The Policy Factor

HEALTHCARE PROVIDERS: VICTIMS OR ARCHITECTS OF PUBLIC POLICY?

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This column represents the first in an ongoing series of articles on public policy and its impact on the practice of integrative medicine. This premiere discussion paints a portrait of the public policy landscape, explores the extent to which certain healthcare professions have engaged in the policymaking process, and offers practical advice on how individual providers can become involved. Future articles in the series will focus on the legislation and regulation that influence the way healthcare is delivered, at the local, state, and federal levels of government.

> *"There is no mystery or awe to the federal legislative process. The dance of legislation is complex and convoluted, but it is not an enigma. The inner workings of Congress are not opaque and impenetrable. Congress is ready to yield its secrets to those who care to study and understand and participate in how Congress works. The myth of mystery in politics has fallen away."*[1]

The people who show up for conversations about the future of healthcare will in large part influence the nature and quality of the policies that define that future. A provider's perspective regarding public policy is too often characterized by skepticism, frustration, and disenfranchisement; thus, many providers typically fail to participate. These feelings are completely understandable, particularly in the wake of the past decade's push to manage the crisis of spiraling healthcare costs by squeezing providers. Nevertheless, providers have the opportunity to make a deciding difference.

Providers often feel they have been on the receiving end of the stick, with little influence in the current and much-ballyhooed healthcare crisis. However, one way or another, the crisis will evolve and resolve through a series of incremental changes. The resolution of any crisis always generates change, and therein lies an opportunity to influence the nature of that change. The next and subsequent shifts in healthcare will be largely defined through the seemingly unfathomable process of public policy formation. This process is indeed convoluted, but not really so mysterious.

Where does the average provider fit into public policy formation? The answer is, in our opinion, right in the middle, next to the healthcare consumer. The awkward truth is, however, that these 2 groups are the most unorganized and underrepresented groups on the public policy game board. So what's a provider to do?

At a minimum, providers should better understand the dynamics of public policy formation, be better informed about emerging policy discussions, and be involved, even a little bit, in opportunities to make a difference, even if only a small one. A small change in the nature and extent of providers' involvement can make a significant difference in whether they are architects or victims of public healthcare policy. Yes, each provider can make a difference.

DEMYSTIFYING THE PUBLIC POLICY PROCESS

As everyone learned in high school civics classes, the processes used by groups of people to make collective decisions (public policy) sound pretty good in theory. The truth is they are devilishly tricky to make work in the real world, particularly at the macro scale of public policy making. The confounding factor that seems to muck everything up is that people (and their emotions) are involved. Thus, public policy has to be considered with a focus on people and how they do or do not relate to each other, as well as to the substance of the issues. It is on this foundation that an elaborate maze of rules is layered, thus creating the day-to-day context for delivery, consumption, and payment of healthcare.

A key challenge in the public policy formation process is for participants and stakeholders to realize their collective interdependency and interrelatedness,

and to recognize and accept their respective positions. Often the process of discovering the integral nature of public decision making is long, and fraught with difficult conversations, awkward realizations, and win-lose thinking. Public policy formation regarding healthcare issues is particularly thorny, because it has the added complexity that health is individually defined and affects everyone. Thus, healthcare policy is truly a universal issue that is impossible to carve into neat and discrete discussions. As no single voice or stakeholding group can hold a distinctly dominant position in the conversation, many stakeholders feel disempowered in the process. Consequently, they tend to ignore or dismiss opportunities to be involved in public policy discussions. Many seem content to placidly accept the fate "they" impose upon them and complain that "they" should do a better job.

This gloomy description of the public policy landscape is tempered by the fact that public policy formation is as much about the process of making policy as it is about the actual policy that is decided. In this process everyone has a voice and the opportunity to shape the conversation. What makes the difference is who shows up, how well they represent themselves, and how well they understand the rules of engagement. To be effective participants, providers have only to increase their involvement, build relationships, and become more familiar with and less resentful of the overall dynamics of the process.

The first step to more effective participation is to better understand the overall framework. While the marketplace fundamentally drives healthcare, it is public policy that defines the landscape on which individual practitioners are allowed to give care to their patients. This landscape is essentially a simple hierarchy that generates layers of guidance that ultimately set the boundaries and expectations for clinical practice, professional behavior, and even how providers get paid (Figure 1).

Another aspect of this framework is the relationship between various interests that are common in public policy discussions. At the macro level, the world of viewpoints can broadly be divided into 3 perspectives (Figure 2).

Each of these perspectives might be thought of as a sort of tribal identity, including its own values, language, and culture. If you've ever attended a public hearing you can attest to the challenges of crosstribal communications. Everyone is clearly using English terms, but the low degree of genuine dialogue and understanding illustrates the fundamental problem.

Further, each of these perspectives plays a different role in the global, integral discussion required in a public policy process. At the risk of oversimplification, each role might be characterized as follows:

Business

Business is the engine that fundamentally drives much of the change in our socioeconomic system. Further, rightly or wrongly, today it is via the commercial marketplace that we largely define and express our cultural values and collective vision—including the nature and specifics of how we deliver healthcare. However, as is obvious from daily stories in the media, business is not yet mature enough to collectively act in ways that consider, let alone take accountability for, the larger responsibilities associated with the consequences of its actions in the overall social context. Business is not a monolith; it is a tribe made up of many, many sects, subtribes, and internecine fiefdoms. Another interesting feature of business is that it is usually responsible for instigating changes that cause the "problems" that concern people; but it is typically the tribe that in the end is called upon to address and resolve a situation.

Community

Community is where change is felt. Like business, it is a broad collection of independent subgroups, each with its own passionate perspective. Communities are unique in 2 ways. First, they are the reservoir of the true values of the social system. Second, they initiate very little change; mostly they are a reactionary tribe that typically declares its values in terms of what it does not like rather than articulating what it wants. It has exceptional power when aroused, and most often reacts in bursts of passionate activity.

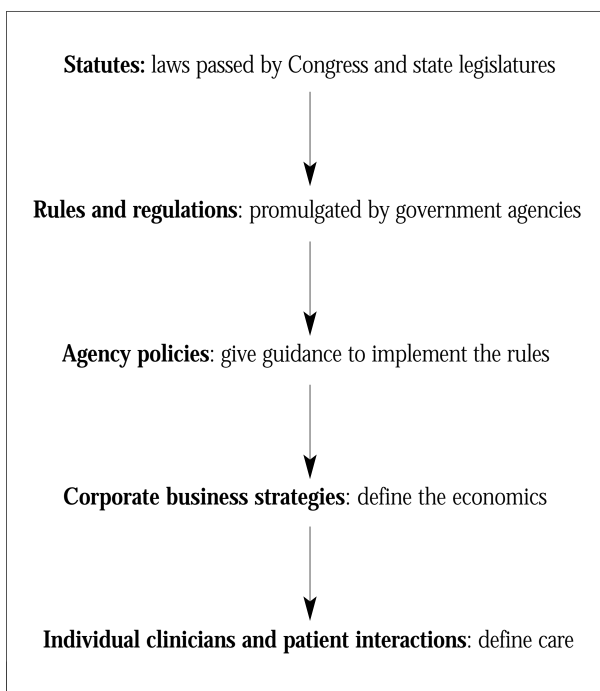

Figure 1
The policymaking hierarchy

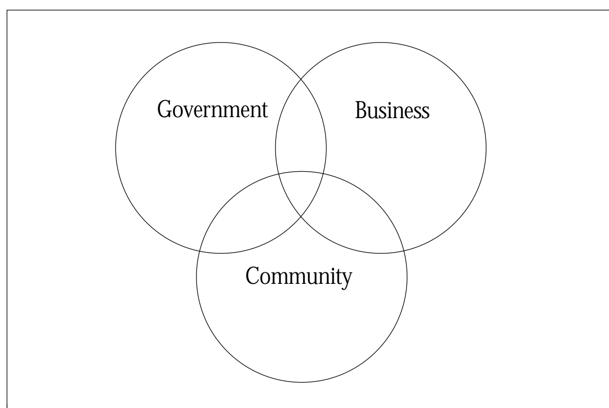

FIGURE 2
THREE PERSPECTIVES OF POLICYMAKING

Government

Government is a bit like the governor on the engine of a car or on a lawn mower. A governor regulates an engine so it doesn't run too fast, overheat, and cause damage. Similarly, government tends to become involved only after things heat up. It is the exception that it initiates genuine change. Notwithstanding the perennial tensions between Republican and Democratic philosophies regarding the role of government, the basic nature of government is to regulate once the need is obvious. And, as in the other 2 tribes, government is a federation of often-competing interests and goals. However, it is even further constricted because it has to deal with nonalignment both vertically (inconsistencies among legislatures, agencies, departments, and offices, at both the federal and state levels) as well as horizontally (inherent conflicts at a given level between agency jurisdictions tasked with expressing legislative intent, at both the federal and state levels).

Multiple Identities

These 3 descriptions are oversimplified categorizations, but they provide a way to begin to sort things out. They are useful even though any individual can identify with each of them, and might participate in different tribes on different days depending on the issue. Many providers agree with the cartoon character Pogo, who once quipped with regard to the complexity of group decision making, "We have met the enemy, and it is us."

Individual providers often are confused about their tribal affiliation. The truth is, as suggested above, there is no single identity, particularly on healthcare policy issues. Rather, providers must develop relationships among the many other voices, and become adept at keeping track of which identity they are assuming, at what time, and on what issue.

COMPETITION OR COLLABORATION?

There is no "them" in a public policy debate, there is only "we." And the "we" includes a great many people outside an individual tribal identity. This manner of thinking stands in strong contrast to the common metaphors and language that usually characterize public policy processes. Typically these are competitive sports analogies or combat metaphors. "We'll have to ambush them during the Senate hearing"; "We have to get our team together and defeat them in the next vote." The fact is that a stakeholder group is interconnected and interdependent, so "us" and "them" thinking eventually spirals back to thwart real progress. While the current democratic process strives to be collaborative, it is very imperfect in its ability to do so. Rather, the process encourages a series of competitive moments and demands that each of the stakeholder groups take responsibility for organizing themselves to participate in the fray. This apparent contradiction between needing to work collaboratively and having to act competitively is the source of much of the confusion and frustration experienced.

For example, an all-too-common response from a policymaker to a constituent's request goes something like this, "I thank you for bringing this to my attention, and I would love to help you. But you'll have to help me get the job done. You'll first have to develop a clear (written) presentation of your issue and organize the people who are affected by it. Then we'll be able to bring it into the larger process of debate with the other stakeholders who are already organized." This request too often is a seemingly insurmountable step in entering the public policy process. It doesn't happen easily. It takes both an enormous amount of work, and a fair level of basic skills in communications and strategic thinking. It takes leadership, resources, and a great deal of patience.

While the elaborate choreography of policymaking is evident at all levels of government, including among the local conversations around council chambers in the smallest of towns, the federal level is a good place to continue our examination. The rising tide of interest in complementary and alternative medicine (CAM) across the country has sparked a great deal of curiosity from federal policymakers, and this provides historic opportunities for the integrated healthcare community. At the federal level, much of the dialogue begins in Congress, with the consideration of legislation, laws, and statutes.

CONGRESSIONAL REACTION TO THE CAM MESSAGE

Providers have much to celebrate. The federal government has taken a strong interest in CAM and collaborative medicine over the past few years, and the trend seems to be positive. Given the above discussion about the "tribe" of government becoming involved once something heats up,

this growing governmental action is more evidence that major change is already in motion. This is the reason that providers must become involved now to make a difference.

Following the Eisenberg article in the early 1990s that revealed just under 50 percent of the US population had used some form of alternative medicine,[2] factions within the many health professions camps began to organize. Once Congress demonstrated an interest in this trend from the consumer demand perspective, each camp began to strategically position itself to leverage a favorable return from policymakers. In fact, at a US Senate hearing in 2000 convened to explore the widespread usage of CAM, committee chairman Sen Arlen Specter (R-PA) proclaimed, "When half of the country stands up and says something, we, as policymakers, have a responsibility to listen and take note."[3]

In the past 3 years alone, federal funding for CAM research has increased more than $50 million,[4] a Congressional Caucus on CAM was established to better familiarize members of Congress with these important issues, and a CAM commission was created by the White House to make recommendations for how public policy can maximize the benefits of CAM therapies. Congressional appropriators have earmarked millions of dollars for allopathic medical schools to weave CAM education into the curricula, and some candidates for Congress are even waging their campaigns in part on their support of CAM.

How did we get here over a relatively short period of time? "It's the disease debt that has captured the attention of consumers, providers, payers, as well as policymakers," asserts Pamela Snider, ND, Associate Dean of Public and Professional Affairs at Bastyr University, a natural-health institution in Seattle, Wash (oral communication, October 2002). Dr Snider points to the gradual increase in lifespan over time, which she suggests will result in 20 more years of chronic disease that conventional medicine has failed to address on its own. "We need to build a renewed national strategy to invest in health, in collaboration with conventional medicine, not in competition," she said. "Consumers have recognized through experience that the CAM disciplines have embraced this as a core value. Increased consumption has attracted Congressional interest, and that interest has motivated the professions to become more vocal."

Among the largest and most vocal of the licensed CAM professions is the chiropractic profession. For many years, chiropractors have successfully leveraged the policymaking process to advance issues of concern about access to care. But a page from the American Chiropractic Association's policy playbook reveals a strategy to broaden healthcare coverage to specific populations. This past year, the profession was successful in securing the enactment of legislation that expanded the coverage of chiropractic services to veterans. This celebrated win came on the heels of another recent victory that extended similar benefits to members of the armed forces. "It's all about providing access to care, which requires a comprehensive awareness campaign to educate policymakers on what it is that we do," stated Jerome McAndrews, DC, national spokesperson for the American Chiropractic Association (oral communication, October 2002). But despite the profession's efforts to inform policymakers on the benefits of its approach, other organized camps in the allopathic community have stepped up their own efforts to derail them. "This is a frustration, but it is a reality," continued McAndrews. "Our profession is committed to building strong bridges with the other professions, but sensitivities surface when the discussion appears economically threatening."

A smaller yet emerging voice among the CAM professions that has influenced the nature of Congressional dialogue on integrated healthcare is the naturopathic profession. Michael Traub, ND, president of the American Association of Naturopathic Physicians, reports that the profession is working to advance legislation that would ban discrimination against licensed CAM providers and accredited institutions in federal programs, including the Medicare program. Naturopathic students currently do not have equal access to medical school loans as enjoyed by their allopathic counterparts. Practicing naturopathic physicians are not permitted to participate in federal loan forgiveness programs. Furthermore, only 3 percent of all federal research dollars for CAM is actually directed toward CAM institutions. "With more than 97 percent of CAM research being conducted at allopathic institutions, a fundamental shift in resource allocation is necessary," said Traub (oral communication, October 2002). For the naturopathic profession, it all boils down to education and awareness. Traub suggests that the profession needs to do a better job in educating policymakers on the principles of naturopathic medicine, which will require "active involvement from every licensed ND and naturopathic student in the country."

While the CAM professions have effectively responded to the opportunities provided through policy, medical doctors and institutions committed to integration have enlisted as well. This is evident in the 15 individual programs funded by the federal government to explore the effects of bringing CAM education into medical schools, nursing schools, residencies, and other programs. "These programs represent not only innovations in education, but innovations in public policy as well," stated Victoria Maizes, MD, Executive Director of the Program in Integrative Medicine at the University of Arizona (oral communication, October 2002). "The conventional way to educate physicians today does not allow them to see the larger tapestry of the healing arts," she continued. "In order to do that, public policy needs to honor what each discipline has to offer, and

understand that each plays a significant part to facilitate health and well being." Dr Maizes' work at the University of Arizona to "bring medicine back to its roots" includes developing joint residency programs in family and integrative medicine, a process that she says requires "substantial involvement in the policymaking process."

The Spirit of Collaboration

Dr McAndrews' frustrations about the reality of competition are equally shared among policymakers themselves. Despite the emergence of CAM, and the political organization of its individual licensed professions, there still remains a responsibility to lawmakers to produce interprofessional consensus on public policy issues. This need was articulated in 1997 by Sen Tom Daschle (D-SD), a friend of CAM in Congress, when he asked representatives of the CAM community to produce an agenda for healthcare integration, including a long-term context for reform.

Once a blueprint for change was presented to Sen Daschle, the authors of the plan were charged with building consensus around the recommendations. A landmark summit was subsequently convened in October 2001 to stimulate communication among policy leaders in the nation's healthcare community about the future of integrated care. Co-hosted by the American Association for Health Freedom, Georgetown University, and Bastyr University, this event included representatives from nearly 60 national organizations and institutions. Participants spent 3 days exploring what an integrated healthcare system would look like, how to achieve it through a defined national policy framework, and how to evaluate it. Significant common ground was identified across the range of stakeholder groups, and a series of consensus recommendations was issued in a final report. This report, "National Policy Dialogue to Advance Integrated Healthcare: Finding Common Ground"[5] led to the development of a robust network of integrated healthcare advocates charged with shaping and moving a shared policy agenda. In January 2002, the Collaboration for Healthcare Renewal Foundation raised the seed funding for the start-up efforts of this ambitious project, and a new group, the Integrated Healthcare Policy Consortium (IHPC), was born.

The IHPC believes that a national policy effort is necessary to ensure that the American public benefits from advancements in the science and understanding of all health systems, disciplines, and modalities. "The IHPC is uniquely equipped with the expert resources to actively engage a wide range of stakeholders in shaping and moving a health policy agenda," stated Candace Campbell, Executive Director of the American Association for Health Freedom and Chair of the IHPC (oral communication, October 2002). With a unified voice representing many conventional and CAM voices, the IHPC will attempt to convey to Congress those policy priorities that represent common ground across the range of healthcare stakeholders

Getting to Know the Players on the Healthcare Policy Field

There is an old maxim from the days of the Civil War that holds just as true today: "Soldiers who understand the mechanics of battle fight better—more effectively, but also more bravely—than soldiers who are motivated chiefly by enthusiasm for a cause." When individual providers appreciate the role of public policy in bringing about change in healthcare, understand the momentum that resulted in Congressional interest in CAM, and have a sense of the movement in the private sector that fosters collaboration among professions, those providers will understand that it is important for them to participate in the public policy playing field.

While combat metaphors and "us" against "them" thinking have the potential for thwarting real progress in forming public policy, as was discussed earlier, it is incumbent upon stakeholders to understand the basic infrastructure for how the health policy game is played. Perhaps more important, however, it is necessary for healthcare providers to understand their unique roles as players.

Congressional committees are the single most important settings in which legislators operate. Committees act as the sounding board for proposed legislation, and if a measure doesn't receive support from the committee to which it was referred on introduction, the measure will die. When healthcare legislation is introduced, it will likely be referred to a minimum of 1 of the committees listed below. Thus, as an individual provider, if you are seeking to identify those members of Congress with the greatest influence over healthcare policy, here is your guide to the star players. (Members of these committees can be located by logging onto http://www.Senate.gov, and http://www.House.gov):

- Senate Health, Education, Labor, and Pensions Committee
- Senate Finance Committee
- House Energy and Commerce Committee
- House Ways and Means Committee

Once new healthcare programs are authorized and ultimately passed by both houses of Congress, the following committees convene annually to determine how much funding will be made available to run them:

- Senate Appropriations Subcommittee on Labor, HHS, and Education
- House Appropriations Subcommittee on Labor, HHS, Education, and Related Agencies

The rosters for these committees are shuffled every 2 years. Check the online membership lists. Get to know the players. Your Senator or Representative might even sit on one of these key committees, which will provide a great opportunity for you to begin to nurture a working relationship.

What's a Provider to Do?

At the simplest level, there are 6 basic activities that providers can apply to improve the chances that their issues and interests are addressed in public policy. These activities can be applied to federal, state, and local levels.

1. **Be curious and stay informed.** Pay attention and seek to understand the issues and the forces that shape them. Be alert for moments when an individual voice can make a difference, even a small one. The most basic job of any professional association is to inform members about such moments, to cull and analyze the news so you don't have to, and to alert you to opportunities to act. That alone is well worth the price of an association membership.
2. **Make your opinion known** to thought leaders, policymakers, the media, and leaders in your profession. Be a tireless advocate for your patients, beyond what you do for them in the clinic. For example, if you believe that patients deserve access and choice, then recognize that this is a public policy issue and speak up when it counts.
3. **Avoid "us" and "them" thinking.** This is difficult because the nature of the policy formation process seems to require it, as described above. The trick is to be genuinely interested in understanding the perspectives and interests of the other voices in the discussion; avoid making attributions about "their" motives and interests. Separate people from problems; get to know the people as people, and seek moments where collaboration can be built around points of commonality.
4. **Join your professional association.** Demand that it cover key issues on your behalf. Express an interest in serving on the association's public policy or government relations committee.
5. **Participate in advocacy groups for healthcare providers.** Support their efforts to build bridges among various providers and help to convey a common-ground agenda to Congress.
6. **Become active in your political community.** Make a point to become acquainted with the officials who represent you and your issues. Sign up for newsletters and electronic lists published regularly by your congressional and state representatives, by elected officials serving on health committees, and by agencies concerned with your issues.

Of course, there is a much longer list of activities for individual providers who want to be supportively involved, but not every provider can or wants to thoroughly fill his or her calendar. However, if every provider consistently followed these 6 simple activities of civic duty for his or her profession, the collective voice would have more substantial sway. That sway can contribute significantly to the vision of a renewed healthcare delivery system that values the principle of integration.

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