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SYMPOSIUM

Health Care Politics and Policy

The Business of Medicine: A Course for Physician Leaders

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This article is a condensed and edited version of a speech delivered to The Business of Medicine: A Course for Physician Leaders symposium presented by Yale-New Haven Hospital and the Medical Directors Leadership Council at Yale University in November 2012 and drawn from *Politics, Health, and Health Care: Selected Essays* by Theodore R. Marmor and Rudolf Klein [1]. It faithfully reflects the major argument delivered, but it does not include the typical range of citations in a journal article. The material presented here reflects more than 40 years of teaching a course variously described as Political Analysis and Management, Policy and Political Analysis, and The Politics of Policy. The aim of all of these efforts is to inform audiences about the necessity of understanding political conflict in any arena, not least of which is the complex and costly world of medical care.

INTRODUCTION

There are many ways to analyze health care politics and policy. Different disciplines and different groups within disciplines fight over the right way to approach public policy, all seeking to impose their own definitions of the subject and to patent their own methodology. My aim is to be clear about what I regard as the fundamental elements of political and policy analysis applied to health care.

By public policy in health care, I mean quite simply what governments do and neglect to do about the world of medical care. By politics, I mean the resolving — or at least attenuating — conflicts about resources, rights, and values. This article sets aside the issue of whether the aim of analysis should be about understanding or prescribing. No prescription, to my mind, is worth the paper it is written on if not based on an understanding of how the world of

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policy making works. Empathy, in the sense of capturing what drives policy actors in a field like politics and medicine and entering into their assumptive worlds, is a crucial foundation.

By assumptive worlds (Vickers 1965), I mean the mental "models" that interpret the environment and prescribe how that environment should be structured. Policy actors have theories about the causes of the problems that confront them. They have views about the appropriate solutions. There is an obvious normative element. Problems are not givens, but framed: the product of social and political understandings. So, if AIDS is seen as a judgment of God punishing sinful behavior, then governments will see this as a matter for the preacher, not the politician. When such assumptive worlds are more tightly organized, we often describe them as ideologies. Ideas — whether identified as ideologies, fundamental beliefs, or social norms — give shape to the issues that come into the conflicts we call politics.

Ideas then are the first element in a trinity of conceptual building blocks for understanding policy and politics in the world of health care. The other two elements are institutions and interests. By institution, I mean rather narrowly the constitutional arrangements within which governments operate, the rules of that game, and the bureaucratic machinery at their disposal. The process of producing health care policies will be very different in a country with a parliamentary constitution than one with the U.S. Constitution, with its multiple veto points and shared authority.

The third element, the interests operating in the political arena of health care, is much noted in analysis but risks conceptual confusion unless carefully unpackaged. First, there is the distinction between material (and self-regarding) interests; the former involve financial stakes, the latter are organized around notions of right or wrong or moral convictions about appropriate or inappropriate action. Second, there is the distinction between concentrated and diffuse interests. Securing a fee increase matters greatly to individual doctors like hematologists; the costs to individual taxpayers are virtually invisible. The scale of the population affected also matters: whether a majority or a minority of the population are involved self-evidently makes a difference. So, too, does the intensity with which convictions and stakes are held. Using these coordinates, it is then possible to construct a conceptual map of majority or minority stakeholders, material or nonmaterial stakes, and either balanced or imbalanced political settings. The configuration may, of course, change over time, as issues are redefined or new actors enter the policy arena. But the conceptual map should demarcate the terrain whether in stasis or change.

WHAT IS SPECIAL ABOUT HEALTH CARE?

The world of health care, from one perspective, is like no other. It is exceptional in the scale, cost, and sheer variety of the activities that go under the general label of "health" or "medical care." The industry's cast of characters is huge, ranging from people who clean floors to scientists in search of Nobel Prizes. It deals with issues of life and death; the emotional pitch of debates in medical care is often very high. Though other policy areas share some of these characteristics, none has quite the same high-octane mix. It is therefore tempting to claim that politics and policy making should be understood in terms of its special characteristics.

But from another perspective, the health care arena is no different from any other policy area. The concepts noted in the introduction provide the tools for understanding the disputes and conflicts that take place within health care, but also in other areas. Ideas about what is desirable and feasible change over time. Interest groups jostle for position as they battle over the distribution of resources and values.

Both perspectives matter, since the ways in which ideas, interests, and institutions interact vary with the context, nature, and timing of specific disputes. We turn to sketching the distinctive characteristics of

the health policy arena, moving them to the categories of conflicts that arise within it.

Health care is one of the fastest-expanding, as well the largest, industries in all rich, developed countries. Although dedicated in theory to improving the well-being of populations, it is also the only industry whose expansion is a cause now of political concern rather than self-congratulation. (This seeming paradox suggests a certain ambiguity in perceptions of the relations among the costs involved, methods of funding, and benefits produced.) As the largest industry, it also has the largest labor force. Its activities can accordingly be usefully analyzed in terms of the benefits — incomes and surpluses or profits — for those working in the industry, as well as the benefits for patients. But while talking about health care as an industry accurately underlines the sheer scale of the enterprise and is a useful corrective to the sentimental view of it as the setting for selfless doctors and nurses engaged in emergency room heroics, it is misleading in one respect. It suggests homogeneity where, in fact, there is only heterogeneity. So let's turn to that heterogeneity of interests and organizations.

At one end of the spectrum, there are the large pharmaceutical companies. These are powerful international actors, often able to play off the governments of different countries against each other. Political pressure to cut drug prices meets threats to relocate research or production facilities elsewhere. In the same category, if on a smaller scale, are manufacturers of medical technology such as scanning equipment, hip or knee replacement implants, and so on. In both cases, there are the same incentives: not only to acquire a larger share of the market but to expand the market. In both cases, too, the firms concerned invest heavily in both political lobbying and promotion of their products. They thus tend to reinforce one of the characteristics of the health care arena that is relevant to other contexts as well: the drive to innovate both by expanding the realm of the possible and by substituting new products for old.

At the other end of the organizational spectrum, there are solo medical practitioners, small group practices, and free-standing specialist offices and clinics. These are, in effect, small businesses, with an incentive to maximize income that is constrained by professional norms and the rules of the particular health care system within which they operate. Organized in quasi-trade unions, typically presenting themselves as professional bodies, they are active on national political stages. Physicians, because of their intimate day-to-day contact with patients, are well placed to mobilize opinion and to present themselves as the voice of the public. This often means equating self-interest with the public interest. But there is no doubting that collectively physicians have a reliable voice in national policy disputes.

Hospitals are small enterprises compared with big pharmaceutical companies, but they are important players in local settings. They are often the largest single employer in a town and a force in the local economy. Their siting, and even more the threat of closure, can unleash strong local feelings. They can appeal to and mobilize local constituencies. Collectively, too, they have a strong national constituency. In the second half of the 20th century, hospital building programs were seen as vote winners by governments, both locally and nationally. For hospitals are the temples of modern medicine, whose priests carry out the high-technology ceremonies of saving lives and allowing the lame to walk again. In less picturesque language, hospitals and the specialists who work in them have a hugely symbolic role — and thus a high political profile — because of their place at the top of the hierarchy of medicine. From here, we turn to the role medicine and its practitioners play in modern societies.

One of the defining features of health care is that while doctors represent only a small fraction of those working in the industry — approximately 1 in 10 — their activities dominate public perceptions and scholarly attention. Nurses account for a far greater proportion of the labor force. Their role in shaping the patient experience and contributing to successful results is crucial, and they in recent years played an increas-

ingly important role in making treatment decisions. But in accounts of policy making in health care, they are largely invisible. So, too, are the growing numbers of nonmedical professionals, computer experts, and skilled technicians required to deliver high-tech medicine. And the army of floor cleaners, kitchen staff, laundry workers, and other workers features only on rare occasions any industry action about working conditions or wage levels. More prominent in some settings — particularly in the United States — are the management consultants, health insurance executives, lawyers, and accountants who increasingly provide costly professional services to one or another part of the health care industry.

There are many reasons why doctors mostly dominate public perceptions and scholarly analyses in the health care field. The first, and the very obvious one, is that doctors do indeed make the decisions that directly affect patients, determine what should be done for whom, and consequently largely drive health care spending. The second reason is the investment of faith we all make in what doctors do. Much of this faith is justified; some of it is not. There is much dispute as to what contribution medicine has made to extending life expectancy, though it can claim dramatic successes in its repair and maintenance function.

Had this essay been written in the 1980s or earlier, the story could probably have ended here. Medical domination of health care could have been taken for granted and rightly so. Collectively organized as a professional, riding the crest of a wave of dramatic innovations in surgery and an expanding repertory of drugs, doctors had in the course of the first three-quarters of the 20th century established themselves as the monopolists of relevant knowledge and successfully asserted the principle that only they could judge medical performance and conduct. Medical autonomy ruled.

This judgment must now be qualified. As always in analyzing policy and politics, chronology matters, and the same actors may play different roles at different moments in time. Over the past 2 to 3 decades, medical autonomy has increasingly come under twin pressures. On the one hand, an international explosion in health care spending from the 1970s onward led to a heightened awareness of economists and policy makers of extreme variations in medical practice. This, of course, provided the scope for saving money by identifying and implementing more cost-effective ways of working. On the other hand, and at much the same time, deviant voices within the medical profession itself — epidemiologists and public health specialists — were calling attention to the same phenomenon, launching what became the "evidence-based medicine" movement. It was a movement that drew attention to the fact that evidence about the efficacy of many — perhaps most — medical interventions was lacking, which in turn prompted calls for generating such evidence. The notion of defining treatments for specific conditions, set out in clinical guidelines based on hard evidence rather than professional consensus, followed.

No longer could individual clinicians interpret medical autonomy to mean they could exercise unfettered discretion, even while grumbling about being forced to practice "cookbook" medicine. The way was open for increased external control over clinical activities. The extent to which this happened has varied from country to country, so, too, has the degree to which discretion in interpreting guidelines is allowed. But insofar as the profession itself retains control over the process of defining what counts as good medicine and appropriate treatment, as it largely does, it has managed to safeguard its collective autonomy even while sacrificing that of its individual members. This is less the case in the United States, where those who pay for care — public or private — increasingly assert their authority over what is permitted by what will be paid for. Threats to autonomy, then, come in different guises.

To underline the heterogeneity of the health care arena suggests two conclusions about what makes it special. The first is that it is an arena marked by an exceptionally high degree of internal competition for re-

sources: between different hospitals, between different specialists within them, between hospital and office-based doctors, between professions, and between the claims of different patient groups, among others. In short, the health care arena includes a multiplicity of internal actors, or interests, making competing demands on a variety of policy makers. Other policy arenas share some of these characteristics, of course. In education, for example, there are a variety of institutions (schools, colleges, universities) and competition among different sectors. Defense, as well, is another huge and complex policy arena, where different branches of the armed services compete for resources. The claim here is simply that the degree of competition in health care is — like its organizational complexity and the heterogeneity of the interests involved — of greater order. We now turn to the conceptual characterization of the policy issues — as distinct from the characterization of the arena in which they are played out.

POLITICAL ANALYSIS AND HEALTH CARE ISSUES

The components of the health care industry — what we have just reviewed — are one obvious grouping for political analysis. Hospitals, physicians, and nurses would provide the target categories for thinking about the politics of hospitals, of nurses, and so on. The politics of provision, of payment, or of regulatory oversight could well be another basis of categorization. And so on. Equally, one might proceed as if the special features of the medical industry shaped the politics of every issue in it. That would presume a common politics of health care.

The politics of industry features is certainly possible. But using professional and industry categories seems to presume too much commonality about medical care disputes. Presuming a common politics of health care on the other hand seems empirically misleading. The undeniable politics *in* do not mean there is a common politics *of* health care.

Instead, we can use the analytic triad — of ideas, institutions, and interests — as the organizing structure. From there, one identifies types of conflicts that regularly arise in health care. There are regular disputes about how medical care should be financed, delivered, managed, and regulated. Where major proposals to change existing arrangements are at stake, we observe what can be called the "high politics" of health care. There are, by comparison, disputes about the purposes of health care that highlight conflicting ideas. Abortion, euthanasia, treatment of the disabled — these illustrate the type of moral controversy that, at different times in different settings, can mobilize passion. There are the movements that are more similar to social causes — mobilizing citizens to back or attack efforts to shape how we live, whether we drink or smoke, and what we eat. Likewise, there are the politics of scandal, whether in medical research or common corruption. None of these categories of conflict are distinctive to medical care, but their distribution over time and space does vary. The result is that, in the world of medical care, we have an ever-changing composition of political conflicts. And to understand that changing world requires analytic approaches that permit one to see similarities and differences from the issues that arise in other arenas of public concern.

REFERENCES

1. Marmor TR, Klein R. Politics, Health, and Health Care: Selected Essays. New Haven, CT: Yale University Press, 2012.