Chapter 15: Health and Welfare
Objectives

• Explain how the federal and state governments became involved in health care.
• Discuss the various public health programs and how the political culture influences how states define public health.
• Describe health care reform efforts of the 1980s to the 2010s.
• Identify current health care issues.
Introduction

Tracing the evolution of healthcare and welfare policy, this chapter provides an overview of the challenges and successes of federal and state programs. Historically, states and localities served as providers of healthcare in the United States. The influence of political culture led to variation in healthcare and welfare policy across states. The Great Depression forced the federal government to pursue a more active role in providing unemployment insurance and retirement compensation. With the emergence of the Great Society under President Lyndon B. Johnson and the creation of Medicare and Medicaid, the federal government became the primary provider of healthcare and welfare in the United States, a movement away from state and local control.

Rising costs and abuses of the social safety net led to the devolution revolution, begun during the Reagan administration, of welfare and healthcare responsibility. Reforms increased state flexibility in the administration of benefits, particularly welfare benefits, but rising healthcare costs eventually forced states to abandon their efforts at healthcare reform.
Introduction

The chapter notes that while states had come to rely on managed care and HMOs to cut healthcare expenses, the increasing costs of prescriptions drugs and the need for increased long-term care for retirees ultimately forced them to reassess healthcare provisions. Some states turned to mandated coverage of their citizens with tax penalties for those opting out and sliding-scale subsidies available for those below the federal poverty line. The passage of the national Patient Protection and Affordable Care Act in March 2010 mandates coverage for all Americans, taking control of public healthcare from state hands. The chapter closes with discussion of the future of healthcare in the United States, focusing on the emergence of health information technologies, the rising need for long-term care resulting from an aging population, and the ongoing role of localities as direct healthcare providers.
Healthcare History

- 2000 years ago the Greek civilization invented the concept of reason that lead to the modern rise of science.
- They were the first to recognize that disease was a natural occurrence and the caused by supernatural forces.
- They also establish the concept that the study of medicine is a professional pursuit guided by a set of moral and ethical principles – The Hippocratic oath states Do no harm, tend to the sick without regard for personal interest, do not divulge private medical information, etc.
- After the fall of the Roman empire and the emergence of the dark ages and middle ages the art of medicine was basically stagnated.
- Modern medicine can trace its beginning to the 19th century. At this time the stethoscope was invented in 1816, anesthesia was discovered in 1840, and dental schools were first open in 1839.
In the 1850s, the people calling themselves doctors had no formal medical training, most were trained by apprenticeships and many were considered charlatans.

In the 1870s, there were only 149 hospitals in the entire U.S.

By their very nature, hospitals are labor-intensive and expensive to operate, with fixed costs that are not dependent on the number of patients being served.

Hospital insurance was established in the 1920s, with the subscribers being charged a yearly premium in return for being provided 21 days of hospital care.

While the fundamental concept of hospital insurance was defective from the beginning, providing 21 days of hospital stay was adequate given the medical technology of the time. Today, this type of arrangement does not begin to cover what most people need given the technology available to cure serious, long-term illnesses.

During World War Two, employer-paid health insurance emerged as a feature of the American healthcare system.
Employer paid health insurance served to distance the Provider of medical care and the consumer of medical care, because there was no incentive to find the most cost-effective service available. When someone else is paying for health care people will accept the choices made by the employer provided plan.

In 1965 the Federal government entered the market place with Medicare for the elderly and Medicaid for the poor.

These programs increased the number of people who could afford medical care, as well as increasing the incomes of medical professionals.

The most important development, was the power state governments had over hospitals. By becoming the largest single source of funds to hospital, state governments were now in a position to influence and even dictate the policy decisions made by hospitals.

As time went by the decisions made by hospitals became more of a political nature, than for medical or economic reasons.
The Role of the Government

• Federalism and the social safety net.
  • AFDC- *Aid to families with dependent children* - 1930s program that provides monetary assistance to women and their children.
  • TANF- *Temporary assistance for needy families* - Provides cash assistance to the poor via block grants to the states.
  • Medicaid- joint state and federal health insurance for the poor.
  • Patient Protection and Affordable Care Act
Affordable Care Act

• Obamacare-Federal government control of health care.
  
  ➢ Current health insurance plan must meet minimum level to be consider health insurance by the government. Required every person to have health insurance (Individual Mandate).
  
  ➢ Created online marketplace where consumer can choose from different types of health plans.
  
  ➢ Health insurance for the poor purchased through the exchanges are subsidized by federal tax credit.
Affordable Care Act

- Partisan divide- Desired policy objective for decades / Expansion of government spending and regulations.
- Medicaid expansion-Federal government pays 100% for 3 years, then less on a sliding scale.
- Medicaid benefits reduction-ACA forbid states to reduce number of individuals eligible for Medicaid, but states scaled back coverage. States eliminate the number of days in a hospital, also eliminated dental care, specialist treatment, etc.
Issues in Public Health

• Pandemics—Prevention of communicable diseases and other medical problems that could be detrimental to society.

• Obesity – dealing with the medical conditions brought about by an over-weight nation and the strain on its health care system.
Political Culture

• Public health across states-
  ➢ Uneven implementation of the law has led to disparity between states and the uninsured population.
  ➢ Also, the cost of service, financial viability of hospitals, availability of hospitals in rural areas, Medicaid reimbursements are all concerns.

• Public opinion and public health-
  ➢ The overall question the public asks is -How best to provide the greatest good, to the greatest number of people in a sustainable way?
• Germany-Started in the 1880s with the world's first medical insurance.

• Historical basis in U.S.-The progressive era of the late 1890s advance the discussion of national health insurance.

• The Great Depression
  • Social Security-did not include a compulsory health insurance program because of opposition from the medical community.
  • AFDC-1930s welfare program.
Entitlement Programs

• Medicare-Federal health insurance program for the elderly.
  ➢ Run and paid for by the Federal government via the general revenue at 41% and financed through payroll taxes (37%). With an additional 14% from beneficiary premiums.
  ➢ As of 2017 it is 15% of total Federal Spending with payments totaling $702 billion.

• Medicaid- Federal-State health insurance for low income and the poor.
  ➢ Administered by the state via block grants from federal government.
  ➢ In 2015 total Medicaid spending total $532 billion.
Medicare

• 1965

• Bipartisan compromise

• Program for the elderly

• Paid for and run by federal government
Medicaid

• Joint state-federal program
• Not mandatory, but all states participate
• Poverty line/poverty threshold
• Standards leeway
Costs of Providing Public Health

• Changing economic conditions-
  ➢ Medicare, Medicaid and Social Security are the largest drivers of the federal budget at 15%, 11% and 23% respectively, that is 49% out of a $4.0 trillion

• Shift in political culture-
  ➢ No longer willing to spend large sums of money on the welfare state.
Devolution Revolution

- Ronald Reagan, Tommy Thompson, and Bill Clinton.
- States and localities as primary actors.
Welfare Reform

• Policy experimentation

➢ AFDC and TANF-Work requirements to maintain eligibility of benefits.

➢ Personal Responsibility and Work Opportunity Reconciliation Act- put a five-year cap on federal payments to welfare recipients.
Healthcare Reform

• Managed care and HMOs-
  • provided an intermediary between consumer and health care provides in an attempt to improve the quality of care people received.
  • Paid providers a flat fee for service in an attempt to lower expenses.
• CHIP
  • Number of uninsured children dropped by 20 percent
  • Not reaching all children who need it
  • Expanded to reach some adults
Failure of Previous Reforms

- Prescription drugs
- Decline of managed care and HMOs
- Long-term care
- Faltering economies
Reform

- Mandated insurance
  - Based on income
  - Too costly for most states
- Patient Protection and Affordable Care Act
- Shift in federalism?
Long-Term Care

- Unique responsibilities of Medicaid
- Growing demand
- Main driver of health care cost.
Public Health

• Terrorism, pandemics, natural disasters.
• Contraception and sexual health education.
• Obesity.
Conclusion

Historically, states and localities were the primary providers of healthcare and safety net programs for citizens. Following the Great Depression, however, the federal government assumed greater responsibility through the creation of Social Security, Medicaid, and Medicare. But the emergence of greater federal involvement did not permanently remove policymaking power from the states.

The devolution revolution of the 1980s precipitated a major shift in social policy. No longer was the federal government the primary factor in determining and distributing benefits. States and localities once again became the primary authorities in regard to the provision of health and welfare benefits. While the states welcomed the increase in policy flexibility, the rising costs of healthcare and welfare put undo constraints on state budgets. As a result, states and localities were forced to become more creative in social policy design and implementation. Although Medicaid continues to place an enormous fiscal burden on states, programs such as SCHIP and TANF have proved successful in terms of appropriately expanding benefits while also reducing caseloads. States continue to serve as the primary distributors of social service benefits, but decreasing federal support, faltering state economies, and the increasing need to provide long-term care to healthcare recipients are placing overwhelming burdens on states to maintain and expand existing programs. Even after passage of federal healthcare reform legislation in March 2010, states will still be at the center of healthcare expansion in the United States. After the U.S. Supreme Court’s June 2012 ruling, states get to decide whether to expand Medicaid under the law. At stake in these choices are many billions of dollars and health insurance for millions of Americans.
1. How has the policy flexibility of TANF affected how states provide welfare benefits? Do methods of distribution differ according to a state’s affluence? How do ideology and demographics influence welfare generosity among states? Does the dominance of one political party or another matter? How does a state’s minority population affect welfare policy and the distribution of funds?

2. Should ads or programs promoting junk food or food be regulated? Recent reports suggest that a significant percentage of all medical expenditures go to treat problems associated with obesity, and the number of obese children in the United States is rising. Should states and localities have the right to remove vending and soda machines in schools? Should government have an active role in dictating individual habits and lifestyles?

3. Should states act to prevent other potentially damaging lifestyle habits? For instance, numerous states view suicide as a public health dilemma. Despite suicidal tendencies being psychological disorders, states are increasingly pursuing strategies aimed at preventing suicides, particularly through educational training and counseling on such mental disorders as depression. Do such preventive measures deflect long-term healthcare costs? Should distinctions be made between state regulation and engagement in mental health issues as opposed to strictly physical health concerns?

4. In 2010, President Obama signed a bill into law mandating individual coverage, subsidizing insurance for low-income Americans, and assessing a tax penalty for those who go without coverage. Should the federal government take this approach to public health? What are the advantages and disadvantages of a universal healthcare program?

5. Should the federal government privatize Social Security? This is frequently debated as a presidential campaign issue. What are advantages and disadvantages of privatizing Social Security?

6. What new challenges might state and local governments face in public healthcare provision? What can localities do to address rising health concerns? Is it appropriate for localities to engage in restrictive policies, such as smoking bans and attempts to control obesity? Why or why not?
• Entitlement Program-A government run program that guarantees unlimited assistance to those who meet its requirements, not matter how high the cost.

• Medicaid-A joint federal and state health insurance program that serves low income mothers and children, the elderly, and people with disabilities.

• Medicare-Federal health insurance program for elderly citizens.

• Public Health-The area of medicine that deals with the protection and improvement of citizen health and hygiene through government agencies.