on Medicaid and the Uninsured, 2012). Most Medicare beneficiaries also have privately purchased supplemental coverage (Medicare Payment Advisory Commission, 2013).

In 2011, 16% of Americans had Medicaid coverage (Kaiser Family Foundation, n.d.). Under the Medicaid programs, states are required to cover specific categories of people (pregnant women, infants and children, seniors, and individuals with disabilities) who meet certain income guidelines (Centers for Medicare and Medicaid Services [CMS], n.d.-c). States have the option to expand eligibility to people not meeting traditional coverage requirements. Such expansions are subject to federal review and approval. Additionally, the Children's Health Insurance Program (CHIP) provides coverage to children whose families cannot afford insurance, even though their annual incomes exceed Medicaid eligibility cutoff levels (CMS, n.d.-a).

In 2011, approximately 16% of Americans (30 million people) lacked coverage (Kaiser Family Foundation, n.d.). The primary goal of the ACA, and one metric by which its success will be measured, is to reduce the number of uninsured individuals. In addition to the planned expansion of Medicaid, as of January 2014, government subsidies based on income are available to help eligible individuals purchase their own health insurance through state, federal, or state or federal exchanges (Kaiser Family Foundation, 2013).

The ACA extended Medicaid coverage to all individuals with incomes up to 138% of the federal poverty level (Kaiser Family Foundation, 2014b). In July 2012, the Supreme Court ruled that the federal government could not require states to change the eligibility for their Medicaid program, giving states the option not to participate in the Medicaid expansions under the ACA (see Figure 2-1). As of August 2014, 28 states, including the District of Columbia, had implemented Medicaid expansions, 2 states were still holding debates, and 21 states had decided not to expand at this time (Kaiser Family Foundation, 2014a).

The safety net for the uninsured varies by location. Scattered throughout every state are federally qualified health centers (FQHCs), which receive federal grants from public health funds and "qualify for enhanced reimbursement from Medicare and Medicaid, as well as other benefits" (HRSA,

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### Figure 2-1. Federalism

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The Tenth Amendment in the U.S. Bill of Rights provides that “the powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people” (U.S. Const. amend. X). This is the clearest legal formulation of federalism, “a system of government in which sovereignty is constitutionally divided between a central governing authority and constituent political units (e.g., states), and in which the power to govern is shared between the national and state governments” (Teitelbaum & Wilensky, 2013, p. 267).

Over the years, the Supreme Court has defined the separation of powers described as “federalism” with varying degrees of strictness. As a result of looser definitions, the boundaries may become blurred, and some government programs better fit the description of “cooperative federalism . . . in which state agencies take primary responsibility for the enforcement of federal laws” (Krotoszynski, 2012, p. 1602).

The Roberts Court has returned to a stricter definition of federalism (Krotoszynski, 2012), and one example of this is the decision regarding the ACA. The sections of the ACA dealing with Medicaid provided that if states did not expand their Medicaid programs as prescribed by the act, they would lose not only the new federal dollars, but all federal funding for their existing Medicaid programs. The majority decision of the Supreme Court described this approach as “a gun to the head” of the states (*National Federation of Independent Business v. Sebelius*, 2012, p. 51). The Court ruled that it was unconstitutional for the ACA to require state participation in the expansion:

As for the Medicaid expansion, that portion of the Affordable Care Act violates the Constitution by threatening existing Medicaid funding. Congress has no authority to order the States to regulate according to its instructions. Congress may offer the States grants and require the States to comply with accompanying conditions, but the States must have a genuine choice whether to accept the offer. (*National Federation of Independent Business v. Sebelius*, 2012, p. 58)

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ACA—Patient Protection and Affordable Care Act

n.d.-b). In exchange, among other requirements, “FQHCs must serve an underserved area or population, offer a sliding fee scale, [and] provide comprehensive services” (HRSA, n.d.-b).

The Emergency Medical Treatment and Labor Act of 1986 provides “public access to emergency services regardless of ability to pay” (CMS, 2012a). Hospitals that participate in Medicare are required to provide examination upon request and treatment and stabilization of any emergency medical condition, including active labor (CMS, 2012a).

Historically, states have been the primary insurance regulators. This has meant that insurance regulation could vary from one state to another. One area of wide state variation has been mandated coverage of specific services, meaning that a specific condition or treatment that is required to be covered by insurance in one state may not be covered in another. Although the precise effects of the ACA are not yet known, it is likely to reduce variation in mandated coverage across state lines because the ACA, itself, mandates

uniform coverage of “essential benefits” (National Conference of State Legislatures, 2014).

## Financing of Care

In 1970, the average healthcare spending per person was \$356 per year, and healthcare spending represented 7.2% of the total economy. Over the next 40 years, healthcare spending steadily grew faster than the economy. By 2010, yearly spending averaged \$8,402 per person, and healthcare spending represented 17.9% of the total economy (Kaiser Family Foundation, 2012). In addition to improving coverage, many health policy analysts and public policy makers see controlling healthcare costs as a high priority (see Figure 2-2).

Controlling the cost of care for their clients is an especially high-priority focus for both public and private healthcare payers. Many models exist by which payers attempt to accomplish this goal; each strategy can have far-reaching and unintended effects. For example, a payer can set a lower reimbursement for a given service. The risk of this approach is that providers may determine that the fee is too low, and opt not to serve that population. Alternatively, a payer can attempt to reduce utilization, either by improving members’ health or by sharing costs with members, which can lead to members forgoing needed care. Or, a payer may partner with providers to increase the quality and efficiency of care and then share the savings with the providers.

Given that more than half of Americans have some form of private insurance coverage, private insurance companies and employers who purchase insurance for their employees are powerful health policy decision makers. Working together, these groups have been able to test innovative ways to achieve

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### Figure 2-2. Choosing Wisely

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There is broad consensus that projected healthcare costs will consume too much of the national income and that healthcare dollars are often spent on unnecessary care. Nevertheless, many Americans are uncomfortable with the idea of government involvement in “appropriate care” discussions, fearing that intervention could lead to rationing. They often express this unease by asserting that such discussions should take place only between clinicians and patients.

Traditionally, clinicians have not considered the larger context of healthcare delivery and policy. In 2009, physician Howard Brody challenged his colleagues to identify commonly ordered tests and treatments that are both expensive and lack evidence to support them. He asked each medical specialty society to develop a “top five” list for their specialty and to work with providers to reduce the use of these procedures (Brody, 2009). Now called the Choosing Wisely initiative and led by the American Board of Internal Medicine Foundation, more than 30 medical specialty organizations have taken on this challenge (American Board of Internal Medicine Foundation, n.d.).

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lower healthcare costs for their members. Many employers have implemented employee wellness plans, partly in an effort to reduce their healthcare costs and keep their employees healthy, thereby reducing absenteeism and enhancing worker productivity. Some insurance plans offer financial or other incentives to members who engage in health-promoting activities, such as healthful eating, physical activity, or health screenings. Some plans and employers offer consumer-driven plans, in which high deductibles coupled with health savings accounts are designed to decrease utilization by making patients aware of cost and engaging them in decisions about their care.

Because government expenditures (primarily through Medicare and Medicaid) represent approximately half (American Hospital Association, 2013) of all healthcare expenditures in the United States, payment systems and structures represent a significant means by which federal and state governments direct health policy.

Medicare is the largest single payer for hospital care, paying a larger proportion of hospital costs than all private insurance combined (American Hospital Association, 2013). Because of this, Medicare policies have long wielded great influence in hospital care and beyond. Medicare payment policies can affect how health care is delivered to all patients, partly because private payers often follow Medicare's lead and partly because hospital systems and processes developed for Medicare patients may affect all patients. A notable example of the latter occurred with Medicare's transition in the 1980s from paying billed charges, or fee-for-service, to using a prospective payment system using diagnosis-related groups, or DRGs. This new system, which paid hospitals based on patient diagnoses rather than services rendered, removed some incentives for providing unnecessary treatments and tests and created new incentives to reduce the length of hospital stay. This massive change caused hospitals to reconfigure how they provided care to all patients (Kahn et al., 1990).

## Quality of Care

The recent emphasis on improving healthcare quality began with the release in 1999 of IOM's seminal report *To Err Is Human* (Kohn, Corrigan, & Donaldson, 2000), which estimated that as many as 98,000 Americans died in hospitals each year as a result of medical error. This publication, together with IOM's report *Crossing the Quality Chasm* (IOM Committee on Quality of Health Care in America, 2001), profoundly affected the world of health policy by highlighting the vital importance of quality (Gardner, Wakefield, & Gardner, 2007).

Improving healthcare quality depends on close collaboration between government and the private sector. Government plays a key role in holding healthcare providers to minimum standards. Both the federal and state governments develop regulations to govern healthcare organizations and clini-

cians and exert direct oversight and inspection to ensure compliance with all relevant requirements.

Private organizations have also played a role in quality assurance. In 1951, a group of professional associations, including the American College of Surgeons, American College of Physicians, American Hospital Association, and American Medical Association, formed what is today known as The Joint Commission (TJC). Originally, TJC only offered accreditation to those hospitals that voluntarily met its standards. In 1965, however, when Congress created the Medicare and Medicaid programs, it also stipulated that hospitals holding accreditation from TJC would not require additional review and would be deemed to have met program standards (TJC, 2013b). Today, although hospitals can choose to undergo routine surveys by state agencies or be accredited by any of several organizations, most hold TJC accreditation (TJC, 2013a).

Many professional organizations set standards for quality care provided by various types of practitioners (e.g., American Dental Association, American Medical Association, American Nurses Association) and specialties (e.g., American Society of Clinical Oncology, Oncology Nursing Society, American Pain Society, Hospice and Palliative Nurses Association). These organizations have used various approaches to achieve quality care, including publishing research related to the field or specialty, offering continuing education opportunities for members, and often offering certification in specialty practice.

In 1999, as the quality imperative took hold, Congress and President Clinton quickly took action. One result was the creation of the Agency for Healthcare Research and Quality (AHRQ) (Gardner et al., 2007) within DHHS. The mission of this agency is “to produce evidence to make health care safer, higher quality, more accessible, equitable, and affordable, and to work within the U.S. Department of Health and Human Services and with other partners to make sure that the evidence is understood and used” (AHRQ, n.d., “Mission and Budget” section).

Many private organizations also focus primarily or solely on improving healthcare quality. These include the National Committee for Quality Assurance (n.d.), which monitors the quality of care delivered by health insurance plans; the National Quality Forum (n.d.), which focuses on quality in care delivery at the bedside; and the Leapfrog Group (n.d.), a consortium of employers who purchase employee health plans.

## **Leveraging Payment Structures to Achieve Quality Goals**

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Payment policy decisions can affect more than cost. At times, these decisions can have unintended consequences (see Figure 2-3), but in recent

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**Figure 2-3. Hospice**

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In 1967, Dame Cicely Saunders founded the first modern hospice in England. Florence Wald, dean of Yale University School of Nursing from 1959 to 1965, so admired Saunders's work with the dying that she left her position as dean to work with and learn from Saunders in London. Wald then returned to Connecticut and in 1974 was instrumental in founding Connecticut Hospice, the first modern hospice in the United States. The mission of the first hospices was to provide specialized, holistic care, with a focus on symptom control, to the terminally ill (Biewen, n.d.; National Hospice and Palliative Care Organization, n.d.; Yale School of Nursing, 2009).

In 1982, Congress enacted legislation to provide a Medicare hospice benefit (National Hospice and Palliative Care Organization, n.d.). Today, approximately 44% of all people who die are receiving hospice services at the time of their death. Yet because a large majority of hospice patients are Medicare beneficiaries, the parameters of the Medicare hospice benefit have largely defined hospice care, limiting it to patients who are willing to forgo any curative treatment and whose physicians certify that their life expectancy is six months or less. These two requirements have contributed to the problem of terminally ill patients entering hospice care at the very end of their lives, when there is little opportunity for them or their family members to benefit from hospice services. Most receive hospice services for less than a month, and more than a third receive them for only a week or less (National Hospice and Palliative Care Organization, 2012).

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years, groups representing other areas of policy—such as quality and public health—have viewed Medicare and Medicaid (and, to a lesser extent, private insurance) payment policy as a way to effect changes in healthcare practice and delivery more quickly than might be possible through education of providers alone (see Figure 2-4).

Because quality and financing issues necessarily overlap, the quality movement has joined forces with public and private purchasers of health care to improve the quality of care through pay-for-performance. Under this approach, purchasers determine priority quality metrics for a given provider type (e.g., hospital, clinician, or homecare agency) and adjust payments based on how well the provider meets the quality standard. Several pay-for-performance models exist. In one, the payer withholds a small percentage of payment throughout the year and, at the end of the year, disburses the withheld funds based on performance. This means that high-performing providers receive more than they would have otherwise, while low performers receive less (Cromwell, Trisolini, Pope, Mitchell, & Greenwald, 2011).

Adoption of health information technology (HIT) is another example. Although organizations such as IOM and the Leapfrog Group were advocating adoption of HIT, especially computerized physician order entry (Thompson et al., 2007), and President George W. Bush took steps to advance HIT through his Health Information Technology Plan (U.S. DHHS, Office of the Assistant Secretary for Planning and Evaluation, 2004), progress in the early

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**Figure 2-4. Early Elective Deliveries**

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In 1979, the American College of Obstetricians and Gynecologists began to warn against electively (without medical need) delivering babies before 39 weeks of gestation, either by induction or Cesarean section. Physicians and patients may choose to deliver early for a variety of reasons, including convenience or relief of the discomfort associated with the late stages of pregnancy. Yet, early elective deliveries bring increased risk of complications for both mother and infant, and infant complications can require stays in neonatal intensive care. Moreover, evidence suggests that even when they do well at birth, infants born before 39 weeks are more likely to struggle academically (Centers for Medicare and Medicaid Services [CMS], 2012b; Galewitz, 2013). Nevertheless, changing societal norms and medical practice is not easy; despite the evidence and recommendations, early elective deliveries have been “stubbornly persistent” (Galewitz, 2013, para. 1).

A growing number of organizations have been working to bring attention to the problem and identify solutions. This group includes professional associations such as the Association of Women’s Health, Obstetric and Neonatal Nurses (AWHONN), quality organizations such as the Leapfrog Group, and advocacy groups led by the March of Dimes (CMS, 2012b). In September 2011, David Lakey, commissioner of the Texas Department of State Health Services and president of the Association of State and Territorial Health Officials (ASTHO), challenged states to reduce prematurity in the United States by 8% by 2014; one component of the challenge was to reduce early elective deliveries (ASTHO, n.d.). On May 1, 2013, the American Academy of Family Physicians, American Academy of Pediatrics, American College of Nurse Midwives, American College of Obstetricians and Gynecologists, American Hospital Association, AWHONN, and March of Dimes sent a letter to hospital executives outlining actions that hospitals can take to reduce early elective deliveries (American Academy of Family Physicians et al., 2013).

In addition to working with hospitals, clinicians, and the public, advocates identified state Medicaid programs as essential partners in reducing elective deliveries. Nationwide, Medicaid pays for about 45% of all births (CMS, 2012b), making Medicaid payment policy an important lever for groups attempting to improve care for mothers and infants. Options available to state Medicaid programs include performance monitoring and public reporting; regulatory/contracting approaches; education, outreach, and training; and payment/purchasing approaches (CMS, 2012b). As an example of the latter, in Texas, “Medicaid will deny payment for claims [for] non-medically necessary early elective deliveries, but allow retrospective reviews for reconsideration” (CMS, 2012b, Appendix C). Together, these initiatives seem to be yielding results. In 2012, early elective deliveries represented 11.2% of births, down from 17% in 2010. The goal set by the Leapfrog Group is to get this below 5% (Galewitz, 2013).

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2000s was slow. The HIT movement gained momentum and prominence when the American Recovery and Reinvestment Act of 2009 made billions of dollars available for hospitals and clinicians to implement and use electronic health records (EHRs) and systems (Hersh, 2009).

Medicare has offered incentive payments, for a limited time, for providers to transition to EHRs. Those who do not make the transition by 2015 will face penalties in the form of reduced Medicare payments (HRSA, n.d.-a). Proponents anticipate that with time, the increasing use



of HIT will result in improved quality and reduced cost of health care (CMS, n.d.-b).

## Getting Involved in Health Policy

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Equipped with knowledge of the policy process, insights into two major policy frameworks, and familiarity with major principles in public health and health policy, readers are now ready to consider how they might get involved with health policy. Many options are available to pursue: Some involve individual strategies, and others entail working with organizations to advance an issue on the policy agenda.

### Individual Action

One of the most important and easiest ways to engage in health policy is to be well versed in current issues relevant to one's area of interest. Reading a daily national newspaper is a first step in that regard. National newspapers (such as the *New York Times*, *Washington Post*, and *Wall Street Journal*) provide feature stories and editorials on economic, political, and social issues that provide the context for national health policy. They offer analyses of Congress, the presidency, and national economic indicators such as unemployment, inflation, and changes in the consumer price index.

Another individual strategy is to read and follow websites for organizations that continually update their online resources and provide useful data. It is usually best to follow websites for nonpartisan organizations so that the information is as balanced as possible. One of the most frequently used organizational websites for obtaining national and state health policy data is the Kaiser Family Foundation ([www.kff.org](http://www.kff.org)). The foundation's website contains tutorials; interactive maps for comparisons among states; summaries and fact sheets on Medicare, Medicaid, CHIP, and other health programs; and updates on ACA implementation. Other entities that offer innovative ideas and in-depth analyses on health research and policy are the Robert Wood Johnson Foundation ([www.rwjf.org](http://www.rwjf.org)) and the Commonwealth Fund ([www.commonwealthfund.org](http://www.commonwealthfund.org)).

### Collective Action

Interest groups and organizations representing healthcare professionals, providers (e.g., hospitals, home health, or federally qualified health centers), payers, insurers, and specific populations are very important. They provide a collective voice for many health policy stakeholders and can speak with the force of numbers behind them.

Professional organizations and associations can provide opportunities for networking and meeting health policy leaders and may also offer continuing education in health policy. Typically these groups keep members informed about policy related to their field or specialty and may assist members in becoming active in policy efforts.

It is a good idea to be active with and visible in organizations. Participating in the development of policy positions, briefing papers, and other health policy materials can establish one's reputation as a leader or expert in a given area and may lead to opportunities for nomination to boards or government entities.

## Conclusion

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This chapter covered many issues, ranging from the stages of the policy process and policy frameworks to core principles of public health and health policy. No single component or issue discussed is sufficient for unraveling the complexities of public policy or ensuring successful advocacy. Moreover, much of the content presented is a summary of more detailed reports, monographs, or other publications.

One takeaway message is that to advance health, advocates need to have bold action plans. One can always look up facts and figures, but there is also a need for ideas, models, and frameworks to give structure and perspective to raw data. Although it is easy to become absorbed in the details of public health and health reform policies when forming strategies for getting involved, it is important to balance the quest for data and evidence with the human side. After all, the ultimate goal of getting involved in health policy and politics is to improve the health and well-being of people and populations.

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