

# *Health Care Policy*

## **BACKGROUND**

The past decade has seen an increasing awareness of the importance of promoting health throughout the U.S. population, as demonstrated in the goals and objectives set out in the Healthy People 2010 initiative (U.S. Department of Health and Human Services, 2000). Healthy People 2010 has two overarching goals: (1) to increase the quality and years of healthy life and (2) to eliminate health disparities within the U.S. population. Achieving these goals depends on both a health system that reaches all ages and all people in the United States and the integration of personal health care and population-based public health care. The vision of building healthy communities involves broad-based efforts to prevent common health problems by moving beyond health care settings such as hospitals, clinics, and physician's office into neighborhoods, schools, and workplaces within the community. Eliminating disparities in Healthy People 2010 focus areas such as prevention of health problems, tobacco and substance abuse, and injury and violence prevention requires coordination between clinical and public health disciplines, as well as strong community involvement.

Research on health care access has found that barriers to equitable health care for all segments of the population can arise at the public policy, community, organizational, and provider levels (Andersen, 1995; Institute of Medicine, 2002). A key barrier is lack of health care coverage. Individuals without health coverage use fewer health care services and are less healthy than those with coverage (Ayanian, Ginsburg, Schneider, Weismann, & Zaslavsky, 2000; Ku & Broaddus, 2006). The Institute of Medicine

(2004) found that uninsured children and adults suffer worse health and die sooner than those with insurance. Delaying or not receiving treatment can lead to more serious illnesses and avoidable health problems. People without insurance are less likely to receive preventive care than those with insurance and more likely to be hospitalized for conditions that could have been avoided. Charitable care and the safety net of community clinics and public hospitals do not fully substitute for health insurance. State and local government ability to finance health care for uninsured people is most limited during economic downturns, when the need is the greatest.

## ***Financing and Delivery of Health Care***

Equitable access to health care services is complicated by the fragmented nature of health coverage in the United States. The two major methods of coverage are private insurance, whether employer-based or individually contracted, and public programs, such as Medicare, Medicaid, the State Children's Health Insurance Program, and military coverage. Individual states have provided coverage through Medicaid waiver programs for portions of their population not covered by basic Medicaid. However, these types of coverage leave substantial numbers of the population without health insurance coverage. In 2006, the Census Bureau reported that 59.7 percent of the U.S. population was covered by employment-based insurance, 9.1 percent was covered by directly

purchased insurance, 13.6 percent was covered by Medicare, 12.9 percent was covered by Medicaid, and another 3.6 percent by military coverage (DeNavas-Walt, Proctor, & Smith, 2007).

Regardless of the financing, the delivery of health care has moved from fee for service to managed care such as health maintenance organizations and preferred provider organizations. A single payer system has been proposed as a way to provide universal health care in the U.S. However, the trend has been to revise the current multipayer system. The health care systems have become more complex and this causes barriers and challenges for individuals who need to access and navigate their own health care benefits.

## ***ISSUE STATEMENT***

In 2006, 47 million people were uninsured, an increase of 2.2 million from the previous year, largely because of a decline in employer-sponsored insurance. Since 2004, census data indicate that employer coverage has declined but public coverage has not increased, resulting in sharp increases in the number of uninsured adults and children. The increase in loss of insurance was highest among Hispanics compared with Asian, African American, and non-Hispanic white people. Uninsurance rates across states varied from 8.5 percent to 24.1 percent as a result of differences in state economies, patterns of employer coverage, the share of families with low incomes, and the scope of state Medicaid programs. Almost 80 percent of the uninsured are citizens (Kaiser Family Foundation, 2007).

### ***Disparities in Health Care***

Minority and poor populations are disproportionately uninsured. U.S. families with incomes below 200 percent of the federal poverty level run the highest risk of being uninsured. More than 80 percent of the uninsured people are in working families. Low-wage workers, those in small businesses, service workers, and part-time workers run a greater risk of being uninsured. African Amer-

icans and Hispanics are disproportionately likely to be uninsured compared with Asian and non-Hispanic white Americans (Kaiser Family Foundation, 2007). In addition, even among those with health coverage, racial and ethnic minority groups are more likely than are white people to be enrolled in "lower end" health plans characterized by lower reimbursement levels and stricter limits on covered services, leading to potential differences in provider behavior (Phillips, Mayer, & Aday, 2000).

The lack of insurance coverage for minority and poor populations exacerbates other barriers to access within the health care system that prevent vulnerable individuals from receiving appropriate health care. Stigmatizing practices in health care delivery, a lack of racial and ethnic diversity and cultural competence among health care providers, differences in health literacy between groups, and the failure to include minority populations in medical research produce a lower quality of health services for racial and ethnic minority groups even after adjustment for socioeconomic characteristics and other access-related factors (Institute of Medicine, 2002; Kressin & Petersen, 2001). This lower quality of care may be manifested through a failure to provide recommended care or the substitution of less desirable procedures. These disparities exist across a variety of conditions, including cancer, cardiovascular disease, HIV/AIDS, maternal and child health care, diabetes, and mental illness; they are found in treatment for serious disease and also in routine treatments for common health problems (Allison, Kiefe, Centor, Box, & Farmer, 1996; Barker-Cummings, McClellan, Soucie, & Kirshner, 1995; Cunningham, Mosen, & Morales, 2000; Johnson, Lee, Cook, Rouan, & Goldman, 1993). Preventive measures such as breast, cervical, and prostate cancer screenings are not always provided as recommended to minority individuals (Brownstein, 1992). More research is needed to fully understand how patient race or ethnicity, disease status, sexual orientation, and other characteristics may influence physician decision making and the experience of minority groups during health care encounters.

## ***Trends in Health Care Social Work Services***

Every state has deregulated their health care system and lifted regulated rate-setting mandates on hospitals. The subsequent restructuring resulted in a move away from professionally defined structures, such as departments of social work. Social work roles and responsibilities are changing to include case management, discharge planning, and working collaboratively on interdisciplinary teams. However, social workers are also experiencing an increase in workload and a decrease in the psychosocial or clinical component of social work practice (Mizrahi & Berger, 2001).

As part of deregulation, several proposals by the Centers for Medicare & Medicaid Services (which administers Medicaid and Medicare) have been made to lessen the regulations governing providers, including social workers who are reimbursed by Medicare and Medicaid (known as *conditions of participation*). These include actual downgrading or efforts to downgrade the definitions and qualifications for social workers who provide services through Medicare's home health, hospice, skilled nursing facilities, and end-stage renal disease programs. There is now a countervailing trend for increasing social work services in regulatory mandates that is still ahead of the reality of providing qualified health care social work services (Department of Health and Humans Services, 2007; Institute of Medicine, 2008).

## ***POLICY STATEMENT***

NASW supports

- a national health care policy that ensures the right to universal access to a continuum of health and mental health care throughout all stages of the life cycle. The goal of such a policy is to promote wellness, maintain optimal health, prevent illness and disability, treat health conditions, ameliorate the effects of unavoidable incapacities, and provide supportive long-term and end-of-life care. This policy should result in the equitable delivery of services for all people in the United States,

regardless of financial status, race, ethnicity, disability, religion, age, gender, sexual orientation, or geographic location.

- efforts to increase health care coverage to uninsured and underinsured people until universal health and mental health coverage is achieved.
- an equal right to continuous, high-quality care that is effective, efficient, safe, timely, and patient-centered.
- ongoing dialogue and research about the best practices to finance health system.
- efforts to eliminate racial, ethnic, and economic disparities in health service access, provision, utilization, and outcomes.
- the coordination of NASW chapter efforts to influence state and federal health care policy.
- policies and practices requiring that mandated medical social work services be provided by qualified social workers in all health care settings.
- active participation of social workers on public and private health care policy and planning bodies.
- efforts to provide comprehensive education in health care social work, working with the Council on Social Work Education.
- policies and practices that promote and protect social work and social workers in all health and mental health settings.
- improved access, choice, quality, and comprehensiveness of health and mental health services, including parity of mental health care with medical care.
- policies and practices that ensure that patients receive necessary and appropriate care and guarantee patient rights protections.
- workforce development to meet the needs of burgeoning and existing special populations (such as geriatrics, pediatrics, people with disabilities, and so forth).
- active and organized consumer participation in the planning, implementation, evaluation, and maintenance and governance of health and mental health services.

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*Policy statement approved by the NASW Delegate Assembly, August 2008. This policy statement supersedes the policy statement on Health Care approved by the Delegate Assembly in August 1999 and referred by the 2005 Delegate Assembly to the 2008 Delegate Assembly for revision. The 1999 policy statement combined with and superseded the policy statement on Health Care Financing approved by the Assembly in 1990, the policy statement on the Role of Social Work in Health Maintenance Organizations approved by the Assembly in 1981 and reconfirmed by the Assembly in 1990, the policy statement on Social Work in Home Health Care approved by the Assembly in 1990 (that policy statement superseded the policy statement on Social Work in Home Health Care approved in 1981), and the policy statement on Social Work Practice in the Health Care Field approved by the Assembly in 1990 (that policy statement superseded the policy statement on Social Work Practice in the Health Care Field approved by the Assembly in 1984). For further information, contact the National Association of Social Workers, 750 First Street, NE, Suite 700, Washington, DC 20002-4241. Telephone: 202-408-8600 or 800-638-8799; e-mail: [press@naswdc.org](mailto:press@naswdc.org)*