CHAPTER

1

HEALTH AND HEALTH POLICY

Learning Objectives

After reading this chapter, you should be able to

- define health and describe health determinants,
- define public policy and health policy,
- begin to appreciate the important historical roles of Medicare and Medicaid in healthcare in the United States,
- begin to appreciate the important role of the Patient Protection and Affordable Care Act (ACA) of 2010 in healthcare in the United States,
- identify some of the important challenges for health policy,
- understand the four forms of health policies,
- distinguish between allocative and regulatory categories of health policies, and
- understand the impact of health policy on health determinants and health.

Health and its pursuit have long been woven tightly into the social and economic fabric of nations. Health is essential not only to the physical and mental well-being of people but also to nations' economies. The United States will spend about $3.2 trillion in pursuit of health in 2015, representing about 17.6 percent of the nation's gross domestic product (GDP), and may spend more than $5 trillion annually, or almost 20 percent of GDP, by 2023. About half of this spending will be from federal, state, and local governments (Sisko et al. 2014). Thus, it is not surprising that government at all levels is keenly interested in health and how it is pursued. As will be discussed throughout this book, government's interest is expressed largely through public policy.

Despite government's substantive role through policy, most of the resources used in the pursuit of health in the United States are controlled by the private sector. This rather unique public–private endeavor means that when government is involved in the pursuit of health for the citizenry, it

often seeks broader access to health services that are provided predominantly through the private sector.

The long-established Medicare (providing healthcare for many of the nation's elderly and people with disabilities) and Medicaid (providing healthcare for some of the nation's poorer people) programs provide clear examples of this public–private approach, which is continued in the more recent expansion of insurance coverage in the Patient Protection and Affordable Care Act (P.L. 111-148) of 2010. The ACA, as it is known, will continue the pattern of using public dollars to purchase services in the private sector for beneficiaries as is done under Medicare and Medicaid. (Appendixes 1, 2, and 3, respectively, provide overviews of the ACA, Medicare, and Medicaid. These policies are so important to understanding health policy and its effect on health in the United States that you may wish to read the overviews soon; the information provided will be helpful throughout the book.)

This book explores the intricate public policymaking process through which government influences the pursuit of health in the United States. The primary focus is on policymaking at the federal level, although much of the information also applies to state and local levels of government. This chapter discusses the basic definitions of health, health determinants, and health policy and their relationships to one another. Chapter 2 describes the context within which policymaking takes place. Chapter 3 presents a model of the public policymaking process and specifically applies this model to health policymaking. Chapter 4 describes the increasingly important roles played by the courts in health policymaking. Building on the foundational material presented in the first four chapters, subsequent chapters cover in more detail the various interconnected components of the policymaking process. Chapter 10 concludes the book with attention to how health professionals, whether managers or clinicians, can build a more useful level of policy competence. In this book, policy competence simply means that health professionals understand the policymaking process to the point that they can exert some influence on the process to achieve higher levels of human health. The path toward policy competence begins with some key definitions—of health, health determinants, public policy, and health policy.

Health Defined

A careful definition of health is important because it gives purpose to any consideration of health policy. Being precise about what causes or determines health is similarly important. As will be discussed more fully later, policy affects health through its impact on the determinants of health.

The World Health Organization (WHO; www.who.int) defines *health* as the "state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity," a definition first appearing in the organization's constitution in 1946 and continuing unchanged through today (WHO 1946). Other definitions have embellished the original, including one that says health is "a dynamic state of well-being characterized by a physical and mental potential, which satisfies the demands of life commensurate with age, culture, and personal responsibility" (Bircher 2005). Another variation on the definition views health as a "state in which the biological and clinical indicators of organ function are maximized and in which physical, mental, and role functioning in everyday life are also maximized" (Brook and McGlynn 1991). Yet another definition adds the concept of health as a human right by saying health is "a condition of well-being, free of disease or infirmity, and a basic and universal human right" (Saracchi 1997). The former European commissioner for health and consumer protection provides a definition with an important expansion by considering good health as "a state of physical and mental well-being necessary to live a meaningful, pleasant, and productive life" and further noting that "good health is also an integral part of thriving modern societies, a cornerstone of well performing economies, and a shared principle of . . . democracies" (Byrne 2004).

The WHO definition, especially as embellished with considerations of health as a right, a cornerstone of thriving economies, and a key principle of democracies, not only permits consideration of the well-being of individuals and the health of the larger societies they form but also facilitates assessments of the performance of governments in promoting health (Shi 2014). Throughout this book, health is defined as WHO defined it long ago.

Health is important in all nations, although the resources available for its pursuit vary widely. Current international health expenditure comparisons for the member countries of the Organisation for Economic Co-operation and Development (OECD), all of which share a commitment to democratic government and market economies, reflect some of this variation and are available online at www.oecd.org.

The value leaders and citizens of nations place on the health of their populations is partially reflected in the proportions of available resources devoted to the pursuit of health. Exhibit 1.1 shows per capita health spending and percentage of GDP devoted to health in selected countries. As reflected in the high expenditure levels in the United States and the large expenditures by other countries as shown in the OECD data, many nations make significant efforts to help their citizens attain good health.

Important to appreciating the role health policy plays in the pursuit of health is the fact that health is a function of several variables, or as they

are often called, health determinants. The existence of multiple determinants provides governments with a large set of ways to intervene in any society's pursuit of health.

Health Determinants

Health determinants can be defined simply as factors that affect health or more formally as a "range of personal, social, economic, and environmental factors that influence health" both at the individual and population levels (US Department of Health and Human Services [HHS] 2014a). The question of what determines health in humans has been of interest for a long time.

EXHIBIT 1.1 Health Spending in Selected OECD Countries, 2012

Country	Total Health Spending	
	Per Capita	Percent of GDP
Australia	$3,997	9.1%
Canada	$4,602	10.9%
Czech Republic	$2,077	7.5%
Denmark	$4,698	11.0%
France	$4,288	11.6%
Germany	$4,811	11.3%
Israel	$2,304	7.3%
Japan	$3,649	10.3%
Netherlands	$5,099	11.8%
New Zealand	$3,172	10.0%
Norway	$6,140	9.3%
Poland	$1,540	6.8%
Spain	$2,998	9.4%
Sweden	$4,106	9.6%
Switzerland	$6,080	11.4%
United Kingdom	$3,289	9.3%
United States	$8,745	16.9%
OECD median	$3,484	9.3%

Source: Data from OECD (2014).

An important early theory about the determinants of health was the Force Field paradigm (Blum 1974). In this theory, four major influences, or force fields, determine health: environment, lifestyle, heredity, and medical care. In another conceptualization the determinants are divided into two categories (Dahlgren and Whitehead 2006). One category, named *fixed factors*, is unchangeable and includes such variables as age and gender. A second category, named *modifiable factors*, includes lifestyles, social networks, community conditions, environments, and access to products and services such as education, healthcare, and nutritious food.

The research on determinants of health, which is now extensive, has led to a holistic approach to health determinants. For individuals and populations, health determinants include the physical environments in which people live and work; people's behaviors; their biology (genetic makeup, family history, and acquired physical and mental health problems); social factors (including economic circumstances, socioeconomic position, and income distribution; discrimination based on such factors as race/ethnicity, gender, and sexual orientation; and the availability of social networks or social support); and their access to health services.

This inclusive perspective on what factors determine health in humans is clearly reflected in *Healthy People 2020* (www.healthypeople.gov), a comprehensive national agenda for improving health. The following list of health determinants is adapted from its identification and definition of determinants (HHS 2014a):

- *Biology* refers to the individual's genetic makeup (those factors with which he is born), family history (which may suggest risk for disease), and physical and mental health problems acquired during life. Aging, diet, physical activity, smoking, stress, alcohol or illicit drug abuse, injury or violence, or an infectious or toxic agent may result in illness or disability and can produce a "new" biology for the individual.
- *Behaviors* are individual responses or reactions to internal stimuli and external conditions. Behaviors can have a reciprocal relationship with biology; in other words, each can affect the other. For example, smoking (behavior) can alter the cells in the lung and result in shortness of breath, emphysema, or cancer (biology), which then may lead an individual to stop smoking (behavior). Similarly, a family history that includes heart disease (biology) may motivate an individual to develop good eating habits, avoid tobacco, and maintain an active lifestyle (behaviors), which may prevent his or her own development of heart disease (biology).

  An individual's choices and social and physical environments can shape her behaviors. The social and physical environments include all

factors that affect the individual's life—positively or negatively—many of which may be out of her immediate or direct control.

- *Social environment* includes interactions with family, friends, coworkers, and others in the community. It encompasses social institutions, such as law enforcement, the workplace, places of worship, and schools. Housing, public transportation, and the presence or absence of violence in the community are components of the social environment. The social environment has a profound effect on individual and community health and is unique for each individual because of cultural customs, language, and personal, religious, or spiritual beliefs. At the same time, individuals and their behaviors contribute to the quality of the social environment.
- *Physical environment* can be thought of as that which can be seen, touched, heard, smelled, and tasted. However, it also contains less tangible elements, such as radiation and ozone. The physical environment can harm individual and community health, especially through exposure to toxic substances, irritants, infectious agents, and physical hazards in homes, schools, and work sites. The physical environment can also promote good health—for example, by providing clean and safe places for people to work, exercise, and play.
- *Public- and private-sector programs and interventions* can have a powerful and positive effect on individual and community health. Examples include health promotion campaigns to prevent smoking; public laws or regulations mandating child restraints and safety belt use in automobiles; disease prevention services such as immunization of children, adolescents, and adults; and clinical services such as enhanced mental health care. Programs and interventions that promote individual and community health may be implemented by public agencies, such as those that oversee transportation, education, energy, housing, labor, and justice, or through such private-sector endeavors as places of worship, community-based organizations, civic groups, and businesses.
- *Quality health services* can be vital to the health of individuals and communities. Expanding access to services could eliminate health disparities and increase the quality of life and life expectancy of all people living in the United States. Health services in the broadest sense include not only those received from health services providers but also health information and services received from other venues in the community.

Nations differ in the relative importance they assign to addressing the various determinants of health. For example, among the OECD nations, the United States ranks first in health expenditures but twenty-fifth in spending

on social services. This expenditure pattern reflects a particular prioritization among determinants and is not the most effective pattern. It has been shown, for example, that the 1.5 million people in the United States who experience homelessness in any given year make disproportionately high use of costly acute care services (Doran, Misa, and Shah 2013).

Not only do nations prioritize health determinants differently, but people, as individuals and populations, vary in their health and health-related needs. The citizenry of the United States is remarkably diverse in age, gender, race/ethnicity, income, and other factors. Current census data put the US population at approximately 314 million people; 13.7 percent of them are older than 65. By 2020, about 55 million will be older than 65 and about 23 million will be older than 75. Persons of Hispanic or Latino origin make up about 16.9 percent of the population, and African Americans constitute approximately 13.1 percent of the population (US Census Bureau 2014). These demographics are important when considering health and its pursuit.

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

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

In recent years, policymakers have paid greater attention to racial/ethnic disparities in care with notable, although unfinished, progress. Congress legislatively mandated the Institute of Medicine (IOM; www.iom.edu) to study healthcare disparities and established the National Center on Minority Health and Health Disparities at the National Institutes of Health. Congress also required the Department of Health and Human Services (HHS; www.hhs.gov) to report annually on the nation's progress in reducing healthcare and health disparities (HHS 2014b). These steps have established the foundation for better addressing disparities in health and healthcare (James et al. 2007).

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

- raising public and provider awareness of racial/ethnic disparities in healthcare,
- expanding health insurance coverage,
- improving the capacity and quantity of providers in underserved communities, and
- increasing understanding of the causes of and interventions to reduce disparities.

Progress in pursuing this multifaceted strategy continues and received a substantial boost from passage of the ACA. Among the ACA's numerous goals, two of the most important are to reduce the number of uninsured people and to improve access to healthcare services for all citizens (Garfield and Damico 2012; Williams 2011).

In recent years, the impact of income and of wide disparities in levels of income on health has been increasingly understood. Wealthier Americans tend to be in better health than their poorer counterparts primarily because of differences in education, behavior, and environment. Higher incomes permit people to buy healthier food; live in safer, cleaner neighborhoods; and exercise regularly (Luhby 2013). Low income does not necessarily mean poorer health. In part, the impact of income depends on what government does about supporting people with low incomes. A national survey has shown that the income variable interacts importantly with the extant health policy in the various states (Schoen et al. 2013). Using 30 indicators of access, outcomes, prevention, and quality, the survey documents sharp healthcare disparities among states, revealing up to a fourfold disparity in performance for low-income populations. The most important conclusion of this survey is that "if all states could reach the benchmarks set by leading states, an estimated 86,000 fewer people would die prematurely and tens of millions more adults and children would receive timely preventive care" (Schoen et al. 2013).

Although its population is diverse, several widely shared, although not universally shared, values directly affect the approach to healthcare in the United States. For example, many Americans place a high value on individual autonomy, self-determination, and personal privacy and maintain a widespread, although not universal, commitment to justice. Other societal characteristics that have influenced the pursuit of health in the United States include a common deep-seated belief in the potential of technological rescue and an obsession with prolonging life regardless of the costs (although this attitude is changing). These values shape the private and public sectors' efforts related to health, including the elaboration of public policies germane to health and its pursuit. They also influence the prioritization of attention to the various determinants of health.

Defining Health Policy

A suitable context is necessary to fully understand what health policy is. First, it is important to realize that policy is made in both the private sector and the public, or governmental, sector. Policy is made in all sorts of organizations, including corporations such as Google, institutions such as the Mayo Clinic, and governments at federal, state, and local levels. In all settings, *policies* are officially or authoritatively made decisions for guiding actions, decisions, and behaviors of others (Longest and Darr 2014). The decisions are official or authoritative because they are made by people who are entitled to make them based on their positions in their entities. Executives and other managers of corporations and institutions are entitled to establish policies for their entities because they occupy certain positions. Similarly, in the public sector, certain people are positionally entitled to make policies. For example, members of Congress are entitled to make certain decisions, as are executives in government or members of the judiciary.

Policies made in the private sector can certainly affect health. Examples include authoritative decisions made in the private sector by executives of healthcare organizations about such issues as their product lines, pricing, and marketing strategies. Official or authoritative decisions made by such organizations as The Joint Commission (www.jointcommission.org), a private accrediting body for health-related organizations, and the National Committee for Quality Assurance (www.ncqa.org), a private organization that assesses and reports on the quality of managed care plans, are also private-sector health policies. This book focuses on the public policymaking process and the public-sector health policies that result from this process. Private-sector health policies, however, also play vital roles in the ways societies pursue health.

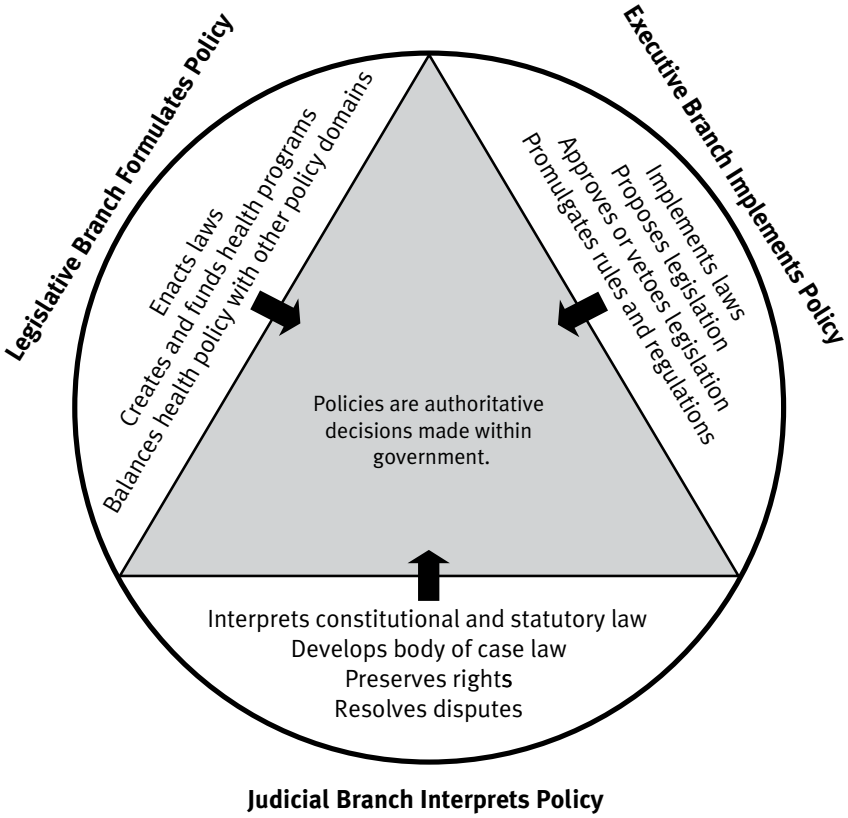
Public Policy

There are many definitions of public policy but no universal agreement on which is best. For example, Peters (2013, 4) defines public policy as the "sum of government activities, whether acting directly or through agents, as those activities have an influence on the lives of citizens." Birkland (2001) defines it as "a statement by government of what it intends to do or not to do, such as a law, regulation, ruling, decision, or order, or a combination of these." Cochran and Malone (1999) propose yet another definition: "political decisions for implementing programs to achieve societal goals." Drawing on these and many other definitions, we define *public policy* in this book as authoritative decisions made in the legislative, executive, or judicial branches of government that are intended to direct or influence the actions, behaviors, or decisions of others.

The phrase *authoritative decisions* is crucial in this definition. It specifies decisions made anywhere within the three branches of government—and at any level of government—that are within the legitimate purview (i.e., within the official roles, responsibilities, and authorities) of those making the decisions. The decision makers can be legislators, executives of government (presidents, governors, cabinet officers, heads of agencies), or judges. Part of these roles is the legitimate right—indeed, the responsibility—to make certain decisions. Legislators are entitled (and expected) to decide on laws, executives to decide on rules to implement laws, and judges to review and interpret decisions made by others. Exhibit 1.2 illustrates these relationships.

In the United States, public policies—whether they pertain to health or to defense, education, transportation, or commerce—are made through a dynamic public policymaking process. This process, which is discussed in Chapter 3, involves interaction among many participants in three interconnected phases: formulation, implementation, and modification.

EXHIBIT 1.2 Roles of Three Branches of Government in Making Policies



Health Policy

Health policy is but a particular version of public policy. Public policies that pertain to health or influence the pursuit of health are health policies. Thus, we can define public-sector *health policy* as authoritative decisions regarding health or the pursuit of health made in the legislative, executive, or judicial branches of government that are intended to direct or influence the actions, behaviors, or decisions of others.

Health policies are established at federal, state, and local levels of government, although usually for different purposes. Generally, a health policy affects or influences a group or class of individuals (e.g., physicians, the poor, the elderly, children), or a type or category of organization (e.g., medical schools, health plans, integrated delivery and financing healthcare systems, pharmaceutical manufacturers, employers).

At any given time, the entire set of health-related policies made at any level of government constitutes that level's health policy. Thus, a government's health policy is a large set of authoritative decisions made through the public policymaking process. Throughout this book, we will say much more about health policy and about the context in which and the process through which these decisions are made. Much of what can be said about health policy in the United States is positive. People are healthier because of the impact of many health policies. However, the United States faces significant challenges in its efforts to improve the health of the citizenry. Although many health policies have had enormous benefit (e.g., Medicare for the elderly and those with disabilities, advances in science and technology fostered by public funding) many challenges remain. Policies, which are decisions made by humans, can be good (with positive consequences) or misguided (with negative or unintended consequences).

Challenges for Health Policy

There is no shortage of thoughtful assessments of what health policy should achieve. One of the best recent determinations of what policy should achieve in the area of healthcare delivery and financing is one made by the Partnership for Sustainable Health Care (2013), a diverse group of healthcare stakeholders including the hospital, business, consumer, and insurance sectors. Brought together under the auspices of the Robert Wood Johnson Foundation (www.rwjf.org), this group envisions "a high-performing, accountable, coordinated health care system where patient experience and population health are improved, and where per-capita health care spending is reduced." The specific elements of their vision for healthcare in the United States are as follows:

- Health care that is affordable and financially sustainable for consumers, purchasers, and taxpayers

- Patients who are informed, empowered, and engaged in their care
- Patient care that is evidence based and safe
- A delivery system that is accountable for health outcomes and resource use
- An environment that fosters a culture of continuous improvement and learning
- Innovations that are evaluated for effectiveness before being widely and rapidly adopted
- Reliable information that can be used to monitor quality, cost, and population health

To date, these are neither widespread nor entrenched characteristics of the American healthcare system. For example, to focus on one of the elements, evidence-based and safe patient care, systematic and sustained improvement in patient care has been sought over the past 50 years, but only limited success has been achieved (Chassin and Loeb 2011; Smith et al. 2012).

The ACA holds promise for achieving, at least in part, these and other goals through improved policy. However, implementation of many aspects of the ACA is proving difficult (Jost 2014; Thompson 2013). Furthermore, not only is it challenging to establish the appropriate policies and implement them successfully, but some policies worsen the problems they are intended to address or foster other problems. For example, one of the important provisions of the ACA was significant expansion of the population covered by Medicaid. One of the expected results of this expansion was a reduction in use of expensive emergency department visits as more people acquired health insurance coverage for routine medical care in physicians' offices. A study of the effects of expanded Medicaid coverage in Oregon, however, found just the opposite: Emergency department use increased by about 40 percent with Medicaid coverage (Taubman et al. 2014).

Evidence-based learning can improve policies and minimize such problems as unintended consequences, "but learning in complex systems is often weak and slow. Complexity hinders our ability to discover the delayed and distal impacts of interventions, generating unintended 'side effects'" (Sterman 2006, 505). The healthcare system may well be the most complex system in the United States (Smith et al. 2012).

Some countries, most notably Canada and Great Britain, have developed expansive, well-integrated policies to fundamentally shape their societies' pursuit of health (Ogden 2012). The United States has begun to take this approach only recently, with enactment of the ACA in 2010. Instead, the traditional approach in the United States has been to have a few large health-related policies, including Medicare and the regulation of pharmaceuticals,

but to take a more incremental or piecemeal approach to health policy in general. The net result is a large number of policies, few of which have dealt with the pursuit of health in a broad, comprehensive, or integrated way until the ACA. The current efforts to fully implement the ACA are facing serious difficulties, and as Gawande (2009) has observed, health reform has not occurred in one dramatic step in any Western democracy.

With enactment of the ACA, the United States has entered a period of major national health reform. The healthcare system has accurately been described as "unsustainable" and "flawed" and is characterized by uncontrolled costs, variable quality, and millions of uninsured and underinsured people. We may reasonably view the ACA as a grand experiment in the large-scale, comprehensive reforms that would systematically address the cost, quality, and access problems that now characterize the nation's healthcare system. We will have to wait a few years to see if this approach works.

Forms of Health Policies

Health policies, which we defined earlier as authoritative decisions, take several basic forms (see Exhibit 1.3). Some policies are decisions made by legislators that are codified in the statutory language of specific pieces of enacted legislation—in other words, laws. Federal public laws are given a number that designates the enacting Congress and the sequence in which the law was enacted. P.L. 89-97, for example, means that this law was enacted by the Eighty-Ninth Congress and was the ninety-seventh law passed by that Congress. A briefly annotated chronological list of important federal laws pertaining to health can be found in Appendix 4.

Stemming from laws are rules or regulations established to implement the laws. Whereas laws are policies made in the legislative branch, rules or regulations are policies made in the executive branch. Both are important forms of policies. A third form of public policies include numerous decisions

EXHIBIT 1.3
Forms of Health Policies

Laws
Rules or Regulations
Other Implementation Decisions
Judicial Decisions

made authoritatively by government officials, organizations, and agencies as they implement laws and operate government and its programs. Policies in the form of implementation decisions are in addition to formal rules or regulations and are typically made by the same executive branch members who establish rules or regulations. Still other policies are the judicial branch's decisions.

Selective examples of health policies include

- the 2010 federal public law P.L. 111-148, the Patient Protection and Affordable Care Act;
- an executive order regarding operation of federally funded health centers;
- a federal court's ruling that an integrated delivery system's acquisition of yet another hospital violates federal antitrust laws;
- a state government's procedures for licensing physicians;
- a county health department's procedures for inspecting restaurants; and
- a city government's ordinance banning smoking in public places within its borders.

Laws

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

Appendix 5 provides an example of a complete federal law, the National Institute of Biomedical Imaging and Bioengineering Establishment Act of 2000. This law established the National Institute of Biomedical Imaging and Bioengineering (www.nibib.nih.gov) to accelerate the development and application of biomedical technologies. Electronic versions of this and other federal laws dating back to 1973, the ninety-third Congress, can be found at www.congress.gov, a website maintained by the Library of Congress that provides access to official federal legislative information.

Rules or Regulations

Another form policies can take is that of rules or regulations (the terms are used interchangeably in the policy context) established by administrative agencies responsible for implementing laws. Administrative agencies, whether created by the federal Constitution, Congress, or a state legislature, are official governmental bodies authorized and empowered to implement laws. These governmental bodies come in many forms, including agencies, departments, divisions, commissions, corporations, and boards. In this book, we will refer to them most often simply as *implementing organizations and agencies.* In Chapter 4, which discusses the role of courts in policymaking, these bodies are referred to primarily as administrative agencies because that is the term for them preferred by the legal profession. More information about implementing organizations and agencies is provided in Chapter 7, and more information about rules and rulemaking is provided in Chapter 8.

The Administrative Procedure Act of 1946 defined *rule* as "the whole or part of an agency statement of general or particular applicability and future effect designed to implement, interpret, or prescribe law," a definition that still stands. Because such rules are authoritative decisions made in the executive branch of government by the organizations and agencies responsible for implementing laws, they fit the definition of public policies. The rules associated with the implementation of complex laws routinely fill hundreds and sometimes thousands of pages. Rulemaking, the processes through which executive branch agencies write the rules to guide law implementation, is an important activity in policymaking and is discussed in detail in Chapter 8.

Rules, in proposed form (for review and comment by those who will be affected by them) and in final form, are published in the *Federal Register* (*FR;* www.gpoaccess.gov/fr), the official daily publication for proposed and final rules, notices of federal agencies, and executive orders and other presidential documents. The *FR* is published by the Office of the Federal Register, National Archives and Records Administration. Appendix 6 contains the summaries of a proposed rule that would revise parts of the Medicare hospital inpatient prospective payment system and a final rule that modifies and updates certain elements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The entire proposed rule and the final rule are available online at the *FR* website.

Implementation Decisions

When organizations or agencies in the executive branch of any level of government implement laws, they must make numerous implementation decisions in addition to establishing rules or regulations needed to implement laws. These decisions, authoritatively made in the implementing organizations and agencies although different from the formal rules that influence

implementation, are policies as well. For example, effectively managing Medicare requires the federal government to undertake a complex and diverse set of management tasks, including the following:

- Implementing and evaluating Medicare policies and operations
- Identifying and proposing modifications to Medicare policies
- Managing and overseeing Medicare Advantage and prescription drug plans, Medicare fee-for-service providers, and contractors
- Collaborating with key stakeholders in Medicare (i.e., plans, providers, other government entities, advocacy groups, consortia)
- Developing and implementing a comprehensive strategic plan to carry out Medicare's mission and objectives
- Identifying program vulnerabilities and implementing strategies to eliminate fraud, waste, and abuse in Medicare

In carrying out these tasks, the Centers for Medicare & Medicaid Services (CMS; www.cms.gov), the agency responsible for implementing the Medicare and Medicaid programs as well as many aspects of the ACA, makes myriad decisions about implementation. Again, because they are authoritative, these decisions are policies.

Examples of implementation decisions can be found in all implementing agencies. For example, the several federal agencies with implementation responsibilities for the Water Quality Improvement Act (P.L. 91-224) establish operational protocols and procedures for dealing with those affected by the provisions of this law. These protocols and procedures are a form of policy because they are authoritative decisions. Appendix 7 provides another example by illustrating an implementation decision made within the federal Food and Drug Administration (FDA; www.fda.gov)—in this instance, a decision to permit marketing of a medical device to prevent migraine headaches.

Judicial Decisions

Judicial decisions are another form of policy. An example in the health domain is the US Supreme Court's (www.supremecourt.gov) 2005 decision not to hear an appeal filed by six health insurers in a bid to stop a class-action lawsuit brought by more than 600,000 doctors who claimed the companies underpaid them for treating patients. This decision allowed a lower court's ruling to stand, meaning that a class-action suit could proceed in federal court. Another example is the Supreme Court's 2008 *MetLife v. Glenn* decision regarding how federal courts reviewing claims denials by plan administrators under the Employee Retirement Income Security Act "should take into account the fact that plan administrators (insurers and self-insured plans) face a conflict of interest because they pay claims out of their own pockets

and arguably stand to profit by denying claims" (Jost 2008, w430). These decisions are policies because they are authoritative and direct or influence the actions, behaviors, or decisions of others.

Although the judicial branch of government has played an important role in health policy for decades, its role is increasingly relevant. For example, the US Supreme Court ruled in 2012 that the ACA was indeed constitutional. This ruling was a crucial milestone for the law, permitting it to proceed (Liptak 2012). Chapter 4 is devoted to the vital role played by the judiciary in health policy.

Categories of Health Policies

All policies, whether law, rule or regulation, implementation decision, or judicial decision, can be categorized in various ways. One approach divides policies into distributive, redistributive, and regulatory categories (Birkland 2001). Sometimes the distributive and redistributive categories are combined into an allocative category; sometimes the regulatory category is subdivided into competitive regulatory and protective regulatory categories. For our purposes, all of the various forms of health policies fit into two basic categories—allocative or regulatory.

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

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

- buyers and sellers have sufficient information to make informed decisions,
- a large number of buyers and sellers participate,
- additional sellers can easily enter the market,
- each seller's products or services are satisfactory substitutes for those of its competitors, and

- the quantity of products or services available in the market does not swing the balance of power toward either buyers or sellers.

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

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

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

Allocative Policies

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

Other subsidies have been used to ensure that certain people have access to health services. A key feature of the ACA is its subsidization of health insurance coverage for millions of people. Preceding the ACA and continuing into the future, however, the Medicare and Medicaid programs have been massive allocative policies. Medicare expenditures will be more than $1 trillion in 2023, and Medicaid expenditures could surpass $918 billion by then (Sisko et al. 2014).

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

Some of the provisions of the American Recovery and Reinvestment Act of 2009 (P.L. 111-5) provide examples of allocative policy. This law, enacted in response to the global financial crisis that emerged in 2008, contains many health-related subsidies. Exhibit 1.4 lists some examples.

Regulatory Policies

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

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

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

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

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

EXHIBIT 1.4 Examples of Health-Related Subsidies Included in the American Recovery and Reinvestment Act of 2009

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

Source: Steinbrook, R. 2009. "Health Care and the American Recovery and Reinvestment Act." *New England Journal of Medicine* 360 (11): 1057–60. Copyright © 2009 Massachusetts Medical Society. All rights reserved. Used with permission.

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

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

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

The Impact of Health Policy on Health Determinants and Health

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

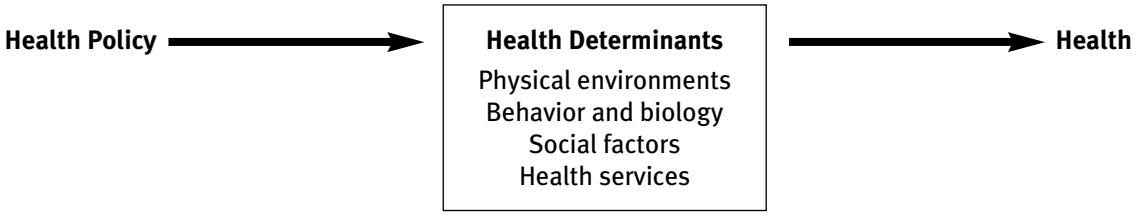
Health policies affect health through an intervening set of variables called health determinants (see Exhibit 1.5). Health determinants, in turn, directly affect health. Consider the role of health policy in the following health determinants and, ultimately, its impact on health through them:

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

Health Policies and Physical Environments

When people are exposed to harmful agents, such as asbestos, dioxin, excessive noise, ionizing radiation, or toxic chemical and biological substances,

EXHIBIT 1.5
The Impact of Policy on Health Determinants and Health



their health is directly affected. Exposure risks pervade the physical environments of many people. Some of the exposure is through such agents as synthetic compounds that are by-products of technological growth and development. Some exposure is through wastes that result from the manufacture, use, and disposal of a vast range of products. And some of the exposure is through naturally occurring agents, such as carcinogenic ultraviolet radiation from the sun or naturally occurring radon gas in the soil.

The hazardous effects of naturally occurring agents are often exacerbated by combination with agents introduced by human activities. For example, before its ban, the widespread use of Freon in air-conditioning systems reduced the protective ozone layer in the earth's upper atmosphere. As a result, an increased level of ultraviolet radiation from the sun penetrated to the earth's surface. Similarly, exposure to naturally occurring radon appears to act synergistically with cigarette smoke as a carcinogen.

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

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

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

Health Policies and Human Behavior and Biology

As Rene Dubos (1959, 110) observed more than a half century ago, "To ward off disease or recover health, men [as well as women and children] as a rule find it easier to depend on the healers than to attempt the more difficult task of living wisely." The price of this attitude is partially reflected in the major causes of death in the United States. Ranked from highest to lowest by the CDC (2014), the leading causes are heart disease, cancer, chronic lower respiratory diseases, stroke, accidents, Alzheimer's disease, diabetes, nephritis/nephritic syndrome/nephrosis, influenza/pneumonia, and suicide.

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

Changes in behaviors can change the pattern of causes of death. The death rate from heart disease, for example, has declined dramatically in recent decades. Although aggressive early treatment has played a role in reducing this rate, better control of several behavioral risk factors—including cigarette smoking, elevated blood pressure, elevated levels of cholesterol, poor diet, lack of exercise, and elevated stress—explains much of the decline. Even with this impressive improvement, however, heart disease remains the most common cause of death and will continue to be a significant cause. Cancer death rates continue to be problematic, with much of the problem attributable to lung cancer, which is strongly correlated with behavior. Appendix 8 describes the extent of state, commonwealth, territory, and municipality laws intended to restrict where smoking is allowed.

Health Policies and Social Factors

A number of social factors can affect health. Chronic unemployment, the absence of a supportive family structure, poverty, homelessness, and discrimination, among other social factors, affect people's health as surely—and often as dramatically—as harmful viruses or carcinogens.

People who live in poverty experience measurably worse health status, meaning more frequent and more severe health problems, than those who are more affluent (Do and Finch 2008). African Americans, Hispanics, and Native Americans, who are disproportionately represented below the poverty line, experience worse health than the white majority (National Center for Health Statistics 2013).

The poor also typically obtain their health services in a different manner. Instead of receiving care that is coordinated, continuing, and comprehensive,

the poor are far more likely to receive a patchwork of services, often provided by public hospitals, clinics, and local health departments. In addition, poor people are more often treated episodically, with one provider intervening in one episode of illness and another provider handling the next episode.

The effect of economic conditions on the health of children is especially dramatic. Impoverished children, on average, have lower birth weights and more conditions that limit school activity compared with other children. These children are more likely to become ill and to have more serious illnesses than other children because of increased exposure to harmful environments, inadequate preventive services, and limited access to health services.

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

An example of health policy intended to address social factors is the Balanced Budget Act of 1997 (P.L. 105-33). This policy provided for expanded health insurance coverage of children by establishing the State Children's Health Insurance Program. In 2009, President Obama signed a renewal of this program into law as the Children's Health Insurance Program (CHIP) Reauthorization Act of 2009 (P.L. 111-3). The CHIP reauthorization significantly expanded coverage to include an additional 4 million children and, for the first time, allowed the spending of federal money to cover children and pregnant women who are legal immigrants. The ACA extended CHIP through 2015. This policy, with many others, has addressed some of the social factors that affect health. However, a great deal remains to be done.

Health Policies and Health Services

As shown in Exhibit 1.5, another important determinant of health is availability of and access to health services, which are any of a host of "specific activities undertaken to maintain or improve health or to prevent decrements of health" (Longest and Darr 2014, 253). Health services can be preventive (e.g., blood pressure screening, mammography), acute (e.g., surgical procedures, antibiotics to fight an infection), chronic (e.g., control of diabetes or hypertension), restorative (e.g., physical rehabilitation of a stroke or trauma patient), or palliative (e.g., pain relief or comfort in terminal stages of disease).

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

Money

As Exhibit 1.6 shows, the United States allocates enormous sums of money to health, and growth of these national health expenditures is expected to continue. As noted earlier, these expenditures may exceed $5 trillion by 2023 at which time the nation will be spending about 20 percent of its GDP on health. About half of these expenditures will be by governments, directed by their policy decisions.

The United States spends more on health than does any other country (OECD 2014). Other countries have been far more likely to adopt policies such as global budgets for their healthcare systems or to impose restrictive limitations on the supplies of health services (Squires 2011).

Current health expenditures and projected future increases have significant implications. The increasing expenditures, in part, reflect higher prices. Higher prices reduce access to health services by making it more difficult for many people to purchase the services or the insurance needed to

	2008	2012	2019[a]	2023[a]
NHE (billions)	$2,412	$2,793	$4,043	$5,159
NHE personal healthcare (billions)	2,017	2,360	3,413	4,360
Government public health activities (billions)	71.5	75.0	102.1	123.9
NHE per capita	7,936	8,915	12,131	14,944
NHE as percentage of GDP	16.4%	17.2%	18.1%	19.3%

Source: Data abstracted from Sisko et al. (2014).

[a]Projected.

EXHIBIT 1.6 National Health Expenditures (NHE), Aggregate and per Capita Amounts, and Share of Gross Domestic Product (GDP) for Selected Calendar Years

cover those services. As the nation works its way through the aftermath of the worst economic downturn since the Great Depression, reduced employment is dramatically affecting the number of uninsured. Implementation of the ACA will help address this problem for millions of people, but expenditure levels will remain problematic. They negatively affect the nation's competitiveness in the global economy (Vietor and Weinzierl 2012), and health expenditures have absorbed much of the growth of many workers' real compensation, meaning that as employers spend more to provide health insurance benefits, wages decrease.

Growing health expenditures are a continuing source of budgetary pressure for the federal and state governments. As health expenditures consume a growing portion of government resources, it is becoming more difficult for government to support other priorities, such as education or homeland security.

Workforce

The talents and abilities of a large and diverse workforce make up another basic resource used to provide health services. The healthcare workforce is directly affected by health policies, whether through public funding of educational programs or licensing of health professionals. There are about 19 million healthcare workers in the United States, representing more than 13 percent of the nation's workforce. Despite the recent economic downturn, which saw jobs decline throughout the economy, jobs in the health sector grew by more than 25 percent and are expected to grow by another 30 percent between 2010 and 2020 (Center for Health Workforce Studies 2012).

The nation's rapidly aging population, coupled with the large increase in insured people triggered by the ACA, will "strain a healthcare delivery system already struggling under the weight of its current load" (Association of Academic Health Centers 2013, 1). These pressures will require a new approach to national health workforce policy. The traditional approach focused on numbers of workers, producing health workforce policy that featured responses to projected shortages in the workforce, especially among physicians and nurses. For example, the number of physicians doubled from the mid-1960s to the mid-1990s, an accomplishment driven by federal policies intended to increase their supply, including the Health Professions Educational Assistance Act of 1963 (P.L. 88-129) and its amendments of 1965, 1968, and 1971. Similarly, the main federal response to a projected nurse shortage was the Nurse Reinvestment Act of 2002 (P.L. 107-205), which authorized the following provisions:

- Loan repayment programs and scholarships for nursing students
- Public service announcements to encourage more people to enter the nursing profession

- Career ladder programs for those who wish to advance in the profession
- Best-practice grants for nursing administration
- Long-term care training grants to develop and incorporate gerontology curriculum into nursing programs
- A fast-track faculty loan repayment program for nursing students who agree to teach at a school of nursing

Going forward, a comprehensive and integrated national health workforce policy will be needed. A good prescription for such a policy for the nation is the following (Association of Academic Health Centers 2013, 2–3):

- Create and fund a national health workforce planning body that engages diverse federal, state, public, and private stakeholders.
- Promote harmonization in public and private standards, requirements, and prevailing practices across jurisdictions.
- Invest in a comprehensive health workforce research component that will
  - address development and dissemination of consensus definitions and terminology;
  - monitor developing technological breakthroughs that require changes in provider numbers, types, and expertise;
  - identify gaps in data collection and current modeling strategies for supply and demand; and
  - promote consistent approaches to research across all health professions.

Provisions in the ACA that created the National Health Care Workforce Commission and the National Center for Health Workforce Analysis hold promise for producing a more comprehensive and integrated workforce policy, but the work of these entities in the future will depend on as-yet-unrealized adequate funding.

Technology

A third type of resource that health policies significantly affect is health-related technology. Broadly defined, *technology* is the application of science to the pursuit of health. Technological advances result in better pharmaceuticals, devices, and procedures. A major influence on the pursuit of health in the United States, technology has helped eradicate some diseases and has greatly improved diagnoses and treatment for others. Diseases that once were not even diagnosed are now routinely and effectively treated. Advancing technology has brought medical science to the early stages of understanding disease at the molecular level and intervening to treat diseases at the genetic level.

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

Health policy provides funding for much of the research and development (R&D) that leads to new technology, although the private sector also pays for a great deal of R&D. The United States has a long history of support for the development of health-related technology through policies that support biomedical research and encourage private investment in such research. The National Institutes of Health (NIH; www.nih.gov) invests more than $30 billion annually in medical research. About 80 percent of the NIH's funding is awarded through almost 50,000 competitive grants to more than 300,000 researchers at more than 2,500 universities, medical schools, and other research institutions in every state and around the world. About 10 percent of the NIH's budget supports projects conducted by nearly 6,000 scientists in its own laboratories, most of which are on the NIH campus in Bethesda, Maryland (NIH 2014).

Encouraged by policies that permit firms to recoup their investments, private industry also spends heavily on biomedical R&D. In fact, the Pharmaceutical Research and Manufacturers of America (PhRMA; www.phrma.org), which represents the nation's leading biopharmaceutical research companies, reports that industry-wide research investment was $48.5 billion in 2012 (PhRMA 2014).

Health policy also affects technology through the application of regulatory policies, such as those promulgated by the FDA to ensure technology's safety and efficacy. The FDA is responsible for protecting the public health by ensuring the safety, efficacy, and security of human and veterinary drugs, biological products, medical devices, the food supply, cosmetics, and products that emit radiation. The FDA also has responsibility for regulating the manufacture, marketing, and distribution of tobacco products to protect the public health and to reduce tobacco use by minors. Finally, the FDA plays a significant role in the nation's counterterrorism capability by ensuring the security of the food supply and by fostering development of medical products to respond to deliberate and naturally emerging public health threats (FDA 2014).

The following are laws the FDA is responsible (or partially responsible) for implementing, including writing rules for implementation:

- Food, Drug, and Cosmetic Act of 1938 (P.L. 75-717)
- Infant Formula Act of 1980 (P.L. 96-359)
- Orphan Drug Act of 1983 (P.L. 97-414)

- Federal Anti-Tampering Act of 1983 (P.L. 98-127)
- Drug Price Competition and Patent Term Restoration Act of 1984 (P.L. 98-417)
- Prescription Drug Marketing Act of 1987 (P.L. 100-293)
- Generic Animal Drug and Patent Term Restoration Act of 1988 (P.L. 100-670)
- Sanitary Food Transportation Act of 1990 (P.L. 101-500)
- Nutrition Labeling and Education Act of 1990 (P.L. 101-535)
- Safe Medical Devices Act of 1990 (P.L. 101-629)
- Medical Device Amendments of 1992 (P.L. 102-300)
- Prescription Drug Amendments of 1992 (P.L. 102-353)
- Mammography Quality Standards Act (MQSA) of 1992 (P.L. 102-539)
- Prescription Drug User Fee Act (PDUFA) of 1992 (P.L. 102-571)
- Animal Medicinal Drug Use Clarification Act (AMDUCA) of 1994 (P.L. 103-396)
- Dietary Supplement Health and Education Act of 1994 (P.L. 103-417)
- FDA Export Reform and Enhancement Act of 1996 (P.L. 104-134)
- Food Quality Protection Act of 1996 (P.L. 104-170)
- Animal Drug Availability Act of 1996 (P.L. 104-250)
- Food and Drug Administration Modernization Act (FDAMA) of 1997 (P.L. 105-115)
- Best Pharmaceuticals for Children Act of 2002 (P.L. 107-109)
- Medical Device User Fee and Modernization Act (MDUFMA) of 2002 (P.L. 107-250)
- Public Health Security and Bioterrorism Preparedness and Response Act of 2002 (P.L. 107-188)
- Animal Drug User Fee Act of 2003 (P.L. 108-130)
- Pediatric Research Equity Act of 2003 (P.L. 108-155)
- Project BioShield Act of 2004 (P.L. 108-276)
- Minor Use and Minor Species Animal Health Act of 2004 (P.L. 108-282)
- Food Allergen Labeling and Consumer Protection Act of 2004 (P.L. 108-282)
- Dietary Supplement and Nonprescription Drug Consumer Protection Act of 2006 (P.L. 109-462)
- FDA Amendments Act of 2007 (P.L. 110-85)
- Family Smoking Prevention and Tobacco Control Act of 2009 (P.L. 111-31)
- FDA Food Safety Modernization Act of 2011 (P.L. 111-353)

Advances in technology drive up the costs of health services as the new technology is used and paid for. One paradox of advancing health-related technology is that as people live longer because of these advances, they then may need additional health services. The net effect drives up health expenditures for the new technology and for other services consumed over a longer life span. The costs associated with use of technology generate policy issues of their own. For example, Medicare policies guide the determination of whether it will pay for new services, treatments, and technologies. Using an evidence-based process, with opportunities for public participation, CMS makes a national coverage determination based on whether an item or service is reasonable and necessary for the diagnosis or treatment of an illness or injury. This complex process can be reviewed at www.cms.gov/Medicare/Coverage/DeterminationProcess/. A specific example of this decision making is CMS's decision to cover implantable cardioverter defibrillators (Hlatky, Sanders, and Owens 2005).

Health System

The health system in any country can be defined as the total national effort undertaken in the private and public sectors that is focused on pursuing health. In the United States, the health system is distinctly divided into public health and healthcare delivery and financing components. The distinctions between these two components are beginning to blur, but major differences remain. Each component is heavily influenced by policies.

The public health component of the health system produces services on a community-wide or population-wide basis, such as health promotion and prevention, communicable disease control, sanitation, food and water safety, the collection and analysis of health statistics, and air pollution control. The healthcare delivery and financing component of the health system provides services primarily to individuals, including diagnosis, treatment, and rehabilitation.

Structurally, the public health component of the health system includes the following (Congressional Research Service 2005):

- About 3,000 county and city health departments and local boards of health
- Fifty-nine state, territorial, and island nation health departments
- Various US Public Health Service agencies in HHS
- Tribal health agencies, coordinated at HHS by the Indian Health Service
- More than 160,000 public and private laboratories

In addition to these public health infrastructure components, some accounts include volunteer organizations such as the American Red Cross,

American Diabetes Association, and American Cancer Society as part of the public health component. Reflecting the blurring of the lines between public health and healthcare components, some accounts also include hospitals and other healthcare services providers. Structurally, however, the healthcare delivery and financing component of the health system in the United States remains largely distinct from the public health component. The healthcare component is also much larger and more elaborate. One way to envision the variety and diversity of healthcare delivery organizations is to consider a continuum of health services that people might use over the course of their lives and to think of the organizational settings that provide them (Longest and Darr 2014).

The continuum could begin before birth with organizations that minimize negative environmental impact on human fetuses or that provide genetic counseling, family planning services, prenatal counseling, prenatal ambulatory care services, and birthing services. This stage would be followed early in life by pediatric ambulatory services; pediatric inpatient hospital services, including neonatal and pediatric intensive care units (ICUs); and ambulatory and inpatient psychiatric services for children.

Healthcare delivery organizations for adults include those providing adult ambulatory services, such as ambulatory surgery centers and emergency and trauma services; adult inpatient hospital services, including routine medical, surgical, and obstetrical services as well as specialized cardiac care units, medical ICUs, surgical ICUs, and monitored units; stand-alone cancer units with radiotherapy capability and short-stay recovery beds; ambulatory and inpatient rehabilitation services, including specific subprograms for orthopedic, neurological, cardiac, arthritis, speech, otologic, and other services; ambulatory and inpatient psychiatric services, including specific subprograms for psychotics, day programs, counseling services, and detoxification; and home health care services.

In their later years, people might add to the list of relevant healthcare delivery organizations those providing skilled and intermediate nursing services; adult day-care services; respite services for caregivers of homebound patients, including services such as providing meals, visiting nurse and home health aides, electronic emergency call capability, cleaning, and simple home maintenance; and hospice care, palliative care, and associated family services, including bereavement, legal, and financial counseling.

Healthcare delivery traditionally took place in autonomous organizations with little attention paid to coordination of the continuum of services. In recent decades, however, most healthcare delivery organizations have significantly changed how they relate to one another. Mergers, consolidations, acquisitions, and affiliations are now commonplace. This activity has led to vertical integration, in which multiple organizations unify in organizational

arrangements or systems. Vertically integrated systems capable of providing a largely seamless continuum of health services—including primary, acute, rehabilitation, long-term, and hospice care—increasingly characterize healthcare in the United States. At the extreme end of this integrative activity are large integrated systems and networks in which providers, spanning the full continuum of health services, are integrated with financing mechanisms such as health plans or insurers (Longest and Darr 2014).

Each component of the health system is heavily influenced by policy. Public health policy concerns the government's power to protect and preserve the health of the citizenry while recognizing individual rights to autonomy, privacy, and other legally protected interests. Policy for healthcare delivery and financing includes licensing of institutions, regulation of health plans, reimbursement arrangements for services, and many other activities. Among its many provisions, the ACA includes some that clearly support the public health component of the health system (e.g., establishing the National Prevention, Health Promotion, and Public Health Council to coordinate federal prevention, wellness, and public health activities) and other provisions that support the healthcare delivery and financing component (e.g., improvements and expansion of the Medicare and Medicaid programs, fostering accountable care organizations).

In terms of government's support, as expressed through policy, for the two components of the health system, it is fair to say that support for public health is inadequate and support for healthcare has historically been generous but is now tightening under pressure for government at all levels to operate under budgetary constraints. Evidence of government's support for healthcare includes enactment in 1946 of the Hospital Survey and Construction Act (P.L. 79-725), a policy that placed Congress squarely in support of expanded availability of health services and improved facilities. Called the Hill-Burton Act after its authors, this legislation provided funds for hospital construction and marked the beginning of a decades-long program of extensive federal developmental subsidies aimed at increasing the availability of health services.

Public policy has also supported and facilitated the expansion of health insurance coverage. During World War II, when wages were frozen for many workers, health insurance and other benefits in lieu of wages became attractive features of the American workplace. Encouraged by policies that excluded these fringe benefits from income taxes and by a US Supreme Court ruling that employee benefits, including health insurance, could be legitimately included in the collective bargaining process, employer-provided health insurance benefits grew rapidly in the mid-twentieth century (Murray 2007).

Medicare and Medicaid are policies providing greater access to mainstream health services through publicly subsidized health insurance for aged

individuals and many poor. With enactment of these programs, 85 percent of the American population had some form of health insurance. Fuller implementation of the ACA will extend health insurance coverage still further.

Summary

WHO (1946) defines health as the "state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity," a definition first appearing in the organization's constitution in 1946 and continuing unchanged to today. Health is a function of many health determinants: the physical environments in which people live and work; their behaviors and genetics; social factors (including economic circumstances, socioeconomic position, and income distribution); discrimination based on factors such as race/ethnicity, gender, or sexual orientation; and the availability of social networks or social support and the type, quality, and timing of health services that people receive. Examples of how health policy affects the various determinants of health are provided in the chapter.

A distinction is made between public- and private-sector policy. Public-sector health policy is defined as authoritative decisions regarding health or the pursuit of health made in the legislative, executive, or judicial branches of government that are intended to direct or influence the actions, behaviors, or decisions of others. In this definition, the phrase "authoritative decisions" is crucial. It specifies decisions made anywhere in the three branches of government—and at any level of government—that are within the legitimate purview (i.e., the official roles, responsibilities, and authorities) of those making the decisions.

Public-sector health policies are the principal means through which governments help shape the pursuit of health. In the United States, policies can take the form of laws, rules or regulations, implementation decisions, and judicial decisions. Health policies, like other public policies, can fit into broad allocative or regulatory categories.

As this chapter concludes, it will be useful to revisit Exhibit 1.5 briefly. With the information provided in this chapter, the reader should be able to define health, health determinants, and health policy and understand the important interrelationships among them. Most important, health policy affects health by affecting one or more of the health determinants listed in Exhibit 1.5.

Review Questions

1. Define health. What are the determinants of health in humans?
2. Define public policies and health policies.
3. What forms do health policies take? Give an example of each.
4. Compare and contrast the two basic categories of health policies.
5. Discuss the connections among health policies, health determinants, and health.

Case Study: U.S. Hospitals and the Civil Rights Act of 1964

The Civil Rights Act of 1964 (P.L. 88-352) is a landmark civil rights policy in the United States. It is also important health policy because it addresses an important determinant of health: discrimination. This case study of the act's emergence and subsequent impact provides vivid examples of many of the concepts and features of health policymaking presented in this book. For example, the case illustrates the formulation, implementation, and modification phases of policymaking. It illustrates both public- and private-sector policy. It illustrates the various forms that public policy takes: laws, rules and regulations, implementation decisions, and judicial decisions. The case includes examples of health policy emerging from the work of legislative bodies, executive branch employees, and the courts. It shows how policy is influenced by and, in turn, influences the larger environment in which policymaking occurs. Most important, the case illustrates the extraordinary role that policy can play in human health as well as the sometimes equally extraordinary difficulties policies face in achieving their intended impact. Written in the summer of 2014, this case looks back 50 years and more.

Next month, the Civil Rights Act of 1964 will celebrate its 50th birthday. It was the product of more than 150 years of advocacy, violence, court fights and public demonstrations during which many people were imprisoned, injured and even killed as they endeavored to force the United States, to use the words of the great Princeton economist Uwe Reinhardt, "to live up to its own Constitution."

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The act had an impact on virtually every aspect of American life, and nowhere did it change things more than in many U.S. hospitals.

A Common Misperception

There has long been a misperception about the act's role in the racial desegregation of American health care. The widespread belief is that passage of the Social Security Amendments of 1965 (Public Law 89-97, which created Medicare and Medicaid) was the determining factor. That was not the case; by the time it was passed, many hospitals that had practiced racial segregation already had abandoned it. Medicare was more of a clean-up operation with recalcitrant facilities. The Civil Rights Act, specifically Title VI, was the key to racial equality in the health care setting.

Uncomfortable as it is to remember less enlightened times, racial segregation was commonplace in U.S. hospitals well into the 20th century. It took several forms. One was simply that, particularly in the South, there were hospitals for white people and hospitals for African-Americans, the latter often founded by African-American physicians who could not obtain admitting privileges at white hospitals. Care at the black hospitals tended to be of lower quality, usually due to lack of resources. Some hospitals admitted both groups, but the African-American patients were segregated, often in subpar attic or basement wards.

In the case of Grady Memorial Hospital in Atlanta, a wall was constructed between the "black" and "white" sides of the hospital, leading many people to refer to the facility as "the Gradies." Segregation in health care took other forms. In some hospitals, white and black patients could not share the same room. African-American physicians could not get privileges except in black hospitals. African-American nurses, no matter how senior, were not allowed to supervise white nurses. Transfusion of blood donated by a member of one racial group to a patient belonging to a different group often was prohibited, regardless of the clinical quality of the match. Even newborns often were segregated in different nurseries.

A Widespread Practice

How widespread was all this? According to Professor P. Preston Reynolds, M.D., Ph.D., of the University of Virginia School of Medicine, who has chronicled the history of hospital desegregation in a series of instructive articles, and on whose work I am drawing heavily for

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this story, it wasn't rare. She reports that in 1959, pioneering African-American physician Paul Cornely, M.D., conducted a survey of racial segregation in health care. He found that 83 percent of Northern hospitals were integrated in terms of patient admissions, but only 6 percent of Southern hospitals were. Of the other 94 percent of facilities in the South, 33 percent admitted no African-Americans, 50 percent admitted them to segregated wards, and segregation was present in some form in the others.

It wasn't much better for African-American physicians. Only 10 percent of Northern hospitals accepted African-American interns or residents; only 20 percent had them on staff. Only 6 percent of Southern hospitals accepted them as interns or residents, and only 25 percent granted them staff privileges.

However, by the late 1950s, 42 percent of medical schools in the South were admitting African-Americans, and 53 percent of Southern medical societies accepted them. Some change was in the wind. But for the most part, it was business as usual.

Segregation had clinical consequences. It is widely believed that the great blues singer Bessie Smith, critically injured in an auto accident, died as a result of being refused admission to a white hospital; the physician who treated her on the scene said that was not the case and that she died of non-survivable injuries. There is also a myth that Charles R. Drew, M.D., another pioneering African-American physician whose work greatly improved blood storage and blood bank efficiency, thus saving thousands of lives, bled to death because he was refused "white" blood. This is also untrue.

But Reynolds reports that prominent African-Americans did die as a result of hospital segregation. One was Juliette Derricotte, dean of women at Fisk University, who died following an auto accident because she was refused care at a hospital that did not accept African-Americans. Another was the father-in-law of Walter White, executive director of the National Association for the Advancement of Colored People, who, after being hit by a car, died after being transferred during a rainstorm from Grady's "white" side to its "black" side. There were undoubtedly many others.

Pressure for Change

Change finally came as the result of years of work by African-American physicians, the NAACP and the courts.

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It should have come earlier than it did, because the Hill-Burton Act of 1946, which provided funds for construction and improvement of hospitals all over the United States, had a provision requiring equal treatment of all patients. However, it also had a "separate but equal" provision, allowing segregated hospitals to receive Hill-Burton funds as long as the quality of care was the same. It wasn't, and neither was the distribution of Hill-Burton funds, which grossly favored white hospitals.

Interpretation of the Hill-Burton requirements sometimes defied logic. The general counsel of the Department of Health, Education, and Welfare decided that Hill-Burton hospitals could not deny admission to any person *to the part of the hospital that used federal funds* (it must have been fun figuring that out), but patients could be denied access to other areas.

Also, even if a Hill-Burton hospital accepted African-American patients, often their black physicians could not continue to treat them once they were admitted, because they did not have privileges and could not get them.

In 1956 (two years after *Brown vs. Board of Education* ended separate-but-equal practices in education), the NAACP decided it was time to challenge the separate-but-equal provision of the Hill-Burton Act. The first lawsuit was *Eaton vs. Board of Managers of the James Walker Memorial Hospital*, filed by a trio of African-American physicians who had been denied privileges. They argued that because the hospital received federal funds, discriminating against them violated the Fourteenth Amendment. They lost at the district and appeals level, and the Supreme Court declined to review the case. However, three justices dissented.

Buoyed by the possibility of future success at the Supreme Court, the NAACP pushed forward, and soon the ideal case emerged. George Simkins, D.D.S., a North Carolina African-American dentist, had been denied privileges at Moses H. Cone Memorial Hospital, which admitted black patients and received Hill-Burton funds. Working with the NAACP, and with support from the Department of Justice, Simkins recruited African-American patients and other practitioners to join a suit, and on February 12, 1962, *Simkins vs. Moses H. Cone Memorial Hospital* was filed in district court. The plaintiffs asked that the separate-but-equal provision of the Hill-Burton Act be struck down, that discrimination in admitting and treatment privileges be ended, and that refusal to admit African-American patients be banned.

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The district court found for the defendants, but the plaintiffs appealed and won at the Fourth Circuit Court of Appeals. The case was appealed to the Supreme Court. At that point, HEW [now HHS] Assistant Secretary James Quigley offered support to the NAACP effort and, as all the stakeholders awaited a decision from the Supreme Court, Quigley stopped Hill-Burton payments to eight hospitals being constructed under the separate-but-equal provision.

On March 2, 1964, the Supreme Court declined to review the case, and the appeals court verdict stood. Separate-but-equal under Hill-Burton was dead. Hospitals receiving funds from the program would have to desegregate.

HEW officials were quick to enforce the decision, although there was little they could do to desegregate hospitals that no longer received Hill-Burton funds or those that never had. That would have to be voluntary on the part of the hospitals.

The Last Nail in the Coffin

But four months later, President Lyndon B. Johnson signed the Civil Rights Act, which was pretty much the last nail in segregation's coffin. The key provision of Title VI read: "No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance."

Passage of a law is one thing; enforcement [and its overall implementation] is quite another. The Eisenhower administration had been lackadaisical in its enforcement of the *Brown vs. Board of Education* decision; the Johnson administration was ready for a full-court press to use Title VI to end, in the words of African-American physician W. Montague Cobb, "the greatest of all discriminatory evils, differential treatment toward African-Americans with respect to hospital facilities."

Less than a month after passage of the Civil Rights Act, Surgeon General Luther Terry, M.D. (back then, the surgeon general was much more than a figurehead), who was one of the federal health officials charged with seeking hospital compliance with the act, wrote an article in *Hospitals* in which he urged American Hospital Association members to comply. He pointed out that Title VI applied to hospitals receiving federal funds of any type.

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He also noted that before the act was even passed, the AHA "had gone on record as favoring the adoption by hospitals of nondiscrimination policies in the admission and care of patients and the granting of staff privileges." He urged health care associations to "create a favorable climate of opinion" to ensure that all hospitals were in compliance with the act. The AHA subsequently took that request seriously.

Federal reviewers fanned out across the country, seeking to document compliance. They encountered a mixed bag, ranging from hospitals that had long since desegregated (or had always been integrated) to those that were trying to comply (hospital administrators would tell the feds that they wanted to end racist policies, but that their boards would not let them) to those that had no interest in complying and were determined to hold out.

On September 1, 1965, HEW Assistant Secretary Quigley spoke at the AHA annual meeting in San Francisco and related some tales of recalcitrance. Some hospitals said there were no African-American newborns in the nurseries because all of their mothers wanted to nurse them, so they were kept in their mothers' rooms. A few administrators said that they did not segregate African-American patients, but rather "reserved" a section of the hospital for them. Other administrators claimed that African-Americans preferred to use entrances that had only recently been marked "Colored." One hospital executive said he could not convince his staff to write "Mr.," "Mrs." or "Miss" in front of an African-American patient's name on the chart. Someone else told reviewers that there were no African-Americans on the hospital board because black people were not public-spirited enough to volunteer. A few administrators said that African-American patients did not want to share rooms with white patients.

One hospital, in Quigley's words, "removed 'Colored' and 'White' signs from their rest rooms and installed locks on the doors—then issued keys only to the white staff." But in what Quigley described as "the ultimate step in our education to date," a hospital placed African-American and white patients in the same rooms, closed the segregated dining room for African-Americans and integrated the nursery—then changed everything back to segregated circumstances once the review team had left town.

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Quigley ended his remarks by asking AHA's members, "You have been unsparing in the past—will you join us now in this biggest job of all?"

And Then Came Medicare

Many hospitals did—but not all. And that posed a problem when Medicare and Medicaid were passed a year later; President Johnson signed the Social Security Amendments of 1965 on July 30. Medicare funds were federal funds; if a hospital received them, it had to be in compliance with Title VI of the Civil Rights Act.

Although federal representatives directed by Sherry Arnstein, HEW's new director of hospital civil rights compliance, had successfully desegregated 21 Southern hospitals, by April 1966—shortly before Medicare and Medicaid were to take effect—only 49 percent of American hospitals were in full compliance with Title VI. In seven Southern states, only 15 percent were.

Federal authorities did everything they could to change the situation, because, very simply, reimbursement for care of Medicare and Medicaid patients would not be forthcoming if a hospital remained segregated. President Johnson had been worried ever since the passage of Medicare that there would not be enough physicians to treat newly enfranchised patients (the AMA had fiercely opposed the legislation); now there might not be enough hospitals willing to accept those patients.

Deputy Surgeon General Leo Gehrig, M.D. (who later served for 10 years as director of the AHA's Washington, D.C., office) approached Edwin Crosby, M.D., president of the AHA, and asked for help. Crosby said he would do anything he could. He arranged many meetings between federal compliance staff and hospital leaders. The AHA also produced a short film and a pamphlet for Southern state hospital associations to help them educate their members about what had to be done.

Federal authorities also made the point that segregation was expensive for hospitals, given the cost of duplicating so many services. And the idea of not being eligible for Medicare and Medicaid reimbursement was also a powerful incentive, once it was obvious that the feds meant business and would not pay noncompliant facilities.

The pressure started to pay off. Even conservative Southern politicians conceded that the fight was over. As Reynolds writes, by June 1965, "The word was out. [The Department of Health, Education, and Welfare] would not cave in."

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By that same month, 85 percent of hospitals were in compliance with Title VI, and Crosby continued to facilitate meetings between federal representatives and officials of hospitals that were still holding out.

Blue Cross and Blue Shield plans, which at the time had an extremely close relationship with the AHA (ah, the good old days!), joined the effort and informed noncompliant hospitals that they would not pay them for patients older than 65 because they would be eligible for Medicare. And if the hospitals wanted Medicare reimbursement for those patients, they would have to comply with Title VI. Sometimes a Catch-22 makes sense.

On June 30—the day before Medicare became effective—federal officials produced the latest numbers. In 14 states and three territories, 100 percent of hospitals were in compliance. In all but five Southern states, 80 percent of hospital beds would be available for Medicare patients. President Johnson told a television audience that night, "Medicare will succeed if hospitals accept their responsibility under the law not to discriminate against any patient because of race." And with the help of their national and state associations, they did just that.

There were many unsung heroes in this effort: the NAACP legal team, which included Thurgood Marshall (later the first African-American Supreme Court Justice), Jack Greenberg and Michael Meltsner (of the hundreds of Hill-Burton complaints sent to the Justice Department, Meltsner wrote most of them); Surgeon General Luther Terry, M.D. (who in 1964 also issued the landmark federal report on the dangers of smoking) and his deputy, Leo Gehrig, M.D.; a host of HEW officials, including James Quigley, Sherry Arnstein and Peter Libassi, who was appointed special assistant to HEW Secretary John Gardner for civil rights; HEW secretaries Anthony Celebrezze and John Gardner; the African-American physicians, dentists and patients who would no longer tolerate being treated as second-class health care citizens; and the American Hospital Association and Edwin Crosby, M.D., who risked his job to do the right thing.

And just for the record, in our current partisan and sometimes hateful times, a lot of these folks were white.

An Unfinished Crusade

So is racism in health care history? Not unless you just took a header off the turnip truck. A 2013 study by the Institute for Diversity in Health Management and the Health Research & Educational Trust found

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that "although minorities represent a reported 31 percent of patients nationally, they comprise only 14 percent of board members, an average of 12 percent of executive leadership positions, and 17 percent of first- and midlevel management positions." Whites continued to be overrepresented on boards, whereas African-Americans and Latinos were grossly underrepresented. Although 58 percent of chief diversity officers were members of minority groups (surprise), only 17 percent of chief medical officers, 13 percent of COOs, 11 percent of chief nursing officers, 9 percent of CEOs and 6 percent of CFOs were.

Racial and ethnic disparities in access to care, insurance and outcomes are still with us, and although progress has been made, some of them seem intractable. And as recently as 2010, there was still racial friction on health care's front lines. That year, Brenda Chaney, a certified nursing assistant in a long-term care facility, sued her employers when they sought to honor a white patient's request to have only white caregivers. The courts found the nursing home in violation of Title VI.

There were casualties of Title VI as well, notably the historically African-American hospitals, of which there were once as many as 500, which in the years after passage of the Civil Rights Act were closed or merged with other facilities. They represented a significant part of health care history, and they are gone. Nathaniel Wesley Jr., however, has chronicled their story, so it has not been lost (see below).

But there has been progress as well. The AHA has had three African-American chairs (the late Carolyn Boone Lewis, Kevin Lofton and John Bluford) and the American Medical Association an African-American president, Lonnie Bristow, M.D. African-Americans have served as both surgeons general and as secretary of HEW (now HHS).

A Cultural Shift

More importantly, the culture has changed. Most people working in hospitals today wouldn't think of determining admission on the basis of color; insurance, maybe, but not color. Most physician privileges are awarded on the basis of qualification. Minorities supervise white employees all the time. In most settings, it just isn't an issue. And hospital efforts to increase minority representation in the C-suite and the boardroom, and to address racial and ethnic disparities, are ongoing.

I was witness to the beginning of this cultural shift. In 1969, I was the laboratory test slip delivery person in a hospital in Oakland,

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California. (It was one of several jobs I have had that no longer exist.) I was crazy about the work, because I love hospitals and I got to roam all over the facility, delivering little pieces of paper and pasting them into charts.

One day, there was an incident, and it was the talk of the hospital. An African-American surgical resident was in danger of being dismissed. It certainly wasn't his skill level; he was considered one of the best surgeons ever to set foot in the place. Nor was it his color.

No, it turned out that a lady friend had embroidered flowers on the lapels of his resident's coat, and he was out of compliance with uniform code. The hospital was threatening to take action against him, not because of his race, but because he had embroidered lapels.

Hey, it was the Bay Area in the '60s. The times they were a-changing.

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Discussion Questions

1. From the case study, provide one example of each of the forms that public policies can take: laws, rules or regulations, other implementation decisions, and judicial decisions.
2. From the case, provide one example of each of the categories of health policies.
3. Why is the Civil Rights Act a health policy as well as a civil rights policy?
4. What environmental forces influenced enactment of the Civil Rights Act?
5. Discuss the role played by the courts in the Civil Rights Act.
6. Discuss the impact of the Civil Rights Act on American hospitals.
7. Discuss the role of private-sector actors in implementing the Civil Rights Act.
8. Based on the limited information provided in the case, was the Hill-Burton Act effective policy?

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