BARRIERS AND STAKEHOLDER DYNAMICS TO HEALTH POLICY REFORM

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Abstract

Purpose: The purpose of this article is to present issues associated with the barriers to national health care reform. These barriers are discussed through an emphasis on history, enduring values, cultural identity and stakeholder dynamics.

Design/methodology/approach: The design of this essay utilizes Kerlinger's (1973) proposition, and Osgood's (1964) semantic differential technique to guide the research.

Findings: Research has suggested the following barriers to health reform: Fear of Government, Historical Precedent, Stakeholder Dynamics, Social Darwinism and Iron Triangle Priorities. Literature associated with findings from previous research suggests the health system is in an irrecoverable death spiral.

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Originality/value: The value of this study is in the identification of potentially hazardous outcomes that may be thwarted with immediate awareness and action by policy makers against policy barriers.

Keywords: Policy, National health care, Health reform, Stakeholder dynamics

Paper type: Research paper

INTRODUCTION

The purpose of this article is to present issues associated with barriers to national health care policy reform. We also address a rationale for the cause of this opposition through stakeholder perspectives identified through methodologies suggested by Kerlinger (1973), and Osgood (1964). Finally, a forecast is presented that offers a timeline to an anticipated shift in health care delivery in American society.

On January 20th 2009, President Barack Obama was sworn in as the 44th President of the Unites States. A major campaign issue to President Obama while running for office was the establishment of universal health care. This vision came to light in 2009 in the form of the President's proposed, *United States National Health Care Act*. However, as originally written, the Act failed to reach the floor of the democratically controlled 111th Congress. When the 112th Republican-controlled Congress came into power, they refused to debate any health care legislation unsupportive of the Grand Old Party (GOP) agenda. This result prevented any further progress on the President's vision for the implementation of universal care.

Subsequent to the takeover of Congress by the Republicans in 2011, compromise solutions to the President's 2009 *United States National Health Care Act* were seen in the form of *H.R. 3962, Affordable Health Care for America Act; H.R. 4789, A Public Option,* and *H.R. 3590, Patient Protection and Affordable Care Act (PPACA)*. Other Acts of less notable public attention were also discussed by stakeholders and partisans from 2009 through 2011. However, apart from the President's 2010, PPACA federal statute, no other significant piece of health care legislation has been signed into law. In the end, President Obama's PPACA proposed initiatives for future increases in national health care spending, reformed certain aspects of existing private health insurance, and provided increased opportunities for access to insurance

for the uninsured. However, the bill fell significantly short of any policy resembling universal care. *Why?* To understand this question, it is first necessary to set a foundation for understanding structures for delivering health care in the United States.

STRUCTURES FOR HEALTH CARE DELIVERY

The United States practices a form of health care called managed care. Managed care is a system of health care delivery that tries to control the cost of health care services while regulating access to those services and maintaining or improving their quality (Kongstvedt, 2012). Managed care is quite different from other structures of health care practiced around the world. In fact, the United States is the last democratic nation of its size in the world currently not offering a form of health care delivery that provides equal access to all of its citizens. Indeed, the current structure of health care delivery in the United States is based on a variety of political, cultural, environmental, stakeholder and historical events that have resulted in a health care delivery system that few are entirely satisfied with—and even fewer would create from scratch if given the opportunity (Shi and Singh, 2013; Kongstvedt, 2012).

Due to the dynamics of health care—and the complexity of implementing health care—uniform definitions for structures and processes are infrequently applied. Regardless, according to Johnson and Stoskopf (2009), three types of health care structures most commonly present themselves as namesakes for the industry. Although quite different in process, most commonly used health care systems around the globe include (but are not limited too), those involving Universal Care, Socialized Health Care (and/or Socialized Medicine), and National Health Systems (NHS). Although the diversity of names for these systems is greater than this in the literature, these three frameworks provide an understanding for the greater resistance to health care change in the United States. Each of the aforementioned frameworks is (briefly) described here:

Universal care

Universal care is a concept of health care that is usually misunderstood. The process is habitually (and incorrectly) associated as a synonym for a socialized system of national health care. In general, universal care systems utilize a structure and process most often affiliated with a "single

payer" (i.e., sometimes called a single payer system). A single payer system is one where a single organization, usually a government entity, is used to pay medical claims. Medicare, Medicaid, and TRICARE/CHAMPUS are examples of systems utilizing a single payer system in the United States (Kongstvedt, 2012).

In actuality, universal care is purely an objective of government policy used to represent a framework that brings together the existing infrastructures of operating health care structures, providers, and payers. The goal is to provide access across systems while simultaneously controlling for costs. Quality of care is the responsibility of the health care delivering agent. Universal care does not singularly represent the health care delivery practices of any one democratic or non-democratic nation. It is commonly found in many forms of governments around the globe (Johnson and Stoskopf, 2009).

Socialized health care (and/or socialized medicine)

The term *"socialized medicine"* was created by the American medical establishment (Porter, 1999). There is no one single definition of socialized health care and/or socialized medicine. Although misrepresented, socialized medicine is most commonly linked with any form of health care delivery offered by a communist or socialist government. The term entered into the parlance of regularly used health care expressions in the United States during President Johnson's period in office from 1963 to 1969. The phrase was coined in response to one part of Johnson's "Great Society" agenda. Johnson's vision for a Great Society involved several social reforms; however, the preponderance of Johnson's domestic agenda failed to be placed into law. Nevertheless, Johnson was successful in establishing Medicare and Medicaid as an amendment to the Social Security Act of 1935 (Social Security History, 2012). This represented the first time in the history of US health policy where taxes from one individual were used to pay for the health services of others. Capitalists of the last century viewed this policy as a step towards a government takeover. As a result, the phrase *socialized medicine* was used as a pejorative to counter any suggestion for health policy reform.

Interestingly enough, health care delivered to personnel in the United States Military, and in Unites States Veteran's Hospitals, may most closely resemble stereotypes associated with socialized medicine. In these systems, health care costs, quality, and access is regulated and

controlled in a uniform manner by the government. Furthermore, care is delivered by government employees, and paid for by taxes collected from the population. Lastly, no one recipient of care has greater or lesser access than another (Boffey, 2007).

National Health System

A National Health System is defined as one where the delivery of health care is primarily under the control of the government. However, a country's adoption of a NHS is not limited to any one political type of government. Both democratic and non-democratic nations currently employ structures for the delivery of a NHS. Furthermore, the adoption of a NHS does not mean there is only one system in place for the delivery or financing of care (Johnson, 2009). For example, the United Kingdom and Canada are examples of nations that collect taxes from individuals to support the NHS, and pay for medical care. However, some employers in the United Kingdom also offer private medical insurance to employees (Private Healthcare UK, 2012). Canada is also an example of a country that offers insurance based on fees for service options for health care.

In contrast, China engages a NHS where health care is financed (primarily) through Gross Domestic Product (GDP). Because costs are an immediate constraint, structures for producing health care differ based on rural and urban areas. Access is often based on the number of portals to health care delivery the government is able to operate. Small experiments in free enterprise and market reform have taken place in China (specifically) in the last ten years; however, the country still produces a tiered NHS that varies greatly in quality and access along demographic densities (Dong, 2009; Grogan, 1995).

HEALTH CARE BECOMES A KEY ISSUE IN UNITED STATES POLICY

In 1990, senatorial candidate Harris Wofford of Pennsylvania became the first candidate in American history to become elected to political office based solely on a platform to reform health care. Prior to 1990, less than 10% of the American public ranked health care among the nation's most important problems in any public survey. Prior to Wofford, politicians viewed health care as too difficult to understand—and of little importance to voters. Capitalizing on Wofford's success, and having a passion for health care reform from his days as Governor of Arkansas, President Clinton brought health care to the national stage in 1992.

According to most health care historians, this is the time that the public embraced health care as a national issue because of what later become known as the "Wofford Factor". Health care reform has remained among the top five issues facing voters since 1992 (Ledlow and Coppola, 2011).

WHY AMERICANS OPPOSE HEALTH CARE REFORM

Since President Clinton made health care reform a priority of government, partisanship on health care goals regarding cost, quality and access remain in debate. For example, seemingly simple phrases regarding concepts of universal care, socialized medicine and national health care (i.e. NHS), cannot be agreed upon. They are interchangeably used by stakeholders to support—or oppose—a wide range of policy issues. It is no wonder that policy reform cannot take place. Without a common frame of reference for debate, the discussion is useless.

The debate on health care reform is clearly divided along political lines. Partisans for reform suggest that health care in America should be considered an "inalienable right" for all citizens. Protagonists for reform also suggest that the long term financial return on investment for the federal government, organizations and individuals would outweigh any short term investments in policy change. Finally, there is an ethical argument for reform. America is the last of the large democratic nations in the world that triages medical care based on an individual's ability to pay (Coppola, 2008).

Antagonists against health reform may have a more eclectic and wide ranging position on health reform. There is no one accepted argument for the opposition to health reform in America. Partisans against health reform may base policy and opinion on enduring political and cultural values that are resistant to suggestions of change. Because the argument against health reform is so ineffable, any position for change defies a common centre of gravity for debate. As a result, this paper offers a framework for understanding this opposition, utilizing methodologies developed by Kerlinger (1973) and Osgood (1964).

METHODOLOGY

Kerlinger (1973) offers a unique methodology utilizing propositions to understand the opposition to health reform. For the purpose of this

health care study, a proposition is defined as a statement of opinion, based on research, which is presented as true until evidence of disconfirmation is presented (Coppola, 2009). Kerlinger's proposition technique allows relevant prose to coalesce around various arguments offered in the literature that lack empirical support. Following this analysis, semantic differential is used to place ideas of similar meaning into categories (Osgood, 1964). The creation of these categories then allows for the presentation of simple sentences describing concepts. These concepts are then used as valid foundations for continuing the research stream. While the statements may not always be exact, they are offered as reliable and trustworthy until additional research suggests otherwise, or more definitive evidence of disconfirmation is provided. Research historically suggests that empirical evidence most often flows from the advancements of theory, qualitative analysis and supposition (Weick, 1995; Whetten, 1989).

This study used several searchable databases specializing in research for business, medicine, health care, sociology, culture, jurisprudence, policy and other related fields, to identify barriers to health reform. We also employed a series of overlapping search terms to filter out lesser used words and concepts in the literature in regards to health reform resistance. After some time, the following propositional statements presented as the major barriers to health reform. These propositional statements are abbreviated by the category derived through semantic differential, Table 1. While the barriers outlined in Table 1 may be subject to debate, they do include many of the seminal concepts behind the conflict to health reform as gathered from the literature.

Propositional statement (Kerlinger, 1973)	Semantic differential category (Osgood, 1964)
Individuals are historically afraid of the government and fear a government takeover of their lives.	Fear of Government
Health reform is unconstitutional and lacks a historical precedent.	Historical Precedent
The great preponderance of people, providers, employers and payers do not want health reform.	Stakeholder Dynamics
American families generally believe in a concept of (sic) "only the strong will survive".	Social Darwinism
Health care cost, quality, access, value and innovation will all suffer as a result of health reform.	Iron Triangle Priorities

Table 1. Barriers to health reform

RESISTANCE TO HEALTH REFORM

Fear of government: As a capitalistic society, many US citizens have a general aversion to increased government intervention. This feeling predates the Declaration of Independence. Early historical literature is full of examples of immigrants coming to America prior to 1776 in an attempt to leave behind societies that had too much government involvement in their lives. For example, immigrants to the American colonies were largely composed of groups of individuals that wanted to get away from a government that desired to place restrictions on individual liberties and responsibilities. As a result, early settlers to the United States were motivated by a desire to have as little interference from political authority figures as possible. This same philosophy continues to this day, and is a key reason why US citizens have visceral feelings for any programme or policy that may place additional restrictions on their daily activities of living, including health reform (Handlin, 2002). This enduring value regarding a fear of government intervention has almost taken on a genetic cultural quality. Strong feelings for individualism and personal liberty are ingrained in the citizenry of the United States.

Historical Precedent: Another argument for a distinct lack of support for health reform is based on perceived principals associated with the intent of our Founding Fathers following 1776. For example, the Declaration of Independence promised, "Life, Liberty and the Pursuit of Happiness"; however, no government documents have ever mentioned that health care is an *inalienable right*. The Constitution, Bill of Rights and similar congressional amendments over the years have likewise carefully omitted any reference to health care being an entitlement—until Medicare and Medicaid were passed in 1965. Americans believe health care is an economic commodity to be paid for rather than an inalienable constitutional right (Corey and Somers, 2011). There has always been a strong aversion for taking discretionary funds from one family (in the form of taxes) to pay for the health care used by another family.

Stakeholder Dynamics: Any suggestion of health reform is generally met with immediate resistance by stakeholders. Key stakeholders include patients, payers, employers and providers. All these actors play a vital role in health reform. With any one of the four major stakeholders in disagreement on policy formulation, failure at some level is sure to occur (Coppola, Erckenbrack and Ledlow, 2008). Additionally, stakeholders may also include professional organizations. For example, the American

Medical Association (formerly known as the American College of Surgeons) has opposed any intervention on practice autonomy for nearly a century (Patel and Rushefsky, 2006). National approbation for large scale health reform has failed to penetrate all voter demographics, and eludes general stakeholder support in America (American Health Care Reform Organization, 2012; Star, 1992; Star 1982).

Social Darwinism: In 1798, Thomas Malthus published, *An Essay on the Principle of Population as it affects the Future Improvement of Society*. Malthus posited humans will eventually exceed the carrying capacity of the planet (Malthus, 1798). Malthus coined the term *Malthusianism*, which was subsequently replaced in the lexicon of sociology by *Social Darwinism*. Malthus was a forerunner of Darwin; however, their concepts of ecology and biology were similar. Both believed that only the strongest of species will survive. However, Malthus's view was focused on the human condition. In this respect, his thoughts were more Machiavellian. Malthus believed that only the strongest (people) should survive (Wood, 1986).

Although surveys suggest that the preponderance of US citizens believe programmes like Medicare and Medicaid are beneficent and provide value, there is also a parallel offensiveness to the perceived lack of efficiencies and effectiveness of the programmes (Weisert and Weisert, 2004). If given a choice, the preponderance of young people paying for Medicare and Medicaid in this era would opt out in lieu of personal health care options. It is clear that personal responsibility was a reoccurring theme in early American policy formulation. A general "take care of yourself" philosophy continues to be a major desire for a (particularly) younger generation in America now too, who believe that the elder generation has bankrupted their future.

Iron Triangle Priorities: No argument against health reform would be complete without addressing issues associated with Kissick's (1994) Iron Triangle of Health Care. These elements include cost, quality and access. Issues are numerous here, and are often posited with both conjecture and modest empirical support. Regardless, antagonists have suggested the costs associated with any health reform policy change will outweigh any future return on investment and/or opportunity cost recaptured. These same partisans have suggested that the creation of a government sponsored, low cost health care system will jeopardize existing health care quality. Furthermore, it is suggested that a government health

programme will deter organizational motivation to compete, earn profit, and maintain customer loyalty, thus lowering the value of our health care system (Coppola and Harrison, 2010; Weisert and Weisert, 2004). It is also suggested that consumer dissatisfaction will increase while consumer confidence with the United States health system will decrease. Finally, Enthoven (1993) suggests a retardation of medical innovation may result. In an apocalyptic case, scholars suggest the US health system will collapse.

DISCUSSION

The current structure of the US health system is unsustainable. Health care costs have continued to increase annually for decades (Shi and Singh, 2013; Kongstvedt, 2012). This has resulted in increasing numbers of both the uninsured, and the underinsured population (Fernandopulle, 2012).

Both major political parties want to see health reform that results in lower costs, increased access and higher quality. However, their approaches to this end differ. Democrats want the government and employer to play a greater role, while the GOP desires to leverage the current system in an effort to increase efficiencies. However, the GOP suggests the Democratic vision will lead to higher taxes, while the Democrats suggest the Republican plan will never encompass all needy recipients.

Economic forecasts

Unless technology and efficiencies can be leveraged for greater outcomes by 2020, increases in the marginal US tax rate are inevitable to support the US health system. Often called the political "third rail", in health reform policy, no politician seeking election/re-election can campaign on a platform of tax increase. In contrast, politicians over the last fifty years have largely campaigned on a tax decrease agenda. For example, many US citizens currently pay lower taxes than have been seen in a generation. It has only been in recent years that Americans have seen upper tax brackets of about 34% for those making over $250,000/year. In contrast, from 1970–1980, the effective tax rate was as high as 70%, and at one time in the 1950s, the upper tax bracket was 90% (Office of Management and Budget, 2011). The affect of decreased taxes and increased health care costs has locked the US health system into a death spiral with little opportunity to recover.

The future of health reform

America spends more per citizen per GDP than any democratic nation in the world for health care. However, the Unites States ranks 24th in the world for population health. Costs for health care continue to exceed available revenues and tax pools. Regardless of what party controls the legislative and executive branches in 2020, health spending will far exceed sustainable reimbursement by employers, the government and private pay avenues before then. Unless acted on before 2020, a dramatic reengineering of health care will be required. This reengineering effort will include higher taxes, mandates for insurance, new government controlled programmes, and (possibly), the rationing of care along access portals. Our nation need only to look at Greece as an example of a country whose leaders let politics and partisanship impede necessary economic reform (NY Times, Editorial, 2012). Greece is currently seeking to write off over 70% of its national debt. Social and domestic programmes—that have been in place for decades—may collapse without notice. The national collapse of the Greek economy will have global implications. Even more apocalyptic will be the collapse of the United States economy due to similar political and partisan impasses. Scholars suggest any (potential) future collapse of the United States economy will make the Wall Street Crash of 1929 seem like an ordinary bad day in the financial district.

SUMMARY

It is not clear at this point in time what, if any, additional health care legislation will be placed into law in President Obama's current term. However, it is interesting to note that similar debates and outrage were raised in 1935 when President Roosevelt passed the Social Security Act, and again in 1965 when President Johnson amended the Social Security Act to include policy for Medicare and Medicaid entitlements/benefits.

Interestingly, all of these legislative outcomes drew visceral outrage and condemnation from partisans at the time, due to their perceived association with socialism, a definitive increase in taxes, and mandates for individual participation. However, Americans today largely agree that Social Security, Medicare and Medicaid are positive entitlements that benefit society. It is only the inefficiencies and wastefulness of the programmes that currently bring debate. With so many partisan opinions, cultural dynamics and ineffable points of view, there may be no short

term solution overcoming the barriers to health reform. In reality, it may take a generation for citizens of the United States to become culturally accepting of any new health reform. The alternative is unthinkable: a major reengineering of the health system by the government due to cataclysmic collapse.

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