Political Science 383/483
Health Policy and Politics in the U.S.
Professor Joseph White
Fall 2025
Tuesday/Thursday 10:00 – 11:15 a.m.
Draft Syllabus as of August 21, 2025

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"It's an unbelievably complex subject. Nobody knew health care could be so complicated." – President Donald J. Trump to a meeting of state Governors, February 27, 2017

"No lesson seems so deeply inculcated by the experience of life as that you never should trust experts. If you believe the doctors, nothing is wholesome; if you believe the theologians, nothing is innocent; if you believe the soldiers, nothing is safe. They all require to have their strong wine diluted by a very large admixture of insipid common sense."
– Lord Salisbury, British politician, June 15, 1877.

The Topic:

This course is an introduction to a huge field. If your main interest is in how the U.S. political system works, it offers a look at how process and power shape citizens' lives – especially access to, costs of, and quality of medical care. If your main interest is the U.S. health care "system," it provides an overview of what that includes, of the issues involved, and how public policy shapes that massive enterprise. From both perspectives, you may begin to learn why improvement seems necessary but is very difficult to achieve.

Measuring by basic results, how the U.S. finances health care, provides health care, and protects the public health with other measures is distinctly worse than

policies in all other rich democracies. Care is extremely expensive, consuming far more of the economy than in any other country. Access to care is uniquely unequal, compared to all other rich democracies. There is little reason to believe that, in return for the higher costs and much less equal access to care, the United States provides better quality of care.

Overall health statistics for the United States are not good at all. For example, the U.S. ranks below all other rich democracies within the OECD (25 other countries) in life expectancy at birth.[1] Much of this performance may be related to social ills that, in addition to poor health care access, make evils such as infant mortality and obesity more likely in the United States. Yet overall, the United States also performs poorly on "avoidable" or "amenable" mortality: terms that refer to deaths that could have been prevented with good medical care and public health efforts. This has been shown in a series of studies over the years.[2] Recent work has distinguished two forms of avoidable mortality. "Preventable" mortality is defined as deaths that "could have been avoided through effective public health and prevention interventions," and "treatable" mortality as "deaths that can be avoided through timely and effective healthcare interventions." Again, U.S. performance is as poor as for life expectancy.[3]

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[1] At 78.4 years as estimated in 2023, the U.S. figure was below those in Australia, Austria, Belgium, Canada, Chile, Costa Rica, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Iceland, Ireland, Israel, Italy, Japan, Korea, Luxembourg, the Netherlands, New Zealand, Norway, Portugal, Slovenia, Spain, Sweden, Switzerland, and the United Kingdom. A few of these I would not count as "rich." Data from the 2025 release (July 1) of the OECD Health Data database, Life Expectancy table here. For an overview of different indicators see https://www.healthsystemtracker.org/chart-collection/quality-u-s-healthcare-system-compare-countries/

[2] See Ellen Nolte and C. Martin McKee, "Measuring the Health of Nations: Updating an Earlier Analysis," *Health Affairs* 27, no. 1 (2008), pp. 58-71. The United States had the worst performance out of 19 countries. The authors compared more recent data for the U.S., France, Germany, and the United Kingdom in, "In Amenable Mortality--Deaths Avoidable Through Health Care—Progress In the US Lags That Of Three European Countries." *Health Affairs* 31, no. 9 (2012), pp. 2114-2122. That study found the U.S. doing better on preventing cancer deaths but worse overall.

[3] The quotes are from page 69 of Organization for Economic Cooperation and Development, Health at a Glance, 2023 (Paris: OECD), available at https://www.oecd.org/content/dam/oecd/en/publications/reports/2023/11/health-at-a-glance-2023_e04f8239/7a7afb35-en.pdf Mortality from treatable causes, the figure that most clearly involves the health care delivery system, was at an age-standardized rate of 98 per 100,000 population in the United States in 2021, compared to, for example, 39 in Switzerland, 47 in Australia, 51 in France, Spain and Norway, and 66 in Germany; data from page 70 of the report

In addition to performance in treating illness, health policy also includes the range of measures generally called **"public health."** The American Public Health Association calls for "health in all policies" – on the grounds that virtually anything affects health outcomes.[4] From one perspective they are right – national defense, for example, involves killing people or preventing them from getting killed. Yet if "health" applies to everything then it is not a field; it might as well be nothing.[5] In this course we will not take such an unlimited view of "health politics and policy." But it surely involves issues such as consumption of tobacco or alcohol, safety of the blood supply, regulation of medical drugs and devices, and controlling the spread of infectious disease. It is a bit of an understatement to say that, in recent years, the United States proved unusually weak, compared to other rich democracies, at controlling the spread of COVID-19, even though it got off to a very fast start in implementing vaccination.[6]

The poor U.S. response to COVID-19 must be part of this course. We need to be careful about drawing conclusions from that experience. Some other governments did not do a lot better, and some governments seemed to be doing well at one time and then had worse results later. We must hope (though should not expect) that nothing like Covid-19 shows up again for quite a while. But the Covid-19 story illustrates many more general points, ranging from the difficulty for any government to confront a new problem, to how responses vary according to recent experiences,[7] to the importance of how responsibilities are allocated among levels of governments, and the ways that partisan politics may have made the United States even less competent in the health policy domain.

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[4] See http://www.apha.org/programs/cba/CBA/health_all_policies?utm_source=Webinar:+Policy&utm_medium=Email&utm_campaign=Health+in+all+policies+release

[5] For a similar argument see Aaron Wildavsky, "If Planning is Everything, Maybe it's Nothing," *Policy Sciences* 4 (1973), 127-53.

[6] For comparison of death rates see https://coronavirus.jhu.edu/data/mortality, clicking on the deaths per 100,000 tab. Other than the Czech Republic, which is borderline for wealth, no country that could be considered a rich democracy had more deaths per 100,000 persons than the United States. Death rates per diagnosed case were also higher in the U.S. except as compared to Canada (which did much better at preventing spread of the disease). For a very brief overview of trends over time, see https://www.thinkglobalhealth.org/article/covid-19-united-states-still-lags-behind-peer-countries

[7] For example governments in the smaller East Asian countries that had experienced SARS – Taiwan and South Korea – reacted quickly, decisively, and relatively successfully.

From a political science perspective, U.S. health care poses a huge question: **Why? Why are costs so much higher, and access so much less equal, for little evident benefit, in the United States?** If health care outcomes are symptoms, then what aspects of the political process are their causes?

Yet this course will also use two other lenses to look at its topic. One, which will get the most attention, is the health care system as public policy. The other is health care as a business.

Studying Politics and Public Policy

Health policy and politics involve interests and institutions, but the topic also reveals the importance of the politics of ideas: of how people think about facts and values, right and wrong, and how the world works.

The study of policy-making or "**the policy process**" shows how government decisions result from a process in which political actors select among the world's *conditions*, define some as *problems*, and place them on some form(s) of decision-making *agenda.* In the case of the "novel coronavirus" (hereafter COVID-19) challenge, the first stage was to recognize it: something President Trump clearly resisted doing, while Ohio Governor DeWine did so relatively quickly. Then political actors (maybe the same, maybe different) attempt to attach *policies* (which they call *solutions*) to problems in a way that enables some new *authoritative decision*, such as legislation or a court ruling.

Yet no policy happens simply because of a single decision. There is always a further process of *implementation*, resistance, and perhaps *modification;* and one time's solution may become the next iteration's "problem" that someone is trying to change - if it ever got implemented at all. A classic example of implementation challenges was the U.S. prohibition of sale of intoxicating beverages in the 18th Amendment – which ultimately was repealed by the 20th. In short, the policy process is endless; as the saying goes, "it's never over."

For any given concern (or *policy domain*) some decisions will be made (for the moment) by political authorities who influence a wide range of policies, such as the legislature or chief executive or budget bureau or courts. But they have to get their ideas from somewhere, and that means that policy domains also involve ***policy communities***: groups of experts, organized interests, journalists, politicians and other public officials who engage continually in problem definition and policy promotion. In order to understand health policy and politics, therefore, we need to look at the ideas about health policy that are promoted in the health policy community. We also have to consider how political authorities respond to inputs from the community of policy "experts" – another dynamic that was highlighted by the COVID-19 crisis.

Such conglomerations influence all fields – there is a defense policy community, an elementary-and-secondary-education community, an energy policy community, and so on. In all cases, policy results from the interaction between the specialist community and other political factors – such as party politics and public opinion. But the politics of health and health care involves an especially complex and divided policy community, with its own very peculiar dynamics. "Experts" may provide inconclusive guidance because some things just are not yet known, as in the World Health Organization's (WHO) varying advice about wearing masks to limit transmission of COVID-19. But they also may disagree because of their own underlying world views – not simply political ideology but their specialized training.

Different people emphasize different "problems" – for instance not only access or cost or quality, but whether the "problem" is health care or health. What we might call tribes of experts promote their conflicting views of how the world works. Parties and economic actors look for experts whose opinions fit their ideological biases or immediate material interests. Both citizens and political authorities can be bewildered by the resulting range of "solutions" that are proposed.

Therefore one purpose of this class is to give students a sense of the politics of expertise. That creates a problem. In most classes, you probably read the material thinking it is telling you how the world works. I think a lot of the reading in this class is pretty useful for understanding the world. But **some of the analyses you read in this course should also be viewed as examples of particular kinds of thinking – as phenomena rather than "truth."**

This class will offer an overview of many of the issues that get called "health policy," and of the worldviews involved. I will emphasize the difficulties of policy analysis: of figuring out the extent of problems, what causes them, and what to do about them. For many challenges there may be no good answer. My mentor Aaron Wildavsky, the last time I saw him before he passed away, told me that, "even Stalin and Beria couldn't get doctors to move to the countryside." If murderous dictators and Secret Police chiefs can't get people to do something, then it's likely really difficult. So sometimes governments fail because a problem is very hard – but sometimes they blow the easy layup.

The Health Care Business

Since the 1970s, and particularly in the 1990s, there has been a movement to make government and policies work more like its advocates think markets work – allegedly with more flexibility, less "bureaucracy" and a closer fit between what citizens want and what they get. This could take the form of "privatization" – delivery of services by non-governmental organizations – or the "New Public Management" (NPM), a whole series of ideas about allowing the management of public organizations more autonomy to serve their "customers."[8]

Privatization and NPM were always controversial, with conflict based in part on underlying trust or distrust of market capitalism. But the zeitgeist of the era encouraged movement in that direction, and distrust of public bureaucracies

[8] For an introduction from the earlier years of the elite movement for NPM see http://newdoc.nccu.edu.tw/teasyllabus/110041265941/hood%20npm%201991.pdf

was hardly confined to conservatives.[9] A "market" approach to policy also flows naturally from the presumptions of the dominant tribe of social scientists and policy analysts, namely economists.

It should be blindingly obvious from recent developments in U.S. health care that the ways markets function for health care do not resemble the simple-minded assumptions of market advocates. Nevertheless market actors and business incentives have been driving transformations of U.S. health care. This may seem a bit of a bias, but when in 2018 I gave talks in Europe about transformations of U.S. health care, I argued that the Affordable Care Act ("Obamacare") was less important than how pursuit of profit was metastasizing across the system. In a growing literature, even eminent economists with strong free-market credentials are raising similar concerns about how the health care business works.

In a sense the issue here is one of the basic aspects of politics in democratic capitalism: power based on the vote vs. power based on money. It is not, as often naively assumed, simply that money influences elections and politicians. Rather, it is that capitalism itself is a structure of authority, with managers and owners deploying resources while also being driven by what they think lenders and investors want. The system is being transformed by market dynamics whether or not that is intended by policy-makers. Many policy challenges involve whether the government will catch up to the dynamics of the market – such as the rise of "surprise billing" for many services, or how insulin became unaffordable for some users.

Class Procedures and Concerns

Theorists of education continually talk about the importance of "experiential learning." My position for this class has always been that, by the most obvious definition, I want as little experiential learning as possible. I don't want

[9] For example many politicians with inner-city constituencies have supported versions of "school choice." See https://www.usnews.com/news/elections/articles/2019-10-24/cory-bookers-school-choice-dilemma

students to have to encounter the health care system. Helping provide care might be OK, but having to receive it is not.

This concern is not theoretical. I've had students with a variety of medical crises. But in recent years, for obvious reasons, avoiding "experience" was a major concern for university and governmental policy. As COVID-19 has become less of a threat, both concern and policies have weakened. I *presume* the various efforts since January 20 to weaken public health protections will not affect this semester, but will take protective measures again if necessary.

I have scheduled office hours at a time that makes sense given when I will be on campus to teach. I know that there will be students who cannot make those times. Please be assured that I will schedule meetings at other times, either in person or by zoom, if you need that. Just let me know.

I prefer that students arrive on time. During a normal term this can be difficult for students who have a class immediately previous on the other side of campus. I ask students to let me know and tell me which class that is.
I expect students to attend the vast majority of classes. The participation grade can be reduced if students miss more than six class sessions.

Some of the topics of this class are quite politically controversial. I have my own views which will be obvious (and could be determined by looking at various things I've written, even if I hid them in class). We should all understand that views about government policies relating to health and health care will be shaped in part by deeply held beliefs about both values and facts. These include, for example, the importance of equality; under what circumstances government's power can legitimately be used to take from some people and give to others; and how well "government" and "markets" tend to work. We must be very careful to recognize that people legitimately have different values.

Yet that does not mean everything is subjective. I will seek to show in this class that, in spite of the strong value preferences, it is possible to consider issues

with analytical rigor. We can be careful about the claims we make and think hard about both the evidence and what general values explain a specific policy preference. That includes taking seriously the views of anyone with whom you disagree, so thinking hard about why those views might make sense to someone who starts from different premises than you do. That does not mean you can't conclude they're wrong! But you need to know the best reasons to disagree.

I expect students' work to be their own. Plagiarism in any form is punishable by a failing grade on the assignment in question; and further penalties on the overall grade for the class or university disciplinary proceedings. Finding "answers" on the internet without properly citing the source is cheating, and that was true before all the recent controversy about ChatGPT. It should go without saying that if ChatGPT or some other generative AI writes your paper, I cannot give you credit for learning anything.

I want students to submit their work by the time assigned. This is especially important because I often want to discuss the assignment in the class on which it was due, which means that if you are late but attend the class you would get an unfair advantage. **Students may be sanctioned by up to half of a grade (i.e. 5 points on a 100 point scale) for each day that an assignment is late.** Whether I do so will depend on your reasons for lateness as documented and explained to me, as well as the general conditions the semester seems to bring.

Cellphones and other electronic devices, other than laptops, should not be used in class. I prefer that students be able to have course readings on their laptops, rather than have to print out everything. But there clearly are many students who have other material on their screens during class. I reserve the right to order all students to immediately reverse their screens so they face me; and to reduce the participation grade for anyone who has non-class material on the screen.

Learning Objectives, Assignments, and Grading:

This course has many objectives, and I hope you will gain some wisdom and understanding that fits each of them.

* Simply to introduce you to the field, and perhaps interest some students in working on it further.

* To give you a working understanding of key dimensions of public policy that influence the health, or at least access to medical care, of residents of the United States.

* To help you understand the value disagreements that shape political conflict. This includes understanding why people could disagree with you.

* To help you understand what disagreements could in principle be resolved by evidence, and which could not. That includes understanding why I think Lord Salisbury's comment at the top of this syllabus is worth considering.

* To give you a sense of the human stakes and drama in health policy and politics.

* To introduce you to understanding politics as a policy process.

* To help you form an understanding of when policy "reform" is likely to achieve what its advocates claim it will achieve.

The work and readings for this class are designed to build towards these objectives.

Assignments will include two quizzes about the reading, a short review of one day's reading, a concluding *in-class* essay, and a research paper about a reform theme.

1) Paper Topics. Your paper can be on one of three topics. You will get some introduction to each of these topics from shared course readings. The course canvas site will also include modules with a somewhat random collection of articles-to-start-with for each of the topics. Some modules will have more material because I have been doing more work on them. The topics are:

1a) **Payment transformation**: Ideas that the cost or quality of medical care – or their combination, known as "value" – can be significantly improved by changing how caregivers are paid.

1b) **Digital transformation**: Ideas that greater use of electronic medical records (EMRs), "AI," "big data" or something that sounds similar can and must improve health system performance.

1c) **Public health transformation**: ideas that policies that emphasized medical care less and the "social determinants of health" more would be both more efficient and more equitable. Unfortunately, as we have seen recently, public health strategies may be extremely expensive and unpopular. They also can also raise divisive issues of economic transformation or moral regulation.

Your paper should first provide your own definition of what might be included in the set of ideas you're discussing. Explain the basic logic for advocating them. Identify what the course material (shared readings and anything you can recall me saying) seem to be suggesting about the likely risks and benefits of these kinds of reforms. Then discuss the extent to which the further material you are using agrees or disagrees with the shared course material. Conclude with your own assessment of the prospects for successful reforms along these lines. You might want to consider how the analysis in my "Three Meanings of Capacity" article might apply.

Please give me your **choice of topic** by e-mail by **September 24**. If more than nine students have signed up for a topic, I may cut it off and require that other students choose something else.

Then you should submit a **topic overview** by **October 14**. This should be no less than 1200 words of text (so not counting references or footnotes). It should include how you are defining the topic (i.e. what you expect to write about) and

explanations of what you have learned from at least four sources. At least one of those sources should not be from the topic modules I will have set up. Your performance on this overview will count for **10 percent of your course grade**.

The final paper should be submitted to me by **December 15 at Noon**. It should be no less than 2500 words of text. Your performance on the final paper will count for **25 percent of your course grade**.

2) Two exams about the reading. These exams will be short-answer quizzes administered for the first 50 minutes of class, but I reserve the right to decide an essay would work better with the material. In either case, you will receive study guides in advance. These will include a set of questions, from which the exam questions will be selected. The first exam is scheduled for **October 7**; the second for **November 13**. Your **performance on each will count for 16% of your course grade, so a total of 32% for both**.

3) Final Essay. This will be written in class during the final examination period, so between 8:30 a.m. and 11:00 a.m. on **December 9**. The prompt will ask you to choose two or three conditions within American healthcare and discuss the extent to which problems (or the challenges of solutions) are due to technical capacity, institutional capacity, or political capacity, as defined in my "Three Meanings of Capacity" article assigned for September 16. Your performance will count for **20% of your course grade**.

4) Comments for Class. Each student will be required to comment in class about one day's assigned reading, sending the comments to me before class. I will post those comments on Canvas. These comments should be no less than 400 words. They can apply to all of the day's reading or (since I usually have assigned a bunch of smaller pieces) just a selection. These comments should identify major points from the reading and pose at least one question for class discussion. <u>They should also suggest a question that could be used for a reading quiz.</u> We will work out a schedule for who will do comments on which

day's readings. **Comments should be submitted by midnight before the class for which the reading was assigned**. Your performance will count for **5% of your course grade.**

5) Class participation. Class oral participation and attendance will count for **8% of your grade**. It is not fair to grade class participation by volume of talk. Some people are more comfortable with that than others. It is reasonable to expect students to do the reading, think about it, and attend class. I will grade participation in such a way that it helps students who make particularly good contributions and it only lowers students' grades if they either have more than six unexcused absences from class, or participate in a rude and abusive manner.

Please note that there will be two dates on which I cannot attend class. On October 2 I will be absent because of Yom Kippur. On October 16 I need to be overseas to attend the wedding of my best friend's daughter. I will assign readings for those days but there will be no class meeting to discuss them. September 23 is Rosh HaShanah but I have not decided what I will do. I might come to class and then attend a conservative synagogue that has a second day of services on September 24. Religious holidays and major life events for family or close friends are, of course, examples of reasons I will accept for absences.

6) Extra credit. As the semester progresses there are sure to be various events on campus relevant to the topic of this course. IF I have a way to monitor participation, I will give extra credit for attending up to three of these programs. Students can earn up to one extra point on their final average (e.g. turning 89 into 90) total, so 1/3 of a point per event. There will certainly be eligible events for the "Friday Lunch" that I organize. I will post a list in Canvas and record participants on that list.

NOTE: Any graduate students will have one further assignment, a book review for which we will agree on the book by September 16. The review will be due by November 6, and the student will give a talk to the class about how that book

contributes to understanding health policy and politics. The review will count for 7% of the grade, and each other assignment for 1% less than below.

Grading Metric Summary:

* First Exam: October 7. **16%**
* First Stage of "Transformation" Paper: October 14. **10%**
* Reading Comments: Assorted Dates. **5%.**
* Second Exam: November 13. **16%**
* In-Class Final Essay Exam: December 9. **20%.**
* Final "Transformation" Paper: December 15, **25%.**
* Participation: **8%.**

Schedule of Assignments and Readings

Course reading shared by all students will include two books and many articles and book chapters. The latter will be on the course Canvas site unless a link is given on this syllabus. I expect you to obtain the following books:

Thomas Bodenheimer, Kevin Grumbach and Rachel Willard-Grace *Understanding Health Policy: A Clinical Approach, 9th ed.* New York: McGraw-Hill/Lange, 2023. Referred to below as "BGW-G." Please note that you must get the 9th edition, but used copies of that edition would be fine.

The Covid Crisis Group, *Lessons From the COVID War: An Investigative Report.* (New York: Public Affairs, 2023).

Introduction: Values and Perspectives

Aug 26 *Introduction and explanation of the course.*

Aug 28 *Core Issues and Perspectives*

BGW-G Preface (pp v-vii), Introduction (1-3) and Chapters 16-18 (201-228)

Also read the syllabus carefully and come with questions.

Sept 2 *Values and Assumptive Worlds*

Donald M. Berwick, Thomas W. Nolan and John Whittington (2008), "The Triple Aim: Care, Health and Cost". *Health Affairs* 27 (3): pp. 759-769

James A. Morone (2005), "Morality, Politics, and Health Policy." From David Mechanic et al. eds., *Policy Challenges in Modern Health Care* (New Brunswick: Rutgers University Press): pp. 13-25.

Mark V. Pauly (1999), "Trading Cost, Quality, and Coverage of the Uninsured: What Will We Demand and What Will We Supply?" In Stuart Altman, Uwe E. Reinhardt, and Alexandra E. Shields eds., *The Future U.S. Healthcare System: Who Will Care For the Poor and Uninsured?* (Chicago: Health Administration Press), pp. 353-373.

Deborah Stone (2011), "Moral Hazard". *Journal of Health Politics, Policy and Law* 36(5), pp. 887-896.

Sept 4 *Basics*

BGW-G Chapter 2, "Paying for Health Care" and Chapter 3, "Health Insurance and Access to Care," pp. 7-29.

Sept 9 *International Perspective*

BGW-G Chapter 15 pp. 185-199

Joseph White, "American Health Care From an International Perspective," Chapter 26 in James Morone and Dan Ehlke eds. *Health Politics and Policy 6th ed.*, Cengage Learning, pp. 334-350.

Sept 11 *Arguments About Fairness*

BGW-G Chapter 5, "Health Equity" and Chapter 6, "Medical Ethics and Rationing of Health Care," pp. 45-72.

Joseph White, "Core Concepts About Medicare, Medicaid and Health Insurance." Unpublished ms., July 27, 2025

Sept 16 *Government Capacity and Incapacity*

Joseph White. "Three Meanings of Capacity: Or, Why the Federal Government Is Most Likely to Lead on Insurance Access Issues." *Journal of Health Politics, Policy and Law* Vol. 28, no. 2-3 (2003), pp. 217-244.

Julie Rovner, "Congress, the Executive Branch, and Health Policy." In Drew Altman ed., *Health Policy 101* (San Francisco, Kaiser Family Foundation: 2025). https://www.kff.org/health-policy-101-congress-and-the-executive-branch-and-health-policy/ (about 10 pages)

Modes of U.S. Health Insurance

Sept 18 *Employer-Sponsored Insurance*

Claxton, G., Rae, M., & Winger, A., "Employer-Sponsored Health Insurance 101." In Altman, Drew (Editor), *Health Policy 101*, (KFF, May 28, 2024) https://www.kff.org/health-policy-101-employer-sponsored-health-insurance/

Jake Spiegel and Paul Fronstin (2023). "What Employers Say About the Future of Employer-Sponsored Health Insurance." Commonwealth Fund Issue Brief, January 26. At https://www.commonwealthfund.org/publications/issue-briefs/2023/jan/what-employers-say-future-employer-health-insurance

Sept 23 *Medicare*

Cubanski, Juliette et al. "Medicare 101." In Drew Altman ed., *Health Policy 101.* (San Francisco: Kaiser Family Foundation May 28, 2024.) https://files.kff.org/attachment/health-policy-101-medicare.pdf

Neuman, Tricia, Jean Fuglesten Biniek and Juliette Cubanski. "Medicare at 60: A Popular Program Facing Challenges." *Journal of Health Politics, Policy and Law* Vol. 50, No.4 (August 2025), pp. 549-570.

Sept 24: Please e-mail your choice of paper topic to Professor White by 8 p.m.

Sept 25 *Medicaid and the 2025 "Big Beautiful Bill"*

Rudowitz, Robin et. al. "Medicaid 101." In Drew Altman ed., *Health Policy 101*. (San Francisco, Kaiser Family Foundation, May 28, 2024). https://files.kff.org/attachment/health-policy-101-medicaid.pdf

Drew Altman, a collection of "Beyond the Data" columns about Medicaid cuts, plus a Larry Levitt overview of what passed in July. 22 pages

Sept 30 *The ACA, and the Costs Problem*

Mark A. Peterson (2020). "The ACA a Decade In: Resilience, Impact, and Vulnerabilities." *Journal of Health Politics, Policy and Law* 45(4): 595-608.

Joseph White (2018). "Hypotheses and Hope: Policy Analysis and Cost Controls (or Not) in the Affordable Care Act." *Journal of Health Politics, Policy and Law* 43(3): 455-482.

Joseph White (2023). "Some Comments on the Politics of Health Insurance for All in the U.S." Unpublished ms., July 27.

Oct 2 *A Few More Basics*

BGW-G Chapter 9, "The Health Care Workforce and the Education of Health Professionals" and Chapter 10, "Long-Term Care." Pp 103-128.

Note: There will be no class meeting today, as it is Yom Kippur

Oct 7 ***First Quiz***

Oct 9 "*Cost Control"*

BGW-G Chapter 4, "Paying Health Care Providers," pp. 31-41; Chapter 11, "Painful Versus Painless Cost Control" and Chapter 12, "Mechanisms for Controlling Costs," pp 131-155.

"Reducing Waste in Health Care," *Health Affairs Policy Brief* (Dec 13, 2012) https://www.healthaffairs.org/do/10.1377/hpb20121213.959735/full/healthpolicybrief_82.pdf

Note: First Stage of "Transformation" Paper Due October 14 by 10:00 a.m.

Oct 14 *Cost Control and the Health Care Business*

Joseph White (2010). "The Cost of Health Care in Western Countries." In David A. Warrell et al. eds., *The Oxford Textbook of Medicine* 5th ed. Vol. 1, pp. 112-116.

Rachel O. Reid, Ashlyn K. Tom, Rachel M. Ross, Erin L. Duffy, Cheryl L. Damberg (2022). "Physician Compensation Arrangements and Financial Performance Incentives in US Health Systems." *JAMA Health Forum* 3(1): 11 pp.

Joseph White and Nicholas Corwin (2022). "Insulin Shocks." *Journal of Health Politics, Policy and Law* 47(6): 731-753

Suhas Gondi and Michael L. Barnett (2023). "Taking Stock of Care Delivery Transformation." *JAMA Health Forum* 4(6): 3pp.

Oct 16 *More on the Health Care Business*

Note: The Class Will Not Meet Today. Please Feel Free to Raise Questions About this Reading at the Next Class Session.

Lawton Robert Burns and Mark V. Pauly (2023). "Big Med's Spread." *The Milbank Quarterly* 101(2): 287-324

Oct 21: ***No Class, Fall Break***

Oct 23 *Still More on the Health Care Business*

John McDonough (2022). "Termites in the House of Health Care." *Milbank Quarterly* Opinion, November 14. https://www.milbank.org/quarterly/opinions/termites-in-the-house-of-health-care/

Hayden Rooke-Ley et al, "The Corporate Backdoor to Medicine: How MSOs Are Reshaping Physician Practices" *Milbank Memorial Fund Issue Brief*, April 2025, 13 pp. https://www.milbank.org/publications/the-corporate-backdoor-to-medicine-how-msos-are-reshaping-physician-practices/

Lynn Unruh and Thomas Rice, "Private equity expansion and impacts in united states healthcare." *Health Policy* 155 (2025), epub March 3, 8 pp.

Mark V. Pauly and Lawton Robert Burns (2024). "Equity Investment in Private Practices: What's All This Brouhaha? *Journal of Health Politics, Policy and Law* 49(4): 631-664

Oct 28 *Organization of Health Care Delivery (1)*

BGW-G Chapters 7 and 8, "How Health Care Is Organized I & II," pp. 75-101.

BGW-G Chapter 13, "Quality of Health Care," pp. 157-170

Oct 30 Organization of Health Care Delivery (2)

Joseph White, "Loving Primary Care to Death?" Unpublished ms. July 2025

Nov 4 *Quality Challenges: Conventional Wisdom, and Its Politics*

Carolyn Clancy, Irene Fraser, Kristi Groves and Pamela L. Owens. "High Quality Health Care." Chapter 11 in *Jonas & Kovner's Health Care Delivery in the United States 13th ed*. James R, Knickman and Brian Ebel eds. New York: Springer Publishing, 2024. Pages 297-332.

Ulrike Lepont (2020). "Improving Quality as a Solution to the Health Care Cost Problem? Health Policy Experts and the Promotion of a Controversial Idea." *Journal of Health Politics, Policy and Law* 43(6): 1083-1106.

Robert A. Berenson and Laura Skopec, "The Medicare Advantage Quality Bonus Program." *Urban Institute Research Report*, March 2024 pp. 1-11, 30-36 (and notes) https://www.kff.org/womens-health-policy/issue-brief/abortion-trends-before-and-after-dobbs/

Nov 6 *Regulation and Litigation*

Anthony D. Dell'Aera (2015). "Prescription Drugs: How a Pill Becomes the Law." Chapter 21 in James Morone and Daniel Ehlke eds, *Health Politics and Policy 6th ed*, pp. 268-282

Brendan M. Reilly (2018). "The Best Medical Care in the World." *New England Journal of Medicine* 378(18), 1741-1743.

David M. Studdert et al. (2006), "Claims, Errors, and Compensation Payments in Medical Malpractice Litigation," *New England Journal of Medicine* 354 (19), 2024-2033.

David M. Studdert and Mark A. Hall (2022). "Medical Malpractice Law – Doctrine and Dynamics." *New England Journal of Medicine* 7 (17): 1533-1537.

Nov 11 *Public Health and Prevention*

Anna Kirkland, "What is Wellness Now?" *Journal of Health Politics, Policy and Law* 39(5) October, 2024, pp. 957-970.

Sherry Glied and Thomas D'Aunno (2023). "Health Systems and Social Services: A Bridge Too Far?" *JAMA Health Forum* 4(8), August 17, 2 pp.

David Mant (2010). "Avoiding Disease and Promoting Health." *Oxford Textbook of Medicine 5th ed.* Vol. 1, pp. 86-94.

Kenneth E. Warner (2005). "Tobacco Policies in the United States: Lessons for the Obesity Epidemic." In David Mechanic et al. eds., *Policy Challenges in Modern Health Care. New Brunswick: Rutgers University Press*, pp. 99-114.

Nov 13 ***Second Exam***

Nov 18 *The COVID Disaster (1)*

Lessons From the COVID War, through Chapter 5 (pp 1-142, 289-316)

Nov 20 *The COVID Disaster (2)*

Lessons From the COVID War, Chapters 6-7 (pp 143-202, 316-321)

Nov 25 *The COVID Disaster (3)*

Lessons From the COVID War, Chapters 8-11 (pp 203-288, 321-326).

Nov 27 ***No Class, Thanksgiving***

Dec 2 *A Bit More on Politics and Markets*

Jonathan Oberlander, "Polarization, Partisanship, and Health in the United States." *Journal of Health Politics and Law* Vol 49, No 3 (June 2024) 329-350.

James A. Morone, "Medicare in Treacherous Markets: From Community Bake Sales to Private Equity." *Journal of Health Politics, Policy and Law* Vol. 50, No. 4 (August 2025), 659-679.

Dec 4 *One Final Surprise*

Karen Diep et al, "Abortion Trends Before and After Dobbs," Kaiser Family Foundation Women's Health Policy brief (July 15, 2025) at https://www.kff.org/womens-health-policy/issue-brief/abortion-trends-before-and-after-dobbs/

December 9, 8:30 – 11:00 a.m. Final in-class essay. Class will meet in Mather House 100

Dec 15: Final "Transformation" Papers Due to Professor White by E-mail by Noon