CHAPTER 1

Moving toward a Healthy Society

Insights

- Social determinants drive health outcomes, with about 80 percent of quality of life and length of life being influenced by factors outside the health care system.
- Addressing systemic inequalities (justice) offers longer-term solutions, rather than focusing solely on equality or equity.
- US health care combines four health care models into one, creating a complex and fragmented system.
- Aligning interests across the 6 Ps is essential for effective, patient-centered health care reform.
- Greater racial diversity correlates with lower health rankings, highlighting the need for tailored, inclusive policies.

When we think of health care policy, more often than not, we are discussing how to ensure all people can see their doctor and get the care they need. While a doctor's office may often be at the forefront of where health care occurs, it is *how* we live that has the greatest effect on our health. From the moment we take our first breath to our last, every moment in between affects our health. Having access to quality health care is the low-hanging fruit; it's the very least a nation can achieve. Why? Because most predictors of our quality of life and length of life occur outside a health care system. Factors such as economic and family stability, community and social factors, the neighborhood and built food environments within which we live, the quality of our work and workplace, and the access and quality of our educational system all have a substantial impact on our quality of life and length of life. It is common sense for health care policy, then, to be inclusive of more than just getting people to a doctor. After all, health care encompasses all the spaces within which we live.

There are approximately 8,765 hours in a year, and doctors generally ask for only one of those hours annually. Even then, only about 83 percent of

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adults will visit a doctor or other health care professional in a given year.[1] Broadly speaking, the challenges for patient care in clinical settings have two constraints: those for the primary care physicians and those for the patients. For primary care physicians, the constraint is largely having sufficient time to provide adequate care. After all, they typically only see a patient once a year unless there is an ailment or pathology that requires more time. For patients, the constraint is largely that of adherence. After all, nearly all year long, they are anywhere but in a primary care physician's office.

Consider, for example, that two people have access to the same doctor. Suppose they are both diagnosed as prediabetic and go home with a prescription to eat healthier and exercise more. They have access to the same doctor, but is that enough? Notably, as illustrated in Figure 1.1,

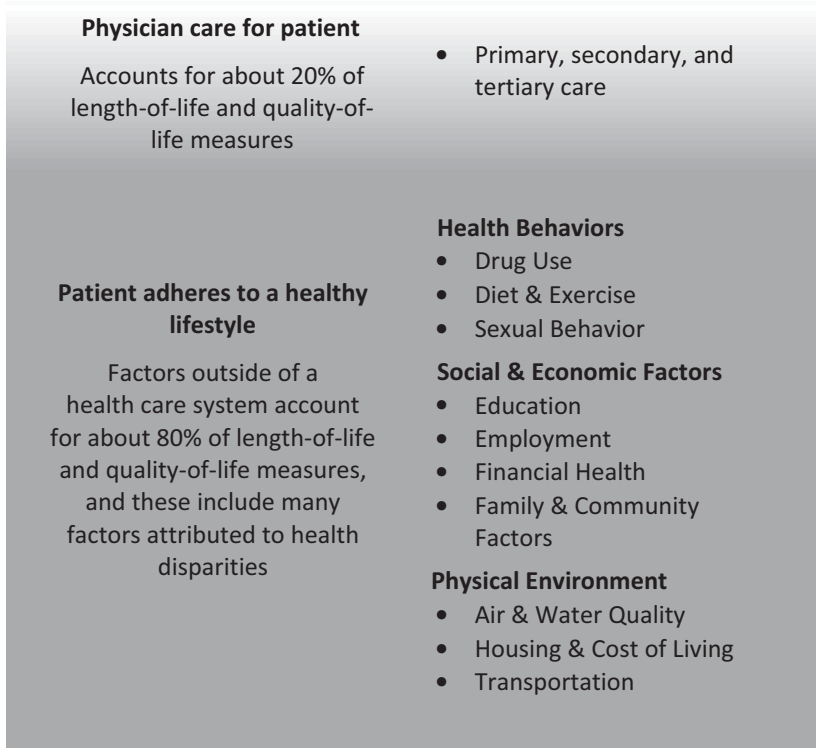


Figure 1.1 Factors that affect the health of a society

[1] Centers for Disease Control and Prevention (CDC), "Ambulatory Care Use."

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factors outside a health care system – those related to the backdrop of *how* we live – account for about 80 percent of length-of-life and quality-of-life outcomes, and these include many factors attributed to health disparities. Continuing with our example, if one person lives in a poorer environment that is less safe, less walkable, and further from a grocery store, with poorer transportation, they will have a more difficult time following the prescription to eat healthier and exercise more. In other words, despite having access to the same doctor, the health disparities that drive inequity between these two individuals still persist.

1.1 Equity and Justice in Health Care

Equity, equality, and justice are often used in discussions about fairness, especially in the context of health care systems. A common strategy to address inequality involves efforts to achieve equality or equity. However, these efforts alone are often insufficient to address inequality in the long term. Rather, efforts toward justice as a means of addressing inequality tend to be better suited to achieve long-term success because in doing so, health disparities can be closed by addressing the underlying causes of inequalities in the system itself. In health care, there is therefore a need to think beyond equality and equity to seek health justice.

To illustrate the need for health justice, let's revisit our example for two people with access to the same doctor and both are diagnosed as prediabetic. They go home with a prescription to eat healthier and exercise more. Let's consider eating healthier in terms of access to getting groceries. When there is inequality, one person has easier access to a grocery store than the other.

- To achieve **equality**, we can distribute resources evenly to all people in the same way. For example, we could give each person a grocery allowance of $100 per month. However, recall that one person lives further from a grocery store and has poorer transportation options, making it more difficult for them to get to a grocery store to spend those dollars. Inequalities that could be addressed still exist.
- To achieve **equity**, we could customize the resources provided to meet the unique needs of each individual. For example, we could give each person a grocery allowance, but give the person from the poorer environment more money to spend on the card. However, this does not address the underlying causes of the inequality in that one person

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still lives further from a grocery store, with poorer transportation. Inequalities that could be addressed still exist.

- To achieve **justice**, we could fix the system to offer equal access to both the resources and the opportunities. For example, the first person can receive the $100 per month grocery allowance, which would suffice for their needs. The person living in the poorer environment can receive the card plus a door-drop service to deliver groceries straight to their door, thereby alleviating the underlying cause of the inequality – their inability to get to a grocery store. In the effort to close health disparities, achieving justice allowed for longer-term success.

Certainly, health care is a complex problem to solve, but it is solvable. For example, we witnessed equity in action with the distribution of vaccines during the COVID-19 pandemic. To directly and quickly reach all communities, including those that were underserved or high-risk, the US federal government created programs such as the Federal Retail Pharmacy Program, the Health Center COVID-19 Vaccine Program, Rural Health Clinic COVID-19 programs, tribal health programs, and Urban Indian Organizations, all of which helped to realize a record distribution of vaccines across the country.[2]

In this book, we evaluate the American health care system and explore how the top health care countries in the world can help to inform US health care policy, in part, to alleviate inequalities in the system. To begin, first we briefly introduce the four major models for health care systems, and then we will introduce the landscape of American health care using the 6 Ps framework, developed by the authors of this text.[3]

1.2 Four Major Models for Systems of Health Care

There are generally four major health care models that are utilized in different ways globally: the Beveridge model, the Bismarck model, the National Health Insurance Model, and the out-of-pocket model. To some extent, most countries typically do not choose one or the other model. Instead, most tend to structure their health care system by featuring one or more of these major models.[4] Each major model for a health care system is summarized in Table 1.1 and described in this section.

[2] U.S. Department of Health and Human Services (HHS), "COVID-19 Vaccines."
[3] Gillespie and Privitera, *Patient-Centric Analytics*. [4] Chung, "Healthcare Reform."

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Table 1.1 *Four major models for health care systems*

Models for health care	Description	Examples	Key strength/limitation
Beveridge model	A system in which the government acts as the single-payer, providing health care coverage for all citizens through income tax payments	United Kingdom, Spain, New Zealand, Cuba	Strength: Costs can be kept low and benefits can be standardized across the country Limitation: Overutilization of the system due to everyone being guaranteed access to health services may lead to increasing costs
Bismarck model	Characterized by mandatory employer and employee contributions through payroll deductions to fund health insurance plans	Germany, Belgium, Japan, Switzerland	Strength: Government can implement control over prices for health services because the insurers do not make a profit Limitation: Identifying how to care for those who are unable to work or those who may not be able to afford contributions
National Health Insurance Model	Combines aspects of the Beveridge and Bismarck models, with the government acting as a single-payer while providers remain private	Canada, Taiwan, South Korea	Strength: This system covers most procedures regardless of income level and can reduce the costs of health insurance Limitation: Overutilization of health resources in nonurgent situations and long waiting lists for patients to see a physician
Out-of-pocket model	Represents the absence of a formalized health care system in which individuals must pay for their own medical expenses out of pocket	India, China, Africa, South America	Strength: Those who have the ability to pay can do so through insurance options Limitation: Disparities in wealth lead to disparities in health outcomes because the poor are unable to afford health care

Note: The United States is a fragmented health system that incorporates aspects of all four models.

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The Beveridge Model

The **Beveridge model**, first developed by Sir William Beveridge in the United Kingdom in 1948, is a system in which the government acts as the single-payer, providing health care coverage for all citizens through income tax payments. This system is often simply called a *single-payer system*. In the United States, the Veterans Health Administration operates under the Beveridge model and is generally considered a socialized system, employing government-funded and government-managed care. Similarly, the Medicare program operates partly under the Beveridge model, with the government acting as a single-payer of health services for citizens aged sixty-five or older.

This system is often centralized through a national health service. The government acts as the single-payer, thereby eliminating market competition and volatility that generally work to keep prices low. Using income taxes to fund health care allows for patient care to be free at the point of service with the patient not having to pay any out-of-pocket fees because of their contribution through taxes. Each citizen is guaranteed by the government the same universal access to care, with a central tenet of this model being that *health is a human right*.

The Bismarck Model

The **Bismarck model**, created near the end of the nineteenth century by Otto von Bismarck, is characterized by mandatory employer and employee contributions through payroll deductions to fund health insurance plans. In the United States, a significant portion of the population receives health coverage through employer-sponsored insurance plans, which, at first glance, seems like an application of the Bismarck model. However, the Bismarck model works under the assumption that the insurers are nonprofit. This is not the case in the United States, with insurers operating for-profit, thereby diverging somewhat from the Bismarck model.

This system is a more decentralized form of health care. Health providers are generally private institutions, though the insurers are considered public. In some countries, there is a single insurer (e.g., France and Korea); others may have multiple, competing insurers (e.g., Germany and the Czech Republic); still others may have multiple, noncompeting insurers (e.g., Japan). Because the insurers do not make

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a profit, this allows the government to implement control over prices for health services.

The National Health Insurance Model

The **National Health Insurance Model** combines aspects of the Beveridge and Bismarck models, with the government acting as a single-payer while providers remain private. In the United States, the Medicare program partly incorporates elements of this model as well, with the government financing health care costs through payroll taxes and premiums, but the delivery of care remains in the hands of private providers rather than a centralized system. Using this system, there are generally fewer financial barriers to care and patients are usually able to choose their health care providers. Public insurance and private practice are balanced as well, thereby allowing hospitals to be independent while also reducing complications with insurance policies.

The Out-of-Pocket Model

The **out-of-pocket model** represents the absence of a formalized health care system in which individuals must pay for their own medical expenses out of pocket. In the United States, a portion of the population remains uninsured and must therefore pay for health care costs out of pocket, which is similar to this model. The out-of-pocket model often results in significant health disparities in which those least capable of paying for their care (i.e., the uninsured) are asked to pay the most; meanwhile, the wealthy can afford medical care through insurance options that reduce their financial burden to access health care. Using this system, disparities in wealth lead to disparities in health outcomes. Less developed nations have too few resources, leaving patients to pay for their health care out of pocket. Unfortunately, this system is common in most nations, with only the wealthiest countries having robust health care systems.

The United States stands out as the only industrialized nation that lacks a uniform, universal health care system for its entire population. Instead, the United States employs a fragmented approach, incorporating aspects of all four models (Beveridge, Bismarck, National Health Insurance, and out-of-pocket) for different segments of the population. This fragmentation results in a complex and multifaceted health care system that differs from most other countries, which typically adopt a single or hybrid model uniformly across their populations. The fragmented nature of US health

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care also means that there are many "players" in this system, with varying interests that are not always aligned to optimize patient health. In the next section, we use the 6 Ps framework for US health care[5] to take a closer look at the "players" in this system, to find out who they are, and the types of questions they ask.

1.3 An Optimal Health Care System: Measuring Quality, Access, and Cost

Using the 6 Ps model of health care, patients are regarded as the foundation of any health care system. The system exists to serve them and, by extension, their health. An optimal health care system therefore optimizes the health for all members of its population. Using the 6 Ps model, three core metrics are used to measure the strength of health care policy in terms of the extent to which it ensures that all people have *access* to *quality* care that they can afford (*costs*). Moving toward a healthy society – the title of this book – reflects a holistic perspective in which there is a continuous pursuit to optimize each metric (quality, access, and cost) for a population. Each metric is critical to serving the health care needs of a nation, and is therefore summarized here before introducing the 6 Ps framework.

Quality is a measure of the excellence of care. While countries use various approaches to measure the quality of health care, one widely utilized approach is the **Donabedian model**, which was developed by Avedis Donabedian, who is widely regarded as the father of modern health care quality management. Using this model, summarized in Figure 1.2, health care quality measures are classified into three categories: structure, process, and outcome.[6] As represented using arrows, the structure of health care using this model has influence on the processes of care, which, in turn, can influence the effect of care on health status.

Access is the ease with which patients can utilize care in the system; the system is most accessible when all patients can seamlessly utilize it for care. There are many ways in which access can be measured. The first is at a national level using the **Healthcare Access and Quality (HAQ) Index**, which is a comprehensive measure used to evaluate and compare the quality of national health care access.[7] This index is measured on a scale from 0 (least accessible) to 100 (most accessible), based on death rates from

[5] Gillespie and Privitera, *Patient-Centric Analytics*.
[6] Donabedian, "Evaluating the Quality of Medical Care."
[7] Younas et al., "Sociocultural and Patient-Healthcare."

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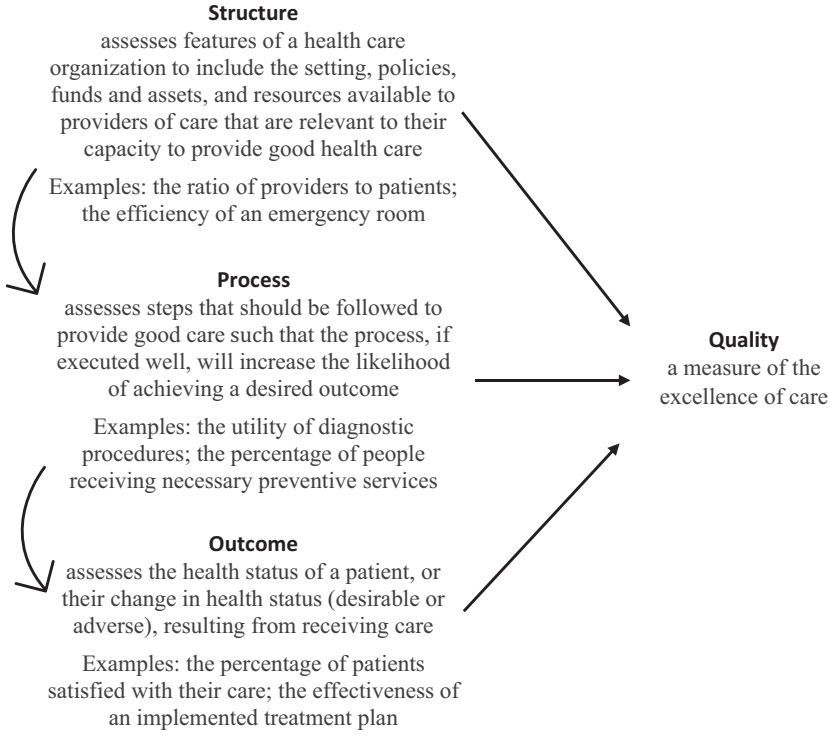


Figure 1.2 The Donabedian model for measuring health care quality
Note: The structure of health care influences the processes of care, which, in turn, can influence the effect of care on health status.

32 causes of death that could be avoided with proper medical care. The HAQ Index is a useful tool for monitoring national levels of health care access and quality.[8]

Other methods of measuring access to health care include: (i) availability of health care services, (ii) geographical accessibility of care, (iii) equity in health care access, and (iv) the efficiency and timeliness of health care access. The availability of health care services is most often measured by calculating the number of hospitals or health facilities per population. The geographical accessibility of care is often measured by assessing the travel time or distance to reach the nearest health care facility or needed services. Equity in health care access is crucial for identifying health disparities and

[8] GBD 2019 Collaborators, "Assessing Performance."

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is a measure of health care access across different demographic groups, such as those based on income levels, race, ethnicity, sex, geographic location, or other socioeconomic and sociodemographic factors. Countries also measure the efficiency and timeliness of health care access, such as waiting times for appointments or procedures, and the ability of the health care system to provide care without harmful delays. Efficient health care systems maximize the benefits of available resources while avoiding risks and waste.[9]

The *costs* of health care tend to be the trickiest metric to solve. Costs reflect the expenditures required to make the system efficient in terms of the time, money, and resources needed to provide care for a population. Assessing costs is relatively challenging because there are many methods that can be considered. Each method of measuring costs in health care is summarized in Table 1.2. Different methods allow for different ways of gaining insights into how much money is being spent and the extent to which spending is efficient.

Table 1.2 *Measuring health care costs*

Method of measuring health care spending	What does it measure?	What information does it convey?
National Health Expenditure as a share of gross domestic product (GDP)	Measures health care costs in the United States with the National Health Expenditure as a share of GDP	It provides a comprehensive overview of how much the nation allocates to health care relative to its overall economic output
Per capita health spending	Measures per capita health spending in the United States	It offers insights into individual health care needs and how they change over time, providing a clear picture of the financial burden that health care puts on the average American
Personal Health Care Expenditures	Encompasses various categories of health care spending, including hospital care, physician and clinical services, prescription drugs, and other personal health care costs	It represents a substantial portion of the total health care costs in the United States, accounting for about 85 percent of National Health Expenditures

[9] World Health Organization, "Quality of Care."

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Table 1.2 (*cont.*)

Method of measuring health care spending	What does it measure?	What information does it convey?
Out-of-pocket costs	Encompasses direct payments made by individuals for health care services, excluding insurance premiums	The impact of out-of-pocket costs on overall health care expenses is influenced by factors such as insurance coverage, health status, and the types of medical services received
Health Insurance Expenditures	Encompasses public and private health insurance spending to include Medicare and Medicaid spending	It highlights the significant role that both private and public insurance play in overall health care costs
Health Care Price Indices	Price indices include: Consumer Price Index, which measures changes in the prices paid by urban consumers for medical care commodities and services, the Producer Price Index, which reflects inflation from the providers' perspective, focusing on actual transaction prices, and Personal Consumption Expenditures, which tracks changes in prices paid on behalf of consumers, including payments by employers, private insurers, and government programs	These indices assess changes in health care costs over time
Sector-specific expenditures	Breaks down expenditures into specific sectors	Sector-specific measures provide detailed insights into which areas of health care are experiencing the most substantial cost increases
Public vs. private spending	Distinguishes between public and private spending	It helps in understanding the distribution of health care costs across different sectors of society and the economy

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1.4 The 6 Ps Framework for Health Care

The health care landscape in the United States is multitiered and not always aligned toward optimizing patient health, which creates its own challenges in developing a uniform, universal health care system for an entire population. Figure 1.3 identifies the **6 Ps pentagonal framework for health care**[10] with examples for the industries in each *P* (i.e., for each health care sector or entity) provided. The 6 Ps identified in Figure 1.3 are as follows:

- Patients
- Policy makers

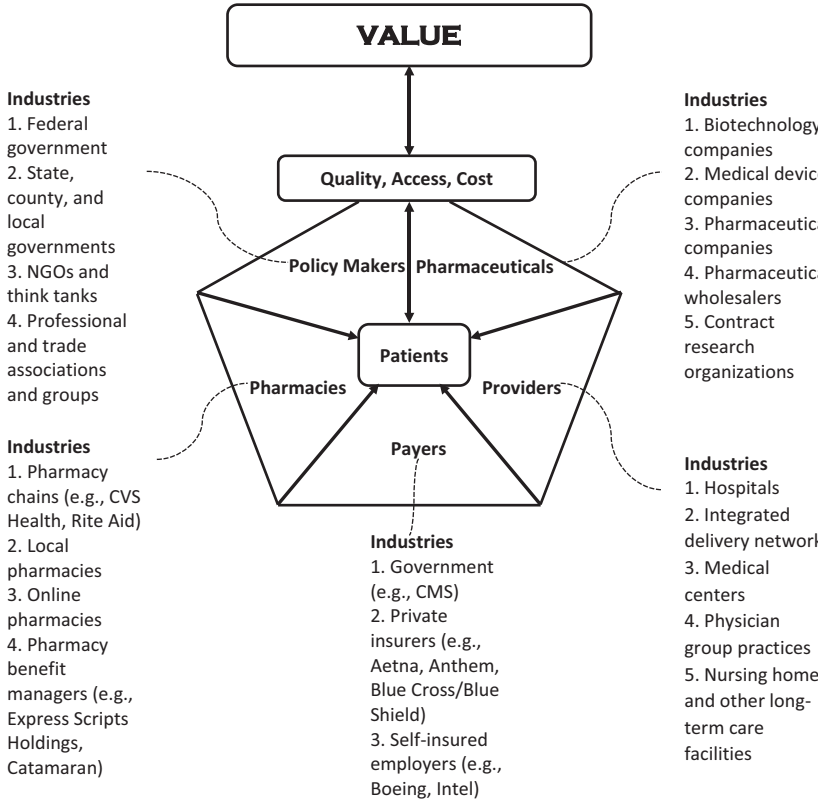


Figure 1.3 The 6 Ps pentagonal framework for health care
Source: Gillespie and Privitera (2018)

[10] Gillespie and Privitera, *Patient-Centric Analytics*.

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- Providers
- Pharmacies
- Pharmaceuticals
- Payers

Using the 6 Ps framework, patients are at the center of the model. In terms of the *flow* of health care, this framework follows the patients, who elect the policy makers, who then adopt the policies/guidelines for providers, pharmacies, and pharmaceuticals, with those entities getting reimbursed by the payers at the end of the process. In this way, the full health care lifecycle is represented in the 6 Ps framework. Because each *P* plays a vital role in the health care ecosystem, it is critical to align their interests if health care policy is to succeed.

Patients

Patients are at the heart of health care. Patient perspectives are increasingly important in shaping the decision-making processes for their care and health care policy. This shift toward patient-centered care, also called shared decision-making,[11] affirms that patients have valuable insights into their own health. This shift is reflected in programs such as the Ask Me 3 program, which aims to empower patients to take a more active role in their health care and enhance communication among patients, families, and health care professionals.[12]

Patients play a substantive role in advancing health care policy as well. For example, patient advocacy groups play a crucial role in influencing health care policy decisions. These organizations represent the collective voice of patients, often advocating for improved access to care, research funding, and policy changes that benefit specific patient populations.[13] Patient perspectives and feedback serve as a valuable tool for health care providers and policy makers to enhance the quality of patient care, address service gaps, and improve overall patient satisfaction.[14] While the importance of patient involvement in health care policy is widely recognized, there are key challenges to implementing truly patient-centric approaches. These include: ensuring diverse representation of patient voices, managing potential conflicts of interest, balancing patient preferences with evidence-based practices, and standardizing methods for collecting and integrating patient feedback into policy decisions.

[11] Montori et al., "Shared Decision-Making."
[12] Institute for Health Care Improvement, "Patient Safety Essentials Toolkit."
[13] Abersone, "Patient Advocacy." [14] Berger, Saut, and Berssaneti, "Using Patient Feedback."

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As health care systems continue to evolve, the role of patients in shaping policy is likely to expand further. Suitably, by fostering a collaborative approach between patients and the other players in the system (i.e., the other 5 *P*s), health care systems can work toward achieving patient-centered care that reflects the needs and values of the populations they serve.

Policy Makers

Policy makers are institutions or groups with the authority to directly impact governmental policies affecting the health care system's operations. They have a wide range of responsibilities that significantly impact the health care landscape and play a vital role in shaping, implementing, and evaluating health care policy.[15] The role of policy makers in health care policy includes:

- Policy development in terms of *setting the agenda* (based on public needs, political feasibility, and evidence from health data), *legislation and regulation* (by drafting, proposing, and enacting laws and regulations that govern health care), and *stakeholder engagement* (by consulting with various stakeholders in health care to gather input and build consensus on health policies).
- Policy implementation in terms of *resource allocation* (including funding for health programs, infrastructure, and research to ensure that financial and human resources are effectively distributed to implement health policies), *program development* (to operationalize health policies by creating specific initiatives such as public health campaigns, insurance programs, and health services), and *regulatory oversight* (by overseeing the enforcement of health regulations and standards, ensuring that health care providers and organizations comply with laws designed to protect patient safety and to promote quality care).
- Policy evaluation in terms of *monitoring and evaluations* (to establish systems to monitor and evaluate the effectiveness of health policies and programs), and *feedback and adjustment* (to ensure that health policies remain relevant and effective over time by evaluating results and stakeholder feedback to make necessary adjustments to policies and programs).

Other ways in which policy makers impact health policy are through advocacy and communication, collaboration and coordination across

[15] Rovner, "Congress and the Executive Branch."

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different levels of government (local, state, and federal), considering ethical and legal issues, and crisis management (such as during a pandemic). Ultimately, a primary function of health policy makers is to create and implement laws and regulations that govern a health care system.[16] By enacting legislation and establishing regulatory guidelines, policy makers can directly influence how health care is delivered and accessed by a population. In this way, the ability for the United States to pass laws capable of establishing a uniform, universal health care system will require the action and leadership of policy makers.

Providers

Health Care providers play a vital role in health care policy. They are at the point-of-service in the health care system by interacting with patients, both directly (e.g., treating an illness) and indirectly (e.g., making health information accessible to patients via flyers and pamphlets). The role of providers in health care policy includes:

- Policy development in terms of providing *expert opinion* (both clinical expertise and firsthand experience), *research and evidence-based insights* (providers help ensure that policies are based on the best available scientific evidence), and *leadership* (including providers in health policy organizations, government agencies, and think tanks).
- Policy implementation in terms of *establishing guidelines* (clinical guidelines and protocols that align with health policies help standardize care and ensure consistency in practice), *education and training* (providers educate and train other health professionals on new policies and best practices), and *providing direct care* (providers implement health policies directly in their daily practice).
- Policy evaluation in terms of *monitoring and feedback* (providers monitor the impact of health policies on patient outcomes and provide valuable feedback on what is working and what needs adjustment), and *quality improvement* (using data and feedback to refine policies and practices to ensure that policies achieve their intended goals).

Other ways in which providers impact health policy are through advocacy (at the patient and professional level), collaboration and communication (in interdisciplinary teams and public health campaigns and initiatives, which help to translate policy into community action), and

[16] World Health Organization, "Consensus Statement."

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by ensuring adherence to ethical and legal principles, regulations, and standards. Health Care providers are essential to the health policy process. Their involvement applies evidence-based approaches to ensure that policies are not only theoretically sound but are also practically feasible and effective in optimizing health outcomes.

Pharmacies

Pharmacies play a vital role in health care policy through various functions, including medication management, patient care, public health initiatives, and policy advocacy. They dispense and sell medications, prescriptions, and health devices (e.g., syringes, needles), making them more accessible to patients. The role of pharmacies in health care policy includes:

- Patient care in terms of providing *pharmaceutical care* (including counseling on medication use, side effects, and adherence, supporting policies aimed at improving patient education and self-management), *chronic disease management* (assisting in managing chronic diseases like diabetes, hypertension, and asthma, aligning with health policies that emphasize disease prevention and management), and *vaccinations* (supporting public health initiatives and policies aimed at increasing vaccination rates).
- Medication management in terms of *dispensing medications* (pivotal in implementing policies related to drug distribution by adhering to regulatory standards and ensuring patient safety), offering *Medication Therapy Management (MTM)* (to identify, prevent, and resolve medication-related problems, which contributes to policy goals of safe and effective medication use), and *formulary management* (developing and managing drug formularies, or lists, ensures that patients have access to essential medications as dictated by health care policies).
- Implementation and compliance in terms of *regulatory compliance* (with health policies and regulations, including controlled-substance laws, medication safety standards, and reporting requirements), and *quality assurance* (through the implementation of programs that are aligned with health policies aimed at ensuring high-quality standards of care and medication safety).

Other ways in which pharmacies impact health policy are through public health initiatives (health screenings, preventive services, and health promotion and education), advocacy (at a professional, regulatory, and health care reform level), data collection and reporting (such as through

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pharmacovigilance programs that contribute to policy development and evaluation by providing insights into medication usage patterns, patient outcomes, and public health trends), collaboration (with health care providers and through referral systems that support policies that promote comprehensive and continuous care), and crisis management (ensuring continuity of medication supply and providing emergency health services during crises). Pharmacies are essential players in the health care policy landscape. Their role ensures that health policies are effectively translated into practice, improving patient outcomes, and contributing to the overall functionality of the health care system.

Pharmaceuticals

Pharmaceutical companies play a significant and multifaceted role in health care policy. Their influence spans drug development, devices, regulation, pricing, accessibility, innovation, and public health. The role of pharmaceuticals in health care policy includes:

- Drug development and implementation in terms of *research and development (R&D)* (driving innovation to discover, develop, and bring new drugs and devices to market), *clinical trials* (to test the efficacy and safety of new drugs, which are essential for regulatory approval and to inform health care policies regarding new treatments and treatment protocols), and through *academic and research partnerships* (aligning with policies that promote scientific research and innovation).
- Pricing and reimbursement in terms of *drug pricing strategies* (drug prices are based on various factors, including R&D costs, market competition, and therapeutic value, which impact patient access to medications and health care costs), *negotiations with payers* (to secure reimbursement for their products, which can impact the inclusion of drugs in formularies and patient access), and through *value-based pricing* (in which drug prices are linked to the clinical outcomes they deliver, which aligns with policies aimed at improving the cost-effectiveness of health care).
- Accessibility and distribution in terms of *global health initiatives* (such as programs like tiered pricing, donations, and public–private partnerships to support global health policies aimed at improving access to essential medicines in underdeveloped countries), and *supply chain management* (to ensure the timely availability of medications, supporting policies aimed at ensuring a reliable supply of essential drugs).

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Other ways in which pharmaceuticals impact health policy are through advocacy (by actively lobbying and collaborating with governmental and nongovernmental organizations to support health policies and initiatives that promote public health and access to medications), regulation (to comply with stringent regulatory requirements set by national and global regulatory bodies), public health and education (such as through disease awareness campaigns and patient support programs), ethical considerations (to adhere to ethical standards in research and clinical trials), corporate social responsibility (such as health care outreach, environmental sustainability efforts, and community support, aligning with broader health policy goals), and crisis preparedness (in developing and distributing vaccines and treatments, and supporting emergency health policies and response strategies). Pharmaceutical companies are at the front lines of innovation, making them a key part of the health care landscape. Their role is crucial in translating health policies into practical outcomes that improve patient care, enhance public health, and foster medical advancements.

Payers

Payers play a central role in shaping health care policy, influencing access, affordability, quality of care, and overall health system efficiency. They provide insurance and payment to offset health care expenses for patients, thereby playing a substantive role in the *costs* of health care. The role of payers in health care policy includes:

- Policy development in terms of *benefit design* (with benefit packages that determine the scope of coverage that affects patient access to care and impacts health policies aimed at promoting comprehensive coverage), *payment models* (various payment models, such as fee-for-service, capitation, and value-based payment, influence provider behavior and support policies aimed at improving quality of care and cost-effectiveness), and through *risk management* (by setting premiums and reserves to align with regulatory requirements and actuarial standards that ensure financial stability and compliance with health insurance policies).
- Implementation of health policies in terms of *coverage decisions* (by deciding which treatments, medications, and services are covered, directly influencing patient access to care and potential out-of-pocket costs for essential health coverage), *provider networks* (network management supports policies promoting patient choice and access to high-quality

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providers), and through *claims processing* (ensures timely reimbursement for providers and financial protection for patients to align with policies for administrative simplification and efficiency).

- Financial protection and access to care in terms of *premium subsidies and assistance programs* (to make coverage more affordable for low-income individuals and families, aligning with policies aimed at expanding access to insurance), and *catastrophic coverage* (to protect patients from financial ruin due to major health events, aligning with policies designed to provide financial protection and reduce medical bankruptcy).

Other ways in which payers impact health policy are through advocacy (to influence health care legislation and regulation related to insurance markets, health benefits, and payment reforms), compliance (to ensure that their operations align with legal standards), quality improvement (through programs incentivizing providers to meet performance benchmarks and improve patient outcomes), care coordination (to manage patient care across multiple providers and settings to reduce fragmentation and support policies promoting integrated and patient-centered care), reporting and analytics (through health data analysis and reporting to assess the effectiveness of interventions, and provide data to regulatory bodies and stakeholders, supporting policies aimed at accountability and informed decision-making), and preventative care and health promotion (by covering preventive services and implementing health promotion initiatives to encourage healthy behaviors and lifestyle choices that align with policies promoting population health and wellness). Payers are integral to the health care policy ecosystem. By collaborating with providers, policy makers, and other stakeholders, insurers can contribute to a more effective and equitable health care environment.

1.5 Across the Pond: How Are Health and Diversity Related?

In a single hour at a clinic, a health care provider might encounter an older construction worker suffering from back pain, a young family concerned about how they will cover their medical expenses, a teenager managing mental health issues, and a patient who is transgender seeking a routine checkup. Even without mentioning race, we can see that health care is diverse in its very nature. With the United States also becoming more racially and ethnically diverse over the last decade,[17] it's increasingly clear that national health care policy must be inclusive of the diversity of those it serves.

[17] Jones et al., "Race and Ethnicity Measures."

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Diversity, which encompasses the unique characteristics and perspectives of individuals in a population, is largely seen as a barrier to health care.[18] To take a closer look at *how* diversity can be a barrier, let's consider the diversity by race/ethnicity of the top thirty-five healthiest nations in the world, listed in Table 1.3.

Health rankings are measured using the **Bloomberg Global Health Index**,[19] which is a holistic measure of national health that includes many factors such as health risks (e.g., obesity), average life expectancy, and living conditions (e.g., water quality). It is scored as a value between 0 and 100, with larger values indicating better health. The diversity of a nation is measured using the **Fractionalization Index**,[20] which is a measure of the likelihood that two people selected at random in a given population will be from two different groups. It is scored as a value between 0 and 100, with larger values indicating greater diversity. Table 1.2 shows the Fractionalization Index score for two different ethnic groups, by nation.

Referring to Table 1.3, it is striking how health and diversity rankings differ. Among the top ten healthiest nations, only three are inside the top 100 for racial diversity. Among the top thirty-five healthiest nations, less than half (fourteen nations) are inside the top 100 for racial diversity. If we compute a Spearman correlation for the rankings of the top thirty-five healthiest countries, we find a negative correlation ($r = -0.33$) with greater racial diversity being related to lower health rankings. In total, 11 percent of the variability in health rankings can be explained by the racial diversity of a given nation. The takeaway: Racial diversity is a key barrier to achieving better national health outcomes.

Let us appeal to the common adage: *correlation is not causation*. When considering diversity, it is important, at a policy level, to consider what factors are related to being more diverse as a nation, particularly in terms of how policy can positively affect health. For example, diversity at an individual level reflects a person's distinct background, beliefs, values, and health care needs that are shaped by their cultural heritage. This diversity of individuals necessitates a personalized approach rather than a standardized care model to avoid isolating patients.[21] Key cultural factors to consider for shaping health policy include:

[18] Centers for Disease Control and Prevention (CDC), "Ambulatory Care Use."
[19] World Population Review, "Healthiest Countries 2024."
[20] World Population Review, "Most Racially Diverse Countries."
[21] Younas et al., "Sociocultural and Patient-Healthcare."

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Table 1.3 *The score and ranking for health and ethnic diversity of a nation*

Country	Bloomberg Global Health Index	Rank	Fractionalization Index (HIEF 2013)	Rank
Spain	92.75	1	0.67	41
Italy	91.59	2	0.11	142
Iceland	91.44	3	0.00	185
Japan	91.38	4	1.90	154
Switzerland	90.93	5	36.70	92
Sweden	90.24	6	21.90	120
Australia	89.75	7	27.60	107
Singapore	89.29	8	39.50	86
Norway	89.09	9	15.10	136
Israel	88.15	10	37.60	87
Luxembourg	87.39	11	0.00	165
France	86.94	12	0.00	183
Austria	86.30	13	27.60	107
Finland	85.89	14	13.80	138
Netherlands	85.86	15	35.40	95
Cameroon	85.70	16	0.00	155
South Korea	85.41	17	9.50	145
United Kingdom	84.28	18	39.90	82
Ireland	84.06	19	17.40	130
Cyprus	83.58	20	34.70	97
Portugal	83.10	21	22.00	119
Germany	83.06	22	18.90	126
Slovenia	82.72	23	25.80	111
Denmark	82.69	24	17.70	128
Greece	82.29	25	16.70	132
Malta	81.70	26	0.00	190
Belgium	80.46	27	59.20	53
Czech Republic	77.59	28	26.20	109
Cuba	74.66	29	51.70	70
Croatia	73.36	30	17.10	131
Estonia	73.32	31	45.80	75
Chile	73.21	32	43.90	79
Costa Rica	73.21	33	39.80	83
United States	73.02	34	52.70	67
Bahrain	72.31	35	58.20	57

- Family and community, which play a crucial role in shaping an individual's beliefs and perceptions, especially in certain cultures. In some communities, the interests of the family take precedence over those of the individual, influencing the health care decision-making process.

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- Religious beliefs can pose barriers to certain treatments or involve dietary restrictions, requiring accommodation in health care plans.
- Perspectives on death and end-of-life care vary across cultures, necessitating culturally sensitive approaches.
- Gender roles and dynamics within relationships can impact health care decisions and willingness to seek treatment.
- Cultural beliefs about health, pain tolerance, and the efficacy of different treatments can influence patient expectations and adherence to treatment plans.
- Genetic and physiological factors may result in varying responses to medication among different cultural groups, impacting treatment outcomes. This feature of culture is part of the exciting growth of personalized medicine.

Health Care systems and policies that are capable of addressing diversity differ across countries, which influences the role of patients. Some nations have decentralized or collaborative approaches to health care planning, involving various stakeholders, while others have more centralized systems. Funding mechanisms for health care can also vary, including general taxation, national health insurance, private insurance, out-of-pocket payments, and charitable donations. The presence or absence of universal health care coverage can likewise impact access and equity for patients. All of these systems and policies impact a nation's ability to close health disparity gaps and reduce barriers to care.

1.6 Moving toward a Healthy Society

The scope of this book is focused on what we refer to as the *axes of the US health care debate*: government and equity. We address government in terms of its involvement in health care, with the perspective that data from the healthiest countries in the world affirms the need for government involvement in health care to ensure access for all. We address equity by asking, "Is the health care debate in the US too focused on insurance for all?" While access to health care is essential, the social determinants of health account for about 80 percent of the variability in quality-of-life and length-of-life measures (as introduced at the beginning of this chapter and illustrated in Figure 1.1). For this reason, to achieve health equity, we must go further than simply guaranteeing health insurance for everyone by also addressing the social determinants *in health care policy*. Suitably, as we dive deeper into the features of health care and health care policy, we present, in

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this book, a focused, data-driven discussion for these two critical, yet related, policy constraints in the US health care debate.

Chapter Summary

This introductory chapter emphasizes the importance of viewing health care policy as beyond merely providing access to doctors. While quality health care is vital, social determinants – such as economic stability, education, and neighborhood environments – play a more substantial role in determining health outcomes. These external factors account for approximately 80 percent of life quality and longevity, underscoring the need for health care policies to address broader societal inequities. Equity, equality, and justice are explored as approaches to reducing health disparities. While equality ensures uniform resource distribution and equity customizes support to individual needs, justice aims to eliminate systemic barriers, offering sustainable solutions. Examples like equitable COVID-19 vaccine distribution underscore the importance of justice-driven policies in reducing health disparities and fostering long-term population health equity.

The chapter also elucidates the fragmented US health care system, which incorporates elements of four global models: Beveridge, Bismarck, National Health Insurance, and out-of-pocket. This fragmentation creates inefficiencies and inequities in access, quality, and costs, measured through tools like the Donabedian model and the HAQ Index. The 6 Ps framework – patients, policy makers, providers, pharmacies, pharmaceuticals, and payers – illustrates the complex interplay of stakeholders in the health care system. To improve US health care, it is important to align interests across the 6 Ps to ensure that all people have *access* to *quality* care that they can afford (*costs*).

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