SECOND EDITION

INTRODUCTION TO Health Policy

LEIYU SHI

INTRODUCTION TO

Health Policy

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Health Administration Press, Chicago, Illinois
Association of University Programs in Health Administration, Washington, DC

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23 22 21 20 19 5 4 3 2 1

Library of Congress Cataloging-in-Publication Data

Names: Shi, Leiyu, author.
Title: Introduction to health policy / Leiyu Shi, Gateway to Healthcare Management.
Description: Second edition. | Chicago, Illinois : Health Administration Press, HAP ; Washington, D.C. : Association of University Programs in Health Administration, AUPHA, [2019] | Includes bibliographical references and index.
Identifiers: LCCN 2018040567 (print) | LCCN 2018041419 (ebook) | ISBN 9781640550261 (ebook) | ISBN 9781640550278 (xml) | ISBN 9781640550285 (epub) | ISBN 9781640550292 (mobi) | ISBN 9781640550254 (print : alk. paper)
Subjects: LCSH: Medical policy—History. | Health care reform. | Public health—International cooperation.
Classification: LCC RA393 (ebook) | LCC RA393 .S473 2019 (print) | DDC 362.1—dc23
LC record available at https://lccn.loc.gov/2018040567

The paper used in this publication meets the minimum requirements of American National Standard for Information Sciences—Permanence of Paper for Printed Library Materials, ANSI Z39.48-1984. ♾™

Acquisitions editor: Jennette McClain; Manuscript editor: Lori Meek Schuldt; Project manager: Andrew Baumann; Cover designer: James Slate; Layout: Cepheus Edmondson

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Health Administration Press
A division of the Foundation of the
American College of Healthcare Executives
300 S. Riverside Plaza, Suite 1900
Chicago, IL 60606-6698
(312) 424-2800

Association of University Programs
in Health Administration
1730 M Street, NW
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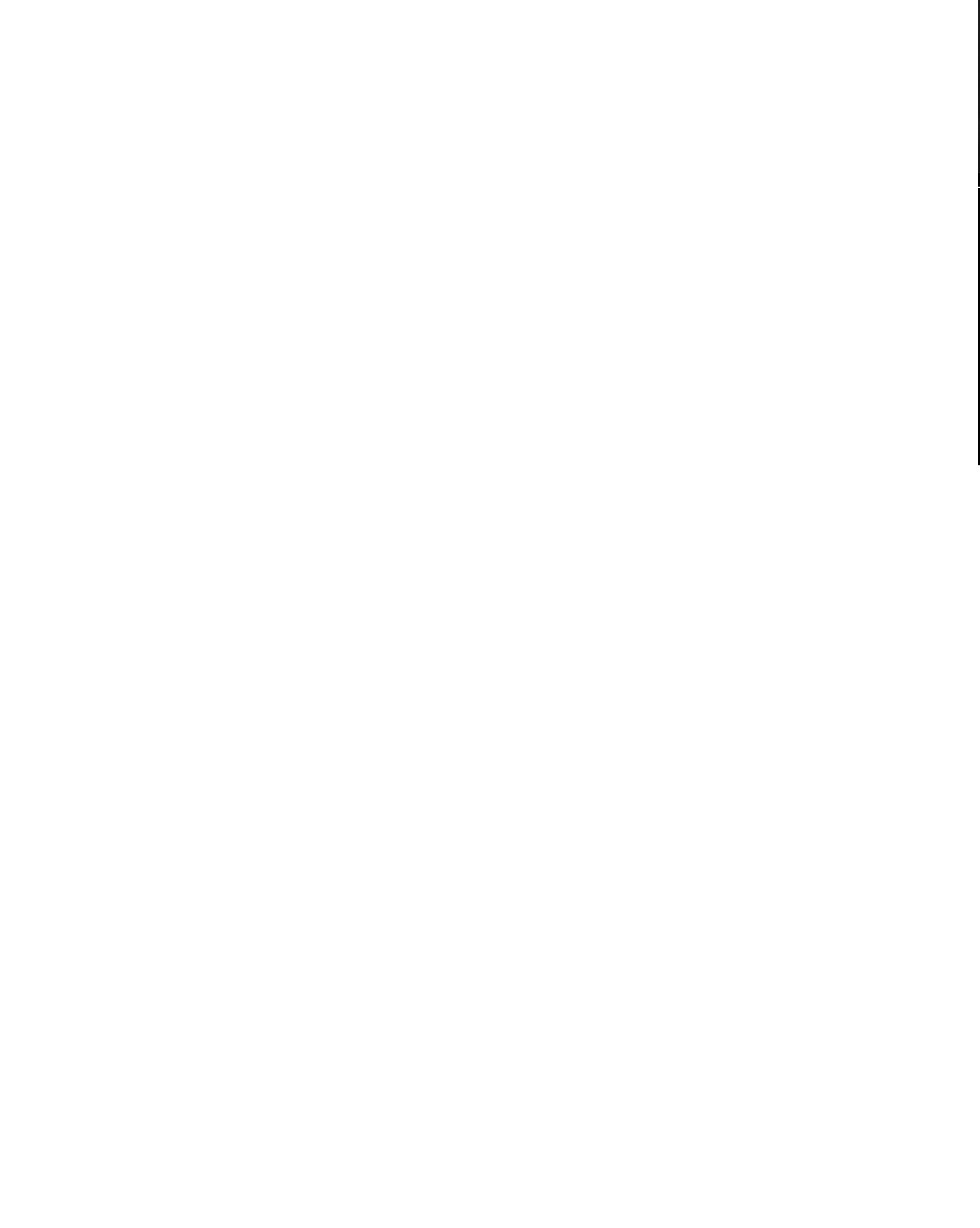
(202) 763-7283

I dedicate this book to my wife, Ruoxian,
and my children, Sylvia, Jennifer, and Victor Shi.



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PREFACE

US policymakers have been struggling for years to find solutions to our healthcare challenges. Thus, healthcare reform is among the top priorities of almost every administration. This introductory textbook on US health policy covers the related areas of health policymaking, critical health policy issues, health policy research, and an international perspective on health policy and policymaking. The book offers the following features:

- Real-world cases to exemplify the theories and concepts presented from a variety of perspectives, including the hospital setting, public health, managed care, ambulatory care, and extended care
- Exhibits and extra feature boxes (Learning Points, For Your Consideration, Key Legislation, Research from the Field, International Policymaking, Global Health Impact, and others) that present background information on concepts, examples, and up-to-date information
- Learning objectives and key points
- Discussion questions

Organization of the Book

This book is organized in four parts: an introduction, an overview of health policymaking, a health policy issues section, and a discussion of health policy research and analysis. Chapter 1, the sole chapter in part I, introduces key terms related to, and the determinants of, health

and health policy. It lists the key stakeholders in health policymaking and presents important reasons for studying health policy. The chapter lays the foundation for the rest of the book.

Part II—containing chapters 2, 3, and 4—examines the policymaking process at the federal, state, and local levels; in the private sector; and in international settings. Chapter 2 focuses on the policymaking process at the federal level of the US government. Important activities within the three policymaking stages—policy formulation, policy implementation, and policy modification—are described. The key characteristics of health policymaking in the United States are analyzed, and the role of interest groups in making policy is discussed.

Chapter 3 focuses on the US policymaking process at the state and local levels and in the private sector, which includes the research community, foundations, and private industry. Examples of policy-related research by private research institutes and foundations are described. The impact of the private sector's services and products on health and policy is illustrated using the fast-food industry as well as tobacco and pharmaceutical companies as examples.

Chapter 4 discusses international health policymaking. The World Health Organization (WHO) is presented as an example of an international agency involved in policymaking related to health and major health initiatives. Three countries—Canada, Sweden, and China—are highlighted to illustrate diverse policymaking processes in distinct geographic regions. The experiences of these countries show that different political systems and policymaking processes lead to diverse approaches to population health and healthcare delivery.

Part III—encompassing chapters 5, 6, and 7—examines the policy issues related to social, behavioral, and medical care health determinants; to people from diverse or medically or socially vulnerable populations; and to international health. Chapter 5 describes how US healthcare is financed and delivered. Private and public health insurance programs are summarized, and the subsystems of healthcare delivery—managed care plans, safety net providers, public health programs, long-term care services, and military-operated healthcare—are introduced. After summarizing the major characteristics of US healthcare delivery, the chapter provides examples of health policy issues related to financing (cost containment) and delivery (healthcare workforce, professional accreditation, antitrust regulations, patient access to care, and patient rights).

Chapter 6 defines medically and socially vulnerable populations and discusses the dominant healthcare policy issues related to those populations. People from diverse populations include members of racial or ethnic minorities, the uninsured, people with low socioeconomic status, the elderly, people with chronic illness, people with mental illness, women and children, people with disabilities, the homeless, and people with HIV/AIDS. In each segment, the magnitude of the problem is summarized and a detailed discussion of the policies and strategies meant to address the problem is presented.

In chapter 7, dominant health policy issues in the international community are discussed, with examples given for select countries, to help students understand not only international health policy applications but also the field of global health. The chapter begins

by examining issues shared by developed countries, such as modifying health systems to better serve aging and diverse populations while maintaining high-quality care at a low cost. It then discusses challenges faced by developing nations, such as controlling the spread of disease, creating and maintaining high-functioning health systems with limited resources, and dealing with the burdens of morbidity and mortality associated with poverty. Several emerging issues are also illustrated that could affect global health in the future.

Part IV—comprising chapters 8, 9, and 10—presents an overview of policy analysis, focusing on examples of commonly used quantitative and qualitative methods. Chapter 8 introduces health policy research (HPR) and highlights the discipline's defining characteristics, including applied, policy-relevant, ethical, multidisciplinary, scientific, and population-based studies. The HPR process is summarized, and the chapter concludes with a discussion of ways to communicate findings and the challenges in implementing those findings in practice.

Chapter 9 illustrates commonly used methods in HPR. Quantitative methods include experimental research, survey research, evaluation research, cost–benefit analysis, and cost-effectiveness analysis. Because evaluation research is closely tied to policy research, the process involved in this type of research is described in greater detail. Qualitative methods include participant observations, in-depth interviews (including focus groups), and case studies. Examples of published studies using these methods are provided.

Chapter 10 provides an example that illustrates the key steps in health policy analysis: assessing the determinants of a health problem, identifying a policy intervention to address the problem, critically evaluating the policy intervention, and proposing next steps in addressing the problem.

New to This Edition

This second edition has retained most of the features of the first edition. In addition, significant updates have been made in the following key areas.

Case Studies

Each of the chapter-opening case studies from the first edition has been revised or replaced, and a new, second case study has been added to chapters 1–9.

Healthcare Reform

The latest developments in healthcare reform and legislation have been incorporated into the book, especially in chapters 2 and 3 and in the many additions to the chapters in part III.

International Health Policy

The international health policy chapters (chapters 4 and 7) have broadened in scope with more examples from the array of countries discussed in the book. New WHO initiatives have also been added.

Updated Content Throughout

Content, references, and data (including in relevant exhibits) have been updated throughout. New and revised content includes coverage of the impact of the Affordable Care Act, new healthcare reform directions, the patient-centered medical home, accountable care organizations, precision medicine and big data, state and local healthcare reform activities, private-sector initiatives, and the pharmaceutical industry. More examples of applications in research have been added.

Acknowledgments

My PhD advisee Sarika Rane Parasuraman contributed chapter 10 (an applied example) and is hereby acknowledged. The editorial staff of Health Administration Press have provided hands-on assistance in editing the manuscript. Of course, all errors and omissions remain my responsibility.

Leiyu Shi

Instructor Resources

This book's Instructor Resources include a test bank, PowerPoint slides for each chapter, and answer guides for the book's discussion questions.

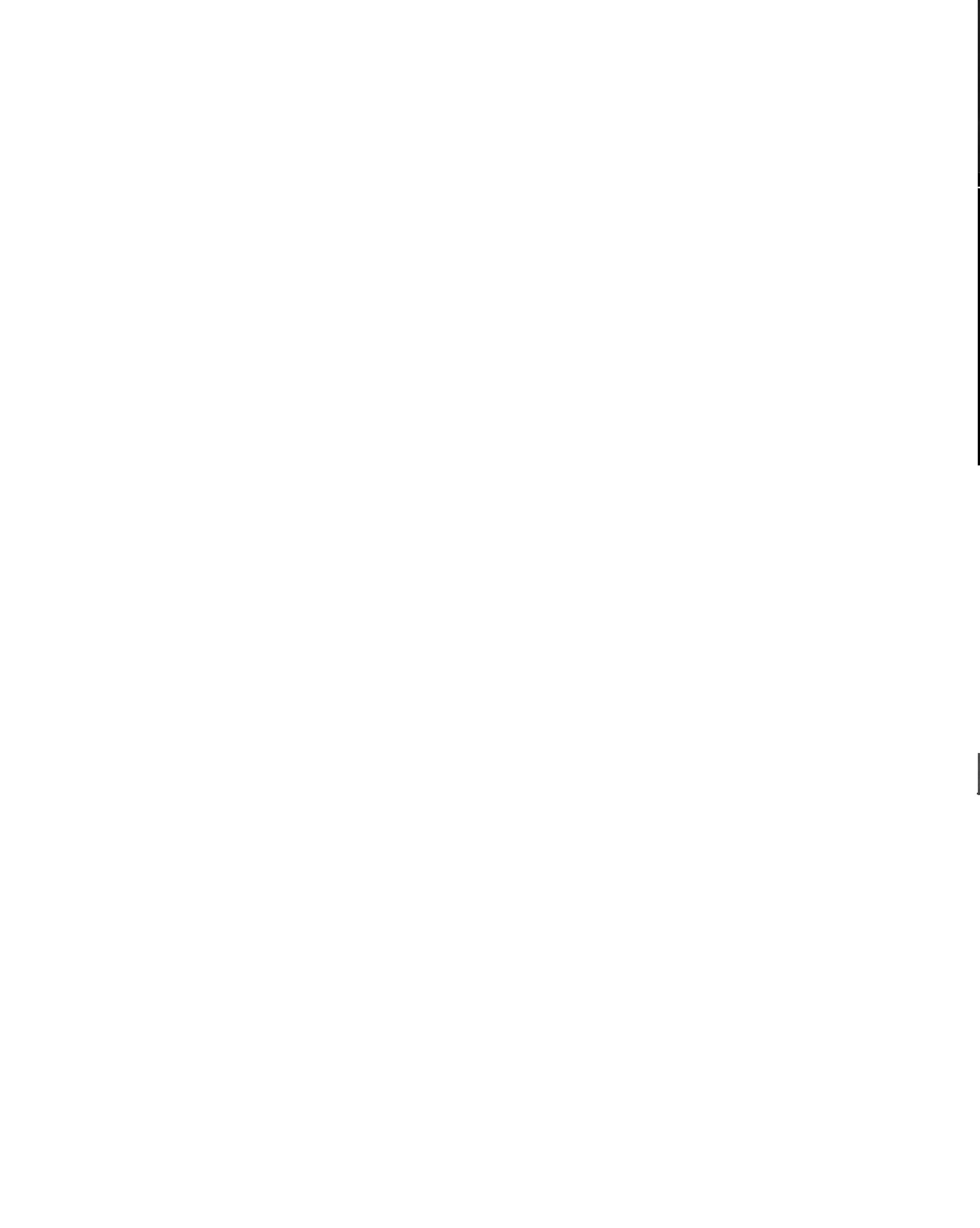
For the most up-to-date information about this book and its Instructor Resources, go to ache.org/HAP and search for the book's order code (2374).

This book's Instructor Resources are available to instructors who adopt this book for use in their course. For access information, please e-mail hapbooks@ache.org.

PART I

INTRODUCTION

The introduction, which consists of chapter 1, provides an overview of health policy. It defines key terms related to health policy, reviews the framework of health determinants, and outlines the concept of health policy formulation. In addition, the chapter introduces topics related to health policy, including stakeholders, major types of health policies, and the importance of studying health policy. The introduction provides readers with a foundation for examining how health policy is established in the United States and elsewhere.



CHAPTER 1

OVERVIEW OF HEALTH POLICY

I have never had a policy. I have simply tried to do what seemed best each day, as each day came.

—Abraham Lincoln

The health and vitality of our people are at least as well worth conserving as their forests, waters, lands, and minerals, and in this great work the national government must bear a most important part.

—Theodore Roosevelt

Learning Objectives

After completing this chapter, you should be able to

- define key terms related to health policy,
- appreciate the influence of health determinants,
- understand the framework of health policy formulation,
- identify the stakeholders in health policy,
- describe the major types of health policies, and
- discuss the importance of studying health policy.

Case Study 1

Healthcare Reform: Hillary Clinton and Barack Obama

Two major healthcare reform initiatives have played out on the US political landscape since the late twentieth century: the Health Security Act, developed by the Clinton administration in the 1990s and spearheaded by First Lady Hillary Clinton, which failed to pass into law, and the Affordable Care Act (ACA), drafted by the Obama administration, which became federal law in March 2010.

The hallmark of the Clinton plan was its universal coverage mandate, which required all employers to contribute to a pool of funds to cover the costs of insurance premiums for their workers, with caps on total employer costs and subsidies for small businesses. Competition among private health plans and a cap on the growth of insurance premiums were to have held costs in check, and additional financing was to have been provided through savings from cuts in projected Medicare and Medicaid spending and increased taxes on tobacco (Oberlander 2007; Pesko and Robarts 2017).

The Obama plan focused on reforming the private health insurance market, extending insurance coverage to the uninsured, providing better coverage for those with preexisting conditions, improving prescription drug coverage in Medicare, and extending the life of Medicare trust fund accounts. The ACA was expected to be financed through taxes, such as a 40 percent tax on “Cadillac” insurance policies (policies that offer the richest benefits) and taxes on pharmaceuticals, medical devices, and indoor tanning services (KFF 2013), and through other offsets or provisions of the law that reduce the overall cost of enacting legislation, such as penalties on uninsured individuals.

The political landscape in 2009, as President Barack Obama’s healthcare reform initiative was being debated, was similar to that in the early 1990s: Both the Clinton and Obama administrations were affiliated with the Democratic Party, both chambers of the US Congress were controlled by Democrats, and national opinion strongly favored healthcare reform (Sack and Connelly 2009).

However, whereas the Obama reform initiative became law, the earlier Clinton healthcare reform package was defeated in Congress. Although Americans supported healthcare reform in theory, the Clinton plan was derailed by the heavy opposition of the medical and insurance industries and by antitax rhetoric. The disenchantment of the electorate following that failed effort helped Republicans gain control of the House of Representatives and Senate in the 1994 election (Trafford 2010), which all but guaranteed that any further Democratic-designed proposal would fail due to increasing political polarization in Congress.

After Republican president Donald Trump took office in January 2017, the Trump administration and the Republican-controlled Congress put forth many efforts to “repeal and replace” the ACA. However, as of mid-2018, none of these attempts had succeeded.

Case Study 2

Healthcare Reform After the ACA

Healthcare reform continues to be a deeply partisan issue in US politics, and political gridlock in Congress has made efforts at reform challenging. Since 2010, Republicans in Congress have unsuccessfully attempted to repeal the ACA, voting more than 60 times to repeal or alter the law (Cowen and Cornwall 2017). In January 2016, the Republican-controlled House and Senate passed a bill that would have repealed the ACA, but President Obama, a Democrat, promptly vetoed it. The Congressional Budget Office (CBO) review of the proposal concluded that the bill would have canceled health insurance for 22 million people by 2018 (Cubanski and Neuman 2018). In the 2016 presidential election campaign, every Republican candidate vowed to "repeal and replace" the ACA (Jost 2015). In January 2017, within hours of taking office, President Trump issued his first executive order, moving to dismantle parts of the ACA (Davis and Pear 2017).

On March 7, 2017, Republicans introduced the two bills that constitute the original American Health Care Act (AHCA) of 2017, H.R. 1628, to partially repeal the ACA. The Trump administration announced its support for AHCA. On March 12, 2017, the CBO released its budget analysis, projecting that 52 million Americans would be left uninsured under the AHCA and those with insurance would have to pay higher premiums through 2020. On May 4, 2017, the House narrowly passed the AHCA, by a vote of 217–213, and sent the bill to the Senate for deliberation. On June 22, 2017, the Senate released a discussion draft for an amendment to the bill, which would rename it the Better Care Reconciliation Act of 2017. On July 28, 2017, the bill was returned to the calendar after the Senate rejected several amendments, including the Health Care Freedom Act, or the "skinny bill," that would have repealed the ACA's individual mandate retroactive to 2016 and the employer mandate through 2025.

Does this legislation point to a new phase of healthcare reform whose success hinges on support from both major political parties? As Wilensky (2017) suggested, Republicans and Democrats might need to find a way to work together to enact comprehensive healthcare reform beyond the ACA.

Or, does it signal a new approach toward dismantling the ACA through the administrative process, such as policy implementation? In reaction to Congress's repeated failure to repeal the ACA, on October 12, 2017, President Trump issued Executive Order 13813, directing federal agencies to expand the use of *association health groups*—groups of small businesses that pool together to buy health insurance (Trump 2017).

The Tax Cuts and Jobs Act of 2017, passed and signed into law in December 2017, effectively repealed the mandate in the ACA that required all Americans to have health insurance. Although the ACA was still the law of the land during the first year of the Trump administration, many of its components were being modified in Trump's second year.

gross domestic product
The value of all goods and services produced within a country for a given period; a key indicator of the country's economic activity and financial well-being.

At 16.9 percent of the nation's total economic activity—also known as the **gross domestic product**—healthcare spending in the United States leads all countries in overall and per capita measures (OECD 2018). Yet the US healthcare system does not perform well compared with those of other industrialized countries. A 2010 World Health Organization (WHO) report ranked the US health system thirty-seventh among 191 countries (Tandon et al. 2018). In addition, a Commonwealth Fund study on healthcare performance ranked the United States behind ten other industrialized countries—Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, and the United Kingdom—on the basis of quality, efficiency, access, equity, and health outcome measures (Davis, Schoen, and Stremikis 2014). The US healthcare system also ranked last in a recent survey of eleven nations (Commonwealth Fund 2017).

Why have health policies tended to fail in the United States while they appear to succeed in other countries? The answer might be found in the context—the United States—and the determinants of health and health policy in the country.

The main purpose of this chapter is to present a framework of health policy determinants and discuss their impact in the United States. Understanding this framework will help the reader appreciate factors that contribute to health policy development in general and in the United States in particular. The chapter first defines key concepts related to health policy and later discusses the importance of studying health policy, including an awareness of its international perspective. The stakeholders of health policy are also presented and analyzed as key parts of the policy context.

Health Defined

WHO (1946) defines *health* as "not merely the absence of disease or infirmity but a state of complete physical, mental and social well-being." This broad definition recognizes that health encompasses biological and social elements in addition to individual and community well-being. Health may be seen as an indicator of personal and collective advancement. It can signal the level of an individual's well-being as well as the degree of success achieved by a society and its government in promoting that well-being (Shi and Stevens 2010). This definition of health implies that issues such as poverty, lack of education, discrimination, and other social, cultural, and political conditions found around the world are essentially public health issues.

However, health is also the result of personal characteristics and choices. This concept is the source of the fundamental tension in public health and has been a major topic of discussion in the United States in the twenty-first century. Major debates continue over whether people can be forced to take actions to ensure their own health, such as buying health insurance (e.g., the "individual mandate" in the ACA), or be prohibited from performing actions that are unhealthy, such as limiting soft drinks in schools. Health policy in the United States must attempt to balance the good of the public health with personal liberty,

KEY LEGISLATION
What Is the Status of Healthcare Reform in the United States?

In the United States, *healthcare reform* typically denotes a government-sponsored program that strives to make health insurance available to the uninsured. Heretofore, healthcare reform has not quite addressed how healthcare should be delivered, such as in resource allocations across preventive, primary, and tertiary care settings. Although universal health insurance is a difficult goal to realize, incremental reforms have been successful when political and economic environments were favorable. The first such program came in the form of the Old Age Assistance program, which was enacted as part of the 1935 Social Security Act and provided direct financial assistance to needy elderly persons.

Full health insurance for the elderly became available under the Medicare program, as did health insurance for the indigent under the Medicaid program. Both programs were created in 1965 under the Great Society reforms of President Lyndon Johnson in an era when civil rights and social justice had taken central stage in the United States. Later, authorized under the Balanced Budget Act of 1997, the State Children's Health Insurance Program—later renamed the Children's Health Insurance Program—was developed, whereby states can use federal funds to cover children up to age 19 through their existing Medicaid programs.

One of the most significant healthcare reform efforts resulted in the Affordable Care Act of 2010, designed to bring about major changes to the delivery of US healthcare. The key objective of the ACA was to provide most, if not all, Americans with health insurance coverage.

often a difficult compromise to make. Indeed, the conflict between the WHO definition of health and many of the social, cultural, and political issues surrounding the US healthcare system is one of the most important areas of debate for health policymakers.

Physical Health

The most common measure of physical health is **life expectancy**—the anticipated number of remaining years of life at any stage. Exhibit 1.1 shows the ten countries ranking highest in their population's life expectancy as of 2015 and includes the US ranking for comparison.

Although good or positive health status is commonly associated with the definition of *health*, the most frequently used indicators measure, instead, lack of health or incidence of poor health—for example, **mortality**, **morbidity**, **disability**, and various indexes that combine these factors. One such measure is **quality-adjusted life years**, which combines mortality and morbidity in a single index. The Learning Point box titled "Measures of Mortality, Morbidity, and Disability" lists categories by which each indicator is measured.

life expectancy
Anticipated number of years of life remaining at a given age.

mortality
Number of deaths in a given population within a specified period.

morbidity
Incidence or prevalence of diseases in a given population within a specified period.

disability
A physical or mental condition that limits an individual's ability to perform functions considered normal.

quality-adjusted life years
A combined mortality–morbidity index that reflects years of life free of disability and symptoms of illness.

Exhibit 1.1
Top Ten Countries with the Longest Life Expectancy, with the United States as Comparison

		Life expectancy at birth (years)		
Rank	**Country (state/territory)**	**Overall**	**Male**	**Female**
1	Japan	83.9	80.8	87.1
2	Switzerland	83.0	80.8	85.1
3	Spain	83.0	80.1	85.8
4	Italy	82.6	80.3	84.9
5	Australia	82.5	80.4	84.5
6	Iceland	82.5	81.2	83.8
7	Norway	82.4	80.5	84.2
8	France	82.4	79.2	85.5
9	Sweden	82.3	80.4	84.1
10	Korea	82.1	79.0	85.2
26	United States	78.8	76.3	81.2

Source: Data from OECD (2018).

Mental Health

In contrast to physical health, measures of mental health are limited. The major categories of mental health measures are mental conditions (e.g., depression, disorder, distress), behaviors (e.g., suicide, drug or alcohol abuse), perceptions (e.g., perceived mental health status), satisfaction (e.g., with life, work, relationships), and services received (e.g., counseling, drug treatment).

Mental illness ranks second, after ischemic heart disease, as a nationwide burden on health and productivity (SAMHSA 2016). An estimated 17.9 percent of the US adult population in 2014 had at least one diagnosable mental disorder, only 41 percent of whom received any treatment (SAMHSA 2016). Serious mental illness costs the United States $193.2 billion in lost earnings per year (SAMHSA 2016). Mental illness is a risk factor for death from suicide, cardiovascular disease, and cancer. Mental health problems are frequently associated with social problems. For example, with easy access to guns, mental health often contributes to gun violence in both public and private settings.

Social Well-Being

The most commonly used measure of relative social well-being is socioeconomic status (SES). An SES index typically considers such factors as education level, income, and occupation. Quality of life is another common measure and may include the ability to perform various roles (e.g., self-care, family care, social functioning), perceptions (e.g., emotional well-being,

LEARNING POINT
Measures of Morbidity, Mortality, and Disability

Morbidity measures

- Incidence of specific diseases: number of new cases in a defined population within a specified period
- Prevalence of specific diseases: number of instances in a defined population within a specified period

Mortality measures

- Crude (unadjusted for any other factors) death rate
- Age-specific death rate
- Condition-specific death rate
- Infant death rate
- Maternal death rate

Disability measures

- Restricted activity days (e.g., bed days, work-loss days)
- Limitations in performing activities of daily living (i.e., bathing, dressing, toileting, getting into or out of a bed or a chair, continence, eating)
- Limitations in performing instrumental activities of daily living (i.e., doing housework and chores, grocery shopping, preparing food, using the phone, traveling locally, taking medicine)

pain tolerance, energy level), and living environment (e.g., pollution levels, crime prevalence). A third set of social well-being measures, often used by sociologists, is composed of **social contacts** and **social resources**. Examples of social contacts include visits with family members, friends, and relatives and participation in social events, such as membership activities, professional conferences, and church gatherings. The social contacts factor can be used as an indicator of social resources by determining whether an individual can rely on social contacts for needed support and company and whether the people involved in these contacts meet the individual's needs for care and love.

social contacts
The frequency of social activities a person undertakes within a specified period.

social resources
Interpersonal relationships with social contacts and the extent to which the individual can rely on the people involved in these contacts for support.

Public Health Defined

In the early twentieth century, Winslow (1920) defined *public health* as "the science and the art of preventing disease, prolonging life, and promoting physical health and efficiency through organized community efforts for the sanitation of the environment, the control of