

Introduction



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There is widespread consensus that the American health care system underperforms relative to the resources it has available, and that gaps in financing and service delivery pose major barriers to improving health, achieving universal insurance coverage, enhancing quality, controlling costs, and reducing disparities. In addition, while the health care system generously allocates resources to medical services, it devotes far fewer resources to prevention activities and promoting healthier living or lifestyles.

Many of the issues facing the American health system today flow from the enterprise itself, such as advances in technology and science, uncertainty about treatment effectiveness, the explosion of information and its accessibility, and growing demand for services. Other problems reflect American government and policymaking, our distinctive individualistic and activist culture, and our ideological conceptions about health and health care provision. Still others relate to the larger social and economic context, the corporatization and privatization of health care, and difficulties in making medical markets work. Finally, some issues derive from our distinctive history and the history of the medical and other health professions as they compete for autonomy, authority, and public trust.

The U.S. health care system is enormously complex, and its \$1.6 trillion annual expenditures—14.9 percent of GNP in 2002—involve many competing interests. The past couple of decades have witnessed much research on health services, although these efforts are minuscule compared to investments in biomedicine. Almost all health services research—and particularly its funding—focuses on immediate and technical challenges that abound in any health care system, especially one as diversified and fragmented as our own. But in our focus on today's most pressing and technical problems, we sometimes lose a broader perspective on how the challenges we face have evolved and on their links with our distinctive history, culture, policymaking processes, and legal and ethical frameworks. Health care now intersects with almost every area of knowledge and all sectors of our economy and social structure. Getting the system right depends as much on economics, politics, behavioral studies, and ethical and philosophical approaches as on the life sciences and the mathematical and material sciences.

This book represents a composite look at some of the striking contemporary

challenges we face in health as addressed by some of the nation's leading thinkers from a range of disciplines, backgrounds, and points of view. Thus the volume offers readers a unique opportunity to consider the forces and dilemmas shaping current and future health affairs from the perspectives of individuals active in working to improve health and health policymaking.

We can examine our health system from numerous vantage points. In this volume we seek a broad perspective, one that links our health practices to larger philosophical, cultural, and political issues. This approach gives equal emphasis to promoting health and providing health care services, and focuses on quality and equity as central concerns in health policymaking. As the chapters that follow make evident, these are not isolated issues. They require policymakers to attend carefully to interconnections if decisions on some issues are not to undermine others.

This volume is organized into four sections. The first provides a broad context for understanding how morality, political processes, and economic considerations shape health issues and acceptable policy alternatives. The second section examines population health and the challenges of reducing health and health care disparities, exploring the interconnections among economic and social conditions, the forces promoting and damaging health, the resulting disparities, and how we might reduce them. In this section the discussion ranges from examining broad sociocultural influences to considering how to reduce injury, disease, and death through policies that address smoking, gun safety, and obesity. The authors seek links among these challenges and examine to what degree common approaches are plausible.

The third section moves to the challenge of improving quality, a topic of increasing public and governmental attention following influential reports from the Institute of Medicine of the National Academy of Sciences. These chapters not only describe the opportunities and barriers to change but also reveal how quality issues interconnect with disparities and other aspects of population health. The fourth and final section addresses some of the challenges in ensuring an equitable system of care given the growing gap between expectations and demands and the capacity to meet them.

The Social Context of Health Policymaking

Significant debates about health policy are often highly moralistic and ideological and unrelated to the preponderance of evidence. They inevitably involve questions of personal versus collective responsibility, government versus self-help, individual fault versus social causation, and a broader framing of populations as worthy and unworthy. For example, some debates entail obviously religious perspectives, as with abortion, use of substances, and sexually related diseases. But as James Morone illustrates in his introductory chapter, these same debates encompass broader issues of public responsibility for providing health care, enforcing morality in contrast to reducing social harm (as in providing clean needles to drug users), bringing health care and sex education into schools rather than leaving it to parents, and of social versus individual interventions to combat obesity.

Major policy discussions rarely get very far from notions of good and evil and the worthy and unworthy.

Morone shows how moral ideologies and disputes—and the resulting politics—shape our notions of health and appropriate health policy. Using school-based health clinics and current interest in the epidemic of obesity as examples, he explores the clash between the Puritan ethic and the social gospel and the dangers of demonization.

Theda Skocpol and Patricia Seliger Keenan delve more deeply into political deliberations and the messy politics of health care reform, which inevitably provoke strong partisanship and require ambiguous decisions to allow people with diverse ideologies to come together. Tracing deliberations on important policy questions such as the lack of health insurance and prescription drug coverage, these authors illuminate the extraordinary cross pressures that policymakers confront as they seek to improve health policy. For example, proposals to expand medical benefits or cover the uninsured can easily be derailed by pressures to reduce government spending or to overhaul health care delivery. Yet despite the many political difficulties in hammering out stable agreements, these two authors see some movement among policy elites toward consensus and compromise on some important issues.

Basic to our health care challenges, as Skocpol and Keenan note, is the large and growing population who are uninsured and underinsured. Most insured Americans today face larger out-of-pocket expenditures, as designers of health benefits try to make patients more discriminating and prudent purchasers of health care, as an alternative to the managed care strategies that consumers and health professionals rebel against. The United States is exceptional in its failure to develop universal coverage, but as almost a century of debate shows, reform is difficult to achieve. The growing size and importance of the health sector—and the many interests that have a stake in it—greatly complicate the challenge.

Many observers point to our employer-based system as one significant source of our difficulties with insurance coverage and argue that using employment as the core basis for health coverage is flawed. In contrast, Sherry Glied builds an impressive defense for the advantages of an employer-based system, although she recognizes the need to add other mechanisms for those who are not employed or employed in circumstances where employer coverage is unavailable or not affordable. Employer-based coverage leads to variability in comprehensiveness of coverage and cost, but Glied argues that such insurance offers significant advantages in promoting efficiency, facilitating choice and flexibility, and avoiding the heavy bureaucracy and cumbersome aspects of large governmental systems. In contrast, advocates of a single-payer approach typical of Canada and the U.S. Medicare program point to the relatively low administrative costs compared with the more pluralistic private health care system.

In addition to facing insurance challenges, the health care system is undergoing continuing transformation, as described by James Robinson. With the managed care backlash, insurers have dropped more intrusive controls on doctors and patients and increasingly put responsibility on employers and patients to cover more of the growing costs of health care. Whether a truly competitive marketplace can

be developed, whether patients can make meaningful and thoughtful choices regarding health care alternatives, and whether in the long run they are willing to accept the cost burdens transferred to them is unclear.

Based on his study of large health care enterprises, Robinson describes a system of continuing turbulence. The earlier effort to develop integrated health systems has now lost momentum, and today U.S. medicine is seeing the rise of single-specialty hospitals and freestanding ambulatory facilities, with specific service chains expanding geographically. Robinson examines new hybrid organizational forms that provide some of the advantages of older organizational forms but function with greater market flexibility. He views health organizations as highly adaptive to the vagaries of reimbursement arrangements, particularly under Medicare, as they develop aggressively in areas of medicine where reimbursement is most favorable. He depicts a system where expectations of continuing growth push large organizational entities beyond their comparative advantage, which then results in crises and contraction followed by new waves of innovation, expansion, and disillusion.

Robinson finds shortcomings in the efforts of public authorities to control the turbulence and growth of unneeded capacity through certificate-of-need legislation and conflict-of-interest regulation, which curb physician referrals to facilities in which they have significant economic interest. In the latter case, for example, he notes that since physicians both diagnose and provide treatment, the physician role itself entails self-referral conflict of interest. Thus efforts to limit such referrals, as in "Stark regulations," may undermine other important goals such as continuity and coordination of care.

More serious are strategies used by large health plans to segment the market by risk. Such practices make it difficult for health care entities to subsidize important but unprofitable services and to pool risk across groups. As the system places more responsibility on consumers and on a pluralistic market, achieving other important goals such as reducing medical errors, encouraging evidence-based practice, and addressing population health concerns also becomes more difficult.

Improving Health and Reducing Disparities

The second section of the book deals with promoting population health, reducing disparities, and their interconnections. Although for much of American history social disparities in health and health care were seen as the inevitable result of people's differing talents and motivations, consensus is growing that disparities in health according to race, ethnicity, class, and other status attributes are unacceptable. The origin of such disparities is complex and involves not only the biological and social development of individuals and families but also influences that are intergenerational. Individuals conceived in more deprived social circumstances face greater risk even in utero, and such risks cumulate over the life course. Much work now focuses on economic and racial and ethnic disparities in health and health care. Bruce Link and Jo Phelan address the fundamental causes of health inequali-

ties and raise important questions about the models through which we view the causes of disease.

As they note, the dominant epidemiological model identifies risk factors proximate to the disease outcome and seeks policies and programs to reduce such risks. These authors, however, observe that risk factors change from one period to another, but socioeconomic status—which is associated with such risks at any single point in time—remains strongly related to health outcomes even as risk factors change. Link and Phelan argue that social status is the more fundamental influence because, regardless of the risks, persons with more resources, information, power, and useful networks are better able to marshal these resources to take advantage of what is known about preventing disease and maintaining health. Thus, they argue, we should identify policies that can equalize such coping advantages so that one's socioeconomic status is not such a powerful determinant of health.

Link and Phelan's analysis has some important and perhaps counterintuitive implications for our understanding of social, racial, and ethnic disparities. One might assume that any major health advance, over the long run, would help reduce disparities in health outcomes. But if Link and Phelan are right, any new health opportunity that gives those with money, power, information, and other resources unequal opportunities will widen health disparities, at least initially. Those with resources will be better located to adopt such interventions, whether they are new forms of health screening, preventive opportunities, or innovative treatments. This argues for seeking interventions that are more universal and depend less on the resources of individuals, or at least compensate those most disadvantaged through special targeting efforts. From Link and Phelan's perspective, designing safer vehicles and road systems is more effective in reducing disparities than trying to teach people to drive more safely; fluoridating water is more effective than encouraging better tooth brushing and flossing; and providing healthy foods and opportunities to exercise safely and pleasantly in schools and communities could be more effective than encouraging people to lose weight.

David Hemenway, in his examination of policy on firearms, follows up on the implications of Link and Phelan's analysis by showing how a public health perspective can be a powerful approach to controlling the misuse of guns and reducing injuries and deaths. He reviews the horrendous challenge of the growing availability of guns of enhanced lethality, and shows how policies that address varying aspects of gun production and accessibility—rather than simply gun users—can help control the devastating effects of a gun culture. Here ideological and cultural issues play an especially large role, and advocates for protecting access to guns have energetic support from important sections of the public and much political influence. Thus the public health challenge is particularly difficult. While most Americans favor serious gun control, their commitment is less intense than the commitment of gun advocates to protecting access. When it comes to gun politics and the ability to mobilize voters, the organized gun lobby carries greater weight. Nevertheless, much can be done through technical and regulatory constraints to reduce potential harm while still allowing continued access to guns.

Hemenway provides a menu of policy options, many of which are politically feasible.

Much effort has been devoted to spurring more healthful behavior by encouraging individuals not to smoke or use other substances, to exercise, to eat healthy diets, and the like. Evidence is growing that the factors that relate to poor health outcomes are as embedded in the social and physical environments of people's lives as they are in their behavioral inclinations, and that advancing health depends on social policies that affect the opportunities and constraints of those environments. Population health issues are pervasive, including the nature of the built environment, exposure to environmental risks through traffic, pollution, and crime, lack of access to jobs, ready availability of dangerous substances, and many more. Alternatively, individuals' access to healthy food, opportunities to exercise safely, education and health care, and social integration and support varies widely. Social policies that affect populations and communities' material and environmental resources offer innumerable opportunities to prevent illness and enhance health.

Kenneth Warner—a major contributor to our understanding of the workings of the tobacco industry—analyzes how we have made significant progress in reducing smoking, the single major cause of death. Warner endorses a multi-factor model of smoking prevention and notes the importance of social and tax policies, regulation of cigarette promotion, and cultural constraints on smoking. As he shows, the great advances in combating the forceful efforts of the tobacco industry and inducements to smoke perhaps reflect global social influences and social policies more than efforts to change the hearts and minds of individual smokers. Warner then turns to the next major damaging influence on health: the epidemic of obesity. While noting many differences between the food and tobacco industries, he examines which aspects of the strategies and policies used to combat tobacco can be applied to the growing problem of obesity.

David Williams further develops the disparities issue as it affects racial and ethnic groups. He shows that such health disparities are large and persistent. Like Link and Phelan, he sees them as embedded in larger influences, primarily socio-economic disadvantage, social isolation, and economic marginalization. He notes the multiple pathways through which these larger influences affect health, such as noxious working and living environments, unemployment, exposure to persistent stress, lack of resources to cope and promote healthy living, and constrained access to medical care. Williams makes the essential point that analysts too easily combine people in racial and ethnic groups that are actually heterogeneous and whose members face different life and health challenges. He argues for data that allow us to better unpack such gross and uninformative categories as Hispanic, black, and Asian.

Williams believes that most of our efforts to reduce disparities are unequal to the challenge and that many interventions that would be more effective face social and political barriers. He cites a survey showing that despite all of the media attention to racial disparities in health, more than half of Americans seem not to understand their extent. Thus, like Link and Phelan, he seeks to identify ap-

proaches to meaningful policy changes that would win public support and address basic influences.

Sara Rosenbaum and Joel Teitelbaum approach the disparities issue from another angle, asking how the law might become an important instrument to push policy change along. They see law as a powerful instrument in American life and examine how classic civil rights law can be revised and expanded to address discrimination in health and health care, using health financing agencies and associated regulations to convey a strong message. These authors also examine a legal strategy addressing health disparities more directly by eliminating the requirement that individuals demonstrate discrimination, and instead propose rules and standards for reducing disparity. They examine the pros and cons of these alternative legal approaches, alone and in combination. Implementing these ideas, of course, entails many challenges and provides no fast remedy, but disparities will be with us for generations and we need to seek more than a quick fix.

Rosenbaum and Teitelbaum's legal approach to reducing disparities is also innovative in that they suggest approaching remedies through the lens of unequal quality rather than relying on more traditional civil rights strategies of unequal access. This chapter therefore provides a transition to the third section, examining quality in health care and how it can be improved.

The Quality Challenge

In recent years the Institute of Medicine (IOM) has brought to broader public awareness the problems of medical errors and poor quality of health care—problems most experts have known about for decades. The publicity generated by the IOM reports has helped push the quality issue higher on the public agenda, but addressing it in our very complex and decentralized health care system is a massive challenge, and efforts to reduce errors face many barriers. Michael Millenson, a strong voice in the quality improvement movement, describes the numerous quality problems in our health care system and the many efforts being made to address them through new information technology and new approaches to disease management. Although Millenson in other contexts has expressed his frustration at the slowness of change in the conditions that kill and maim so many patients each year, he presents a more optimistic picture here, believing that the many activities needed to improve quality may be moving toward a “tipping point” that will lead to impressive progress. Lucian Leape, an indefatigable advocate and leader in reducing medical errors and adopting a systems approach, and a member of the IOM panel that publicized this issue, describes the many efforts around the country by professional and other groups to push the quality movement forward. He argues the centrality of culture change in this endeavor and recommends a number of approaches for improving patient safety. These include adopting systems approaches to reducing errors in the hospital setting, investing in information technology to computerize medical records and order entry systems, clarifying the labeling of prescription drugs, and increasing federal funding of patient safety research.

Linda Aiken then addresses the role of nursing in providing quality health care, the impending gap between the need for nurses and the supply, the various ways that hospitals and other health organizations are reducing nurse staffing and increasing nurse workloads, and the many challenges these developments pose. Analysts have long known that the quality of nursing is central to preventing errors in hospitals and providing high-quality care. Aiken and her colleagues, as well as others, have demonstrated an association between nurses' workload and the number of deaths in hospitals. These researchers have also shown an association between nurses' education and the number of hospital deaths. Many hospital nurses are highly dissatisfied with their working conditions and lack of autonomy, and many leave nursing because of these dissatisfactions and burnout. Studies have suggested that when nurses have more control over their work, care improves and hospitals function better.

Lisa Iezzoni addresses the quality of care for persons with disabilities and shows how the Medicare program can foster rehabilitation and improve function. While she focuses on the specific question of how existing policy affects persons with difficulty walking because of disease or impairment, millions of Americans who suffer from serious chronic illnesses and disabilities face similar issues. Iezzoni brings to the study of ambulatory problems a passionate personal interest as a scooter-wheelchair-dependent person and an understanding gained from her intensive study of many individuals with limited mobility. She describes some of the catch-22s embodied in public programs that create difficulties for people with chronic illnesses and disabilities, and recommends specific modifications in Medicare that could greatly enhance the lives of many persons who need mobility assistance. Iezzoni, a talented physician who is one of the nation's experts on case-mix adjustment, represents in her personal life the vigorous way one can live as a full participant with appropriate access to the community, transportation, work, medical care, and other supports most people take for granted.

In the final chapter on quality, Rosemary Stevens examines the growing complexity of specialty organizations in American medicine, the disputes among specialties for turf and favorable relative remuneration, and the role of specialty organizations, working individually and together, to set standards for certification and lifelong learning and to introduce new quality initiatives. Stevens describes the complex interconnections between government payment deliberations and specialty concerns and shows how payment decisions can impede high-quality care. Stevens believes, as both an analyst and a participant in specialty deliberations, that specialty associations can play an important role in enhancing quality, and she offers an optimistic view of their recent initiatives and collaboration.

Toward an Equitable System of Health Care

The volume concludes with two chapters on frameworks for fairness in health care policy. First, Richard Frank and Thomas McGuire address longstanding concerns regarding how health insurers separate mental health and substance abuse

benefits from most other forms of medical care, and the challenges of integrating mental health and substance abuse care into a more holistic approach. In recent decades we have learned much about the association between mental health and substance abuse and their effects on the course of other medical illnesses, and the enormous disabling consequences of conditions such as major depression, bipolar disease, schizophrenia, and various addictions. These problems cause great distress, interfere with function, lessen productivity, substantially reduce well-being and quality of life, and increase suicide.

Frank and McGuire address several issues related to the challenge of integrating mental health and substance abuse services with other aspects of health care. First, differential insurance coverage for mental health versus other health services results partly from stigmatization, and the fear that coverage will prompt people to use more services at greater cost, a pattern supported by some data. The evidence shows, however, that a managed mental health benefit provided on the same basis as other medical conditions produces only a small additional cost. Still other studies suggest that new kinds of inequality are introduced when behavioral health is managed more strictly than other medical services. Another challenge is the poor medical care persons with mental health morbidities and substance abuse problems receive because of the segmentation of their care. Third are the challenges of designing benefits and financing that lead to efficient and effective services integrated at the point of service. Frank and McGuire explore how to structure an insurance program to produce more equitable and effective results.

In the final chapter Norman Daniels addresses the crucial issue of how we can gain public legitimacy for necessary limits on the provision of health care. Most thoughtful people understand the need for limits in health care as in every other facet of life, but much of the public resists limits when their own health or that of their loved ones is at stake. The backlash against managed care resulted largely from the unwillingness of the public and many health professionals to accept the strategies used by managed care organizations to control the costs of care. Insurance plans have withdrawn from using vigorous utilization management approaches, and as a result health insurance premiums are now rising rapidly, more costs are being transferred to employers and their employees, and more people are becoming uninsured.

Daniels reports on his work with James Sabin on a theory and process they refer to as “accountability for reasonable limits.” Daniels argues that decisions on insurance coverage must be transparent and publicly accessible, rest on principles that fair-minded people can accept, allow for challenges and changes when supported by appropriate evidence, and be subject to an oversight process that ensures fidelity to these conditions. Although Norman Daniels is a philosopher and an academic, he and James Sabin, his physician-colleague, have been working with various health insurance plans to test the potential of their ideas and address the practical challenges of implementing them. Daniels offers examples of both progress and difficulties and begins to outline approaches to gaining legitimacy for constraints among patients and professionals. Winning public acceptance for

equitable limits is a profound challenge, but failure will eventually result in a many-tiered system of differential care that varies with one's socioeconomic position.

All of the chapters in this book derive from the Investigator Awards in Health Policy Research, a national program of The Robert Wood Johnson Foundation. Over the past decade, this program has encouraged highly respected and innovative scholars in the social sciences, medicine, and related fields, as well as outstanding scholars early in their careers, to undertake ambitious study of significant health policy issues. Applicants are encouraged to propose projects that apply new perspectives to policy issues and that explore the historical evolution, underlying values, and interplay of social, economic, and political forces that shape emerging structures, processes, and patterns of care. Our belief is that a broader appreciation of forces influencing the health of populations and the organization of health services will result in innovative ideas that will make important contributions to health policy.

There is, of course, no simple, direct path from a research result—however rigorous and innovative—to the making of social policy. Much of the value of health policy research and analysis is in helping frame the perspectives of policymakers, the media, and the educated public, and this is a continuous process. Policymaking is inherently political and depends on much more than perspective and evidence. It requires balancing competing needs and demands, the pressures of various interests both public and private, and public attitudes, values, and beliefs, and thus the perceived legitimacy of policy options.

Many of the program's investigators are influential less because they have succeeded in changing a specific policy decision and more because they help us understand how policymakers and opinion leaders address health policy issues, and because they offer insights on how to improve the process for developing policy. Important changes in the framing of policy questions and the options the public and policymakers see as acceptable often take years, even decades. The major problems in our health care system—managing threats to population health, coverage, financing, quality, and disparities, among others—will remain on our public agenda for years.

Health and medicine are extraordinarily dynamic areas, constituting a seventh of our economy and employing millions of people. Circumstances can change rapidly with the introduction of new knowledge and technologies, evolving economic conditions and financial arrangements, trends in public opinion, and shifts in political power. But the presence of large, important, and powerful interest groups that have a stake in the sector, and the complexity and decentralization of the system, can pose enormous barriers to successfully addressing problems. These characteristics make it especially important that we seek a broader appreciation of how health care functions, and understand that quick technical fixes are unequal to the challenges we face now and in the future.