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HEALTH POLICY ANALYSIS

Health policy analysis is of increasing interest to sociologists in the areas of medical sociology and health services research. Health policy analysis draws on perspectives from across the social science disciplines: from anthropology and economics to political science and sociology, as well as law, medical ethics, and the applied fields of public health, public administration, and public policy. Leading sources of policy analysis are scholars in twenty to thirty university-based health policy and health services research centers and institutes and the myriad and growing number of private sector "think tanks" such as the Brookings Institution, the Urban Institute, RAND, the National Bureau of Economic Research, Project Hope, and the American Enterprise Institute. An early indicator of advances in the field of policy studies was the publication of the *Policy Studies Review Annual*, which commenced in 1977 (Nagel 1977) and continues to cover the field with an editorial advisory board made up of distinguished social scientists.

Major federal agencies that both sponsor and conduct health policy analysis include the National Center for Health Statistics (NCHS); the Health Care Financing Administration (HCFA); the Agency for Health Care Policy and Research (AHCPR); the Alcohol, Drug Abuse, and Mental Health Administration (ADMHA); the Social Security Administration; the National Institute on Aging (NIA); and the Office of the Assistant Secretary for Planning and Evaluation. Federal research funding is the mother's milk of health policy analysis; although limited, it has assured the slow but gradual accumulation of health services research knowledge.

Several journals are sources for the latest developments in health policy analysis: *Health Affairs*, *Health Care Financing Review*, *Health Services Research*, *Journal of Health and Social Behavior*, *Journal of the American Medical Association*, *Milbank Quarterly*, *International Journal of Health Services*, *New England Journal of Medicine*, and *Journal of Health Politics, Policy and Law*. A recent, comprehensive text, *Understanding Health Policy* (Bodenheimer and Grumbach 1998), though written by physicians and with a clinical orientation, is nonetheless critical of chronic systemic tensions and inequalities in U.S. health care delivery. The authors integrate social science literature throughout, one indication of a growing consensus regarding salient problems among scholars, practitioners, and "patients" alike, in a nation shaken by unprecedented corporate intrusions into health and medical encounters.

There are multiple paradigms in and approaches to health policy analysis in schools of public policy, public health, public administration, and social work. The same diversity is present in sociology and other social science disciplines. However, we detect and discuss important areas of convergence between current controversies in U.S. health policy and perspectives and methods that are well established in sociology. We believe these areas of convergence are likely to enhance the stature and usefulness of the discipline in the analysis of health policy, in public as well as in academic life.

The various disciplines, substantive specializations, and methodologies represented in such work have contributed an array of perspectives to the definition of health policy analysis, how it is conducted, and how professional training is oriented and organized. As the number of programs offering health and related policy training has increased, the academic respectability of such work has grown apace. In sociology, vestiges of an invidious distinction between "basic" and "applied" research are still with us, and policy research is both less visible and less valued than is warranted, given its potential public impact. Nonetheless, an expanded topical definition of health policy analysis, following from the recent political and cultural tumult over changes in health care, is conducive to research in several vibrant research genres in sociology, including political economy (see, e.g., *International Journal of Health Services*), constructionist approaches to medical encounters and social problems (Brown 1995; Spector and Kitsuse 1987), phenomenology of illness and medical practice (Benner 1994), community-based studies (Israel et al. 1998), and comparative sociocultural studies of health systems (Mechanic 1996; Kleinman 1980). The latter, bordering medical anthropology, encompasses conventional treatment regimen, as

well as "self-help" and various nonbiomedical, "alternative" health practices, be they traditional or sacred (Baer 1995). Such topical breadth is also evident in "mainstream," medically oriented outlets. In recent years, the *Journal of the American Medical Association (JAMA)* has devoted sustained attention to public health issues such as gun violence (Sinauer et al. 1996), domestic violence, motor vehicle accidents, and terrorism.

For sociologists, the primary point of entry into health policy analysis has been medical sociology, which has long been sustained by its applied relevance to and sponsorship by agencies in government and medicine (Cockerham 1988). Other contributing subfields include aging/social gerontology, political sociology, gender studies, and social stratification. Despite productive cross-pollination between these related fields of scholarship, the number of sociologists working in health policy analysis is small relative to those involved overall in studies of health care and of social policy, broadly conceived. Though medical sociologists continue to comprise one of the largest sections of the American Sociological Association (ASA)—with more than 1,000 members—their presence in the smaller Association for Health Services Research (AHSR), a major professional association, is modest: only 5 percent of its 1,400 members report primary disciplinary training in sociology, compared to 20 percent from medicine and 14 percent from economics (other members were trained in other social sciences, the allied health fields, and business). Health policy analysis is not, however, confined to conventional research roles and careers; many working in health policy analysis hold master's degrees, are employed on the staffs of governmental and private agencies, and are not oriented toward academic theory or publication (Luft 1999).

Sociologists' limited involvement in health policy analysis reflects the sources of, and agendas driving, health services research funding. Many problems in the planning and administration of large, complex programs favor orientations and methodological skills others can best provide, primarily those in economics and business. It reflects as well an unfortunate trend in which "the division of intellectual labor in our discipline tends to replicate program divisions. Experts on aging study Social Security; experts on health care study Medicare; experts on poverty study Aid to Families with Dependent Children" (Quadagno 1999, p. 8). More generally, the American health care system is itself increasingly governed by business principles of cost control and administrative efficiency, under corporate managed care. The dramatic growth of for-profit health maintenance organizations (HMOs), "now accounting for 75 percent of all HMOs and enrolling over 50 percent of all subscribers" (Fein 1998, p. 10), has intensified public debate over quality, access, and humanity in health care.

The products of health policy analysis range from journalistic and descriptive accounts to sophisticated quantitative analyses and projections. But over the last decade or more, health policy analysis has reflected a societal struggle to come to terms with a secular change in the organization and financing of medical care, away from solo, fee-for-service practice toward corporate managed care. Given the current emphasis on cost savings and efficiencies, and on mechanisms for achieving them such as capitation, risk adjustment, and "utilization management" or "practice guides" for physicians' clinical discretion, economic models and analyses have been paramount in health policy analyses funded by government agencies and large corporate entities. The justification advanced for these competitive efforts has typically been a need to check inflationary costs and "excessive" demands for medical services by consumers, ostensibly free to operate in a "market" for such services.

Consequently, traditional foci of sociological interest—including professional status and autonomy, access to and stratification of health care services, and continuity Federal safety-net policies rooted in the postwar *social contract* (Quadagno 1999; Rubin 1996)—have been pushed to the margins of public and policy debates. However, sociological perspectives are both rejuvenated and needed at this time. One important line of critique has been to challenge attributions of market choice and consumer autonomy in the face of corporate managed care (Freidson 1994; Freund and McGuire 1999). Another is to reject the very notion of "system" in relation to health care and medical coverage in the United States and instead to document, as does Diamond (1995), the collective vulnerability and implications arising from the arbitrary and confusing patchwork quilt that is American

health policy—a paradox of "excess and deprivation" (Bodenheimer and Grumbach 1998). Yet another is to demonstrate how health care professions may act to mediate between users of health services and their often remote provider organizations. In an important analysis of how doctors are implicated in this process, Freidson (1994) argues for a rebirth of *professionalism*, based on client service and trust, as bases for health care reform. Although one may question the likelihood of this scenario, given the mistrust of doctors at the heart of the consumer backlash of recent decades, the answers are sure to be significant both for social theory and policy. These are but a few examples of the distinctive contributions sociologists are making to health policy analysis, broadly defined.

Consistent with this public spotlight, sociological research on health policy and other segments of the welfare state is gaining momentum. The 1998 president of the American Sociological Association devoted her address to a historical analysis of changes in welfare policy provision, including social security and medicare, as central to understanding the erosion of the postwar social contract in the United States (Quadagno 1999). Furthermore, the demographic aging of America, along with a dramatic increase since mid-century in women's labor-force participation (with resultant strains in traditional sources of familial care), are propelling the neglected problems of chronic illness, community-based care, and allocation of resources—that is, between capital-intensive hospital treatments and more equitable provision of basic health care—to the forefront of the national and research agendas.

In recent years, then, the inventory and scope of topics subsumed under the heading *health policy analysis* have expanded in ways that energize and demand the attention of sociologists. The legislative failure of the Clinton administration's national health plan demonstrated the necessity for a coherent set of principles—moral and political, as well as technocratic—in order to implement large-scale policy reform; resistance to "environmental racism" by those unduly exposed to hazardous jobs and industrial toxins has assumed global dimensions; and such widely publicized conflicts as those over public versus corporate liability for the expense of tobacco-related illness (Glantz et al. 1996) and firearms and other forms of violence (Prothrow-Stith 1998; Sinauer et al. 1996)—all these have underscored the political, economic, and cultural forces that shape the health problems, as well as the spectrum of policy options, that analysts address. Indeed, health policy analysts have periodically been buffeted directly by political currents. During the Reagan administration, conservative forces in Congress sought to curtail sharply the collection of health-related data at the federal level; and spokespersons for the failed Clinton plan were attacked as proponents of a federal "takeover" of health care. This attack reflected and accelerated the devolution of federal discretion and responsibility for health care and other policies to state and local governments. Thus, health policy analysis, like health policy itself, has become increasingly politicized.

Research in health policy analysis necessarily concerns itself most directly with timeliness, pragmatism, and specificity in an effort to improve health and health care delivery. Research and analysis are conceived to inform social policy by (1) illuminating features of social organization and social action that are relevant to health policy planning, (2) identifying the social and health problems that require formulation in attempts to develop health policy, and (3) organizing and interpreting data that monitor the effects and outcomes of health policy decisions and the relative impact of programmatic alternatives.

In response to this mission, health services research contributes two major types of knowledge: *engineering* and *enlightenment* knowledge (Weiss 1978). In turn, these models imply distinctly different roles for analysts in the policy process (Marris 1990). In the *engineering* model, researchers seek to provide instrumental knowledge for practical assessment of alternatives and problem solving, accepting the values and goals inherent in existing policies largely as givens. Many influential health policy analyses first appear as fugitive documents directed to internal governmental audiences, addressing particularistic needs and interests of government agencies and actors, and are based on reports designed with an evaluative purpose. Policy analysis of this kind is, again, primarily funded and supported by government, with a lesser role played by such private foundations as the Robert Wood Johnson Foundation.

In the *enlightenment* model, researchers critically—even irreverently—scrutinize the implicit empirical, moral, and political assumptions embedded either in discrete policies or in broader debates (e.g., about the "right to die" or national health insurance). Rather than dealing with how policies work in a technical or engineering sense, enlightenment research contributes to the root understanding of how, by whom, and with what unintended consequences problems in health policy are socially constructed. Often, enlightenment research promotes shifts in what Thomas Kuhn (1970) calls "paradigms," that is, fundamental ways of looking at problems. The enlightenment model is rooted as well in a critical, Weberian tradition in which the *formal rationality* of internal program functioning is juxtaposed with the *substantive rationality* of such programs, as they affect individual freedom and social equity.

As Marris (1990) shows, the engineering model is most effective and appropriate when policies have clear goals, enjoy broad consensual support, and can be linked directly to social outcomes. At the macro level especially, such conditions have rarely obtained regarding health policy in the United States. Moreover, experienced observers have concluded that however well conceived and conducted, research has had a limited direct role on the adoption and implementation of health policy (e.g., Lee 1998; Mechanic 1974). Important, though less often discussed, is that analysts in the engineering model are dependent on access to reliable, comprehensive, and timely data sets. Such a research infrastructure is difficult to develop and maintain, even where data collection is mandated at state or federal levels of government (Mechanic 1974). Given the present trend of privatization in the management and delivery of health services, sources, collection, and linkage of data are correspondingly more varied and less subject to public oversight. For example, while public health departments have a responsibility to serve the population at large, HMOs, however carefully they document utilization of services among their thousands of subscribers, have no such obligation to the public. This poses serious questions regarding the coordination of public and private health entities (Goldberg 1998).

Among other fertile research questions being posed in the expanding, multidisciplinary field of health policy analysis are the following: How is the global resurgence in infectious disease—termed the *third epidemiologic transition* (Barret et al. 1998)—linked to our more global economy and consumer culture, and what strains is it likely to impose on outdated public health networks? To what extent is globalization leading to convergence in the organization of health care systems internationally (Mechanic 1996)? How are the successes of the American health care system in increasing human longevity creating new conceptions of and practices in medical ethics? Inasmuch as chronic illnesses are often peripheral to direct treatment by doctors, what roles are nurses and other medical practitioners playing in the revision of medical ethics and practice (Thomasma 1994)? What is the place and role of communities in our increasingly corporate health care system? And how might we rethink research practices to better conceptualize and tap community-level perspectives and dynamics (Israel et al. 1998)? Many contemporary problems in health care—from mechanisms by which AIDS and other diseases are transmitted, to discrimination against minority groups seeking care—would seem to rest on understanding community-level dynamics.

Sociology has a long tradition of reformism and interest in finding solutions to applied problems. Robert Lynd's *Knowledge for What?* (1986) called sociologists to the task, and a long line of American sociologists have worked within the applied tradition. Particular examples are from the Chicago School (Bulmer 1984; Deegan 1988; Deegan and Burger 1981; Park 1952) and Columbia University, where Lazarsfeld and his colleagues advanced the field of applied research after World War II. These efforts were followed by work on the uses of sociology (Lazarsfeld et al. 1967) and a burgeoning of critical scholarship in the wake of the "counterculture" of the 1960s. These forerunners laid the foundation for what has become an increasingly exciting enterprise: the study of health policy. Freeman's (1978) observation on the nature of health policy analysis as a scientific enterprise remains applicable: that policy studies are rather specialized and "content limited," demonstrating few attempts to develop overriding conclusions about the policy process; hence, "there is practically no effort at 'grand theory' and little at 'middle-range theory' either" (Freeman 1978, p.

11). Nevertheless, narrow, highly specialized studies are not policy studies if they have no use beyond the most limited and specialized areas of concern. "Policy studies . . . need to be broad in implications, insightful to those beyond the narrow band of experts in a particular field, and intermeshed with work in related areas" (Freeman 1978, p. 12). The stimulation of and funding for policy analyses has been driven largely by the immediacy of existing (rather than emerging) problems that catch the attention of policy makers. Therefore, there is tension between the need to conduct carefully controlled definitive studies and the need to enlarge the focus of such research to contribute broader application and significance.

The growth of health policy analysis was shaped by the social problem definitions of health care from the 1960s to the 1980s (Rist 1985), and these, in turn, have been shaped by the political and economic exigencies of these periods. Health care was defined in the 1960s by the crisis of access, in the 1970s by the crisis of fragmentation and lack of comprehensive planning, and in the 1980s by the crisis of cost and the resurgence of market forces in health care. The widening reverberations of these forces throughout the 1990s presents sociology with an urgent and relevant research agenda. The cost of medical care continues to rise at two or three times the rate of inflation; the costs to business, government, and individuals skyrocket; more and more Americans are uninsured each year; the annual expenditure on the medical-industrial complex climbs above $600 billion; and the population is aging. In the wake of these dramatic developments, the health care system and the policies creating it have been increasingly exposed to criticism and investigation. The key health policy issues for the new century are the cost, quality, and outcomes of care; the organization, financing, and delivery of acute and long-term care services; and expanding access to care.

(SEE ALSO: *Health-Care Utilization and Expenditures*; *Health Promotion and Health Status*; *Medical-Industrial Complex*; *Medical Sociology*)

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