Fourth Edition

Basics of the U.S. Health Care System

Nancy J. Niles

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About the Author

Nancy J. Niles, PhD, MS, MBA, MPH, is in her 15th year of full-time undergraduate teaching. She is in her fifth year of teaching undergraduate and graduate healthcare management and administration courses at Rollins College in Winter Park, Florida. Prior to Rollins College, she taught 8 years of undergraduate business and healthcare management classes in the AACSB-accredited School of Management at Lander University in Greenwood, South Carolina, having spent 4 years teaching in the Department of Business Administration at Concord University in Athens, West Virginia. She became very interested in health issues as a result of spending two tours with the U.S. Peace Corps in Senegal, West Africa. She focused on community assessment and development, obtaining funding for business and health-related projects. Her professional experience also includes directing the New York State lead poisoning prevention program and managing a small business development center in Myrtle Beach, South Carolina.

Her graduate education has focused on health policy and management. She received a Master of Public Health from the Tulane School of Public Health in New Orleans, Louisiana, a master of management with a healthcare administration emphasis, and a master of business administration from the University of Maryland University College, and a doctorate from the University of Illinois at Urbana–Champaign in health policy.

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Preface

There are some major changes to this textbook. In Chapter 1, I included a milestones table on nursing education which was long overdue. I merged Chapter 2, the Affordable Care Act (ACA), with Chapter 8, Healthcare Payors and Financing. I also included a new Chapter 6 on Long-Term Care Services. As our life expectancy increases, information on long-term care is needed. As always, a major goal of any of the editions to this textbook is to provide updated data. The Organisation for Economic Cooperation and Development (OECD) data has been updated including data dashboards on risk factors of health. I continue to review and update the student activities. There are chapter quizzes, ebook quizzes, and ample midterm and final exams. The following is a summary of teach chapter.

Chapter 1

It is important as a healthcare consumer to understand the history of the U.S. healthcare delivery system, how it operates today, who participates in the system, what legal and ethical issues arise as a result of the system, and what problems continue to plague the healthcare system. We are all consumers of health care. Yet, in many instances, we are ignorant of what we are actually purchasing. If we were going to spend $1000 on an appliance or a flat-screen television, many of us would research the product to determine whether what we are purchasing is the best product for us. This same concept should be applied to purchasing healthcare services.

Despite U.S. healthcare expenditures, disease rates in the United States remain higher than those of many other developed countries because the United States has an expensive system that is available to only those who can afford it. A recent Gallup survey indicates that over 55% of Americans are greatly concerned about the availability of the rising cost of health care, which marks the fifth year in a row that this issue is ranked or tied first with concerns (Jones, 2018). Because the United States does not have universal health coverage, there are more health disparities across the nation. Persons living in poverty are more likely to be in poor health and less likely to use the healthcare system compared to those with incomes above the poverty line. If the United States offered universal health coverage, the per capita expenditures would be more evenly distributed and likely more effective. The major problem for the United States is that healthcare insurance is a major determinant of access to health care. Although there has been a decrease in the number of uninsured in the United States as a result of the individual mandate to purchase health insurance by the ACA, there is still limited access to routine health care. The infant mortality rate is often used to compare the health status of nations worldwide. Although our healthcare expenditures are very high, our infant mortality rates rank higher than those of many countries. Racial disparities in disease and death rates continue to be a concern. Both private and public participants in the U.S. health delivery system need to increase their collaboration to focus on health education aimed to reduce the prevalence of obesity and disease. Leaders need to continue to assess our healthcare system using the Iron Triangle to ensure that there is a balance between access, cost, and quality.

Increasing healthcare consumer awareness will protect you in both the personal and the professional aspects of your life. You may decide to pursue a career in health care either as a provider or as an administrator. You may also decide to manage a business where you will have the responsibility of providing health care to your employees. And finally, from a personal standpoint, you should have the knowledge from a consumer point of view, so that you can make informed decisions about what matters most—your health. The federal government agrees with this philosophy. The ACA's health insurance marketplaces provide cost and service data, so that consumers can determine what is the best healthcare insurance to purchase and what services they will be receiving for that purchase. Recently, the Centers for Medicare and Medicaid Services (CMS) used its claim data to publish the hospital costs of the 100 most common treatments nationwide.

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The purpose of this effort is to provide data to consumers regarding healthcare costs because the costs vary considerably across the United States. This effort may also encourage pricing competition of healthcare services. The U.S. Department of Health and Human Services is providing funding to states to increase their healthcare pricing transparency.

Despite U.S. healthcare expenditures, disease rates in the United States remain higher than those of many other developed countries because the United States has an expensive system that is available to only those who can afford it. Findings from a recent MetLife annual survey indicate that healthcare costs are worrying employees and their employers. Over 60% of employees are worried they will not be able to pay out-of-pocket expenses not covered by insurance. Employers are increasing the cost sharing of their employees for healthcare benefits because of the cost increases. Because the United States does not have universal health coverage, there are more health disparities across the nation. Persons living in poverty are more likely to be in poor health and less likely to use the healthcare system compared to those with incomes above the poverty line. If the United States offered universal health coverage, the per capita expenditures would be more evenly distributed and likely more effective. The major problem for the United States is that healthcare insurance is a major determinant of access to health care. Although there has been a decrease in the number of uninsured in the United States as a result of the individual mandate to purchase health insurance by the ACA, there is still limited access to routine healthcare statistics. The infant mortality rate is often used to compare the health status of nations worldwide. Although our healthcare expenditures are very high, our infant mortality rates rank higher than those of many countries. Racial disparities in disease and death rates continue to be a concern. The United States has more work to do regarding this issue. Both private and public participants in the U.S. health delivery system need to increase their collaboration to reduce these disease rates. Leaders need to continue to assess our healthcare system using the Iron Triangle to ensure that there is a balance between access, cost, and quality. This chapter provides an overview of the different U.S. healthcare system components.

New to Chapter: The chapter has expanded to include a discussion about health literacy. I have also included a table of milestones of nursing education and a discussion of a new prevention category-quaternary prevention.

Chapter 2

The one commonality with all of the world's healthcare systems is that they all have consumers or users of their systems. Systems were developed to provide a service to their citizens. However, the U.S. healthcare system, unlike many other systems in the world, does not provide healthcare access to all of its citizens. It is a very complex system that is comprised of many public and private components. Healthcare expenditures comprise approximately 17.9% of the gross domestic product (GDP). Health care is very expensive, and most citizens do not have the money to pay for health care themselves. Individuals rely on health insurance to pay a large portion of their healthcare costs. Health insurance is predominantly offered by employers. The government believes this is the result of the universal mandate for individual health insurance coverage. However, with the recent federal ruling stating that the universal mandate is unconstitutional, it is expected that the uninsured rate may increase.

In the United States, in order to provide healthcare services, there are several stakeholders or interested entities that participate in the industry. There are providers, of course, that consist of trained professionals, such as physicians, nurses, dentists, and chiropractors. There are also inpatient and outpatient facilities; the payers, such as the insurance companies, the government, and self-pay individuals; and the suppliers of products, such as pharmaceutical companies, medical equipment companies, and research and educational facilities. Each component plays an integral role in the healthcare industry. These different components further emphasize the complexity of the U.S. system. The current operations of the delivery system and utilization statistics will be discussed in depth in this chapter. An international comparison of the U.S. healthcare system and select country systems will also be discussed in this chapter, which provides another aspect of analyzing the U.S. healthcare system.

The U.S. healthcare system is a complicated system comprised of both public and private resources. Health care is available to those who have health insurance or who are entitled to health care through a public program. One can think of the healthcare system as several concentric circles that surround the most important stakeholders in the center circle—the healthcare consumers and providers. Immediately surrounding this relationship are payors of services—health insurance companies and governmental programs, such as Medicare and Medicaid, healthcare facilities, pharmaceutical companies, and laboratories,

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all of which provide services to consumers to ensure that they receive quality health care, as well as support providers to ensure that they provide quality health care. The next circle consists of peripheral stakeholders that do not have an immediate impact on the main relationship but are still important to the industry. These consist of the professional associations, the research organizations, and the medical and training facilities. This figure emphasizes the number of institutions and personnel that provide direct and indirect care to healthcare consumers.

It is important to assess the system from an international perspective. Comparing different statistics from the OECD is valuable to assess the health of the United States. Despite the amount of money spent on health care in the United States, the United States ranked lower on many measures than other countries that spend less on their healthcare systems. These statistics may point to the fact that there is a combination of influencing factors, such as the effectiveness of countries' healthcare systems and different determinants of health, and that many of the OECD countries have universal healthcare systems that increase access to healthcare services.

New to Chapter: All data have been updated. I have also included four new OECD data dashboards on health status, impact of smoking and alcohol use on health, access to health care, and healthcare resources. Other new tables include the percentage of generalists and specialist physicians, doctor visits missed due to cost, prescriptions drugs missed due to cost, and long-term care beds available.

Chapter 3

During the Depression and World War II, the United States had no funds to start a universal healthcare program—an issue that had been discussed for years. As a result, a private-sector system was developed that did not provide healthcare services to all citizens. However, the government's role in providing healthcare coverage evolved as a regulatory body to ensure that the elderly and poor were able to receive health care. The passage of the **Social Security Act of 1935** and the establishment of the Medicaid and Medicare programs in 1965 mandated the government's increased role in providing healthcare coverage. Also, the State Children's Health Insurance Program (SCHIP), now the Children's Health Insurance Program (CHIP), established in 1997 and reauthorized by the ACA through 2019, continues to expand the government's role in children's health care. The laws require states, upon enactment, to maintain current income eligibility levels for CHIP through September 30, 2019 (CHIP, 2018). In addition to the reauthorization of the CHIP program, the ACA increased governmental interaction with the healthcare system by developing several of the governmental initiatives that focus on increasing the ability of individuals to make informed decisions about their health care.

In these instances, the government increased accessibility to health care as well as provided financing for health care to certain targeted populations. This chapter will focus on the different roles the federal, state, and local governments play in the U.S. healthcare system. This chapter will also highlight different governmental programs and regulations that focus on monitoring how health care is provided.

The government plays an important role in the quality of the U.S. healthcare system. The federal government provides funding for state and local governmental programs. Federal healthcare regulations are implemented and enforced at the state and local levels. Funding is primarily distributed from the federal government to the state government, which then allocates funding to local health departments. Local health departments provide the majority of services for their constituents. More local health departments are working with local organizations, such as schools and physicians, to increase their ability to provide education and prevention services.

The Department of Homeland Security (DHS) and Federal Emergency Management Agency (FEMA) now play an integral role in the management and oversight of catastrophic events, such as natural disasters, earthquakes, floods, pandemic diseases, and bioterrorism. The DHS and FEMA are also involved in managing school and workplace violence incidents, which have become more commonplace in society. The DHS and FEMA collaborate closely with the Centers for Disease Control and Prevention (CDC) to ensure that both the state and local health departments have a crisis management plan in place for these events. These attacks are often horrific and frightening with a tremendous loss of life, and as a result, the state and local health departments need to be more prepared to deal with catastrophic events. They are required to develop plans and be trained to deal effectively with many of these catastrophic issues.

New to Chapter: I have reviewed and updated all government agency information. I have also included the Environmental Protection Agency because of the issues with environmental health.

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Chapter 4

There are two important definitions of public health. In 1920, **public health** was defined by Charles Winslow as the science and art of preventing disease, prolonging life, and promoting physical health and efficiency through organized community efforts for the sanitation of the environment, control of community infections, and education of individuals regarding hygiene to ensure a standard of living for health maintenance (Winslow, 1920). Sixty years later, the **Institute of Medicine (IOM)**, in its 1988 *Future of Public Health* report, defined public health as an organized community effort to address public health by applying scientific and technical knowledge to promote health (IOM, 1988). Both definitions point to broad community efforts to promote health activities to protect the population's health status. The ACA is also emphasizing the importance of prevention and wellness. The establishment of the Prevention and Public Health Fund (PPHF) has supported several community-based public health programs. It is the first mandatory funding stream for improving public health. For 2017 activities, the PPHF has awarded $931 million to federal agencies, including the CDC, Administration for Community Living (ACL), and Substance Abuse and Mental Health Services Administration (SAMSHA), to develop programs to address several public health issues, such as youth suicide, lead poisoning prevention, and stroke prevention (HHS, 2019).

The development of public health is important to note as part of the basics of the U.S. healthcare system because its development was separate from the development of private medical practices. Public health specialists view health from a collectivist and preventative care viewpoint: to protect as many citizens as possible from health issues and to provide strategies to prevent health issues from occurring. The definitions cited in the previous paragraph emphasize this viewpoint. Public health concepts were in stark contrast to traditional medicine, which focused on the relationship between a provider and a patient. Private practitioners held an individualistic viewpoint—people more often would be paying for their services from their health insurance or from their own pockets. Physicians would be providing their patients guidance on how to cure their diseases, not preventing disease, although there is now more collaboration between public health and traditional medicine. This chapter will discuss the concept of health and healthcare delivery and the role of public health in delivering health care. The concepts of primary, secondary, tertiary, and quaternary prevention and the role of public health in those delivery activities will be highlighted. Discussion will also focus on the origins of public health, the major role epidemiology plays in public health, the role of public health in disasters, and core public health activities.

New to Chapter: I have included a figure of the *Healthy People 2020* report on Social Determinants of Health. I have updated the prevention activities to include the category of quaternary prevention. I have included a section on organizational risk factors for workplace violence and the Department of Homeland Security's recommendations for action during an active shooter situation and a section on social marketing and social media marketing.

Chapter 5

Historically, the U.S. healthcare industry was based on the provision of inpatient services provided by hospitals and outpatient services provided by physicians. As our healthcare system evolved, hospitals became the mainstay of the healthcare system, offering primarily inpatient with limited outpatient services. Over the last two centuries, hospitals have evolved from serving the poor and homeless to providing the latest medical technology in order to serve the seriously ill and injured (Shi & Singh, 2008). Although their original focus was inpatient services, as a result of cost containment and consumer preferences, more outpatient services are now being offered by hospitals. Hospitals can be classified by who owns them, length of stay, and type of services provided. Inpatient services typically focus on acute care, which includes secondary, tertiary, and quaternary care levels that most likely require inpatient care. Inpatient care is very expensive and, throughout the years, has been targeted for cost-containment measures. Hospitals have begun offering more outpatient services because they do not require an overnight stay and are less financially taxing on the healthcare system. The percentage of the U.S. GDP that consisted of healthcare expenditures continues to increase, and consequently, more cost-containment measures have evolved. Outpatient services have become more prevalent for that reason and because outpatient services are preferred by consumers. Technological advances in health care have allowed for more healthcare services to be performed as outpatient services.

The healthcare industry has recognized that outpatient services are a cost-effective method of providing quality health care and has, therefore, evolved into providing quality outpatient care. This type of service

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is the preferred method of receiving health care by many consumers (CDC, 2018b). However, as medicine has evolved and more procedures, such as surgeries, can be performed on an outpatient basis, different types of outpatient care have evolved. As discussed previously, there are more outpatient surgical centers, imaging centers, urgent and emergent care centers, and other services that used to be offered on an inpatient basis. There will continue to be an increase in outpatient services being offered. Technology will increase the quality and the efficiency of health care for consumers. Telemedicine has become a more widely used model for health care because of continued advances in technology. The implementation of patient electronic health record systems nationwide will be the impetus for the development of more electronic healthcare services.

New to Chapter: All data have been updated.

Chapter 6 (New Chapter)

According to the Department of Health and Human Services, long-term care services include a broad range of health, personal care, and supportive services that meet the needs of older people and other adults whose capacity for self-care is limited because of a chronic illness; injury; physical, cognitive, or mental disability; or other health-related condition. People with intellectual and developmental disabilities need long-term care services. Most long-term care is not medical care but rather assistance with the basic personal tasks of everyday life. These tasks are sometimes called activities of daily living (ADLs) and include bathing, dressing, eating, and going to the bathroom. Long-term care services also provide assistance for instrumental activities of daily living (IADLs), such as housework, money management, taking medications, grocery or clothes shopping, pet care, and using the telephone. Individuals may need these services for years. In general, long-term care services usually are provided by unpaid caregivers—family and friends—in home and community-based settings. Over the last 20 years, the shift of institutional long-term care provision has been toward community and home-based settings as a result of the **Olmstead decision**. The Supreme Court's Olmstead decision found that the Americans with Disabilities Act violated the rights of persons with disabilities by keeping them institutionalized, thereby increasing the need for community-based services.

As life expectancy increases, individuals will require long-term care services, which already comprise a significant percentage of national healthcare expenditures paid for by Medicaid. The Commission on Long-Term Care, created by the American Taxpayer Relief Act of 2012, issued a report in 2013 that indicated there needs to be a coordinated program in place that focuses on long-term care services for individuals across the United States, and the Commission recommended funding for a system to be developed. As of this writing, long-term care services vary based on state priorities. In general, healthcare experts recognize the need for creating innovative ways to deliver long-term care services. A component of this type of innovation is the long-term care navigator. This service can assist individuals and their families with researching the different types of long-term care services provided by the state, reviewing their financial support for long-term care services, researching the types of long-term care facilities in their local area, and assisting them with the transition to a long-term care provider.

Chapter 7

The health industry is one of the largest employers in the United States and employs more than 13% of the U.S. workforce. Because of the aging of our population, the Bureau of Labor Statistics (BLS) indicates that the health industry will generate nearly 2.5 million new jobs by 2026 (BLS, 2018a). When one thinks of healthcare providers, one automatically thinks of physicians and nurses. However, the healthcare industry is composed of many different health services professionals, such as dentists, optometrists, psychologists, chiropractors, podiatrists, nonphysician practitioners (NPPs), administrators, and allied health professionals. Allied health professionals, who represent nearly 60% of the healthcare workforce, provide a range of essential healthcare services that complement the services provided by physicians and nurses.

Health care can occur in varied settings. Many physicians have their own practices, but they may also work in hospitals, mental health facilities, managed care organizations, or community health centers. They may also hold government positions, teach at a university, or be employed by an insurance company. Health professionals, in general, may work at many different for-profit and not-for-profit organizations. It is the responsibility of the human resources (HR) department to be aware of the different types of healthcare jobs in the industry. When employees transfer within an organization or decide to change their healthcare career goals, their main resource is the HR department. This chapter will provide a description of the

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diverse types of healthcare jobs, their educational requirements, job responsibilities, median annual salaries, and their roles in the healthcare system.

This chapter will provide an overview of the different types of employees in the healthcare industry. Some of these positions require many years of education; however, others can be achieved through 1- to 2-year education programs. There are more than 200 occupations and professions among the more than 14 million healthcare workers in the United States. The healthcare industry will continue to progress as the U.S. trends in demographics, disease, and public health patterns change and as cost and efficiency issues, insurance issues, technological influences, and economic factors continue to evolve. More occupations and professions will develop as a result of these trends.

The major trend that will affect the healthcare industry is the aging of the U.S. population. The BLS predicts that half of the next decade's fastest growing jobs will be in the healthcare industry. Physician extenders and allied healthcare professionals will continue to play an increasing role in the provision of health care. There were several career choices discussed in this chapter that may provide an opportunity for an existing employee to work in another department or organization. Organizations may provide education reimbursement for quality employees in return for an extended employment contract.

New to Chapter: All labor statistics have been updated. Included is a table of generalists and specialists. Included are different allied health professionals. The new health navigator position is discussed.

Chapter 8 (New Title: Healthcare Payors and Financing)

The percentage of the U.S. GDP devoted to healthcare expenditures has increased in recent decades. According to 2016 statistics, the United States spent $3.3 trillion or $10,739 per person on healthcare expenditures or 17.9% of its GDP. The CMS predicts annual healthcare costs will be $4.64 trillion by 2024, which represents nearly 20% of the U.S. GDP (CMS, 2018a). The increase in healthcare spending can be attributed to three causes: (1) When prices increase in an economy overall, the cost of medical care will increase and, even when prices are adjusted for inflation, medical prices have increased. (2) As life expectancy increases in the United States, more individuals will require more medical care for chronic diseases, which means there will be more healthcare expenses. (3) As healthcare technology and research provide for more sophisticated and more expensive procedures, there will be an increase in healthcare expenses. In 2016, health expenditures were as follows: for hospital care, 32.4%; for nursing care and continuing care retirement communities, 4.9%; for physician and clinical services, 19.9%; and for prescription drugs, 9.8%. Unlike countries that have universal healthcare systems, payment of healthcare services in the United States is derived from (1) **out-of-pocket payments** or **cost sharing** from patients who pay entirely or partially for services rendered; (2) health insurance plans, such as indemnity plans or managed care organizations; (3) public or governmental funding, such as Medicare, Medicaid, and other governmental programs; and (4) health savings accounts (HSAs) and consumer-driven health plans, such as health reimbursement accounts (HRAs). Much of the burden of healthcare expenditures has been borne by private sources—employers and their health insurance programs. Individuals may continue to pay their health insurance premiums through the Consolidated Omnibus Budget Reconciliation Act (COBRA) once they are unemployed, but most individuals cannot afford to pay the expensive premiums.

To understand the complexity of the U.S. healthcare system, this chapter will provide a breakdown of U.S. healthcare spending by source of funds, and the major private and public sources of funding for these expenditures. It is important to reemphasize that there are three parties involved in providing health care: the provider, the patient, and the fiscal intermediary, such as a health insurance company or the government. Therefore, also included in the chapter is a description of how healthcare providers are reimbursed for their services and how reimbursement rates were developed for both private and public funds. There is also an in-depth section on the ACA of 2010, the landmark healthcare reform legislation that is patient-centered, focusing on affordable and quality health care.

New to Chapter: All data have been updated. I eliminated the ACA as a separate chapter and integrated it into this chapter. I replaced the Bundled Payments Initiative table with a CMS Innovation models table, and I added a table on CMS Quality Payment Program Models. I also included a discussion of chronic disease prevention and how to improve public health and transparency and integrity as it relates to healthcare expenditures.

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Chapter 9

Managed care is a healthcare delivery system organized to manage cost, utilization, and quality. Managed care refers to the cost management of healthcare services by controlling who the consumer sees and how much the service costs. Managed care organizations (MCOs) were introduced 40 years ago but became more entrenched in the healthcare system when the Health Maintenance Organization (HMO) Act of 1973 was signed into law by President Richard Nixon. Healthcare costs were spiraling out of control during that period. Encouraging the increase in the development of HMOs, the first widely used managed care model would help to control the healthcare costs. MCOs' integration of the financial industry with the medical service industry resulted in controlling the reimbursement rate of services, which allowed MCOs more control over the health insurance portion of health care. Physicians were initially resistant to managed care models because they were threatened by loss of income. As the number of managed care models increased, physicians realized they had to accept this new form of healthcare delivery and if they participated in a managed care organization, it was guaranteed income. Managed care health plans have become a standard option for consumers. Medicare Part C, which is commonly called Medicare Advantage, offers managed care options to their enrollees. Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and MCOs that accept a set payment per member per month (capitation) for these services. Many employers offer managed care plans to their employees.

Physicians have also had problems with timely reimbursement from MCOs. There were issues with fraudulent reimbursement rates of out-of-network services, which resulted in members paying exorbitant out-of-pocket expenses. However, the American Medical Association has developed tools to assist physicians with managed care contracting and reimbursement processes. The ACA mandate that insurance companies must spend 80%–85% of their premium revenues on quality care or be penalized with fines, give rebates to their members, or both is an incentive for MCOs to provide quality and affordable care. As health care continues to focus on providing quality care and cost reduction, having a database, such as Health Plan Employer Data and Information Set (HEDIS), can provide important information to both the healthcare providers and the consumers. This chapter will discuss the evolution of managed care and why it developed, the different types of managed care, the MCO assessment measures used for cost control, issues regarding managed care, and how managed care has impacted the delivery of healthcare services.

New to Chapter: The data have been updated.

Chapter 10

The general term "informatics" refers to the science of computer application to data in different industries. Health or medical informatics is the science of computer application that supports clinical and research data in different areas of health care. It is a methodology of how the healthcare industry thinks about patients and how their treatments are defined and evolved. Health informatics is used in the healthcare industry in four ways: financial tracking to ensure that billing is appropriate, clinical compliance to ensure that patients are receiving appropriate care in a timely manner, quality improvement to assess patient health outcomes, and patient satisfaction. Health information systems are systems that store, transmit, collect, and retrieve these data. The goal of health information technology (HIT) is to manage the health data that can be used by patients–consumers, insurance companies, healthcare providers, healthcare administrators, and any stakeholder that has an interest in health care.

HIT impacts every aspect of the healthcare industry. All of the stakeholders in the healthcare industry use HIT. Information technology (IT) has had a tremendous impact on the healthcare industry because it allows faster documentation of every transaction. When an industry focuses on saving lives, it is important that every activity has a written document that describes the activity. Computerization of documentation has increased the management efficiency and accuracy of healthcare data. The main goal of HIT is the national implementation of an electronic patient record. This is the foundation of many IT systems because it will enable different systems to share patient information, which will increase the quality and efficiency of health care. This chapter will discuss the history of IT, different applications of IT health care, and the status of electronic health records and barriers for its national implementation.

The healthcare industry has lagged behind other industries utilizing IT as a form of communicating important data. Despite that fact, there have been specific applications developed for HIT, such as e-prescribing, telemedicine, ehealth, and specific applied technologies, such as the PatientPoint,

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MelaFind optical scanner, the Phreesia Pad, Sapien heart valve, robotic checkups, Accuson P10, and the Piccolo xpress, which were discussed in this chapter. Healthcare organizations have recognized the importance of IT and have hired CIOs and CTOs to manage their data. However, healthcare consumers need to embrace an electronic patient record, which is the basis for the Microsoft Health Vault. This will enable patients to be treated effectively and efficiently nationally. The patient health record can be integrated into the electronic health records that are being utilized nationwide. Having the ability to access a patient's health information could assist in reducing medical errors. As a consumer, utilizing a tool like HealthVault could provide an opportunity to consolidate all medical information electronically; so, if there are any medical problems, the information will be readily available. The major IT issue in health care is the need to establish the interoperability of electronic health records (EHRs) systems nationwide. Establishing health information exchanges (HIEs) and regional health information organizations (RHIOs) is the foundation of interoperability in a geographic area. This communication between systems will enable patients to be treated more quickly because there will be immediate access to their most current medical information. Although the federal government has indicated this communication between systems is necessary to ensure the full success of the EHR system, progress continues.

New to Chapter: All data have been updated, including meaningful use. Included is a discussion on mobile health, HIEs and RHIOs, Blockchain technology, and IBM Watson. Also expanded is the section on telemedicine.

Chapter 11

To be an effective healthcare manager, it is important to understand basic legal principles that influence the work environment, including the legal relationship between the organization and the consumer—the healthcare provider and the patient, and the employer and the employee. As both a healthcare manager and healthcare consumer, it is imperative that you are familiar with the different federal and state laws that impact the healthcare organization. It is also important that the managers understand the differences between civil and criminal law and the penalties that may be imposed for breaking those laws. Federal and state laws have been enacted and policies have been implemented to protect both the healthcare provider and the healthcare consumer. New laws have been passed and older laws have been amended to reflect needed changes regarding health care, to continue to protect participants from both a patient and an employee or employer perspective.

The basic concepts of law, both civil and criminal healthcare law, tort reform, employment-related legislation, safety in the workplace, and the legal relationship between the provider and the patient will be discussed in this chapter. I have included some examples of LGBT-related claims that U.S. Equal Employment Opportunity Commission (EEOC) views as unlawful sex discrimination.

New to chapter: All data have been updated. I expanded tort reform discussion and Emergency Medical Treatment and Active Labor Act (EMTALA) discussion. I included a definition of affirmative action plan and also an expansion of the Americans with Disabilities Act (ADA) definition. I updated the information on ACA legal issues.

Chapter 12

Legal standards are the minimal standard of action established for individuals in a society. Ethical standards are considered one level above a legal action because individuals make a choice based on what is the "right thing to do," not what is required by law. There are many interpretations of the concept of ethics. Ethics has been interpreted as the moral foundation for standards of conduct. The concept of ethical standards applies to actions that are hoped for and expected by individuals. Actions may be considered legal but not ethical. There are many definitions of ethics, but, basically, ethics is concerned with what are right and wrong choices as perceived by society and individuals.

The concept of ethics is tightly woven throughout the healthcare industry. It has dated back to Hippocrates, the father of medicine, in the fourth century BC, and evolved into the Hippocratic Oath, which is the foundation for the ethical guidelines for patient treatment by physicians. In 1847, the American Medical Association (AMA) published a *Code of Medical Ethics* that provided guidelines for the physician–provider relationship, emphasizing the duty to treat a patient. To this day, physicians' actions have followed the code of ethics that demands the "duty to treat."

Applying the concept of ethics to the healthcare industry has created two areas of ethics: medical ethics and bioethics. Medical ethics focuses on the decisions that healthcare providers make concerning medical treatment of patients. Euthanasia or physician-assisted

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suicide would be an example of a medical ethics topic. Advance directives are orders that patients give to providers to ensure that if they are terminally ill and incompetent to make a decision, certain measures will not be taken to prolong that patient's life. If advance directives are not provided, the ethical decision of when to withdraw treatment may be placed on the family and provider. These issues are legally defined, although there are ethical ramifications surrounding these decisions.

This chapter will focus primarily on bioethics. This field of study is concerned with the ethical implications of certain biologic and medical procedures and technologies, such as cloning; alternative reproductive methods, such as *in vitro* fertilization; organ transplants; genetic engineering; and care of the terminally ill. Additionally, the rapid advances in medicine in these areas raised questions about the influence of technology on the field of medicine.

It is important to understand the impact of ethics in different aspects of providing health care. Ethical dilemmas in health care are situations that test a provider's belief and what the provider should do professionally. Ethical dilemmas are often a conflict between personal and professional ethics. A healthcare ethical dilemma is a problem, situation, or opportunity that requires an individual, such as a healthcare provider, or an organization, such as a managed care practice, to choose an action that could be unethical. A decision-making model is presented that can help resolve ethical dilemmas in the healthcare field. This chapter will discuss ethical theories, codes of healthcare conduct, informed consent, confidentiality, special populations, research ethics, ethics in public health, end-of-life decisions, genetic testing and profiling, and biomedical ethics, which focuses on technology use and health care.

New to Chapter: All data have been updated. Workplace bullying is included in this chapter because of its violations of organizational ethics and their code of conducts.

Chapter 13

According to the World Health Organization, mental wellness or mental health is an integral and essential component of health. It is a state of well-being in which an individual can cope with normal stressors, can work productively, and is able to make a contribution to his or her community. Mental health behavioral disorders can be caused by biological, psychological, and personality factors. Approximately 75% of suicides occur in low- and middle-income countries and about half of mental disorders begin before the age of 14 (World Health Organization, 2018). Mental disorders are the leading cause of disability in the United States. Mental illnesses can impact individuals of any age, race, religion, or income. In 2016, nearly one in five adults live with a mental illness. There are two broad categories of mental illness: Any Mental Illness (AMI), which is a mental, behavioral, or emotional disorder, and All Mental Illness and Serious Mental Illness (SMI), which is also a mental, behavioral, or emotional disorder but it impacts the patients' manner of functioning in daily life. The prevalence of AMI is higher among women. Young adults (18–25 years) had the highest prevalence of AMI (22%) compared to those 50 years of age and older (14.5%). In 2016, 64.8% of adults with SMI received treatment. Mental health treatment is defined as inpatient or outpatient counseling or treatment with prescription medications. Although mental health is a disease that requires medical care, its characteristics set it apart from traditional medical care. U.S. Surgeon General David Satcher released a landmark report in 1999 on mental health and illness, *Mental Health: A Report of the Surgeon General*. The Surgeon General's report on mental health defines mental disorders as conditions that alter thinking processes, moods, or behavior and result in dysfunction or stress. The condition can be psychological or biological in nature. The most common conditions include phobias, which are excessive fear of objects or activities; substance abuse; and affective disorders, which are emotional states, such as depression. Severe mental illness includes schizophrenia, major depression, and psychosis. Obsessive-compulsive disorders (OCD), intellectual disabilities, Alzheimer's disease, and dementia are also considered mentally disabling conditions. According to the report, mental health ranks second to heart disease as a limitation on health and productivity (U.S. Public Health Service, 1999). People who have mental disorders often exhibit feelings of anxiety or may have hallucinations or feelings of sadness or fear that can limit normal functioning in their daily life. Because the causes or etiologies of mental health disorders are less defined and less understood compared to traditional medical problems, interventions are less developed than in other areas of medicine. This chapter will discuss the following topics: the history of the U.S. mental healthcare system, a background of healthcare professionals, mental healthcare law, insurance coverage for mental health, barriers to mental health care, the populations at risk for mental disorders, the types of mental health disorders as classified by the American Psychiatric Association's **Diagnostic and Statistical Manual**

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of Mental Disorders (DSM), liability issues associated with mental health care, an analysis of the mental healthcare system, and guidelines and recommendations to improve U.S. mental health care.

New to Chapter: All data have been updated. I included a section on B4Stage4, which is a proactive philosophy to treat mental health issues.

Chapter 14

The U.S. healthcare system continues to evolve. Technology will increase its impact on health care. Consumers have more information to make healthcare decisions because of health information technology. There are now opportunities to use mobile health devices to self-monitor, and access care via telemedicine and other virtual consultations. There are now drugstore clinics that operate nationally which provide an alternative to urgent care centers. Providers can provide more quality care from access to clinical decision support systems and the nationwide increase of patient EHR systems.

Long-term care needs will increase as we live longer. The Green House Project is an exciting initiative that may transform how long-term care will be implemented. As our population becomes grayer, more citizens will want to live as independently as possible for a longer period of time, and the Green House Project is an excellent template for achieving this goal.

All of these initiatives are exciting for the healthcare consumer. There are also now trained healthcare workers called patient navigators who provide assistance to patients regarding the healthcare system. This type of system provides an opportunity to increase the patient's health literacy.

The ACA has provided many incentives to improve the quality of and access to the U.S. healthcare system. The Center for Medicaid and Medicare Innovation has over 40 demonstration projects that focus on different types of financing models that are based on the performance of healthcare providers.

The discussion concerning different countries' healthcare systems indicates that all countries have problems with their healthcare systems. Establishing a universal healthcare system in the United States may not be the answer. There are aspects of each of these programs that could be integrated into the U.S. system. There are a surprising number of similarities. The major differences are in the area of the control the government places on pharmaceutical prices and health insurers. Some governments limit drug manufacturers' and insurers' profitability in order to increase healthcare access to their citizens. The main difference between Japan, Switzerland, France, and the United States is in the willingness of individuals to pay more, so that all citizens can receive health care. That collectivistic attitude does not prevail in the United States and would be difficult to institute. However, the mandates for both business and individuals to purchase health insurance coverage through the establishment of state health insurance marketplaces should improve the overall health of the United States.

This chapter will compare the U.S. healthcare system and the healthcare systems of other countries. This chapter will also discuss trends that impact the U.S. healthcare system, including the increased use of technology providing health care, complementary and alternative medicine use, new nursing home models, accountable care organizations, and the universal-healthcare-coverage programs in Massachusetts and San Francisco, California. The ACA will also be briefly discussed because of its major impact on the U.S. healthcare system.

New to Chapter: All data have been updated. There are new healthcare trends discussed. Discussions of cultural competency and cultural awareness is presented.

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CHAPTER 1

History and Overview of the U.S. Healthcare System

LEARNING OBJECTIVES

The student will be able to:

- Describe the five milestones of medicine and medical education, the hospital system, public health, and health insurance.
- Explain the differences between primary, secondary, tertiary, and quaternary prevention.
- Explain the concept of the iron triangle as it applies to health care.
- Discuss the importance of health literacy to health consumers.

DID YOU KNOW THAT?

- When the practice of medicine first began, tradesmen such as barbers practiced medicine. They often used the same razor to cut hair as to perform surgery.
- In 2017, the United States spent 17.9% of the gross domestic product on healthcare spending, which is the highest in the world.
- The United States is the only major country that does not have universal healthcare coverage.
- In 2002, the Joint Commission issued hospital standards requiring them to inform their patients if their results were not consistent with typical care results.

Introduction

It is important as healthcare consumers to understand the history of the U.S. healthcare delivery system, how it operates today, who participates in the system, what legal and ethical issues arise as a result of the system, and what problems continue to plague the healthcare system. We are all consumers of health care. Yet, in many instances, we are ignorant of what we are actually purchasing. If we were going to spend $1000 on an appliance or a flat-screen television, many of us would research the product to determine if what we

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are purchasing is the best product for us. This same concept should be applied to purchasing healthcare services.

Increasing healthcare consumer awareness will protect you in both the personal and the professional aspects of your life. You may decide to pursue a career in health care either as a provider or as an administrator. You may also decide to manage a business where you will have the responsibility of providing health care to your employees. And last, from a personal standpoint, you should have the knowledge from a consumer point of view, so you can make informed decisions about what matters most—your health. The federal government agrees with this philosophy.

As the U.S. population's life expectancy continues to lengthen—increasing the **"graying" of the population**—the United States will be confronted with more chronic health issues because, as we age, more chronic health conditions develop. The U.S. healthcare system is one of the most expensive systems in the world. According to 2017 statistics, the United States spent $3.3 trillion or $10,328 per person on healthcare expenditures or 17.9% of its gross domestic product. The **gross domestic product (GDP)** is the total finished products or services that are produced in a country within a year. These statistics mean that nearly 18% of all of the products made within the borders of the United States within a year are health care related. In 2016, health expenditures for hospital care were 32.4%, for nursing care and continuing care retirement communities 4.9%, for physician and clinical services 19.9%, and for prescription medications 9.8% (CDC, 2019). The **Patient Protection and Affordable Care Act of 2010 (PPACA)**, more commonly called the **Affordable Care Act (ACA)**, attempted to increase access to affordable health care. One of the mandates of the Act is the establishment of electronic health insurance marketplaces, which provides opportunities for consumers to search for affordable health insurance plans. There is also a mandate that individuals who do not have health insurance can purchase a health insurance plan if they can afford it or pay a fine. Both of these mandates have decreased the number of uninsured in the United States. However, with the change in administration and the recent federal judge ruling that the individual mandate of the ACA is not constitutional, it is unclear what impact these events will have on the ACA and ultimately healthcare coverage nationally.

According to the U.S. Census Bureau 2017 estimates, the national health insurance uninsured rate is nearly 29 million people or 8.8% of the population. These rates vary by states and are impacted by whether the state has expanded their Medicaid programs coverage. Texas and Oklahoma have the highest uninsured rates, with Massachusetts having the lowest uninsured rate. Hawaii, Iowa, Rhode Island, Vermont, and Minnesota have rates under 5%. In general, these rates have been attributed to the insurance mandate of the ACA. Between 2010 and 2018, the uninsured rate dropped from 16% to 8.8% of the U.S. population (Keith, 2018). The Institute of Medicine's (IOM) (1999), now National Academy of Medicine (NAM), report indicated that between 44,000 and 100,000 citizens die each year as a result of medical errors in U.S. hospitals. These data have received scrutiny over the past decades; some research studies indicate a higher rate and other studies indicate a lower rate (Shojania & Woods, 2017). One death due to a medical error is one too many.

Although U.S. healthcare costs are very high, the United States does not offer healthcare coverage as a right of citizenship. The United States is the only major country that does not offer a **universal healthcare program**, which means access to all citizens. Many of these systems are typically run by the federal government, have centralized health policy agencies, and are financed through different forms of taxation, and payment of healthcare services is by a single payer—the government (Shi & Singh, 2019). France and the United Kingdom have been discussed as possible models for the United States to follow to improve access to health care, but these programs have problems and may not be the ultimate solution for the United States. However, because the United States does not offer any type of universal healthcare coverage, many citizens who are not eligible for government-sponsored programs are expected to provide the service for themselves by purchasing health insurance or the actual health services that are considered out-of-pocket expenses. Many citizens cannot afford these options, resulting in not going to a healthcare provider for routine medical care. The ACA's health insurance marketplaces provide cost and service data, so consumers can determine what is the best healthcare insurance to purchase and what services they will receive for that purchase. Recently, the **Centers for Medicare and Medicaid Services (CMS)** used its claim data to publish the hospital costs of the 100 most common treatments nationwide. The purpose of this effort is to provide data to consumers regarding healthcare costs because the costs vary considerably across the United States. This effort may also encourage pricing competition of healthcare services. The U.S. Department of Health and Human Services provides funding to states to increase their healthcare pricing transparency (Bird, 2013).

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Consumer Perspective on Health Care

What Is Health?

The World Health Organization (WHO) defines **health** as the state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity (WHO, 1942). IOM defines health as a state of well-being and the capability to function in the face of changing circumstances. It is a positive concept emphasizing social and personal resources as well as physical capabilities (IOM, 1997). According to the Society for Academic Emergency Medicine (SAEM), health is a state of physical and mental well-being that facilitates the achievement of individual and societal goals (SAEM, 1992). The Robert Wood Johnson Foundation's definition focuses on longevity and quality of life. They believe that being healthy provides an opportunity for everyone to strive and thrive (What is health, 2018). All of these definitions focus on the impact an individual's health status has on his or her quality of life.

What Is Health Literacy?

Title V of the ACA defines **health literacy** as the degree to which an individual has the ability to obtain and absorb basic health information to make the best health decision for themselves (CDC, 2019). Individual health literacy is impacted by culture, the complexity of the health system, the ability of the health consumer to navigate these systems, and communication by the healthcare providers. It is important that healthcare professionals, both medical and public health, clearly communicate to their patients what they need to accomplish to be healthy by increasing their health literacy levels (Health literacy basics, 2019). In 2010, the Department of Health and Human Services created a National Action Plan to Improve Health Literacy. The plan is based on the principles that (1) everyone has the right to health information that helps them make informed decisions and (2) health services should be delivered in ways that are understandable and beneficial to health, longevity, and quality of life. The plan targets both the health consumers as well as healthcare organizations and healthcare providers to ensure that the healthcare message is clear to their consumers (DHHS, 2019).

Determinants of Health

Health has several determinants or influences that impact the status of an individual's health. The individual lifestyle factors, such as exercise, diet, and sexual activity, are direct determinants of a person's health. Within the immediate environment of an individual, there are social and community networks—external influences on health. In addition to the **social and community networks**, there are general **macroenvironmental conditions** of socioeconomic, cultural, and environmental conditions that impact health, such as education, work environment, living and working conditions, healthcare services, food production, job status, water and sanitation, and housing. These determinants of health can result in **health disparities** if these conditions are not optimal, such as safe housing and work environment or educational opportunities, which are disadvantages to achieving optimal health. When conditions exist for everyone to have a fair opportunity to be as healthy as possible, **health equity** exists. Health equity is the result of removing restrictions, such as poverty and discrimination, and providing a healthy environment, quality education, and access to health care (What is health, 2018). These **determinants of health** tie into the activities of the U.S. healthcare delivery system which can impact an individual's health. These activities are often categorized as primary, secondary, tertiary, and quaternary prevention (Determinants of Health, 2019). These concepts are vital to understanding the U.S. healthcare system because different components of the healthcare system focus on different areas of health, which often results in lack of coordination between these different components.

Primary, Secondary, Tertiary, and Quaternary Prevention

According to the *American Heritage Dictionary* (2001), prevention is defined as "slowing down or stopping the course of an event." **Primary prevention** avoids the development of a disease. Promotion activities, such as health education, are primary prevention. Other examples include smoking cessation programs, immunization programs, and educational programs for pregnancy and employee safety. State health departments often develop targeted, large education campaigns regarding a specific health issue in their area. **Secondary prevention** activities focus on early disease detection, which prevents progression of the disease. Screening programs, such as high blood pressure testing, are examples of secondary prevention activities. Colonoscopies and mammograms are also examples of secondary prevention activities. Many local health departments implement secondary prevention activities. Tertiary prevention reduces the impact of an already established disease by minimizing disease-related complications. **Tertiary prevention** focuses on rehabilitation and monitoring of diseased individuals. A person with high blood pressure who

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is taking blood pressure medication is an example of tertiary prevention. A physician who writes a prescription for that blood pressure medication to control high blood pressure is an example of tertiary prevention. **Quaternary prevention**, a recent concept, focuses on mitigating unnecessary efforts on interventions that do not work and providing care that is medically acceptable (Less is more medicine, 2019). Traditional medicine focuses on tertiary prevention, although more primary care providers are encouraging and educating their patients on healthy behaviors, which falls under primary and secondary prevention (Centers for Disease Control and Prevention [CDC], 2007).

We, as healthcare consumers, would like to receive primary prevention to prevent disease. We would like to participate in secondary prevention activities, such as screening for cholesterol or blood pressure, because it helps us manage any health problems we may be experiencing and reduces the potential impact of a disease. And, we would like to also visit our physicians for tertiary and/or quaternary measures for evaluative purposes, so, if we do have a disease, it can be managed by taking a prescribed medication or receiving some other type of treatment. From our perspective, these four areas of health should be better coordinated for the healthcare consumer, so the United States will have a healthier population.

In order to understand the current healthcare delivery system and its issues, it is important to learn the history of the development of the U.S. healthcare system. Four major sectors of our healthcare system that have impacted our current system of operations will be discussed in this chapter: (1) the history of practicing medicine and the development of medical education, (2) the development of the hospital system, (3) the history of **public health**, and (4) the history of health insurance. In **TABLES 1-1–1-5**, several important milestones are listed by date and illustrate the historic highlights of each system component. The list is by no means exhaustive but provides an introduction to how each sector has evolved as part of the U.S. healthcare system.

TABLE 1-1 Milestones of Medicine and Medical Education, 1700–2015

- 1700s: Training and apprenticeship under one physician was common until hospitals were founded in the mid-1700s. In 1765, the first medical school was established at the University of Pennsylvania.
- 1800s: Medical training was provided through internships with existing physicians who often were poorly trained themselves. In the United States, there were only four medical schools, which graduated only a handful of students. There were no formal tuition and no mandatory testing.
- 1847: The American Medical Association (AMA) was established as a membership organization for physicians. It did not become significant and effective until the 1900s when it organized its physician members by county and state medical societies. The AMA wanted to ensure that these local societies were protecting physicians' financial well-being. It also began to focus on standardizing the medical education curricula.
- 1900s–1930s: The medical profession was represented by general or family practitioners who operated in solo practices. A small percentage of physicians were women. Total expenditures for medical care were less than 4% of the GDP.
- 1904: The AMA created the Council on Medical Education to establish standards for medical education.
- 1910: Formal medical education was attributed to Abraham Flexner, who wrote an evaluation of medical schools in the United States and Canada, indicating that many schools were substandard. The Flexner Report led to standardized admissions testing for students called the Medical College Admission Test (MCAT), which is still used as part of the admissions process today.
- 1930s: The healthcare industry was dominated by male physicians and hospitals. Relationships between patients and physicians were sacred. Payments for physician care were personal (out of pocket).
- 1940s–1960s: When group health insurance was offered, the relationship between patient and physician changed because of third-party payers (insurance). In the 1950s, federal grants supported medical school operations and teaching hospitals. In the 1960s, the Regional Medical Programs provided research grants and emphasized service innovation and provider networking. As a result of the Medicare and Medicaid enactment in 1965, the responsibilities of teaching faculty also included clinical responsibilities.

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- 1970s–1990s: Patient care dollars surpassed research dollars as the largest source of medical school funding. During the 1980s, third-party payers reimbursed academic medical centers with no restrictions. In the 1990s with the advent of managed care, reimbursement was restricted.
- 2016: The AMA collaborated with medical schools nationally to advance medical school curricula by creating innovative courses.
- 2017: As a result of the opioid epidemic, medical schools are actively developing curricula that specifically teach ways to manage patient pain management.

TABLE 1-2 Milestones of Nursing Education

1798: A New York physician developed lectures for nursing education for maternity patients.
1854: Florence Nightingale, a British nurse, established the Nightingale Principles for nursing education for British nurses.
1861–Civil War: 20,000 nurses provided care, which encouraged more nursing education programs.
1869: The first nursing class graduated from the Women's Hospital of Pennsylvania school.
1873: Three nursing programs in New York, Massachusetts, and Connecticut based on the Nightingale Principles began operations and became the foundation of nursing education in the United States.
1890s: Nurses organized professional associations, which later became the American Nurses Association. State nursing associations organized licensing systems.
1914: World War I: 23,000 nurses provided care. There was critical demand for specialty nurses.
1920–1930s: As more hospitals were built, nurses were relied on to provide patient care.
1939: World War II: 78,000 nurses continued to provide care.
1948: The Carnegie Foundation's The Brown Report recommended that nursing schools be placed in academic settings rather than hospitals.
1960: 172 college-based nursing programs were operating.
1970s: Nurse Practice Act allowed nurses to diagnose and prescribe medication.
1990: The Department of Health and Human Services studied the nursing shortage.
2003–2008: Studies indicated patient outcomes improved when nursing staff held a Bachelor of Science in Nursing (BSN).
2010: The IOM issued a report called "The Future of Nursing," indicating that 80% of the nursing workforce should hold a BSN and should be leaders in health care.
2012: Many employers were providing incentives for nurses to return to school to receive their BSN.
2014: In response to the IOM report, the *Nurses on Boards Coalition* was created to assist nurses in becoming pivotal leaders in the healthcare industry.

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TABLE 1-3 Milestones of the Hospital and Healthcare Systems, 1820–2016

- 1820s: Almshouses or poorhouses, the precursor of hospitals, were developed to serve primarily poor people. They provided food and shelter to the poor and consequently treated the ill. Pesthouses, operated by local governments, were used to quarantine people who had contagious diseases, such as cholera. The first hospitals were built around areas such as New York City, Philadelphia, and Boston, and were used often as a refuge for the poor. Dispensaries or pharmacies were established to provide free care to those who could not afford to pay and dispense medications to ambulatory patients.
- 1850s: A hospital system was finally developed but hospital conditions were deplorable because of unskilled providers. Hospitals were owned primarily by the physicians who practiced in them.
- 1890s: Patients went to hospitals because they had no choice. More cohesiveness developed among providers because they had to rely on each other for referrals and access to hospitals, which gave them more professional power.
- 1920s: The development of medical technological advances increased the quality of medical training and specialization and the economic development of the United States. The establishment of hospitals became the symbol of the institutionalization of health care. In 1929, President Coolidge signed the Narcotic Control Act, which provided funding for the construction of hospitals for patients with drug addictions.
- 1930s–1940s: Once physician-owned hospitals were now owned by church groups, larger facilities, and local, state, and federal government.
- 1970–1980: The first Patient Bill of Rights was introduced to protect healthcare consumer representation in hospital care. In 1974, the National Health Planning and Resources Development Act required states to have certificate of need (CON) laws to qualify for federal funding.
- 1980–1990: According to the American Hospital Association (AHA), 87% of hospitals were offering ambulatory surgery. In 1985, the Emergency Medical Treatment and Active Labor Act (EMTALA) was enacted, which required hospitals to screen and stabilize individuals coming into emergency rooms, regardless of the consumers' ability to pay.
- 1990–2000s: As a result of the Balanced Budget Act cuts of 1997, the federal government authorized an outpatient Medicare reimbursement system.
- 1996: The medical specialty of hospitalists, who provide care once a patient is hospitalized, was created.
- 2002: The Joint Commission on the Accreditation of Healthcare Organizations (now The Joint Commission) issued standards to increase consumer awareness by requiring hospitals to inform patients if their healthcare results were not consistent with typical results.
- 2002: The CMS partnered with the Agency for Healthcare Research and Quality (AHRQ) to develop and test the HCAHPS (Hospital Consumer Assessment of Healthcare, Providers and Systems Survey). Also known as the CAHPS survey, the HCAHPS is a 32-item survey for measuring patients' perception of their hospital experience.
- 2007: The Institute for Health Improvement launched the Triple Aim, which focuses on three goals: improving patient satisfaction, reducing health costs, and improving public health.
- 2011: In 1974, a federal law was passed that required all states to have CON laws to ensure the state approved any capital expenditures associated with the construction and expansion of hospitals and medical facilities. The act was repealed in 1987, but as of 2014, 35 states still have some type of CON mechanism.
- 2011: The ACA created the Centers for Medicare and Medicaid Services' Innovation Center for the purpose of testing "innovative payment and service delivery models to reduce program expenditures … while preserving or enhancing the quality of care" for those individuals who receive Medicare, Medicaid, or Children's Health Insurance Program (CHIP) benefits.
- 2015: The Centers for Medicare and Medicaid Services posted its final rule that reduces Medicare payments to hospitals that have exceeded readmission limits of Medicare patients within 30 days.
- 2017: The American Hospital Association and its members have developed a Hospitals Against Violence initiative that targets youth and workplace violence, and human trafficking.

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TABLE 1-4 Milestones in Public Health, 1700–2015

- 1700–1800: The United States was experiencing strong industrial growth. Long work hours in unsanitary conditions resulted in massive disease outbreaks. U.S. public health practices targeted reducing **epidemics** or large patterns of disease in a population. Some of the first public health departments were established in urban areas as a result of these epidemics.
- 1800–1900: Three very important events occurred. In 1842, Britain's Edwin Chadwick produced the Report on the Sanitary Conditions of the Labouring Population of Great Britain, which is considered one of the most important documents of public health. This report stimulated a similar U.S. survey. In 1854, Britain's John Snow performed an analysis that determined contaminated water in London was the cause of a cholera epidemic. This discovery established a link between the environment and disease. In 1850, Lemuel Shattuck, based on Chadwick's report and Snow's activities, developed a state public health law that became the foundation for public health activities.
- 1900–1950: In 1920, Charles Winslow defined public health as a focus of preventing disease, prolonging life, and promoting physical health and efficiency through organized community efforts.
- During this period, most states had public health departments that focused on sanitary inspections, disease control, and health education. Throughout the years, **public health functions** included child immunization programs, health screenings in schools, community health services, substance abuse programs, and sexually transmitted disease control.
- In 1923, a vaccine for diphtheria and whooping cough was developed. In 1928, Alexander Fleming discovered penicillin. In 1946, the **National Mental Health Act (NMHA)** provided funding for research, prevention, and treatment of mental illness.
- 1950–1980: In 1950, cigarette smoke was identified as a cause of lung cancer.
- In 1952, Dr. Jonas Salk developed the polio vaccine.
- The **Poison Prevention Packaging Act of 1970** was enacted to prevent children from accidentally ingesting substances. Childproof caps were developed for use on all medications. In 1980, the eradication of smallpox was announced.
- 1980–1990: The first recognized cases of AIDS occurred in the United States in the early 1980s.
- 1988: The IOM Report defined *public health* as organized community efforts to address the public interest in health by applying scientific and technical knowledge and to promote health. The first Healthy People Report (1987) was published and recommended it as a national prevention strategy.
- 1990–2000: In 1997, Oregon voters approved a referendum that allowed physicians to assist terminally ill, mentally competent patients to commit suicide. From 1998 to 2006, 292 patients exercised their rights under the law.
- 2000s: The second Healthy People Report was published in 2000. The terrorist attack on the United States on September 11, 2001 impacted and expanded the role of public health. The Public Health Security and Bioterrorism Preparedness and Response Act of 2002 provided grants to hospitals and public health organizations to prepare for bioterrorism as a result of September 11, 2001.
- 2010: The ACA was passed. Its major goal was to improve the nation's public health level. The third Healthy People Report was published.
- 2015: There has been a nationwide increase of children who have not received vaccines due to parents' beliefs that vaccines unsafe. As a result, there have been measles outbreaks throughout the nation even though measles was considered eradicated decades ago.
- 2017: The Center for Disease Control and Prevention received $475 million for opioid overdose prevention to support state efforts.

Milestones of Medicine and Medical Education

The early practice of medicine did not require a major course of study, training, board examinations, and licensing, as is required today. During this period, anyone who had the inclination to set up a physician practice could do so; oftentimes, clergy were also medical providers, as were tradesmen, such as barbers. The red and white striped poles outside barber

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TABLE 1-5 Milestones of the U.S. Health Insurance System, 1800–2015

- 1800–1900: Insurance was purchased by individuals in the same way one would purchase car insurance. In 1847, the Massachusetts Health Insurance Co. of Boston was the first insurer to issue "sickness insurance." In 1853, a French mutual aid society established a prepaid hospital care plan in San Francisco, California. This plan resembles the modern health maintenance organization (HMO).
- 1900–1920: In 1913, the International Ladies Garment Workers began the first union-provided medical services. The National Convention of Insurance Commissioners drafted the first model for regulation of the health insurance industry.
- 1920s: The blueprint for health insurance was established in 1929 when J. F. Kimball began a hospital insurance plan for schoolteachers at Baylor University Hospital in Texas. This initiative became the model for Blue Cross plans nationally. The Blue Cross plans were nonprofit and covered only hospital charges so as not to infringe on private physicians' income.
- 1930s: There were discussions regarding the development of a national health insurance program. However, the AMA opposed the move (Raffel & Raffel, 1994). With the Depression and U.S. participation in World War II, funding required for this type of program was not available. In 1935, President Roosevelt signed the **Social Security Act (SSA)**, which created "old age insurance" to help those of retirement age. In 1936, Vassar College, in New York, was the first college to establish a medical insurance group policy for students.
- 1940s–1950s: The War Labor Board froze wages, forcing employers to offer health insurance to attract potential employees. In 1947, the Blue Cross Commission was established to create a national network of doctors. By 1950, 57% of the population had hospital insurance.
- 1965: President Johnson signed the Medicare and Medicaid programs into law.
- 1970s–1980s: President Nixon signed the HMO Act, which was the predecessor of managed care. In 1982, Medicare proposed paying for hospice or end-of-life care. In 1982, diagnosis-related groups (DRGs) and prospective-payment guidelines were developed to control insurance reimbursement costs. In 1985, the Consolidated Omnibus Budget Reconciliation Act (COBRA) required employers to offer partially subsidized health coverage to terminated employees.
- 1990–2000: President Clinton's Health Security Act proposed a universal healthcare coverage plan, which was never passed. In 1993, the **Family Medical Leave Act (FMLA)** was enacted, which allowed employees up to 12 weeks of unpaid leave because of family illness. In 1996, the Health Insurance Portability and Accountability Act (HIPAA) was enacted, making it easier to carry health insurance when changing employment. It also increased the confidentiality of patient information. In 1997, the Balanced Budget Act (BBA) was enacted to control the growth of Medicare spending. It also established the State Children's Health Insurance Program (SCHIP).
- 2000: The SCHIP, now known as the Children's Health Insurance Program (CHIP), was implemented.
- 2000: The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act provided some relief from the BBA by providing across-the-board program increases.
- 2003: The Medicare Prescription Drug, Improvement, and Modernization Act was passed, which created Medicare Part D prescription plans for the elderly.
- 2006: Massachusetts mandated that all state residents have health insurance by 2009.
- 2009: President Obama signed the **American Recovery and Reinvestment Act (ARRA)**, which protected health coverage for the unemployed by providing a 65% subsidy for COBRA coverage to make the premiums more affordable.
- 2010: The ACA was signed into law, making it illegal for insurance companies to rescind insurance on their sick beneficiaries. Consumers can also appeal coverage claim denials by the insurance companies.

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- 2013: As of October 1, 2013, individuals could buy qualified health benefits plans from the Health Insurance Marketplaces. If an employer does not offer insurance, effective 2015, consumers can purchase it from the federal Health Insurance Marketplace. The federal government provided states with funding to expand their Medicaid programs to increase preventive services.
- 2015: The CMS posted its final rule that reduces Medicare payments to hospitals that readmit Medicare patients within 30 days after discharge. This rule is an attempt to focus hospital initiatives on quality care.
- 2018: On November 1, 2018, CMS finalized its rule for the 2019 Physician Fee Schedule and the Quality Payment Program, which will promote access to telemedicine services.
- In 2018, a federal judge ruled that the ACA's individual mandate to purchase health insurance is unconstitutional.

shops represented blood and bandages because the barbers were often also surgeons. They used the same blades to cut hair and perform surgery (Starr, 1982). Because there were no restrictions, competition was intense. In most cases, physicians did not possess any technical expertise; they relied mainly on common sense to make diagnoses (Stevens, 1971). During this period, there was no health insurance, so consumers decided when they would visit a physician and paid for their visits out of their own pockets. Often, physicians treated their patients in the patients' homes. During the late 1800s, the medical profession became more cohesive as more technically advanced services were delivered to patients. The establishment of the **American Medical Association (AMA)** in 1847 as a professional membership organization for physicians was a driving force for the concept of private practice in medicine. The AMA was also responsible for standardizing medical education. In working with the American Medical Association of Colleges, medical schools are developing curricula that focuses on managing patient pain management issues (AMA, 2019a; Goodman & Musgrave, 1992).

In the early history of medical education, physicians gradually established large numbers of medical schools because they were inexpensive to operate, increased their prestige, and enhanced their income. Medical schools only required four or more physicians, a classroom, some discussion rooms, and legal authority to confer degrees. Physicians received the students' tuitions directly and operated the school from this influx of money. Many physicians would affiliate with established colleges to confer degrees. Because there were no entry restrictions, as more students entered medical schools, the existing internship program with physicians was dissolved and the Doctor of Medicine (MD) became the standard (Vault Career Intelligence, 2019). Although there were major issues with the quality of education provided because of the lack of educational requirements, medical school education became the gold standard for practicing medicine (Sultz & Young, 2006). In 1910, the publication of the **Flexner Report**, which evaluated medical schools in Canada and the United States, was responsible for forcing medical schools to develop curricula and admission testing. These standards are still in existence today.

When the Medicare and Medicaid programs were enacted in 1965, Congress recognized that the federal government needed to support medical education, which resulted in ongoing federal funding to teaching hospitals to maintain medical resident programs. The responsibilities of teaching now included clinical duties. During the 1970s–1990s, patient care dollars exceeded research funding as the largest source of medical school support. Academic medical centers would be reimbursed without question by third-party payers. However, with the advent of managed care in the 1990s, reimbursement restrictions were implemented (Rich et al., 2002). With the passage of the ACA, which increased the need for primary care providers, more medical schools are focusing on primary care curriculum initiatives (AAMAC, 2016). The AMA has been collaborating with medical schools nationwide to advance medical school curricula by creating innovative courses that include technology, a discussion of health reform, healthcare systems thinking and ways to address patient pain management (AMA, 2019c).

Milestones of Medicine and Nursing Education

According to *A Timeline of Nursing Education* (2016), formal nursing education is approximately 150 years old. In the mid-1800s, physicians trained women to perform menial tasks for them. Because nurses held a

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low position in society, most of the sick were cared for by family members. However, in 1854, Florence Nightingale, the mother of Nursing, a British nurse, established the Nightingale Principles, which was the foundation for nursing education. In 1860, the Nightingale Training School for Nurses was started in England and became known as the reason modern nursing exists today. During the Civil War (1861) and World Wars I and II, thousands of nurses provided critical care, which encouraged the development of more nursing education programs. In 1873, based on the Nightingale Principles, three nursing programs were established in Massachusetts, New York, and Connecticut hospitals. There continued to be recommendations that nursing education should be college based.

By 1900, there were 400 hospital-based nursing programs. Unfortunately, there was no standardization of the programs. Finally, in 1909, a college-based nursing program was established in Minnesota, which awarded the first baccalaureate program. The 1923 Goldman Report and the 1948 Brown Report indicated the need for standardization of nursing programs and their placement in a university setting. This is similar to the Flexner Report recommendations for medical school standardization for physicians. By 1960, there were 172 college-based nursing programs, which included both community college and 4-year programs. Currently, the associate degree in Nursing is typically offered by community colleges. Many of those students continue their education to receive a BSN degree to increase their career choices (Niles, 2019).

With the passage of the Nurse Practice Act of 1964, which allowed nurses to diagnose and prescribe medications, the role of nurses in society continued to elevate. However, there continued to be recommendations that nurses should be trained to receive a BSN. Studies from 2003 to 2008 indicated that patient outcomes were more positive when a BSN-trained nurse was involved in their care. These recommendations continue to be relevant in 2019. Many employers prefer BSN-trained nurses. The Nurses on Board Coalition was created in 2014 as a result of the IOM report that indicated more nurses should be leaders with pivotal decision-making opportunities. This Coalition assists in placing nurses in leadership positions (Nurses on Boards Coalition, 2019).

Milestones of the Hospital System

In the early 19th century, **almshouses** or **poorhouses** were established to serve the indigent. They provided shelter while treating illness. Government-operated **pesthouses** segregated people who might otherwise spread their diseases. The framework of these institutions set up the conception of the hospital. Initially, wealthy people did not want to go to hospitals because the conditions were deplorable and the providers were not skilled, so hospitals, which were first built in urban areas, were used by the poor. During this period, many of the hospitals were owned by the physicians who practiced in them (Rosen, 1983).

In the early 20th century, with the establishment of a more standardized medical education, hospitals became more accepted across socioeconomic classes and became the symbol of medicine. With the establishment of the AMA, which protected the interests of providers, the physicians' reputation increased. During the 1930s and 1940s, the ownership of the hospitals changed from physician owned to church related and government operated (Starr, 1982).

In 1973, the first **Patient Bill of Rights** was established to protect healthcare consumers in hospitals. In 1974, a federal law was passed that required all states to have **certificate of need (CON)** laws to ensure the state-approved capital expenditures associated with hospital and medical facility construction and expansion. The Act was repealed in 1987, but as of 2016, over 35 states still have some type of CON mechanism (National Conference of State Legislatures [NCSL], 2018). The concept of CON was important because it encouraged state planning to ensure their medical system was based on need. In 1985, the **Emergency Medical Treatment and Active Labor Act (EMTALA)** was enacted to ensure that consumers were not refused emergency treatment. During this period, inpatient hospital use was typical; however, by the 1980s, many hospitals were offering outpatient or ambulatory surgery that continues into the 21st century. The BBA of 1997 authorized outpatient Medicare reimbursement to support these cost-saving measures. **Hospitalists**, created in 1996, are providers who focus exclusively on the care of patients when they are hospitalized. Creation of this new type of provider recognized the need of providing quality hospital care (American Hospital Association [AHA], 2016; Sultz & Young, 2006). In 2002, the Joint Commission on the Accreditation of Healthcare Organizations (now **The Joint Commission**) issued standards to increase consumer awareness by requiring hospitals to inform patients if their outcomes were not consistent with typical results (AHA, 2013). The CMS partnered with the AHRQ to develop and test the HCAHPS (also known as the CAHPS survey). The HCAHPS is a 32-item survey for measuring patients' perception of their hospital experience. In May 2005, the National

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Quality Forum (NQF), an organization established to standardize healthcare quality measurement and reporting, formally endorsed the CAHPS® Hospital Survey. The NQF endorsement represents the consensus of many healthcare providers, consumer groups, professional associations, purchasers, federal agencies, and research and quality organizations. Since 2008, it has been nationally recognized as a standardized measurement for hospital comparisons (HCAHPS Fact Sheet, 2018).

In 2007, the Institute for Health Improvement launched the **Triple Aim**, which focused on the three goals of patient satisfaction, improving public health, and reducing healthcare costs (American Hospital Association, 2015).

In 2011, the ACA created the Centers for Medicare and Medicaid (CMS) Innovation Center for the purpose of developing innovative care and payment models. Section 3025 of the ACA required the establishment of a Hospital Readmissions Reduction Program (HRPP). In 2015, the CMS also posted its final rule that reduces Medicare payments to hospitals that readmit Medicare patients within 30 days. This rule is an attempt to focus hospital initiatives on quality care (Rau, 2015). As a result of this rule, many hospitals are focusing on the concept of quality improvement processes and performance-driven planning to ensure that these readmissions do not occur. In addition to this quality performance program, effective 2019, the 21st Century Cures Act requires CMS to assess penalties on hospitals if their performance is not consistent with other hospitals that treat patients who are both Medicaid and Medicare eligible. In 2017, The American Hospital Association and its members have developed a Hospitals Against Violence initiative that targets youth and workplace violence, and human trafficking (AHA, 2019).

Hospitals are the foundation of our healthcare system. As our health insurance system evolved, the first type of health insurance was hospital insurance. As society's health needs increased, expansion of different medical facilities increased. There was more focus on ambulatory or outpatient services because first, we, as consumers, prefer outpatient services; and second, it is more cost effective. Although hospitals are still an integral part of our healthcare delivery system, the method of their delivery has changed. More hospitals have recognized the trend of outpatient services and have integrated those types of services in their delivery.

Milestones of Public Health

The development of public health is noteworthy because the process was separate from the development of private medical practices. Physicians were worried that government health departments could regulate how they practiced medicine, which could limit their income. Public health specialists also approached health from a collectivistic and preventive care viewpoint—to protect as many people as possible from health problems and to provide strategies to prevent health problems from occurring. Private practitioners held an individualistic viewpoint—citizens more often would be paying for physician services from their health insurance or from their own pockets and physicians would be providing them guidance on how to cure their diseases, not prevent them. The two contrasting viewpoints still exist today, but there have been efforts to coordinate and collaborate on additional traditional and public health activities.

From the 1700s to the 1800s, the concept of public health was born. In their reports, Edwin Chadwick, Dr. John Snow, and Lemuel Shattuck demonstrated a relationship between the environment and disease (Chadwick, 1842; Turnock, 1997). As a result of their work, public health laws were enacted and, by the 1900s, public health departments were focused on the environment and its relationship to disease outbreaks.

Disease control and health education were also integral components of public health departments. In 1916, the Johns Hopkins University, one of the most prestigious universities in the world, established the first public health school (Duke University Library, 2019). Winslow's definition of public health focuses on the prevention of disease, while the IOM defines public health as the organized community effort to protect the public by applying scientific knowledge (IOM, 1988; Winslow, 1920). These definitions are exemplified by the development of several vaccines for whooping cough, polio, smallpox, diphtheria, and the discovery of penicillin. All of these efforts focus on the protection of the public from disease.

The three most important public health achievements are (1) the recognition by the U.S. Surgeon General that tobacco use is a health hazard, (2) the development of many vaccines that have eradicated some diseases and controlled the number of childhood diseases that exist, and (3) the development of early detection programs for high blood pressure and heart attacks as well as smoking cessation programs, which have dramatically reduced the number of deaths in this country (Shi & Johnson, 2014).

Assessment, policy development, and assurance—core functions of public health—were developed based on the 1988 report, *The Future of Public Health*, which indicated that there was an attrition of public health activities in protecting the community (IOM, 1988). There were poor collaboration between public

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health and private medicine, no strong mission statement, weak leadership, and politicized decision-making. **Assessment** was recommended because it focused on the systematic continuous data collection of health issues, which would ensure that public health agencies were vigilant in protecting the public (IOM, 1988; Turnock, 1997). **Policy development** should also include planning at all health levels, not just federally. Federal agencies should support local health planning (IOM, 1988). **Assurance** focuses on evaluating any processes that have been put in place to ensure that the programs are being implemented appropriately. These core functions will ensure that public health remains focused on the community, has programs in place that are effective, and has an evaluation process in place to ensure that the programs do work (Turnock, 1997).

The **Healthy People 2000** report, which started in 1987, was created to implement a new national prevention strategy with three goals: increase life expectancy, reduce health disparities, and increase access to preventive services. Also, three categories of health promotion, health prevention, and preventive services were identified, and surveillance activities were emphasized. *Healthy People 2000* provided a vision to reduce preventable disabilities and death. Target objectives were set to measure progress (CDC, 2019).

The **Healthy People 2010** report was released in 2000. The report contained a health promotion and disease prevention focus to identify preventable threats to public health and to set goals to reduce the threats. Nearly 500 objectives within 28 focus areas were developed. Focus areas ranged from access to care, food safety, education, and environmental health, to tobacco and substance abuse. An important component of *Healthy People 2010* is the development of an infrastructure to ensure public health services are provided. Infrastructure includes skilled labor, information technology, organizations, and research. In 2010, **Healthy People 2020** was released. It contains 1200 objectives that focus on 42 topic areas. According to the **Centers for Disease Control and Prevention (CDC)**, a smaller set of *Healthy People 2020* objectives, called leading health indicators (LHIs), have been targeted to communicate high-priority health issues. The goals are to attain high-quality, longer lives free of preventable disease, disability, injury, and premature death; achieve health equity, eliminate disparities, and improve the health of all groups; create social and physical environments that promote good health for all; and promote quality of life, healthy development, and healthy behaviors across all life stages. There are several new topic areas, including dementias, blood disorders, and blood safety, health-related quality of life, sleep health, healthcare-associated infections, and lesbian, gay, bisexual, and transgender health. The CDC is currently planning for *Healthy Report 2030* (CDC, 2019; Healthy People Reports 2020, 2019). The goals for all of these reports are consistent with the definitions of public health in both Winslow's and the IOM's reports. It is important to mention the impact on the scope of public health responsibilities of the terrorist attack on the United States on September 11, 2001; the anthrax attacks; the outbreak of global diseases, such as severe acute respiratory syndrome (SARS); Ebola; the Zika virus; and the U.S. natural disaster of Hurricane Katrina. As a result of these major events, public health has expanded its area of responsibility. The terms "bioterrorism" and "disaster preparedness" have more frequently appeared in public health literature and have become part of strategic planning. The **Public Health Security and Bioterrorism Preparedness and Response Act of 2002** provided grants to hospitals and public health organizations to prepare for bioterrorism as a result of September 11, 2001 (CDC, 2019).

There have been measles outbreaks throughout the world even though measles was considered eradicated decades ago. In the United States, the number of measles cases has increased six-fold between 2017 and 2018, reaching nearly 800 cases, although the national measles vaccine rate is 90%. Although claims about health risks from vaccines have been unproven, there are parents who are reluctant to vaccinate their children. Therefore, more education is needed to increase the number of children who will receive a measles vaccine (Welch, 2019).

The opioid epidemic began in the 1990s when the pharmaceutical companies assured physicians these pain relief medications were not habit forming which naturally increased the number of prescriptions for these medications. In 2010, there was an increase in the illegal opioid, heroin use, because it was easier to obtain. Deaths from heroin use between 2002 and 2013 increased by 286%. Over 75% of heroin users also abused opioid prescriptions. In 2013, there was an increase in opioid deaths because of the increased use of fentanyl which is a synthetic heroin. The Centers for Disease Control and Prevention has issued guidelines on prescribing medications for chronic pain (History of the opioid epidemic, 2019).

Public health is challenged by its very success because the public now takes public health measures for granted: Several successful vaccines targeted almost all childhood diseases, tobacco use

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has decreased significantly, accident prevention has increased, there are safer workplaces because of the Occupational Safety and Health Administration (OSHA), fluoride is added to the public water supply, and there is decreased mortality from heart attacks (Turnock, 1997). When major events like the Ebola crisis or *Escherichia coli* outbreaks occur or man-made events such as mass shootings or natural disasters happen, people immediately think that public health will automatically control these problems. The public may not realize how much effort, dedication, funding, and research are required to protect them.

Milestones of the Health Insurance System

There are two key concepts in **group insurance**: "risk is transferred from the individual to the group and the group shares the cost of any covered losses incurred by its member" (Buchbinder & Shanks, 2007). Like life insurance or homeowner's insurance, **health insurance** was developed to provide protection should a covered individual experience an event that requires health care. In 1847, a Boston insurance company offered sickness insurance to consumers (Starr, 1982).

During the 19th century, large employers, such as coal mining and railroad companies, offered medical services to their employees by providing company doctors. Fees were taken from their pay to cover the service. In 1913, the International Ladies Garment Workers union began providing health insurance, which was negotiated as part of the contract (Duke University Library, 2019). During this period, there were several proposals for a national health insurance program, but the efforts failed. The AMA was worried that any national health insurance would impact the financial security of its providers. The AMA persuaded the federal government to support private insurance efforts (Raffel & Raffel, 1994).

In 1929, a group hospital insurance plan was offered to teachers at a hospital in Texas. This became the foundation of the nonprofit Blue Cross plans. To placate the AMA, Blue Cross initially offered only hospital insurance in order to avoid infringement of physicians' incomes (Blue Cross Blue Shield Association [BCBS], 2019; Starr, 1982). In 1935, the SSA was enacted; Social Security was considered "old age" insurance. During this period, there was continued discussion of a national health insurance program. But, because of the Depression and World War II, there was no funding for this program. The federal government felt that the SSA was a sufficient program to protect consumers. These events were a catalyst for the development of a health insurance program that included private participation. Although a universal health coverage program was proposed during President Clinton's administration in the 1990s, it was never passed. In 2009, there was a major public outcry at regional town hall meetings opposing any type of government universal healthcare coverage. In 2006, Massachusetts proposed mandatory health coverage for all residents, so it may be that universal health coverage would be a state-level initiative (Shi & Singh, 2019).

By the 1950s, nearly 60% of the population had hospital insurance (AHA, 2007). Disability insurance was attached to Social Security. In the 1960s, President Johnson signed into law **Medicare** and **Medicaid**, which assist elderly, disabled, and indigent individuals. President Nixon established the HMO, which focused on cost-effective measures for health delivery. Also, in the 1980s, DRGs and prospective payment guidelines were established to provide guidelines for treatment. These DRGs were attached to appropriate insurance reimbursement categories for treatment. The **Consolidated Omnibus Budget Reconciliation Act (COBRA)** was passed to provide health insurance protection if individuals change jobs. In 1993, FMLA was passed to protect an employee if there is a family illness. An employee can receive up to 12 weeks of unpaid leave and maintain his or her health insurance coverage during this period. The **Uniformed Services Employment and Reemployment Rights Act (USERRA)**, enacted in 1994, entitles individuals who leave for military service to return to their job. In 1996, the **Health Insurance Portability and Accountability Act (HIPAA)** was passed to provide stricter confidentiality regarding the health information of individuals. The BBA of 1997 required massive program reductions for Medicare and authorized Medicare reimbursement for outpatient services (CMS, 2018).

At the start of the 21st century, cost, access, and quality continue to be issues for U.S. health care. Employers continue to play an integral role in health insurance coverage. The largest public coverage program is Medicare, which covers 55 million people. In 2014, Medicare benefit payments totaled nearly $600 billion (Facts on Medicare, 2015). The SCHIP, renamed CHIP, was implemented to ensure that children who are not Medicare eligible receive health care. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act provided some

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relief from the BBA of 1997 by restoring some funding to these consumer programs. In 2003, a consumer law, the **Medicare Prescription Drug, Improvement, and Modernization Act**, created a major overhaul of the Medicare system (CMS, 2018). The Act created Medicare Part D, a prescription drug plan that became effective in 2006 and provides different prescription programs to the elderly, based on their prescription needs. In 2014, approximately $6 billion in Medicare benefits was spent on Medicare Part D (Facts on Medicare, 2015). The Act also renamed the Medicare cost plans to Medicare Advantage, which is a type of managed care program. Medicare contracts with private health insurance programs to provide services. This program, called Medicare Part C, provides both Medicare Parts A and B benefits. In 2014, approximately $24 billion in Medicare benefit dollars were spent on the Medicare Part C plan (Facts on Medicare, 2015). In 2008, the **National Defense Authorization Act** expanded FMLA to permit families of military service members to take a leave of absence if the spouse, parent, or child was called to active military service. The 2010 ACA required individuals to purchase health insurance by 2014. In June 2018, a federal judge ruled this mandate unconstitutional, so this ruling could have an impact on the ACA overall. Despite this ruling, individuals continue to sign up for insurance through the health marketplace programs. In 2018, approximately 11.8 million have enrolled in the marketplace exchange programs, with 27% categorized as new members (CMS, 2019a).

Current System Operations

Government's Participation in Health Care

The U.S. government plays an important role in healthcare delivery. In the United States, three governmental levels participate in the healthcare system: federal, state, and local. The federal government provides a range of regulatory and funding mechanisms, including Medicare and Medicaid, established in 1965 as federally funded programs to provide health access to the elderly (65 years or older) and the poor, respectively. Over the years, these programs have expanded to include individuals with disabilities. They also have developed programs for military personnel and veterans and their dependents.

Federal law, specifically EMTALA, ensures access to emergency services regardless of ability to pay (Regenstein, Mead, & Lara, 2007). The federal government determines a national healthcare budget, sets reimbursement rates, and also formulates standards for providers for eligible Medicare and Medicaid patients (Barton, 2003). The state level is responsible for regulatory and funding mechanisms but also provides healthcare programs as dictated by the federal government. The local or county level of government is responsible for implementing programs dictated by both the federal and the state levels.

The United States has several federal health regulatory agencies, including the **CDC** for public health, the **Food and Drug Administration (FDA)** for pharmaceutical controls, and the **Centers for Medicare & Medicaid Services (CMS)** for the indigent, disabled, and the elderly. The Joint Commission is a private organization that focuses on healthcare organizations' oversight, and the **Agency for Healthcare Research and Quality (AHRQ)** is the primary federal source for the quality delivery of health services. The **Center for Mental Health Services (CMHS)**, in partnership with state health departments, leads national efforts to assess mental health delivery services. Although the federal government is to be commended because of the many agencies that focus on major healthcare issues, with multiple organizations there is often duplication of effort and miscommunication that result in inefficiencies (SAMHSA, 2019). However, several regulations exist to protect patient rights. One of the first pieces of legislation was the **Sherman Antitrust Act of 1890** and ensuing legislation, which ensures fair competition in the marketplace for patients by prohibiting monopolies (Niles, 2019). Regulations such as HIPAA protect patient information; COBRA gives workers and families the right to continue healthcare coverage if they lose their job; the **Newborns' and Mothers' Health Protection Act (NMHPA)** of 1996 prevents health insurance companies from discharging a mother and child too early from the hospital; the **Women's Health and Cancer Rights Act (WHCRA)** of 1998 prevents discrimination against women who have cancer; the **Mental Health Parity Act (MHPA)** of 1996 and its 2008 amendment require health insurance companies to provide fair coverage for mental health conditions; the **Genetic Information Nondiscrimination Act of 2008** prohibits U.S. insurance companies and employers from discriminating based on genetic test results; the **Lilly Ledbetter Fair Pay Act of 2009** provides protection for unlawful employment practices related to compensation discrimination; and finally, the **ACA of 2010** focuses on increasing access to health care, improving the quality of healthcare delivery, and increasing

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the number of individuals who have health insurance. All of these regulations are considered **social regulations** because they were enacted to protect the healthcare consumer.

Private and Public Health Insurance Participation in Health Care

The majority of individuals in the United States have private insurance. In 2017, nearly 9% or 29 million did not have health insurance at some point during the year. In 2017, private health insurance, such as Blue Cross, covered 67.2% of individuals who had health insurance compared to 32.7% who had government coverage, such as Medicare or Medicaid. Employer-based coverage included 56% of the private health insurance coverage, followed by Medicaid (19.3%), Medicare (17.2%), individual purchase coverage (16%), and military coverage (4.8%) (Berchick, Hood, & Barnett, 2018).

The different providers are an integral part of the medical care system and need to coordinate their care with the layers of the U.S. government. In order to ensure access to health care, communication is vital between public and private components of healthcare delivery.

Assessing Your Healthcare System Using the Iron Triangle

Many healthcare systems are evaluated using the **Iron Triangle of Health Care**—a concept that focuses on the balance of three factors: quality, cost, and accessibility to health care (**FIGURE 1-1**). This concept was created in 1994 by Dr. William Kissick (1994). If one factor is emphasized, such as cost reduction, it may create an inequality of quality and access because costs are being cut. Because lack of access is a problem in the United States, healthcare systems may focus on increasing access, which could increase costs. In order to assess the success of a healthcare delivery, it is vital that consumers analyze the balance between cost, access, and quality. Are you receiving quality care from your provider? Do you have easy access to your healthcare system? Is it costly to receive health care? Although the Iron Triangle is used by many experts in analyzing large healthcare delivery systems, as a healthcare consumer, you can also evaluate your healthcare delivery system by using the Iron Triangle. An effective healthcare system should have a balance between the three components.

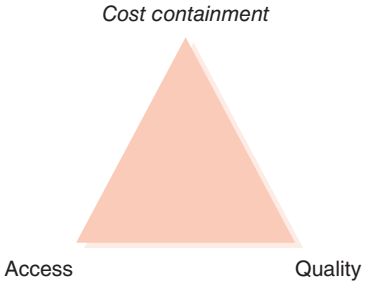

FIGURE 1-1 The Iron Triangle of Health Care

Reproduced from Kissick, W. (1994). *Medicine's dilemmas*. New Haven and New London, CT: Yale University Press. Reprinted by permission.

Conclusion

Despite U.S. healthcare expenditures, disease rates in the United States remain higher than those of many other developed countries because the United States has an expensive system that is available to only those who can afford it (Regenstein, Mead, & Lara, 2007). A recent Gallup survey indicates that over 55% of Americans are greatly concerned about the availability of the rising cost of health care, which marks the fifth year in a row that this issue is ranked or tied first with concerns (Jones, 2018). Because the United States does not have universal health coverage, there are more health disparities across the nation. Persons living in poverty are more likely to be in poor health and less likely to use the healthcare system compared to those with incomes above the poverty line. If the United States offered universal health coverage, the per capita expenditures would be more evenly distributed and likely more effective. The major problem for the United States is that healthcare insurance is a major determinant of access to health care. Although there has been a decrease in the number of uninsured in the United States as a result of the individual mandate to purchase health insurance by the ACA, there is still limited access to routine health care. The infant mortality rate is often used to compare the health status of nations worldwide. Although our healthcare expenditures are very high, our infant mortality rates rank higher than those of many countries. Racial disparities in disease and death rates continue to be a concern. Both private and public participants in the U.S. health delivery system need to increase their collaboration to focus on health education aimed to reduce the prevalence of obesity, disease and health literacy. Leaders need to continue to assess our healthcare system using the Iron Triangle to ensure there is a balance between access, cost, and quality.

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Wrap-Up

Vocabulary

Agency for Healthcare Research and Quality (AHRQ)
Almshouses
American Medical Association (AMA)
American Recovery and Reinvestment Act (ARRA)
Assessment
Assurance
Center for Mental Health Services (CMHS)
Centers for Disease Control and Prevention (CDC)
Centers for Medicare and Medicaid Services (CMS)
Certificate of need (CON)
Consolidated Omnibus Budget Reconciliation Act (COBRA)
Constitutional factors
Cost sharing
Determinants of health
Emergency Medical Treatment and Active Labor Act (EMTALA)
Employer health insurance
Epidemics
Family Medical Leave Act (FMLA)
Flexner Report
Food and Drug Administration (FDA)
Genetic Information Nondiscrimination Act of 2008
Graying of the population
Gross domestic product (GDP)
Group insurance
Health
Health disparities
Health equity
Health insurance
Health Insurance Portability and Accountability Act (HIPAA)
Health literacy
Healthy People reports (2000, 2010, 2020)
Hospitalists
Iron Triangle of Health Care
Joint Commission
Lilly Ledbetter Fair Pay Act of 2009
Macroeconomic conditions
Medicaid
Medicare
Medicare Prescription Drug, Improvement, and Modernization Act
Mental Health Parity Act (MHPA)
National Defense Authorization Act
National Mental Health Act (NMHA)
Newborns' and Mothers' Health Protection Act (NMHPA)
Nurse
Out-of-pocket payments or expenses
Patient Bill of Rights
Patient Protection and Affordable Care Act of 2010 (PPACA or ACA)
Pesthouses
Poison Prevention Packaging Act of 1970
Policy development
Poorhouses
Primary prevention
Public health
Public health functions
Public Health Security and Bioterrorism Preparedness and Response Act of 2002
Quaternary prevention
Secondary prevention
Sherman Antitrust Act of 1890
Social and community networks
Social regulations
Social Security Act (SSA)
Tertiary prevention
Triple Aim
Uniformed Services Employment and Reemployment Rights Act (USERRA)
Universal healthcare program
Voluntary health insurance
Women's Health and Cancer Rights Act (WHCRA)

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Notes

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Student Activity 1-1

In Your Own Words

Based on this chapter, please provide a definition of the following vocabulary words in your own words. DO NOT RECITE the text definition.

Group insurance:

Gross domestic product (GDP):

Pesthouses:

Voluntary health insurance:

Public health functions:

Primary prevention:

Secondary prevention:

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Tertiary prevention:

Quaternary prevention:

Student Activity 1-2

Complete the following case scenarios based on the information provided in the chapter. Your answer must be **IN YOUR OWN WORDS.**

Real-Life Applications: Case Scenario One

Your mother knows that you are taking classes for your healthcare management degree. She just returned from a physician checkup, and she was confused by the terminology they were using at the office. They mentioned several activities related to primary, secondary, tertiary, and quaternary prevention.

Activity

Define each of the terms and provide examples of these types of prevention.

Responses

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Case Scenario Two

You have recently heard the term "health literacy," and you are curious about how that applies to you as a consumer of health care.

Activity

Perform an Internet research regarding the concept of health literacy and how it applies to healthcare consumers. Provide examples to your classmates about how to be literate in health care.

Responses

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Case Scenario Three

One of your friends had a very serious medical emergency and had to go to the hospital for treatment. She was very upset because on her arrival at the hospital, she was asked to provide her insurance card, which she did not have, and she was quickly transferred to another hospital. You had learned there is a law that makes this type of treatment by a hospital illegal. However, before sharing your opinion with your friend, you wanted to learn more about this law and whether it applied to her situation.

Activity

Perform an Internet research on public health regulations and write a report on whether you think the Emergency Medical Treatment and Active Labor Act (EMTALA) was applicable in this situation.

Responses

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Case Scenario Four

As a public health student, you are interested in different public health initiatives the CDC has put forth over the years and whether they have been successful. You continue to hear the term "Healthy People reports." You are interested in the results of these reports.

Activity

Visit the CDC website and write a report on the Healthy People initiatives and whether or not you think they are successful initiatives.

Responses

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Student Activity 1-3

Internet Exercises

Write your answers in the space provided.

- Visit each of the websites listed here.
- Name the organization.
- Locate their mission statement or statement of purpose on their website.
- Provide an overview of the organization's activities.
- How do these organizations participate in the U.S. healthcare system?

Websites

http://www.ama-assn.org

Organization Name:

Mission Statement:

Overview of Activities:

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Importance of Organization to U.S. Health Care:

http://www.cdc.gov

Organization Name:

Mission Statement:

Overview of Activities:

Importance of Organization to U.S. Health Care:

http://www.cms.hhs.gov

Organization Name:

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Mission Statement:

Overview of Activities:

Importance of Organization to U.S. Health Care:

http://www.hhs.gov

Organization Name:

Mission Statement:

Overview of Activities:

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Importance of Organization to U.S. Health Care:

Student Activity 1-4

Discussion Questions

The following are suggested discussion questions for this chapter.

1. What is the Flexner Report? How did it impact health care in the United States?

2. What are the Healthy People report initiatives? Describe three current initiatives to your classmates.

3. Why was health insurance developed? What was Kaiser's role in this?

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4. Describe how the Iron Triangle can be used to assess health care. Give specific examples.

5. What is the Patient Bill of Rights? Why was it developed? Have you ever seen the Patient Bill of Rights posted anywhere?

6. Give five examples of public health activities in your personal or work environment.

Student Activity 1-5

Current Events

Perform an Internet search and find a current events topic over the last 3 years that is related to this chapter. Provide a summary of the article and the link to the article and explain how the article relates to the chapter.

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CHAPTER 2

Current Operations of the U.S. Healthcare System

LEARNING OBJECTIVES

The student will be able to:

- Identify the stakeholders of the U.S. healthcare system and their relationships with each other.
- Discuss the importance of healthcare statistics.
- Compare the United States to five other countries using different health statistics.
- Discuss complementary and alternative medicine and its role in health care.

DID YOU KNOW THAT?

- According to the Bureau of Labor Statistics, the projection for job growth in the healthcare industry over a 10-year period is 9.8 million jobs by 2024.
- Most healthcare workers have jobs that do not require a 4-year college degree, but health diagnostic and treatment providers are the most educated workers in the United States.
- The healthcare industry and social assistance industry reported more work-related injuries than any other private industry.
- Life expectancy and infant mortality rates are an indication of the health of a population.

Introduction

The one commonality with all of the world's healthcare systems is that they all have consumers or users of their systems. Systems were developed to provide a service to their citizens. However, the U.S. healthcare system, unlike many other systems in the world, does not provide healthcare access to all of its citizens. It is a very complex system that is comprised of many public and private components. Healthcare expenditures comprise approximately 17.9% of the **gross domestic product (GDP)**. Health care is very expensive, and most citizens do not have the money to pay for health care themselves. Individuals rely on health insurance to pay a large portion of their healthcare costs. Health insurance is predominantly offered by employers.

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The government believes this is the result of the universal mandate for individual health insurance coverage. However, with the recent federal ruling stating that the universal mandate is unconstitutional, it is expected that the uninsured rate may increase.

In the United States, in order to provide healthcare services, there are several **stakeholders** or interested entities that participate in the industry. There are providers, of course, that consist of trained professionals, such as physicians, nurses, dentists, and chiropractors. There are also inpatient and outpatient facilities; the payers, such as the insurance companies, the government, and self-pay individuals; and the suppliers of products, such as pharmaceutical companies, medical equipment companies, and research and educational facilities (Sultz & Young, 2006). Each component plays an integral role in the healthcare industry. These different components further emphasize the complexity of the U.S. system. The current operations of the delivery system and utilization statistics will be discussed in depth in this chapter. An international comparison of the U.S. healthcare system and select country systems will also be discussed in this chapter, which provides another aspect of analyzing the U.S. healthcare system.

Overview of the Current System Update

The United States spends the highest proportion of GDP on healthcare expenditures compared to any country. The system is a combination of private and public resources. Since World War II, the United States has had a private fee-for-service system that has produced generous incomes for physicians and has been profitable for many participants in the healthcare industry (Jonas, 2003). The healthcare industry operates like traditional business industries. Organizations designated as for profit need to make money in order to operate. The main goal of entities that are designated nonprofit is based on a particular social goal such as increasing healthcare access, but they also have to make money in order to continue their operations.

There are several major stakeholders that participate or have an interest in the industry. The stakeholders identified as participants in the healthcare industry include consumers, employers, healthcare and non-healthcare employers, healthcare providers, healthcare facilities, governments (federal, state, and local), insurance companies, educational and training institutions, professional associations that represent the different stakeholders, pharmaceutical companies, and research institutions. It is also important to mention the increasing prominence of alternative therapy medicine. Each role will be discussed briefly.

Major Stakeholders in the Healthcare Industry

Consumers

The main group of consumers consists of patients who need healthcare services from a physician, a hospital, or an outpatient facility. From an organizational perspective, the consumer is the most important stakeholder for an organization. The healthcare industry operates like a business. If a consumer has the means to pay out of pocket, from governmental sources, or from health insurance, the services will be provided. If an individual does not have the means to pay from any of these sources of funding, a service may not be provided. There is a principle of the U.S. healthcare system, **duty to treat**, which means that any person deserves basic care (Pointer, Williams, Isaaacs, & Knickman, 2007). In some instances, healthcare providers will give care to someone who has no funding source and designate the care provided as a **charitable care or bad debt**, which means either the provider does not expect payment after the person's inability to pay has been determined or the efforts to secure the payment have failed (DiSalvatore, 2015). Businesses also take the same action. Many of them provide a community service or donate funds to a charitable cause, yet both traditional businesses and healthcare organizations need to charge for their services in order to continue their operations (**FIGURE 2-1**).

Employers

Employers consist of both private and public employers. The healthcare industry is the largest U.S. employer. According to the **Bureau of Labor Statistics (BLS)**, there are several segments of the healthcare industry, including ambulatory healthcare services, hospitals, and nursing and **residential care facilities**. Ambulatory healthcare services are comprised of physicians, dentists, other health practitioners, outpatient care centers, medical and diagnostic laboratories, home healthcare services, and other ambulatory care. The hospital segment provides inpatient services primarily, with outpatient as a secondary source. It provides general and surgical care, psychiatric substance-abuse hospitals, and other specialty hospitals. Residential care facilities include nursing care, mental health, substance abuse and mental disabilities, community care

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