FIFTH EDITION

Financial Management for Nurse Managers

Merging the Heart with the Dollar

J. Michael Leger

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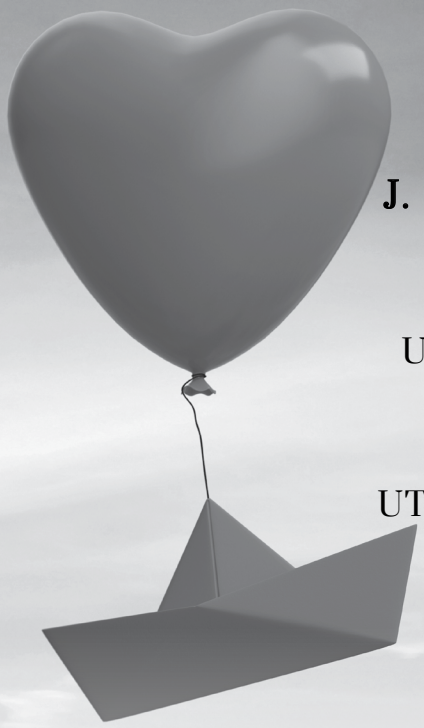

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This book is dedicated to the many nursing students who encourage me to lead by example through the editing of this text. And nurse administrators and leaders who have served as mentors, colleagues, and friends. I have learned so much from you, and I salute you.

I want to thank Charles, my spouse and best friend, for supporting me in yet another opportunity in my ever-evolving career path. And a special thanks to Kathleen, Carolyn, and Yolie for your unwavering support of me as your student and now as a colleague.

—JML

Brief Contents

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Preface

After working for more than 15 years as a nurse leader—director, CNO, and VP of nursing—I made the decision to follow my passion for teaching. During my first semester as faculty in a graduate nursing program, I was assigned to teach a financial management course because of my extensive experience in healthcare operations. It was then that I realized the gap of knowledge that many graduate-level nurses have with regard to healthcare financial management.

The class was composed of professional nurses with various levels of understanding of healthcare financial management, ranging from novice to expert. I also recognized that many of my students were serving in nursing leadership roles but not in inpatient settings. While the majority of the students had a basic knowledge of many of the financial terms presented in the course textbook, application of those terms and the actual process of budgeting were elusive to a majority of the students. The reason for this is that healthcare financial management continues to be driven by financial professionals, often to the detriment of the nurse leader truly understanding their role in healthcare finance.

When asked about my interest in serving as editor for the next edition of *Financial Management for Nurse Managers: Merging the Heart with the Dollar,* I saw an opportunity to forge a different sort of path with how the material is presented. My vision was to provide a tool for nurse leaders at all levels of understanding, working in different areas along the healthcare continuum—inpatient, outpatient, acute, and subacute—to empower them with the knowledge they need, both theoretical and practical, to be more effective in their leadership roles and have a greater impact in managing finances. While the information provided in the previous editions serves students well, I recognized the need to provide students with practical examples of the material in an effort to promote their learning through application. Therefore, in editing material for the most recent edition, I made a conscious decision to remove some topics that I believe will serve students better in nonfinancial courses.

I sincerely appreciate all the contributing authors for their expertise and time in putting this book into the hands of nurse leaders, both current and future, who play such a large role in health care.

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I would like to thank the author contributors in this book, in addition to the healthcare financial experts who served as sounding boards, for sharing their time and expertise for this very worthwhile project.

Introduction

It's no longer about strategic development. It's about financial management.

—Michael Diekmann

This text addresses healthcare financial management issues for nurse leaders in a variety of positions and settings: hospitals, ambulatory/outpatient clinics, long-term care facilities, and home care. My vision for this text is to provide you, its reader, with useful, evidence-based information that pertains to each of these healthcare settings. You will also see that we refer to the "nurse leader" throughout the book. That is because no matter the title, a nurse leader has some role in financial accountability to their unit, department, and institution.

To be successful in financial management, nurse leaders must understand, regardless of setting, what affects the healthcare environment and the financial implications that result from these forces. The nurse leader must express what needs to happen for good nursing practice and also must be able to articulate the financial aspects involved. Understanding the organization's finances is not sufficient. A nurse leader must be able to anticipate actions in response to a changing financial environment and to encourage staff to do the same.

This text covers a wide range of financial information, including evidence in healthcare finance, economics, budgeting, comparing reimbursements with costs of services provided, accounting, and financial strategies. Concepts are presented, followed by examples. At times, we make suggestions for actions that we have found to be helpful. Although many of the examples have an inpatient focus, a great number are provided from other healthcare settings, such as ambulatory care, home care, and long-term care.

Even though this book has a financial title, there is more included here than just the financial part of health care. This is because everything in health care is *interrelated/interconnected/interwoven* with finances. For example, when administrators discuss budgeting, they must also be aware of the nurse leaders' concerns with staffing, patient acuity, and the productivity of staff, as well as quality standards. We cannot ignore leadership in an organization, because if that is ineffective, then so is everything else.

It is important to note here that every financial decision we make has management implications. The same is true in reverse: Every management decision has financial implications. So, we cannot ignore the additional aspects we have included in this book because they are all interwoven and, if one is ignored, such oversight can negatively affect the bottom line.

The bottom line should *never* be the primary focus in a healthcare organization. *When the bottom line is most important, the organization will lose money.* Many in the organization will have forgotten that our reason for existence is to *serve patients*. That is our primary focus. As long as we stay in touch with this truth, we will thrive.

This is not to say that we can ignore the financial implications. As we have heard time after time: no margin, no mission. We cannot exceed the budget we have—if we do, we must have another area in the budget that we can draw from to counter the overspending. The bottom line must remain solvent. However, the patient *always* comes first.

We have entered into a new *value-based reimbursement environment* that demands different approaches for healthcare organizations to stay solvent. Our old volume-based reimbursement environment of the previous century is outdated. Healthcare organizations cannot continue to survive unless we change and create a value-based environment that is focused on the patient and the patient's outcomes. Quality drives reimbursement. This text outlines what is needed to achieve this objective.

For value-based reimbursement, the American Hospital Association advocates nurse and physician leadership at the point of care and making decisions with the patient about that care within the available finances. Administrators' roles need to change to support the point-of-care leaders. Teamwork and interdisciplinary shared governance are necessities. Everyone—from the board/CEO/CNO/CFO to nurse aides/housekeepers—needs to be doing regular rounds listening to patients. This needs to replace some of the meetings, especially ones where administrators have no perception of what is going on at the point of care. Patients are more likely to get what they value when the whole thrust of the organization is toward finding out this information, and then providing it as much as possible.

In the value-based environment, we need to examine current practices. For instance, we burden RNs with a lot of paperwork and non-valued-added activities that take them away from the bedside for more than 50% of their time. We understaff units, which creates negative environments for everyone, yet we expect staff will provide the care that is necessary to achieve quality outcomes, thereby resulting in positive reimbursement. Evidence shows that missed care is occurring, which may cause side effects for the patient, such as pressure sores, infections, and frequent hospital readmissions requiring care that will not be reimbursed. Yet we do not pay sufficient attention to these issues until it impacts our margins. We need to value the staff nurse at the bedside, encouraging staff to lead and make changes as they do their work. In fact, 90% of the decisions about their work needs to be made by staff as they take care of patients each day.

An enormous challenge in the current healthcare climate is achieving quality care and safety while keeping expenses down. This is especially important now that reimbursement depends on appropriate, timely care and does not cover errors. The patient has historically suffered from care driven by the bottom line, but now with value-based reimbursement, healthcare organizations are being penalized with lower reimbursement by not allowing quality outcomes to drive care.

The healthcare environment is complex and continues to increase in complexity. This causes increased bureaucracy, more errors, and more expense. Complexity and chaos are constantly changing the environment and affecting our work organizationally. We need to strive to involve all stakeholders, including those at the bedside—physicians, patients, and families—to simplify the environment. What we do today will be outdated tomorrow, so we need to continually stay tuned in to new evidence. This is interwoven with ethical and legal implications that cannot be ignored.

Finally, the financial aspects of health care cannot be ignored. To respond effectively in this complex healthcare environment and to work successfully with the financial arm of the healthcare entity, nurse leaders must understand financial concepts, such as staffing, budgeting, identifying and analyzing variances, measuring productivity, costing, accounting, and forecasting, as well as the strategies that achieve a positive bottom line. Although finance and accounting terminology is used throughout the book, chapters focused specifically on accounting and assessing financial performance are included.

This text provides nurse leaders with an interconnected view of the nursing and financial sides of health care and suggests methods nurses can use to successfully integrate these viewpoints. This realistic integration of

nursing and finance (along with all the other departments and professions) enhances nurse leader effectiveness.

A critical element for success is the ability of nurse managers to interface effectively with finance department personnel. An unusual feature of this book is that it contains both typical nursing administration terminology and financial accounting terminology. Suggestions are made for nurse leaders about how to communicate with and maximize the understanding of concepts and issues by financial personnel, who may come from different (non-healthcare) backgrounds and attach different meanings to the same terms.

The problem with the financial aspect of health care is that it is often viewed as a separate silo—where nurses do not enter and where financial personnel reside. Meanwhile, nurses are in their own silo, and financial personnel are not found there. In writing this book, we believe it is time to end this silo mentality. Our effectiveness in healthcare demands that *nursing and finance interface regularly* and conduct a healthy ongoing dialogue about every issue. We are most effective if we can face these issues *together.*

Nurses need to express themselves more effectively using financial principles and data; *financial personnel need to more effectively understand the care side of health care.* Because this book is written for the nurse leader, we emphasize the first part. We hope this book will be helpful for finance personnel as well.

A problem that occurs when nurses and financial people try to talk together is that financial officers often think in a linear way. When they talk to each other, they talk about numbers, ratios, and stats. Nurses, however, tend to think in an abstract, interpersonal way. When nurses talk to each other, they talk about how someone feels, how someone will be affected by a certain treatment, or whether particular tasks have been accomplished.

The breakdown in communication occurs when nurses talk to financial people using abstract language, while financial people talk to nurses using linear language. The conversations run parallel to each other, with both sides not understanding what the other is talking about. Nurses complain that financial people never think about anything but the bottom line, while financial people complain that all nurses do is whine about quality. Thus, true dialogue and communication do not occur.

This book gives examples that nurses can use to better communicate with financial personnel, as well as with other linear-thinking administrators. In addition, we recommend that if a nurse leader really wants to talk effectively with financial administrators, they should be able to *express/communicate the abstract information using linear language* (i.e., numbers that will be affected by something that has or has not occurred or that is being planned, including specific amounts of money needed to implement a project, and so forth).

Abstract thinking is effective in communication between nurses and physicians. However, it is often ineffective when communicating with the finance department. For example, concepts such as "care" might not have meaning to a finance officer. *Caring* is an abstract term that does not provide any real form of measure. Exceptions occur when a financial person experiences a serious illness or when the financial officer previously worked as a healthcare professional.

At times, this communication problem can be compounded by simple differences in male and female communication techniques (remember *Men Are from Mars, Women Are from Venus* [Gray, 1992]), especially if the chief financial officer is male and the chief nursing officer is female. This is changing with less gender-specific roles in the workplace. In the past, a male chief nursing officer often had an edge because he could be "one of the boys." This is also slowly changing with more males in nursing and more females in finance.

Properly prepared nurse managers and nurse administrators can successfully provide

an interface between finance and nursing, making decisions based on *both* clinical and financial perspectives. A nurse manager, as well as financial personnel, cannot make the mistake of ignoring the whole while dealing with the individual parts.

This interconnection goes beyond just nursing and finance. In this book, we strongly encourage every person and every department and profession to collaborate as they provide what the patient values. Because of this interconnection, there is a ripple effect. What one person or department does affects all the others. Nevertheless, some of us cling to the old silo mentality.

Another financial silo exists when the organization's mentality is that staff are not leaders and should not be involved with financial information. We are in the information age. Transparency is best. Because we are all interconnected, every task a staff member performs has financial implications. It is critical to *involve all staff and nurse leaders with the finances,* such as the following: payment structures and how much is actually received; reimbursement that is lost when timely, appropriate care is not given; costs of technology and supplies; staffing costs; quality and safety costs; costs incurred with safety or quality issues; and legal costs. They should understand the impact their actions have on the bottom line and, thus, patient care.

Staff members need to be making 90% of the care decisions right at the point of care. Administrators only *serve* the staff and help them do their best work for the patients. We need to create positive environments because evidence shows that such environments generate the best outcomes—even regarding the bottom line. We need to empower staff, but more than that, we need to support them as being leaders in their work and support patients being leaders in what care they choose to receive.

Solutions are always better when the people directly involved are included in the process of devising the solutions. Therefore, we advocate that *staff and patients, as well as administrators, come to the table on issues and decide on the best way to accomplish the work through* interdisciplinary *shared governance.* This gets rid of another silo—the one where administrators make all the decisions and do not delegate to others—which is a leftover from the previous century.

We will have small successes we can celebrate, and we will have failures. Failures are natural, a fact of life. As they occur, we need to learn from each one and adapt and implement changes to simplify the environment. Many errors are caused by a series of events—because we are all interconnected. Dealing with failures goes beyond being blame-free. We must make incremental changes to simplify processes that have become cumbersome.

The *Fifth Edition* of this book comes at an interesting time. The US economy is beginning a climb out of one of the worst recessions we have seen since the Great Depression due to the COVID-19 global pandemic. Weather events and climate disasters are getting more severe and more costly, with an estimated $95 billion in damages in 2020 alone (NOAA, 2021). Despite all of these trials, we have pulled together in such times of crisis, and, hopefully, we can pull together in fixing our healthcare system. It takes each of us. We are all interconnected.

Discussion Questions

1. How does understanding complexity break down silos?
2. What silos exist in your workplace? In your own thinking? How will you contribute to breaking down these silos?
3. What actions further the silo concept?
4. Give an example where a nurse administrator effectively expresses a need to the finance department using numbers and dollars.
5. State an administrative decision and explain its financial implications.

6. Describe a financial decision, giving the administrative implications of this decision.
7. Describe an administrative or financial decision and map out the ripple effect of this decision.

References

Gray, J. (1992). *Men are from Mars, women are from Venus*. HarperCollins.

NOAA National Centers for Environmental Information. (2021). *U.S. billion-dollar weather and climate disasters.* https://doi.org/10.25921/stkw-7w73

PART I

Health Care, Our History, and Its Economics

CHAPTER 1

What Got Us to Where We Are?

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Janne Dunham-Taylor, PhD, RN, and **Joellen Edwards**, PhD, RN, FAAN

OBJECTIVES

- Understand the historical underpinnings that propelled the development of health policy in this country.
- Describe how access to care and cost impact our healthcare system in the United States.
- Discuss the impact of the federal government's role on health policy and its impact on healthcare delivery systems.
- Appraise ways in which the Patient Protection and Affordable Care Act has influenced healthcare delivery and outcomes.

How Did We Get into This Mess?

Despite our best efforts, health care continues to be a complicated economic and quality quagmire with many issues requiring our attention. Although Merriam-Webster (n.d.) defines health care as "efforts made to maintain or restore physical, mental, or emotional well-being especially by trained and licensed professionals," this definition is a contradiction in the United States. Our historical approach to healthcare delivery has been to address "illness care" rather than a focus on what brings about good health. We use the term *health care* in this book only because it is the common nomenclature for our illness system. While the promotion of health and prevention of diseases are strategies that continue to emerge and are becoming more prevalent (National Research Council Panel on Statistics for an Aging Population & Gilford, 1988), we continue our climb up this slippery slope.

Based on our rising costs and declining outcomes, it is clearly evident that our *tertiary approach* to illness care—focusing on people affected by a disease—has many serious problems. Trust for America's Health (Auerbach, 2017) reported chronic disease *prevention* expenditures at a meager $4 per person, yet treatment of these same chronic illnesses costs

the United States more than $1.5 trillion annually. The United States is the only highly developed nation that still fails to provide basic health services to all its citizens, creating sweeping and glaring disparities in the health of our population.

So, how did we get into this mess? Examining the U.S. history of health care can give us a better understanding of the present situation and unresolved dilemmas, and offers us some idea of what may come next. Although we have seen many attempts to achieve healthcare reform in the United States, it is important to include a discussion about why attempts at reform are often impeded due to our country's culture, the makeup of our political system, and the power of special interest groups (Wilensky & Teitelbaum, 2020).

Collectively, the rules and regulations that define who gets which healthcare services, who can deliver them, and how those services are paid for are the core of health policies. The World Health Organization (WHO, n.d.) defines health policy as

> decisions, plans, and actions that are undertaken to achieve specific health care goals within a society. An explicit health policy can achieve several things: it defines a vision for the future which in turn helps to establish targets and points of reference for the short and medium term. It outlines priorities and the expected roles of different groups; and it builds consensus and informs people.

These decisions include those of the executive, legislative, and judicial branches of government. Over time, a number of partially successful attempts to repair the healthcare system in our country have occurred through the development of policies at all levels of government. However, they often address specific, isolated problems—concerns about quality, rising costs, disparities of health, high rates of uninsured—rather than creating a well-coordinated system that makes health care accessible and affordable to everyone.

Healthcare policies in the United States attempt to address three specific aspects related to concerns about health care: (1) *access* to healthcare services, (2) *cost and cost control* of healthcare services, and (3) *quality of care* provided to the population. The remainder of this chapter examines the development of healthcare policies that address these first two concerns; quality will be discussed in greater detail in Chapter 3.

Foundations of Health Care: The Early Days of Our Country

Early in this country's history, care was provided by women in the family who tended to the health needs of relatives in the home. With no formal education or training for these women, they relied on their personal knowledge, experience, and advice from others. If they received any education or training at all, it was from other family members or neighbors who were "healers," or if they could read, they learned about it from books.

Physicians, if available, were consulted for more complicated or extreme medical conditions, and home visits were the norm. Formal medical education in the United States did not begin until 1765 at the College of Philadelphia (Fee, 2016). However, a person could become a physician by apprenticing with another practitioner or attending a privately owned school with minimal admission requirements, and little scientific basis for the profession existed. There was no mechanism for testing competence, and licensure was not a requirement to practice.

Health care was a private matter, paid for by patients or their families with cash or barter. There were no regulatory interference or supportive services from federal, state, or local governments to protect and improve people's health. As our nation matured, governmental

regulation of many aspects of health-related issues occurred. Over time, our governments became more and more involved in ensuring public well-being through the following:

- Regulations about the direct provision of health care through agencies and hospitals
- The promotion of sanitation and the prevention of epidemics through formal public health departments
- Health professions education and licensing, especially for physicians and nurses

Eventually, as presented in the following sections, governments became involved not only in the regulation of, but the actual payments for, healthcare services.

The development of the public health system serves as a good example of the gradually increasing governmental regulation of health-related issues. The origins of the Public Health Service date back to 1798 when Congress passed An Act for the Relief of Sick and Disabled Seamen. Public health activities first began in larger cities in the early 1800s with the dramatic increase in immigration into the United States. The main focus was sanitation and prevention of epidemics of smallpox, typhoid fever, tuberculosis, and diphtheria, among other highly contagious diseases. Regulations were concerned with waste removal, swamp drainage, and street drainage. If epidemics occurred, homes or ships would be quarantined. As immunizations were developed, public health officials got involved with administering them. The first state board of health was formed in 1869 in Massachusetts. By 1900, each state had a board of health that worked on the preceding issues with local boards of health. Today, myriad public laws and regulations affect people's health, and departments of health at the national, state, and local levels assess health needs, monitor compliance with health regulations, and implement programs to improve the public's health. **Figure 1-1** provides a timeline of the major healthcare policies in the United States in response to access to care issues.

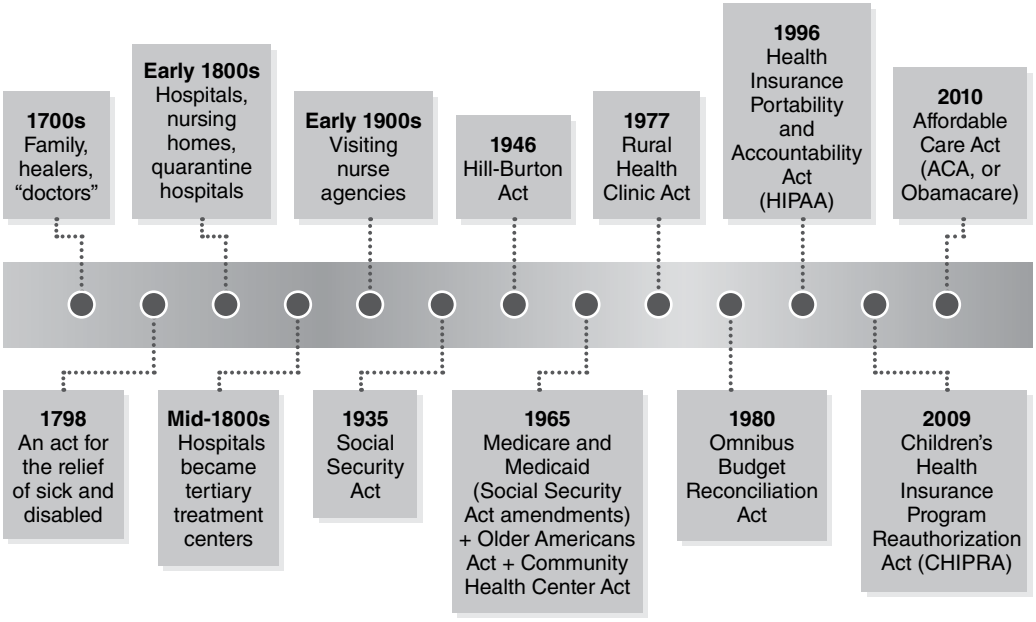

Figure 1-1 Access to health care: A U.S. timeline

Policies Addressing Access to Care

Access, or the *availability of care*, is a huge issue in the U.S. healthcare system. And, while legislation has been enacted to improve access of care providing more than 20 million adults with health insurance coverage, the problem is that millions of Americans continue to lack basic coverage (U.S. Department of Health and Human Services, n.d.). The Institute of Medicine (IOM, 1993) defined access as the timely use of personal health services to achieve the best health outcomes. Access includes the effective and efficient delivery of healthcare services, meaning that the services need to be culturally appropriate and geographically available, as well as delivered at a cost the user can afford. Data from Healthy People Midcourse Review (Centers for Disease Control and Prevention [CDC], 2016) indicate disparities by sex, age, race, ethnicity, education, geography, and family income continue to be significant barriers to healthcare access.

Our system is unique in the developed world in that we do *not* systematically provide access to basic healthcare services for the entire population (*primary care*). The greatest contributing factors for access to healthcare services and getting recommended care is the ability to pay for them and the availability of health insurance.

As of 2017, Medicare and Medicaid, federal and state policies that provide health programs, pay for various kinds of care for 36.5% of our citizens (Berchick et al., 2018). The Indian Health Service offers basic health care to Native Americans living on reservations. Employer-based insurance, most commonly with costs shared between employers and employees, covers 56% of the U.S. population, although many find themselves "underinsured" when it is time to pay the healthcare bills. Those individuals who have no healthcare coverage at all are left to pay healthcare bills from their own pockets, or to seek care through safety net providers such as free clinics, rural health clinics (RHC), or federally qualified health centers (DeNavas-Walt et al., 2012). However, since the implementation of the Patient Protection and Affordable Care Act of 2010 (known as the Affordable Care Act, ACA, and "Obamacare"), the most monumental piece of healthcare legislation in 50 years, the rate of uninsured citizens has dropped from 15.7%, or 48.6 million individuals in 2010, to 8%, or 26.1 million individuals in 2019 (United States Census Bureau, 2020).

Access to Direct Services: Hospitals and Beyond

Access to care beyond that available in the home was addressed by:

- Creating hospitals, nursing homes, and in-home care programs by trained nurses. Hospitals and nursing homes existed in the early 1800s, but they existed on voluntary charitable contributions and served the indigent.
- Quarantine hospitals, opened and closed sporadically by public health officials to deal with epidemic diseases such as smallpox, yellow fever, or, later, tuberculosis.
- Access to health care for the wealthy who could pay for the services (i.e., hiding a family member with a psychiatric illness in an insane asylum).

By the mid-1800s, hospitals, for better or worse, became accepted as tertiary treatment centers for all types of diseases. Instruments such as the stethoscope, thermometer, sphygmomanometer, and microscope were introduced; air was viewed as a disinfectant, so good ventilation became important; antiseptic and sterile procedures were gradually introduced; better ways had been discovered to manage pain in surgery; and, in the 1890s, the X-ray was invented.

In the early 1900s, visiting nurse agencies were started, especially in larger cities, to make health care more accessible for

primarily poor residents. If able, clients paid a small fee for services provided. These services were financed, in part, through raised funds to support their work with the poor. Public health departments broadened to include maternal and child services and, in the slums of large cities, to detect tuberculosis (which had become the leading cause of death) and to control then-named venereal disease. In 1935, federal monies were made available to strengthen the work performed by local and state public health departments.

The Social Security Act

A major societal shift occurred in 1935 with the passage of the Social Security Act, which dramatically affected health care in the midst of the Great Depression. Until this event, local and state governments, individuals, and families had been responsible for providing healthcare services for the poor. In a landmark legislative effort, the Social Security Act shifted that responsibility to the federal government. Although not specifically intended to provide healthcare services, the Social Security Act provided funds for health-related programs for the poor in areas such as public health, maternal and child health, crippled children's programs, and benefits for elderly adults and disabled individuals.

The Social Security Act also dramatically affected the nursing home industry. This act specified that money be given to private nursing homes but excluded public institutions (this latter exception was later repealed). Thus, for-profit and privately owned nursing homes proliferated to serve the welfare patient. These homes gave priority to paying patients because the government reimbursement was substantially lower than fees for services.

Healthcare Access Changes Post-World War II

Our healthcare system, as we know it today, emerged after World War II. Through funding from the 1946 Hill-Burton Act, government money was made available to build hospitals, as more medicines, anesthesia agents, and technologies became available. National legislation emphasized *secondary/tertiary care*—highly technical hospital-based care, rather than *primary care*—defined as preventive, restorative, or medical treatment given while the patient lives at home. Hill-Burton funds focused especially on building hospitals in rural areas, creating geographic access to services that had not previously been available. Hill-Burton also required state-level planning for healthcare services.

Psychiatric treatment also changed dramatically. With the advent of psychotropic medications, more psychiatric patients could be treated in outpatient settings. In 1963, the federal government established community mental health centers for this purpose. Thus, many psychiatric patients who had been hospitalized for years were able to leave the hospitals and function in the community setting. Unfortunately, those who were more severely mentally ill requiring continued hospitalization suffered greatly because less money was available for their care.

Medicare and Medicaid: New Forms of Access

Until 1965, the federal government financed little in the way of direct healthcare services, concentrating only on public health issues and providing services for military personnel and Native Americans. Less than half of elderly adults and disabled Americans were covered by health insurance. State and local governments established and supported special facilities for mental illness, mental retardation, and communicable diseases such as tuberculosis.

Then, in a wave of entitlement programming, the federal government became enmeshed in health care by establishing Medicare and Medicaid. Naturally, this Social Security Act Amendment (Titles XVIII and XIX) opened previously unavailable access to care for elderly, disabled, and poor persons giving them more access to health care. Further,

providers—hospitals, other healthcare organizations, physicians, and even suppliers and the building industry—benefited as well. Medicare often became *the largest source* of revenue for healthcare providers, resulting in the building of more hospitals, growth in the number of independent medical practices, and the expansion of long-term care programs. Both Medicare and Medicaid pay for hospital and long-term care, primary care, and some preventive services. As more personnel were needed for the expansions, additional federal programs were funded to supply more physicians, nurses, and allied health professionals.

Medicare induced significant changes in long-term care. The federal government redefined who was eligible to care for Medicare patients by establishing care standards and requirements for skilled nursing facilities (SNF) and intermediate care facilities (ICF) that raised the level of care and expanded medical services available to the public.

Medicare and Medicaid also infused the home health industry with money to expand agencies and services. Whereas there were approximately 250 home health agencies in 1960, by 1968 there were 1,328 official agencies providing home health services. Federal funding over the next 20 years gradually refocused home health on post-acute services. Unfortunately, money became less available for the chronically ill client who needed longer-term services. Services also changed in the home health industry as home health funding began to include rehabilitative services—physical therapy, occupational therapy, speech therapy, and social work services. This continues today with more than 12,200 home health agencies in the United States (CDC, n.d.).

In 1965, the Older Americans Act mandated and funded Area Agencies on Aging (AAA). These agencies fund a wide array of services for elderly adults including:

- Senior centers with nutrition and recreation programs
- Health promotion and screening programs
- Mental health evaluation and treatment
- Respite care
- Case managers to plan care for elders so that they can stay in their homes rather than be institutionalized
- Services to the homebound, such as meals, homemaker services, chore services, and transportation

In 1980, the Omnibus Budget Reconciliation Act aided home care by expanding Medicare benefits. For the first time, for-profit home care agencies could become Medicare-certified providers. In addition, advanced technology, such as ventilators, renal hemodialysis, and infusion therapy—originally found only in hospitals—all moved into the home, expanding the need for home care nurses. This need was coupled with changes to reimbursement (prospective payment) for hospitals resulting in earlier discharges and greater use of home care. The number of home care agencies increased exponentially. Battles ensued in response to the escalating cost of home care, and in 1984, visits were restricted to the homebound client. Later, after a 1989 court ruling (*Duggen v. Bowen*), eligibility requirements were eased once again. Following the onset of the COVID-19 public health emergency in early 2020, CMS announced its proposed Home Health Prospective Payment System Rule effective for calendar year 2021. These regulatory changes made provisions for, and increases to, reimbursements regarding the use of telehealth services, home infusion therapy services (Yood & Awanyai, 2020), and home dialysis services (Brady, 2020).

Because Medicare standards required hospitals to renovate and rebuild in the 1970s, for-profit hospitals, like many other businesses, began to offer publicly traded stocks. Stockholders expected these hospitals to make a profit so stocks would increase in value and provide good dividends. In this arrangement, hospitals had to pay attention to stockholder interests. The profit-making motive applied to not-for-profit hospitals as well. They had

to make profits too—using the money for pay increases, new equipment or building projects, and investments—but called it *excess of revenue over expenses* rather than profit. Investor-owned nursing homes and home care facilities also increased, creating access for those with private or public insurance.

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 provides Medicare participants with access to coverage for prescription drugs. Coverage, which started in 2006, is provided through private standalone prescription drug plans or Medicare Advantage prescription drug plans administered by approved insurance companies. Prior to this act, Medicare beneficiaries had no prescription drug coverage. In 2020, following unsuccessful attempts by both houses of Congress to address drug pricing, the president signed executive orders providing lower prescription drug prices and discounts in Medicare Part D costs to U.S. seniors (U.S. Department of Health and Human Services [DHHS], 2020).

Beneficiaries have seen their premiums and copays continue to rise and have experienced closer monitoring of their utilization management. Although Medicare drug legislation has certainly provided relief for the costs of drugs, especially for lower-income beneficiaries, all beneficiaries experience a gap in coverage, often called the "doughnut hole." When Medicare recipients reach a level of spending on prescriptions (adjusted yearly, $4,130 in 2021), beneficiaries will pay a discounted rate for their prescriptions unless they qualify for the Extra Help program or are covered by a Medicare replacement plan (U.S. Centers for Medicare & Medicaid Services, n.d.).

This spending gap resulted in serious health consequences for Medicare beneficiaries, along with costs of more than $22.2 billion in preventable hospitalizations (McDermott & Jiang, 2020). The ACA signed into law in March 2010, includes provisions to address the coverage gap. The U.S. Department of Health and Human Services (DHHS) reports that, as of 2017, seniors had already saved more than $26 billion in prescription drug costs as a result of the coverage assistance provided by the ACA (DHHS, 2017).

Safety Net Providers

Safety net practices are defined by the IOM as "those providers that organize and deliver a significant level of health care and other needed services to uninsured, Medicaid and other vulnerable patients" (Lewin & Altman, 2000). Safety net healthcare services have gradually emerged in an effort to fill the care gaps in our system. These include services for underserved and uninsured rural and inner-city populations, non-English-speaking immigrants, homeless persons, and migrant workers. Two examples of legislated support for the poor and uninsured can be found in the clinics and services targeted toward these populations.

The Community Health Center (CHC) Act, passed in 1965, provided funds for comprehensive health and supportive social services to be provided through clinics established to make primary care available to specific types of populations in the clinic's service area. CHCs receive funding through federal grants available through the DHHS and operate under specific rules and conditions. They are required to provide services to anyone who needs access, regardless of the person's ability to pay.

The RHC Act, passed in 1971, established higher rates of Medicare and Medicaid payments to rural primary care practices, provided that they employ a nurse practitioner (NP) or physician assistant and meet the qualifications for federal approval as an RHC. RHCs can be freestanding clinics or can be associated with a rural hospital or nursing home. Although there are no specific requirements to provide care to the uninsured, most RHCs do strengthen the rural safety net beyond just Medicare and Medicaid patients.

As the movement toward advanced nursing practice gained momentum, schools and

colleges of nursing established primary care and nursing practice centers and community health services, collectively known as *nurse-managed care*. Community nursing centers (CNCs), community nursing organizations (CNOs), and nursing health maintenance organizations (HMOs) have been sponsored by local communities, community groups, and churches, and also by university schools and colleges of nursing that provide the majority of these access points. Most nursing centers provide care to poor and underserved population groups (Harris, 2009).

ACA

The ACA has been labeled "the most monumental piece of U.S. federal health policymaking" (p. 2) since the enactment of the Social Security Act Amendment of 1965 (Wilensky & Teitelbaum, 2020).

One of the primary objectives of the ACA was to address access to care by making healthcare insurance coverage more affordable. To this end, many people were able to procure health insurance between 2010 and 2011, reducing the rate of uninsured in the United States from 16% to 11.1% (Wilensky & Teitelbaum, 2020). Since the national election of 2016, however, with Republicans having a majority in the U.S. House of Representatives and the Senate, led by a Republican White House, there have been ongoing (and mostly futile) attempts to repeal and replace the ACA. Presidential executive orders have been implemented in an attempt to rewrite existing legislation without much success. Despite these efforts to overturn the ACA, the majority of the policy remains in its original state. **Table 1-1** offers a broad overview of the original legislation.

Policies Addressing Cost

Cost, and controlling the cost of providing care, is one of the most perplexing issues facing the U.S. healthcare system today. The *cost* of health care can be defined as *the cost of production of healthcare services* and refers to the total amount spent on a particular item or service (Brownlee et al., 2012). Both cost and controlling cost are important concepts, but expenditures are more easily measured and tracked and thus are more commonly used to analyze financial aspects of the healthcare system.

Consumers and third-party payers have seen consistently higher increases in healthcare costs and expenditures than in other segments of the economy, with rates of increase slowing slightly for the past few years but continuing to rise (Warshawsky, 2016). Given that U.S. healthcare spending grew 4.6% in 2018, reaching $3.6 trillion or $11,172 per person (American Medical Association, n.d.), insurance companies, employers, federal and state governments, and users of direct healthcare services are all vitally interested in payment systems and cost control.

Blue Cross/Blue Shield: Setting Trends in Paying for Care

The emergence of health insurance was a significant change in healthcare financing, moving payment for health care from personal business transactions to a third-party mediator. Initially, insurance coverage was created either to provide health care for people involved in rail or steamboat accidents or for mutual aid where small amounts of disability cash benefited members experiencing an accident or illness, including typhus, typhoid, scarlet fever, smallpox, diphtheria, and diabetes.

Then, in 1929, Justin Ford Kimball established a hospital insurance plan at Baylor University in Dallas, Texas. He had been a superintendent of schools and noticed that teachers often had unpaid bills at the hospital. By examining hospital records, he calculated that "the schoolteachers as a group 'incurred an average of 15 cents a month in hospital

Table 1-1 Patient Protection and Affordable Care Act (P.L. 111–148)

Overall approach to expanding access to coverage	■ Requires most U.S. citizens and legal residents to have health insurance. Creates state-based American Health Benefit Exchanges through which individuals can purchase coverage, with premium and cost-sharing credits available to individuals/families with income between 133% and 400% of the federal poverty level (the poverty level was $19,530 for a family of three in 2013), and creates separate exchanges through which small businesses can purchase coverage. Requires employers to pay penalties for employees who receive tax credits for health insurance through an exchange, with exceptions for small employers. Imposes new regulations on health plans in the exchanges and in the individual and small group markets. Expands Medicaid to 133% of the federal poverty level.
Individual Mandate	
Requirement to have coverage	■ Requires U.S. citizens and legal residents to have qualifying health coverage. Those without coverage pay a tax penalty that will be phased in according to the following schedule: $95 in 2014, $325 in 2015, and $695 in 2016 for the flat fee or 1.0% of taxable income in 2014, 2.0% of taxable income in 2015, and 2.5% of taxable income in 2016. Beginning after 2016, the penalty will be increased annually by the cost-of-living adjustment. Exemptions will be granted for financial hardship, religious objections, American Indians, those without coverage for less than three months, undocumented immigrants, incarcerated individuals, those for whom the lowest cost plan option exceeds 8% of an individual's income, and those with incomes below the tax filing threshold (in 2009, the threshold for taxpayers under age 65 was $9,350 for singles and $18,700 for couples). *This mandate was later determined to be unconstitutional and dropped from the ACA.*
Employer Requirements	
Requirement to offer coverage	■ Assesses employers with 50 or more full-time employees that do not offer coverage and have at least one full-time employee who receives a premium tax credit fee of $2,000 per full-time employee, excluding the first 30 employees from the assessment. Employers with 50 or more full-time employees that offer coverage, but have at least one full-time employee receiving a premium tax credit, will pay the lesser of $3,000 for each employee receiving a premium credit, or $2,000 for each full-time employee, excluding the first 30 employees from the assessment. (Effective January 1, 2014.) Employers with up to 50 full-time employees are exempt from any of the previously mentioned penalties.
Other requirements	■ Requires employers with more than 200 employees to automatically enroll employees into health insurance plans offered by the employer. Employees may opt out of coverage.

(continues)

Table 1-1 Patient Protection and Affordable Care Act (P.L. 111–148) *(continued)*

Expansion of Public Programs	
Treatment of Medicaid	■ Expands Medicaid to all non-Medicare-eligible individuals under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% FPL, based on their modified adjusted gross income (under current law, undocumented immigrants are not eligible for Medicaid).
Treatment of CHIP	■ Requires states to maintain current income eligibility levels for children in Medicaid and the Children's Health Insurance Program (CHIP) until 2019 and extends funding for CHIP through 2015.
Health Insurance Exchanges	
Creation and structure of health insurance exchanges	■ Creates state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges, administered by a governmental agency or nonprofit organization, through which individuals and small businesses with up to 100 employees can purchase qualified coverage.
Eligibility to purchase in the exchanges	■ Restricts access to coverage through the exchanges to U.S. citizens and legal immigrants who are not incarcerated.
Qualifications of participating health plans	■ Requires qualified health plans to report information on claims payment policies, enrollment, disenrollment, number of claims denied, cost-sharing requirements, out-of-network policies, and enrollee rights in plain language.
Basic health plan	■ Permits states the option to create a Basic Health Plan for uninsured individuals with incomes between 133–200% FPL who would otherwise be eligible to receive premium subsidies in the exchange. Individuals with incomes between 133–200% FPL in states creating Basic Health Plans are not eligible for subsidies in the exchanges.
Abortion coverage	■ Permits states to prohibit plans participating in the exchanges from providing coverage for abortions. ■ Prohibits plans participating in the exchanges from discriminating against any provider because of an unwillingness to provide, pay for, provide coverage of, or refer for abortions.
Changes to Private Insurance	
Temporary high-risk pool	■ Establishes a temporary national high-risk pool to provide health coverage to individuals with preexisting medical conditions. U.S. citizens and legal immigrants who have a preexisting medical condition and who have been uninsured for at least six months will be eligible to enroll in the high-risk pool and receive subsidized premiums.
Medical loss ratio and premium rate reviews	■ Requires health plans to report the proportion of premium dollars spent on clinical services, quality, and other costs, and provide rebates to consumers for the amount of the premium spent on clinical services and quality that is less than 85% for plans in the large group market and 80% for plans in the individual and small group markets. (Requirement to report medical loss ratio effective plan year 2010; requirement to provide rebates effective January 1, 2011.)

	■ Establishes a process for reviewing increases in health plan premiums and require plans to justify increases. Requires states to report on trends in premium increases and recommend whether certain plans should be excluded from the exchanges based on unjustified premium increases. Provides grants to states to support efforts to review and approve premium increases. (Effective beginning plan year 2010.)
Dependent coverage	■ Provides dependent coverage for children up to age 26 for all individual and group policies. (Effective six months following enactment.)
Consumer protections	■ Develops standards for insurers to use in providing information on benefits and coverage. (Standards developed within 12 months following enactment; insurer must comply with standards within 24 months following enactment.)
State Role	
State role	■ Enrolls newly eligible Medicaid beneficiaries into the Medicaid program no later than January 2014 (states have the option to expand enrollment beginning in 2011), coordinates enrollment with the new exchanges, and implements other specified changes to the Medicaid program. Maintains current Medicaid and CHIP eligibility levels for children until 2019 and maintains current Medicaid eligibility levels for adults until the exchange is fully operational. Permits states to create a Basic Health Plan for uninsured individuals with incomes between 133% and 200% FPL in lieu of these individuals receiving premium subsidies to purchase coverage in the exchanges. (Effective January 1, 2014.)
Cost Containment	
Medicare	■ Restructures payments to Medicare Advantage (MA) plans by setting payments to different percentages of Medicare fee-for-service (FFS) rates, with higher payments for areas with low FFS rates and lower payments (95% of FFS) for areas with high FFS rates. Phases in revised payments over three years beginning in 2011, for plans in most areas, with payments phased in over longer periods (four years and six years) for plans in other areas. Provides bonuses to plans receiving four or more stars, based on the current five-star quality rating system for MA plans, beginning in 2012; qualifying plans in qualifying areas receive double bonuses. Modifies rebate system with rebates allocated based on a plan's quality rating. Phases in adjustments to plan payments for coding practices related to the health status of enrollees, with adjustments equaling 5.7% by 2019. Caps total payments, including bonuses, at current payment levels. Requires MA plans to remit partial payments to the secretary if the plan has a medical loss ratio of less than 85%, beginning in 2014. Requires the secretary to suspend plan enrollment for three years if the medical loss ratio is less than 85% for two consecutive years and to terminate the plan contract if the medical loss ratio is less than 85% for five consecutive years.

(continues)

Table 1-1 Patient Protection and Affordable Care Act (P.L. 111–148) *(continued)*

	■ Reduces annual market basket updates for inpatient hospitals, home health, SNFs, hospices, and other Medicare providers and adjusts for productivity. (Effective dates vary.) ■ Reduces Medicare Disproportionate Share Hospital (DSH) payments initially by 75% and subsequently increases payments based on the percent of the population uninsured and the amount of uncompensated care provided. (Effective fiscal year [FY] 2014.) ■ Allows providers organized as accountable care organizations (ACOs) that voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program. To qualify as an ACO, organizations must agree to be accountable for the overall care of their Medicare beneficiaries, have adequate participation of primary care physicians, define processes to promote evidence-based medicine, report on quality and costs, and coordinate care. (Shared savings program established January 1, 2012.) ■ Creates an Innovation Center within the Centers for Medicare and Medicaid Services to test, evaluate, and expand Medicare, Medicaid, and CHIP different payment structures and methodologies to reduce program expenditures while maintaining or improving quality of care. Payment reform models that improve quality and reduce the rate of cost growth could be expanded throughout the Medicare, Medicaid, and CHIP programs. (Effective January 1, 2011.) ■ Reduces Medicare payments that would otherwise be made to hospitals by specified percentages to account for excess (preventable) hospital readmissions. (Effective October 1, 2012.) ■ Reduces Medicare payments to certain hospitals for hospital-acquired conditions by 1%. (Effective FY 2015.)
Medicaid	■ Extends the drug rebate to Medicaid managed care plans. (Effective upon enactment.) ■ Prohibits federal payments to states for Medicaid services related to healthcare acquired conditions. (Effective July 1, 2011.)
Waste, fraud, and abuse	■ Reduces waste, fraud, and abuse in public programs by allowing provider screenings, enhanced oversight periods for new providers and suppliers, including a 90-day period of enhanced oversight for initial claims of DME suppliers, and enrollment moratoria in areas identified as having an elevated risk of fraud in all public programs, and by requiring Medicare and Medicaid program providers and suppliers to establish compliance programs. Develops a database to capture and share data across federal and state programs, increases penalties for submitting false claims, strengthens standards for community mental health centers, and increases funding for anti-fraud activities. (Effective dates vary.)

Improving Quality/Health System Performance	
Medicare	■ Establishes a national Medicare pilot program to develop and evaluate paying a bundled payment for acute, inpatient hospital services, physician services, outpatient hospital services, and post-acute care services for an episode of care that begins 3 days prior to a hospitalization and spans 30 days following discharge. If the pilot program achieves the stated goals of improving or not reducing quality and reducing spending, it develops a plan for expanding the pilot program. (Establish pilot program by January 1, 2013; expand program, if appropriate, by January 1, 2016.) ■ Creates the Independence at Home demonstration program to provide high-need Medicare beneficiaries with primary care services in their home and allow participating teams of health professionals to share in any savings if they reduce preventable hospitalizations, prevent hospital readmissions, improve health outcomes, improve the efficiency of care, reduce the cost of healthcare services, and achieve patient satisfaction. (Effective January 1, 2012.) ■ Establishes a hospital value-based purchasing (VBP) program in Medicare to pay hospitals based on performance on quality measures and extends the Medicare physician quality reporting initiative beyond 2010. (Effective October 1, 2012.) Develops plans to implement VBP programs for SNF, home health agencies, and ambulatory surgical centers. (Reports to Congress were due January 1, 2011.)
Primary care	■ Increases Medicaid payments in FSS and managed care for primary care services provided by primary care doctors (family medicine, general internal medicine or pediatric medicine) to 100% of the Medicare payment rates for 2013 and 2014. States will receive 100% federal financing for the increased payment rates. (Effective January 1, 2013.)
National quality strategy	■ Develops a national quality improvement strategy that includes priorities to improve the delivery of healthcare services, patient health outcomes, and population health. Creates processes for the development of quality measures involving input from multiple stakeholders and for selecting quality measures to be used in reporting to, and payment under, federal health programs. (National strategy was due to Congress by January 1, 2011.)
Prevention/Wellness	
National strategy	■ Develops a national strategy to improve the nation's health. (Strategy due one year following enactment.) Creates a Prevention and Public Health Fund to expand and sustain funding for prevention and public health programs. (Initial appropriation in FY 2010.) Creates task forces on Preventive Services and Community Preventive Services to develop, update, and disseminate evidence-based recommendations on the use of clinical and community prevention services. (Effective upon enactment.)

(continues)

Table 1-1 Patient Protection and Affordable Care Act (P.L. 111–148) *(continued)*

	■ Establishes a grant program to support the delivery of evidence-based and community-based prevention and wellness services aimed at strengthening prevention activities, reducing chronic disease rates and addressing health disparities, especially in rural and frontier areas. (Funds appropriated for five years beginning in FY 2010.)
Coverage of preventive services	■ Authorizes the secretary to modify or eliminate Medicare coverage of preventive services, based on recommendations of the U.S. Preventive Services Task Force. (Effective January 1, 2011.) ■ Reimburses providers 100% of the physician fee schedule amount, with no adjustment for deductible or coinsurance for personalized prevention plan services when these services are provided in an outpatient setting. (Effective January 1, 2011.) ■ Provides incentives to Medicare and Medicaid beneficiaries to complete behavior modification programs. Requires Medicaid coverage for tobacco cessation services for pregnant women. Requires qualified health plans to provide recommended immunizations, preventive care for infants, children, and adolescents, and additional preventive care and screenings for women.
Wellness programs	■ Provides grants for up to five years to small employers that establish wellness programs. Permits employers to offer employee rewards—in the form of premium discounts, waivers of cost-sharing requirements, or benefits that would otherwise not be provided—of up to 30% of the cost of coverage for participating in a wellness program and meeting certain health-related standards. Employers must offer an alternative standard for individuals for whom it is unreasonably difficult or inadvisable to meet the standard. The reward limit may be increased to 50% of the cost of coverage if deemed appropriate.
Nutritional information	■ Requires chain restaurants and food sold from vending machines to disclose the nutritional content of each item.
Other Investments	
Workforce	■ Improves workforce training and development: • Increases the number of Graduate Medical Education (GME) training positions by redistributing currently unused slots, with priorities given to primary care and general surgery and to states with the lowest resident physician-to-population ratios to promote training in outpatient settings and ensure the availability of residency programs in rural and underserved areas. Increases workforce supply and the support training of health professionals through scholarships and loans; supports primary care training and capacity building; provides state grants to providers in medically underserved areas; trains and recruits providers to serve in rural areas; establishes a public health workforce loan repayment program; provides medical residents with training in preventive medicine and public health; promotes training of a diverse workforce; and promotes cultural competence training of healthcare professionals.

	• Addresses the projected shortage of nurses and the retention of nurses by increasing the capacity for education, supporting training programs, providing loan repayment and retention grants, and creating a career ladder to nursing. Offers grants for up to three years to employ and provide training to family nurse practitioners who provide primary care in federally qualified health centers and nurse-managed health clinics. Supports the development of training programs that focus on primary care models such as medical homes, team management of chronic disease, and those that integrate physical and mental health services.
Requirements for nonprofit hospitals	■ Imposes additional requirements on nonprofit hospitals to conduct a community needs assessment every three years and adopt an implementation strategy to meet the identified needs, adopt and widely publicize a financial assistance policy that indicates whether free or discounted care is available and how to apply for the assistance, limits charges to patients who qualify for financial assistance to the amount generally billed to insured patients, and makes reasonable attempts to determine eligibility for financial assistance before undertaking extraordinary collection actions. Imposes a tax of $50,000 per year for failure to meet these requirements.
American Indians	■ Reauthorizes and amends the Indian Health Care Improvement Act.

Data from Kaiser Family Foundation. (2013). *Summary of the Affordable Care Act.* http://www.kff.org/health-reform/fact-sheet/summary-of-the-affordable-care-act/

bills. To assure a safe margin, he established a rate of 50 cents a month.' In return, the schoolteachers were assured of 21 days of hospitalization in a semiprivate room" (data from Raffel & Raffel, 1994, p. 211). This was the beginning of the Blue Cross plans that developed across the country. Blue Cross offered *service benefits* rather than a *lump-sum payment*, or *indemnity*, the type of benefits offered by previous insurance plans.

Following the success of Blue Cross, in 1939 the California Medical Association started the California Physicians Service to pay physician services. This became known as Blue Shield. In this plan, doctors were obligated to provide treatment at the fee established by Blue Shield, even though the doctor might charge more to patients not covered by Blue Shield. Blue Shield was, in effect, for people who earned less than $3,000 a year. In one of many unsuccessful attempts at national healthcare reform, physicians designed and agreed to this plan to *prevent the establishment of a national health insurance plan.*

Although Blue Cross was quite successful, Blue Shield was not. As inflation occurred and patients made more money, the base rate was not changed, so fewer people were eligible for the Blue Shield rates. "Blue Shield made the same dollar payment for services rendered, but because the patient was above the service-benefit income level, the patient frequently had to pay an additional amount to the physician" (Raffel & Raffel, 1994, p. 213).

After World War II, private insurance companies proliferated and offered health

insurance policies both to individuals and to employers. Large employers were expected to offer employees healthcare benefits due in large part to unionization. Health insurance became an *entitlement*. Soon private insurance companies (third-party payers) enrolled more than half the U.S. population. The McCarren-Ferguson Act of 1945, 15 U.S.C. §§ 1011-1015 "gave states the exclusive right to regulate health insurance plans.... As a result the federal government has no agency that is solely responsible for monitoring insurance" (Finkelman, 2001, p. 188).

The Federal Role in Cost Containment

To administer the complex Medicare and Medicaid programs that had been established, in 1965 the federal government initiated the Health Care Finance Administration (HCFA), now called the Centers for Medicare and Medicaid Services (CMS), within the DHHS. Payment for Medicare and Medicaid services was based on the *retrospective* cost of care—calculated and billed to the government by healthcare organizations and by physicians seeing patients. This fee-for-service system did not limit what providers could charge for their services, and initially there was no systematic approach to fees: Providers charged what the market would bear. In the 1970s, faced with escalating healthcare expenditures, states began controlling the amount they would pay to a provider for a particular service. The rationale for setting rates that would be paid was to encourage providers to voluntarily control the costs of the care they delivered.

The federal government, along with states, was spending a tremendous amount of money on health care. The gross domestic product (GDP) for health care has grown from 6%, when Medicare and Medicaid were introduced, to 17.7% in 2018. Medicare spending accounts for 21% ($3.6 trillion) of GDP while Medicaid accounts for 16% ($750.2 billion). To find money to support these programs, the government was faced with increasing taxes, shifting money from other services such as defense or education, or curbing hospital and physician costs. Curbing costs was the first choice for policymakers.

Hospital Prospective Payment: Not the Outcome on Cost Savings as Intended

The next direct step by the federal government to control healthcare costs, particularly those generated in hospital settings, was the implementation of a *prospective* pricing system for Medicare patients. In 1983, the HCFA implemented a plan to pay a set price to each hospital for each diagnosis regardless of how much the facility actually spent to provide the care. This payment strategy was called *diagnosis-related groups* (DRGs). If hospital staff could provide care for a patient with a hip fracture, for example, at less than the DRG payment, they could keep the money and, in a sense, make a profit. If the cost of care for the patient went above the DRG payment, the hospital lost money. DRGs required hospitals to become more efficient and aware of costs. Yet, the requirements of the DRG policy induced providers to release patients from the hospital as quickly as they could and to shift costs to other third-party payers who did not engage in prospective payment (e.g., home health agencies, SNF), leaving doubt as to the "bottom line" in cost savings to the healthcare system overall.

Prospective payment was expanded in 1989 to include physician services outside the hospital with the introduction of the *resource-based relative value system* (RBRVS). This policy, through Medicare Part B legislation, applied the same concept as hospital DRGs to the outpatient setting. Two goals of RBRVS were to control costs and to put more emphasis on primary care and prevention.

Health Maintenance Organizations

In another attempt to hold down healthcare costs, the Health Maintenance Organization Act of 1973 provided federal grants to develop *HMOs*. This act required employers with more than 25 employees to offer an HMO health insurance option to employees. HMOs had a good track record of bringing down healthcare costs because they had traditionally been serving younger, healthier populations. Thus, starting more HMOs sounded like a way to cut healthcare costs. This act provided a specific definition of what an HMO was and gave the states oversight (or licensing) responsibility.

The concept of *managed care*, as delivered by HMOs, has taken hold in the public sector as well. Both Medicare and Medicaid (in many states) have taken their own steps to promote managed care by contracting with private insurers or HMOs to take on the primary care of groups of people enrolled for healthcare coverage and to serve as gatekeepers to specialty services. These measures were intended to control healthcare costs for federal and state governments and to improve the quality of care. The managed care market has shown to impact both those who are, and who are not, receiving healthcare services through a managed care model. There are observable market-level changes, varied based on market penetration, which may affect the cost and outcomes of care (Bundorf et al., 2004). In actual practice, results have been mixed as the costs of health care continue to climb.

The Health Insurance Portability and Accountability Act of 1996

The *Health Insurance Portability and Accountability Act* (HIPAA; Pub. L. 104–191, 110 Stat.) addresses several significant issues including access, quality, and cost. Major portions of HIPAA address the financing of health care. This act "establishes that insurers cannot set limits on coverage for preexisting conditions, . . . guarantees access and renewability [of health insurance], . . . [and] addresses issues of excluding small employers from insurance contracts on the basis of employee health status. In addition, the law provided for greater tax deductibility of health insurance for the self-employed" (Finkelman, 2001, p. 192).

HIPAA started the *medical savings accounts,* or *health savings accounts* (HSA)*,* a tax-free account provided by employers. Here the employee can annually set up an account and pay in the amount of money the employee expects to have to pay for health coverage for the year. The money paid into the account takes place before taxes are taken out by the employer. At the end of the year, if the money is not spent, it goes back to the employer. For 2021, the annual limit on HSA contributions is $3,600 for individuals and $7,200 for family coverage.

The Balanced Budget Act of 1997

The *Balanced Budget Act* (BBA) significantly lowered payments for psychiatric care, rehabilitation services, and long-term care. Because ambulatory services, SNFs, and home care services were rapidly expanding and costing more healthcare dollars, the idea was to curb spending by placing these services under prospective payment. *Prospective payment* means that the payer (led by Medicare and Medicaid) determines the cost of care before the care is given:

- The provider is told how much will be paid for the given care.
- An *ambulatory payment classification system* was created, establishing a fixed dollar amount for outpatient services diagnoses.
- SNF experienced prospective payment through the *resource utilization group* (RUG) system.
- Home care was regulated by the *Outcome and Assessment Information Set* (OASIS) system.

BBA mandated payment reductions limiting DRG and RBRVS payment rates (as described previously), as well as reduced capital expenditures, graduate medical education, established open enrollment periods, and medical savings accounts for Medicare recipients. Benefits for children's health care were increased through the creation of the Children's Health Insurance Program (CHIP), that "expands block grants to states increasing Medicaid eligibility for low-income and uninsured children, establishing a new program that subsidizes private insurance for children or combining Medicaid with private insurance" (Finkelman, 2001, p. 398). BBA also created new penalties for fraud.

BBA had a major impact on health care, causing a number of hospitals, long-term care facilities, and home care companies to fold. Profit margins were drastically reduced, and rural hospitals were disproportionately affected. BBA had such profound cost-cutting effects that in December 2000, Congress passed relief legislation providing additional money for hospitals and managed care plans.

Another positive aspect of the BBA was a major impact on recognition of the nursing profession. Under BBA, NPs and clinical nurse specialists (CNSs) practicing in any setting could be directly reimbursed for services provided to Medicare patients at a rate equal to 85% of physician fees. This occurred to both better serve populations not receiving medical care and to save costs because studies had determined that NPs could deliver as much as 80% of the medical care at less cost than primary care physicians could with comparable, and sometimes better, clinical outcomes. This federal legislation overrode state legislation that, in some cases, required NPs to work under direct physician supervision, with reimbursement made only to physicians. This act was reauthorized in 2009, after a long battle in Congress. In 2015, the Medicare Access and CHIP Reauthorization Act of 2015 assured patient access to NPs while expanding the ordering authority of NPs to include durable medical equipment (DME) and other medical supplies/equipment.

The Affordable Care and Patient Protection Act

The ACA, enacted on March 23, 2010, is the most sweeping healthcare legislation since the inception of Medicare and Medicaid in 1965. Numerous attempts have been made to reform U.S. health care, but the ACA is the first to attempt to accomplish this overarching objective. It was passed after a hard-fought battle that extended from the 2008 presidential campaign into President Barack Obama's first months in office. The political battle to repeal and replace the ACA is ongoing as evidenced by the recent failure of the proposed American Health Care Act (https://www.congress.gov/bill/115th-congress/house-bill/1628) in March 2017 and the ongoing litigation that made its way to the U.S. Supreme Court in November 2020 (https://www.nafcclinics.org/content/supreme-court-aca-california-v-texas).

The overall goals of the ACA are to strengthen and systematize U.S. health care and to provide near-universal coverage for U.S.citizens and legal immigrants. The legislation is complex and multifaceted—a true attempt at system reform. The ACA seeks to strengthen patient rights and protections, make coverage more affordable and widespread, ensure access to care, and create a stronger Medicare system to care for the growing number of elderly adults in our country. **Table 1-1** provides a broad overview of the ACA based on the original legislation; a useful, detailed summary of the ACA and its many components can be found at the Kaiser Family Foundation Health Reform website (http://kff.org/health-reform).

As part of the Tax Cuts and Jobs Act of 2017, the 114th U.S. Congress eliminated the ACA's tax penalty for most people who are not covered by health insurance effective in 2019. Thus, there is no financial risk for an individual who fails to purchase health insurance on the marketplace. As a result of this action,

Texas (and a number of other states, the Aggrieved States), filed a lawsuit claiming that if there is no penalty for noncompliance, then the mandate in the ACA is not severable from the individual mandate (a "core provision"). If the mandate is not legal, then the entire mandate is unconstitutional. On December 14, 2018, a federal judge in Texas agreed with the States' argument. (This case continues to be heard through the appeals process.) However, as recently as December 2020 (Kaiser Family Foundation, 2017), comments made during oral arguments by the Supreme Court justices suggest that, with respect to the key issue of severability, it is highly likely that the Supreme Court will find that that the rest of the ACA can continue on even if the individual mandate is struck down (Anelli & Bowers, 2020).

A Look to the Future

Issues of access and cost will remain driving forces in the healthcare world for years to come, and perhaps forever. *Ever-tightening governmental funding and regulations*, such as the value-based reimbursement issues and the requirements of the ACA, force healthcare providers and institutional leaders to pay attention to patient outcomes in ways never before expected.

Our *aging population* of baby boomers, estimated at about 73 million Americans in 2020, will continue to strain our healthcare system in both private and public sectors. Shortages of healthcare professionals (such as nurses, physical therapists, and, in some parts of the United States, physicians) to care for them, as well as those who are newly insured through the provisions of the ACA, will continue to be a problem. Women especially feel the impact of this because they live longer and possibly face living at the poverty level in their older years. According to the National Council of State Boards of Nursing's (NCSBN, n.d.) 2017 National Nursing Workforce Study, 92% of the current nursing workforce are women with more than 53% over the age of 60 and, in the general workforce, earn 85% of what their male counterparts make (Graf et al., 2019). Retirement incomes will continue to reflect this societal problem.

Economic issues continue to plague federal, state, and local budgets as all face major deficits. Increasing taxes has not been popular, although as of 2013 federal taxes have increased. Although the 2017 Tax Cuts and Jobs Act (TCJA) reduced individual income tax rates, a newly elected U.S. president's tax proposals are pending as of this writing. Increased spending cuts are also not popular. The ACA creates an additional burden for federal and state budgets, with many state governors working on ways to both cut Medicaid payments and not support ACA requirements for Medicaid (a states' rights issue as yet unresolved).

The effects of the ACA, particularly the impact of ACOs and provider payments, will bear watching, especially as they are implemented in safety net and rural areas. Hospital closures in the past have disproportionately affected safety net and rural areas, and it is possible that some provisions of the ACA may have unintended consequences for citizens. As more people become insured and seek primary care, a dedicated effort will need to be made to ensure there are enough primary care providers to meet the anticipated needs. Federal laws to ensure the full scope of practice for NPs and other advanced practice nurses may be required to adequately meet patient needs, especially because some states continue to artificially limit advanced practice.

Alternative therapies generally focus on health promotion. In the midst of all the cost-cutting in our illness care system, alternative therapies have been enjoying increased popularity with the U.S. public, even though consumers most often pay out of pocket for the services. As patients visit physicians and receive medications for diseases, they frequently discover this does not cure the problem. In many cases, the medications cause other medical problems. Alternative therapies provide a

way to stay healthy, as well as to treat disease, and bring comfort without producing as many side effects and as much pain. These are likely to assume even greater importance in health care in the future. As recently as December 2020, in response to the COVID-19 emergency response, several states temporarily suspended or waived existing collaboration, supervision, and protocol requirements (American Association of Nurse Practitioners, 2020).

Another issue affecting our future in health care is the technology explosion, particularly as evidenced in response to the COVID-19 pandemic. As telehealth capabilities increase, healthcare availability expands to meet the demand, opening the door for increased access to care for selected populations. Electronic health records (EHRs) have great potential for increasing patient safety and the efficiency of care; yet present the ethical challenge of protecting patients' personal health information, and the cost of implementation is burdensome on healthcare organizations. In addition, the internet has vastly improved clinician information on evidence-based practice. Consumers continue to access the internet to research their specific illnesses and determine which providers are most effective and will continue to do so with even more frequency in the future (Findlay, 2016).

The science of *genomics* adds a new dimension to health care that looks to have an ever-increasing presence in the future. Currently, scientists have joined forces with private companies that supply enormous funds to map genes. With commercial enterprises involved, it has created great ethical implications because business leaders believe this information can produce future profits.

On one side of the U.S. healthcare landscape are people with excellent insurance, high levels of computer literacy, and life situations that allow them to seek the best care available, wherever it is available. These people will be able to obtain the "personalized medicine" offered by genetic breakthroughs. On the other side of the landscape are the uninsured and those who are losing benefits, such as retirees, who may lack access to such sophisticated technologies. The growing numbers of uninsured and underinsured people, as well as the documented health disparities in health status of racial and ethnic minority populations and all populations living in poverty, will eventually force our legislators to address the inequalities of access and quality of care in our system.

Another contributor to future changes in our healthcare system will be the effects of global warming, magnetic field fluctuations, solar flares, and the earth's poles changing directions. The impact of extreme weather events, including ice-age conditions, heat waves, fires, volcanic eruptions, earthquakes, floods, and storms, is predicted to lead to higher levels of insect- and waterborne illnesses and the reduction of food production and safe drinking water. Healthcare providers will need to address the physical and mental health needs that arise from these conditions (Blashki et al., 2007). Hospitals and other institutional providers will need to be even more focused on disaster preparedness and be ready to deal with increasing numbers of patients needing care for illnesses related to heat exposure and poor air quality (Longstreth, 1999). Drug-resistant organisms are predicted to increase, bringing new challenges in the treatment of infectious diseases, such as with the fungal meningitis outbreak in 2013, the Zika virus outbreak of 2015–2016, and the COVID-19 global pandemic of 2020. These developments require significant adaptation in healthcare delivery and are likely to disproportionately affect children, elderly adults, and poor people. Yet, the rapidity in time to market with COVID vaccines has been nothing short of miraculous in which "never before have prospective vaccines…entered final-stage clinical trials" as we witnessed in 2020 (Joseph, 2020).

The problem is that healthcare costs are still high, with many individuals and employers finding health care unaffordable. Recent

health policy changes hold promise to better manage healthcare resources but are fraught with political and economic unknowns. This is a time in the development of our healthcare system when nursing leadership is of paramount importance. Nurses represent the lived reality of the system; they see and hear on a daily basis patients' stories of both healing and unnecessary complications. Nursing knowledge and leadership are critical to improving our healthcare system and ensuring access, cost, and quality care for all.

That which is, already has been; that which is to be, already is.

—Ecclesiastes 3:15

Summary

This chapter shows how the United States became a tertiary care, illness-based system that often does not meet the needs of our population, even those who are lucky enough to have health insurance. Historically, when people were ill someone in the home cared for them. Amazingly, we are moving back toward that model again. Meanwhile, we can examine how insurance companies surfaced; how Social Security, Medicare, and Medicaid coverage emerged as the most prominent players in healthcare financing; how legislation like the Hill-Burton Act drove the healthcare industry to build hospitals and provided money for hospital (tertiary) care rather than for home care; and how value-based reimbursement and prospective payment have affected finances in health care. This has led to an ineffective U.S. healthcare system, which probably will not be able to pay for itself in a few years. With the present poor U.S. economy, health care is now at a crisis point. Hopefully, nurses, using the knowledge presented here to understand how we got to our present situation in health care, can more effectively deal with our current situation.

Discussion Questions

1. How did the introduction of a tertiary care, illness-based system affect the profession of nursing? Do you view this as a positive or negative influence?
2. What changes might you anticipate in your employment setting as the effects of the ACA continue to face changes through legislation and/or litigation?
3. What implications do the increasing number of elderly and frail elderly adults hold for nurse leaders across settings?
4. In your opinion, what health policy has had the greatest impact on health care in the United States? Why?
5. What are some of the short-term and long-term implications of the aging, female-dominated workforce in nursing?

Glossary of Terms

Access The availability of health care to the population; the use of personal health services in the context of all factors that impede or facilitate getting needed care. This includes effective (culturally acceptable) and efficient (geographically accessible) delivery of healthcare services.

Ambulatory Payment Classification System Prospective payment system for ambulatory settings giving a fixed dollar amount for outpatient services diagnoses.

Cost The value of all the resources used to produce services and expenditures.

Diagnosis-Related Groups (DRGs) Prospective payment plan for hospitals where reimbursement is based on the diagnosis of the patient.

Entitlement What a population expects from government (started in 1935 with Social Security).

Gross Domestic Product (GDP) Monetary value of all private or public sector goods and services produced in a country on an annual basis less imports.

Health Insurance Portability and Accountability Act (HIPAA) Legislation that ensures that written, oral (telephone inquiries and oral conversations), and electronic (computer or fax) patient health information is kept confidential and private.

Health Maintenance Organizations (HMOs) Type of health insurance that provides a full range of integrated care but limits coverage to providers who are employees of or contract with the insurance organization.

Health Policy The entire collection of authoritative decisions related to health that are made at any level of government through the public policy-making process.

Indemnity Lump-sum payment for healthcare services based on the retrospective cost of the care.

Managed Care Healthcare coverage where insurance companies and Medicare/Medicaid contract with private insurers or HMOs that assume the primary care of groups of people enrolled in a plan and serve as gatekeepers to specialty services. These measures were intended to control healthcare costs and to improve the quality of care.

Outcome and Assessment Information Set (OASIS) Prospective payment system for home care.

Outsourcing Where another organization that can provide services (such as housekeeping, food service, and groundskeeping) efficiently for a healthcare organization is hired to perform those services.

Primary Care Basic healthcare services provided as the first and continuing point of contact for prevention and health promotion, diagnosis and treatment, and referral.

Prospective Payment Where the payer determines the cost of care before the care is given; the provider is told how much will be paid to give the care.

Quality of Care Extent to which the provided healthcare services achieve or improve desired health outcomes; these are based on the best clinical evidence, are provided in a culturally competent manner, and involve shared decision making.

Resource-Based Relative Value System (RBRVS) Prospective payment system for physician services.

Resource Utilization Group (RUGs) Prospective payment system for skilled nursing facilities.

Secondary/Tertiary Care Highly technical hospital-based care or long-term care.

Utilization Review (UR) Where providers are required to certify the necessity of admission, continued stay, and professional services rendered to Medicare and other insurance beneficiaries.

References

American Association of Nurse Practitioners. (2020, December 7). *COVID-19 state emergency response: temporarily suspended and waived practice agreement requirements.* https://www.aanp.org/advocacy/state/covid-19-state-emergency-response-temporarily-suspended-and-waived-practice-agreement-requirements

American Medical Association. (n.d.). *Trends in health care spending.* https://www.ama-assn.org/about/research/trends-health-care-spending

Anelli, J., & Bowers, L. S. (2020, December 15). *US Supreme Court's oral argument in California v. Texas: Reports of the Affordable Care Act's demise may be greatly exaggerated.* https://www.jdsupra.com/legalnews/us-supreme-court-s-oral-argument-in-70613

Auerbach, J. (2017, April 19). Prevention efforts can ward off many chronic and expensive conditions. So why aren't we investing in them? *STAT News.* http://www.statnews.com/2017/04/19/prevention-chronic-illness-investing

Berchick, E. R., Hood, E., & Barnett, J. C. (2018, September 12). *Health insurance coverage in the United States: 2017.* United States Census Bureau. https://www.census.gov/library/publications/2018/demo/p60-264.html

Blashki, G., McMichael, T., & Karoly, D. J. (2007). Climate change and primary health care. *Australian Family Physician*, *36*(12), 986.

Brady, M. (2020, November 2). CMS signs off on new payments to encourage home dialysis. *Modern Healthcare*. https://www.modernhealthcare.com/payment/cms-signs-new-payments-encourage-home-dialysis

Brownlee, S., Colucci, J., & Walsh, T. (2012, December 22). What "health care costs" really means. *The Atlantic*. https://www.theatlantic.com/health/archive/2012/12/what-health-care-costs-really-means/266522/

Bundorf, M. K., Schulman, K. A., Stafford, J. A., Gaskin, D., Jollis, J. G., & Escarce, J. J. (2004, February). Impact of managed care on the treatment, costs, and outcomes of fee-for-service Medicare patients with acute myocardial infarction. *Health Services Research*, *39*(1), 131–152.

Centers for Disease Control and Prevention. (2016). *Healthy people 2020 midcourse review*. https://www.cdc.gov/nchs/healthy_people/hp2020/hp2020_midcourse_review.htm

Centers for Disease Control and Prevention. (n.d.). *Home health care*. https://www.cdc.gov/nchs/fastats/home-health-care.htm

DeNavas-Walt, C., Proctor, B., & Smith, J. (2012). *Income, poverty, and health insurance coverage in the United States: 2006*. http://www.census.gov/prod/2012pubs/p60-243.pdf

Fee, E. (2016, May 16). The first American medical school: The formative years. *Perspectives: The Art of Medicine*, *385*(9981),1940–1941.https://doi.org/10.1016/S0140-6736(15)60950-3

Findlay, S. D. (2016, April). Consumer's interest in provider ratings grows, and improved report cards and other steps could accelerate their use. *Health Affairs*, *35*(4). https://doi.org/10.1377/hlthaff.2015.1654

Finkelman, A. W. (2001). *Managed care: A nursing perspective*. Prentice Hall.

Graf, N., Brown, A., & Patten, E. (2019, March 22). *The narrowing, but persistent, gender gap in pay.* https://www.pewresearch.org/fact-tank/2019/03/22/gender-pay-gap-facts

Harris, M. D. (2009). *Handbook of home healthcare administration* (5th ed.). Jones & Bartlett Learning.

Institute of Medicine. (1993). *Access to Healthcare in America*. National Academies Press.

Joseph, A. (2020, July 30). "A huge experiment": How the world made so much progress on a COVID-19 vaccine so fast. *STAT*. https://www.statnews.com/2020/07/30/a-huge-experiment-how-the-world-made-so-much-progress-on-a-covid-19-vaccine-so-fast

Kaiser Family Foundation. (2013). *Summary of the Affordable Care Act.* http://www.kff.org/health-reform/fact-sheet/summary-of-the-affordable-care-act/

Kaiser Family Foundation. (2017, September 18). *Compare proposals to replace the Affordable Care Act.* https://www.kff.org/interactive/proposals-to-replace-the-affordable-care-act/

Lewin, M. E., & Altman, S., (Eds.). (2000). *America's health care safety net: Intact but endangered.* National Academies Press.

Longstreth, J. (1999). Public health consequences of global climate change in the United States: Some regions may suffer disproportionately. *Environmental Health Perspectives*, *107*(Suppl. 1), 169.

McDermott, K. W., & Jiang, H. J. (2020, June). Characteristics and costs of potentially preventable inpatient stays, 2017. *HCUP-US*. https://www.hcup-us.ahrq.gov/reports/statbriefs/sb259-Potentially-Preventable-Hospitalizations-2017.jsp

Merriam-Webster. (n.d.). Healthcare. In *Merriam-Webster.com dictionary*. Retrieved November 23, 2020, from https://www.merriam-webster.com/dictionary/health%20care

National Council of State Boards of Nursing. (n.d.). *2017 National nursing workforce study*. https://www.ncsbn.org/workforce.htm

National Research Council (US) Panel on Statistics for an Aging Population and Gilford, D. M. (Eds.). (1988). *The aging population in the twenty-first century: Statistics for health policy.* National Academies Press.

Raffel, M. W., & Raffel, N. (1994). *The U.S. health system: Origins and functions* (4th ed.). Delmar.

United States Census Bureau. (2020, September 15). *Income, poverty and health insurance coverage in the United States: 2019.* https://www.census.gov/newsroom/press-releases/2020/income-poverty.html

U.S. Centers for Medicare & Medicaid Services. (n.d.). *Costs in the coverage gap.* https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/costs-in-the-coverage-gap

U.S. Department of Health and Human Services. (2012). *People with Medicare save more than $4.1 billion on prescription drugs*. http://www.hhs.gov/news/press/2012pres/08/20120820a.html

U.S. Department of Health and Human Services. (2017, January 13). *Nearly 12 million people with Medicare have saved over $26 billion on prescription drugs since 2010.* https://www.cms.gov/newsroom/press-releases/nearly-12-million-people-medicare-have-saved-over-26-billion-prescription-drugs-2010

U.S. Department of Health and Human Services. (2020, July 24). *Trump administration announces historic action to lower drug prices for Americans.* https://www.hhs.gov/about/news/2020/07/24/trump-administration-announces-historic-action-lower-drug-prices-americans.html

U.S. Department of Health and Human Services. (n.d.). Access to health services. *Healthypeople.gov*. https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services

Warshawsky, M. (2016, June 10). Earnings inequality: The implications of the rapidly rising cost of employer-provided health insurance. *Mercatus Working Paper*. http://dx.doi/org/10.2139/ssrn.3191482

Wilensky, S. E., & Teitelbaum, J. B. (2020). *2019 annual health reform update*. Jones & Bartlett Learning.

World Health Organization. (n.d.). *Health policy.* https://www.euro.who.int/en/health-topics/health-policy

Yood, K., & Awanyai, S. (2020, July 10). CMS Issues proposed home health agency rule on making certain telehealth flexibilities permanent, increasing Medicare payment rates and home infusion therapy service payment rates for CY 2021. *Sheppard Mullin Healthcare Law Blog*. https://www.sheppardhealthlaw.com/2020/07/articles/federal-healthcare-programs/home-health-telehealth-flexibilities/

CHAPTER 2

The Economics of Health Care

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OBJECTIVES

- Provide a broad view of the economics involved in the healthcare environment that includes competition, regulation, and patient care.
- Understand the impact of regulation on the U.S. healthcare system and the costs associated with it.
- Demonstrate the impact of the nursing shortage and staffing ratios, and how these affect the healthcare industry.

Introduction

The complexity of healthcare economics began with the introduction of a prospective payment system (PPS) for health care established by the Social Security Amendments of 1983. Since that time, our current healthcare economic environment grows increasingly complicated every year, which is most evident in the major U.S. economic recession manifested by the COVID-19 pandemic beginning in 2020. Despite the massive federal budget deficit ($3.1 trillion in fiscal year [FY] 2020 [Bipartisan Policy Center, 2021]), along with a dwindling middle class, simplification of our healthcare economic system would serve as a tremendous benefit to patients and payers alike; however, we continue to create more chaos with layers upon layers of increasing complexity.

Today, health care is a business where patient care is considered as a single service and patients are no longer the only constituent. Their caring (and in some cases, curing) processes are now high-tech, research-based, and financially driven, and serve a number of stakeholders, such as physicians, investors, patients, families, and employees, such as nurses. Balancing the stakeholders' goals and supporting the many purposes of the healthcare firm require identification of the main pressures shaping its operation: (1) competition, (2) regulation, (3) profit motive, and (4) quality patient care.

This chapter examines the first three of these key forces (Chapter 3 presents the changing dynamic of quality in, and its impact on health care) from the standpoint of theory and practices in *economics* and cost

accounting focused on the healthcare firm. Health care once derived its processes almost solely from its mission, but now a margin comes first. Like all businesses without a (profit) margin, the organization ceases to exist, and hence there is no mission. This chapter in no way provides a comprehensive survey of these interrelated forces but instead offers an explanatory primer, with examples for economic and business behavior. An overview of the disciplines of economics and cost accounting is provided to acquaint you with what is probably an entirely new way of thinking (and talking) about the healthcare institution. This way, the profession, through nurse leaders, communicates with key nonprovider hospital decision makers, such as the chief executive officer or chief financial officer, using the same language, which creates a more level playing field.

Economics of Health Care: Macroeconomics, Microeconomics, and Cost Accounting

This section addresses the question, What is economics and what does it have to do with nursing? *Economics*, as defined by the American Economic Association (n.d.), is "the study of scarcity, the study of how people use resources and respond to incentives, or the study of decision-making." Economics can be divided into two categories—macroeconomics and microeconomics—which are contrasted in **Table 2-1**. *Macroeconomics* (the prefix *macro* means large) is the study of the economy or market system on a large scale. *Microeconomics* is the study of individual decisions consumers make in relationship to their markets.

The role that healthcare systems play in the implications of macroeconomics is crucial to understanding the challenges with making healthcare policy. Consideration for the fiscal contributions—through research, employment, and output—in conjunction with the short-term financial decisions that impact development and long-term sustainability are often overlooked or, at least, undervalued (Darvas et al., 2018). Because of the complexity of the health sector on macroeconomic measures—such as inflation, tax policy, exchange rates—the remainder of this section will focus on microeconomics and cost accounting.

Microeconomics focuses on the activities of the individual business and how internal decisions impact behaviors, such as the response to the theory of supply and demand. Healthcare economics, however, offers a set of

Table 2-1 Two Categories of Economics

Macroeconomics	
Considers:	The aggregate performance of all markets, including the outcomes or performance of all companies or firms in all industries
Gives us:	Indices, or measures (indicators), of a nation's economy, such as stock prices, interest rates, jobless claims, and housing starts
Microeconomics	
Considers:	The choices made by smaller economic units, such as consumers or individual (hospital) firms
Gives us:	Concepts such as profit, profit maximization, price strategy, and nonprice competition to consider

exceptional characteristics that differ from that standard model:

- an interest by third parties (insurers, governments);
- consumers (patients) are not necessarily aware of the services they require and often are not responsible for payment of said services; and
- insurers, not market prices, determine the allocation of resources (Mankiw, 2017).

What are some notable examples of microeconomics in health care that are relatable to the nurse leader? Some examples might include recruitment and hiring of personnel, supporting the value of the role of the advanced practice nurse (APN) as an alternative to a medical doctor, making cost- and quality-conscious decisions with supply and medical equipment purchasing selections, or staffing decisions to extend the hours of a clinic. All of these are attributed to the microeconomics of a healthcare firm.

Cost accounting is an element of financial management that generates information about the costs of an organization and its components associated with providing a service or producing a product. It is a subset of accounting in general and involves distinguishing fixed and variable costs that are useful to managers in their organizational roles. Keep in mind that the goal in generating this information is to provide a basis for decision making. A few typical cost accounting–type questions in our field might include: What should the nurse-to-patient ratio be and on what basis is this decided? How many, and what type of, patient visits will cover the fixed cost to operate a clinic? What type of medical equipment do we need, and what is the return on investment (ROI) for such a large purchase price, or should it be leased?

The field of cost accounting affords us tools to address the tough nursing financial questions, such as break-even analysis, profitability analysis, overtime-versus-outsource decision making, marginal cost calculations, and cost-quality trade-off analysis. Cost accounting is comprised of two other accounting fields: *financial accounting* (information generated by firms largely for external purposes) and *managerial accounting* (information generated by firms for their own internal use). The relationship of the accounting disciplines is depicted in **Figure 2-1**. As the number of nurses undertaking formal study of these quantitative disciplines, such as in master of business administration (MBA), master of public health (MPH), and some doctor of nursing practice (DNP) programs increase, we find ourselves on equal footing with lay administrators in the top echelons of the healthcare hierarchy.

The nurse at the top of the administrative hierarchy, the nurse executive, may have trained with advanced preparation in all three disciplines discussed here: microeconomics, cost accounting, and nursing. The American Organization for Nursing Leadership (AONL, 2005) published its common set of core competencies that the nurse executive should have. Among these are healthcare economics and financial management. Examples that demonstrate competency in each of these areas include:

- analyses of supply and demand data;
- analysis of financial statements;
- articulation of business models based on economics, strategic, and business planning; and
- the development of future business skill sets in leadership team members.

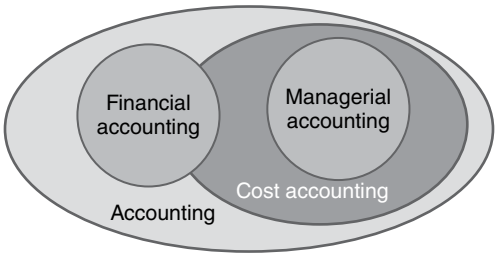

Figure 2-1 Relationship of the accounting disciplines

This dramatizes how important it is for current and future nurse leaders to maintain their own skill set in business and financial matters and to share this process with other key nursing leaders in their organizations, such as nurse managers. The deployment of nurse resources at the unit/department level could quite possibly be the most important decision made in health care because it is through the provision of quality nursing care that quality patient outcomes are realized.

Competition

The theory of the firm (or, the theory of supply and demand) explains and predicts price, the quantity of products, and the likelihood of survival of firms in a competitive industry.

For centuries, the relationship between supply and demand has been thought to be largely the result of the intervening variable of price. In the fictional "market for widgets," supply of a product consistently meets the demand for it, given a set of assumptions about the market for *widgets*. This theory (of the firm) explains a lot about the way the world works, pending the strength of these assumptions:

1. large numbers of buyers and sellers,
2. perfect information about the product,
3. absence of barriers to entry and exit as a business entity in the industry, and
4. homogeneity of the product.

Note that a full description of all four assumptions as they pertain to markets for health care is beyond the scope of this text. However, a focus on two of the assumptions—a large number of healthcare buyers and sellers and the existence of good information—is key.

In health care, the four assumptions are less clearly visible than in the fictitious market for widgets for a variety of reasons. Among them are the fact that, until recently, relatively little is known to the buyer of health care (the insurance company), about the quality of care purchased from the seller (in our case, the provider of health services), and the demand for health care is a derived demand—the demand comes from health insurance companies as the intermediary between healthcare providers (hospitals and practitioners) and the individual patient (consumer). When health care entered the competitive arena, decision makers became highly sensitized to the customary business practices of restricting expenses and maximizing revenue while producing a service of measurable quality whenever possible.

The change from a system loosely concerned with quality of care to a system that prices services strategically while competing on quality has resulted in a cost-conscious era unlike any ever seen before in health care. It is widely recognized that as healthcare systems compete to provide services, they seek to strike a vital balance between cost reduction and quality of care to adapt successfully to external competitive threats to their market share and, in some instances, survival. In an attempt to successfully adapt, organizations make an effort to (1) optimize profit through pricing strategies and contract negotiations, (2) reduce expenses through decisions about the delivery of health care (e.g., personnel, supplies, equipment), and (3) achieve reimbursable patient outcomes by satisfying consumers through both high-tech and caring approaches.

Better provision of care services may result in better patient outcomes, which result in better reimbursement and is purported to be a benefit of an openly competitive, deregulated healthcare market. For example, hospitals that can demonstrate a higher quality of care, or even adequacy of care, will win higher reimbursement from payer plans, more patients, and better-qualified care providers. Over time, "good" hospitals will survive because they have established a pattern of good outcomes. The higher the hospital's performance or improvement, the higher the value-based incentive payments. With ongoing changes to reimbursement, the same can be attributed to

post-acute, ambulatory, and individual providers of healthcare services.

Additional evidence regarding this theory can be found through such organizations as Healthgrades (see www.healthgrades.com) and *U.S. News and World Report*'s ranking system (see http://health.usnews.com). Both report such measures as risk-adjusted mortality rates, as well as complication rates, such as patient population-specific measures of comparative quality.

The importance of these ranking systems available to the consumer is that the information about the quality of the product or service is accurate enough to create comparison ratings used by payers as well as by others (e.g., patients and their families) interested in these data. Hence, the information qualifies as perfect information (not to be taken literally).

What microeconomic theory states regarding the eventual number of healthcare firms within an industry under long-run equilibrium (firms that are rivals or that compete over the long term) is that those firms with better products or services will survive, but those with inferior products and services will not. This is the result of the achievement of quality held by payers and consumers, which, in part, drives the industry's (derived) demand. Unfortunately, relatively little is known about the tenets of competition in health care. More will come to light as variations in the quality of patient outcomes based on reimbursement become available. So, the usefulness of this theory for the explanation and prediction of future activities in health care remains challenged. "Supply and demand—it just doesn't work in health care!" is not an emotionally charged statement devoid of reason. It is, instead, appropriate to say that the predictive power of this theory in health care is limited to more than its explanatory power of interpreting the how and why of a healthcare firm's behavior. Stated another way, all healthcare operations seek to maximize patient outcomes/reimbursement and thus maximize performance ratings thereby improving their competitiveness in the marketplace.

In the world of competitive healthcare management, new sources of information continually become available in both print and electronic media, so decision makers—payers and consumers—contract for healthcare services based on price and quality through managed care negotiations.

Regulation and Managed Care

The soaring cost of health care has been one of the most pressing domestic issues for decades. Politicians and pundits speak of how changes in laws could affect this crisis, sometimes provoking a discussion of socialized medicine and cross-country comparison of U.S. versus "other" healthcare expenditures and outcomes. With no clear answer to this issue in health care emerging soon, most would agree that although our healthcare system is among the most market oriented (competitively driven) in the world, it remains *the* most heavily regulated sector of the U.S. economy (Michigan State University, 2019). The American Hospital Association's (AHA) *Regulatory Overload Report* (2017) found that health systems, hospitals, and post-acute providers of care "must comply with 629 discrete regulatory requirements across nine domains," which equates to $38.6 billion per year spent on compliance administrative costs. This estimate does not include all expenditures by federal or state regulators that oversee, inspect, supervise, monitor, or award privileges to healthcare providers, such as physicians, nurses, and hospitals. In just a quick survey of nursing regulation costs alone, for example, consider the following:

- Office of Safety and Health Administration (OSHA) inspection of workplace safety.
- The National Labor Relations Board (NLRB) monitoring of nurse unions.
- National Council of State Boards of Nursing (NCSBN) licensing exam requirements.

- Every state board of nursing.
- The American Association of Colleges of Nursing (AACN) and the National League for Nursing (NLN) accreditation of nursing schools.
- National Practitioner Data Bank (NPDB) housing information on practitioners.
- Limitations on registered nurse (RN) working hours.
- Fraud and abuse protections.

Each one of these organizations or protections has staff, overhead, a place of business to run, and extensive reporting requirements to yet another governmental or quasi-governmental organization. The AHA report (2017) estimates that the United States spends "over a trillion dollars a year" on the cost of administering these regulations.

Although in our discussion of competition and what healthcare firms must do to survive, a convincing case is made about the benefits of the competitive, or market-driven, environment for health care, which is not diametrically opposed to regulatory efforts. This needs to be said because, in essence, a highly competitive market-driven industry is a bit like the polar opposite of one that is highly or completely regulated, as is the case in countries with a national single-payer health system. In short, the market for health care is not what is known as "purely competitive," as is the market for widgets—far from it, in fact. It holds, instead, a complicated mixture of free-market principles, huge regulatory demands, a demand for sick-care services that is derived and not direct, and the most complicated reimbursement scheme known in modern times in any industry.

Managed care was originally intended to reduce healthcare costs to the consumers through the restriction of resource allocation and improve the overall health of individuals. Now, it is a generic term for healthcare payment systems that attempt to control costs and is considered an economic success and a social nightmare. Managed care has reduced healthcare costs by tying clinical decisions to economic ones that previously were mutually exclusive. In these arrangements, a hospital or group of doctors, for example, agrees to provide services in exchange for third-party payment. Managed care networks make available to their members only those providers authorized by the plan. Often, this designation is geographically derived, thereby restricting individuals' choices to go to what they see as the "best" orthopedic or cancer care providers if unavailable locally. It is worth mentioning that individuals still have free choice (lots of it)—if they are willing to get out their checkbook to cover the out-of-network costs!

In managed care, the provider (physician, APN, or hospital) provides covered services at a discounted rate in exchange for a steady revenue stream. If the economics novice reading this wonders why providers would "settle for less" by receiving a discounted rate, consider the alternative. Providers would have an uncertain revenue stream that challenges their abilities to cover the basic costs of doing business (reduces uncertainty), not to mention there are few alternative ways of conducting business in health care. Stated another way, consider what is known as the first rule of finance: A dollar today is worth more than a dollar tomorrow, as a result of the time value or opportunity cost of money. Any entity that gains revenue in a timely manner not only can retire debt (an asset) but invest; hence, the time value of money is realized. Remember that fee-for-service medicine has all but disappeared, taking with it the old model of the solo-practice physician, and patients who pay for medical care out of pocket (other than co-pays and deductibles) are rare.

Under a per diem (daily) rate agreement, for example, the managed care plan pays the hospital a fixed rate for each day of care based on the patient's diagnosis. Nurses are in a particularly strategic position to observe that costs per diem to the institution can be (very) variable for each patient's stay. Consider the surgical patient who consumes relatively few

resources on the morning of admission for a procedure that afternoon. Once the patient enters the operating room, costs to the institution soar steeply and remain high as the patient travels to the post-anesthesia recovery room. This can include even more costs if intensive care is involved. For a monthly fee paid by the insurance company, the hospital must provide the specified services to the third-party payer's enrollees. Under this arrangement, the hospital is ensured money in a relatively timely fashion (based on the average consumption of patients who have received similar services within that diagnosis related group [DRG] and other clinical factors) and the patient-consumer knows he or she will be covered for procedures that are preapproved.

The overall aim of managed care is to make the patient a better healthcare customer, evaluating whether the services being received are what is being paid for (assuming the individual pays health insurance premiums). Also, the burden of prevention and wellness increases in importance for the patient. Presumably, physicians and APNs share in this responsibility by virtue of recent changes in medical and nursing education. In this type of healthcare insurance model, the patient has less control over the selection of the provider and may be responsible for higher deductibles and co-payments, as well as penalties for services done outside the network.

From a positive (or factual) point of view, the real cost savings to the healthcare system and society at large are through the reduction and elimination of unnecessary services, tests, and procedures. Conversely, some savings are realized through time delays as requested services work their way through the authorization process where untold numbers of individuals drop off, or attrition out of, the care-seeking process. While some promote this as a "savings," others contend delays in medical services only increase future spending for the delayed care required by these same medical conditions.

Profit Motive and Patient Care

In an influential book during its time, *The Profit Motive and Patient Care*, Bradford Gray (1991) made the previously unexplored claim that two unique accountability factors exist in health care that do not exist in other organizations: the vulnerability of the consumer (patient) being served and the absence of payers at the point of service. Gray goes on to describe the ways in which the profit motive has come to shape the behavior of all parties, including providers of health care, suppliers of their capital, physicians, employers who provide benefits for their employees, and administrators of health plan benefits. It is this shift in the paradigm of aligning profits with patient care that will shape how providers and purchasers of healthcare services respond to the two great accountability problems.

Gray's explanation of whom the important stakeholders are and how they are motivated to perform has far-reaching implications for the overall philosophical *and* business approaches that healthcare providers, such as nurses, might take. His was among the first credible writings to shake the foundations of why a hospital exists, as well as to articulate the important forces shaping stakeholders' behaviors.

Using hospitals as an example, not enough is said about why a hospital exists. A hospital exists to satisfy the needs of its various stakeholders: physicians, nurses, and other employees; patients and their families; consumers; researchers; schools of medicine and nursing; and the community at large. Although many agree that today's hospitals exist for the provision of sick care, there are other compelling reasons for them to subsist. The hospital is a business entity, and, as such, it responds to many demands from its stakeholders. Among these demands are the volume and morbidity of patients, requests from physicians and nurses in advanced practice for necessary

equipment and the efficient flow of patients, concerns from patients and families about inefficient or substandard care, and training opportunities for students of medicine and nursing. The profit motive drives all of these.

In this section, it is necessary to debunk a few myths that still prevail in certain sections of our society, sometimes even among healthcare providers:

> *Myth 1*: We are a nonprofit entity; therefore, we do not have profit.
>
> *Myth 2*: We are here to provide the highest possible quality of care.

These are among the most important misconceptions maintained by many stakeholders, among them nurses. Replacing what might be our wishes (myths) with factual statements helps us understand the universal, persistent economic forces shaping our work.

Getting the Word *Profit* Back

Profit, loosely defined as the excess of revenues over expenses, is as necessary to healthcare firms, irrespective of profit designation, as oxygen is to the living system. Almost no healthcare organization could survive without it because it could not remain solvent. Without it, the firm eventually goes out of business just like any other entity, leaving services unprovided and employees out of jobs, not to mention all the downstream providers of supplies and services. Profitability, as a construct, is measured by these variables: total margin ratio, operating profit margin, nonoperating gain ratio, and return on equity. As you continue reading the next section on the cost inputs for varying levels of quality, keep in mind that costs to the firm (what is expensed on the income statement) relative to revenue (money received in lieu of care provided) are nearly synonymous with profitability, at least in the short run.

It is important to clarify the two types of healthcare organization profit status designations: investor owned (IO), formerly known as *for profit*, and not-for-profit, formerly known as *nonprofit*. All healthcare providers can—and must—have profit to continue in business. How each approaches profit optimization, as well as descriptive characteristics—public versus private ownership, urban versus rural, small margin versus large margin, safety net versus nonsafety net, and teaching versus nonteaching—may differ. A number of these factors may covary with profit status. For example, major teaching hospitals tend to be not-for-profit (NFP), and nearly all IO hospitals are private.

Finally, an accounting note about the differences in IO versus NFP entities. In lay terms, the key differences between these two sets of business models on the matter of profit goes like this: The dollar line item of profit is found on the income statement of general funds for NFPs versus the profit and loss statement for the corporation; profit is called *profit* in the IO world, versus a *positive fund balance* in the NFP one; and the IO distributes profit (after taxes) at year's end to the shareholders, whereas the NFPs cycle profits back into facility maintenance or expansion after paying no taxes.

Costs to Society

Social policy is the domain that aims to improve human welfare and to meet human needs for education, health, housing, and social security. Health is a part of public policy that has to do with social issues. There was a time when health was considered the absence of disease. Couple this limited definition of health with the Hippocratic admonition "to do no harm" to identify what the public expects from a hospital: to emerge from the experience with an improved state of health or, at a minimum, to avoid increased morbidity as a result of seeking hospital care. Although it is touted as a modern concept, remember that the Hippocratic admonition regarding harm emerged centuries ago (Hippocrates, n.d./2004). Previously,

it was noted that, at a minimum, quality care is identified as the absence of adversity or the absence of adverse events.

The costs to society of this adversity are understudied or underreported in modern health services research. The costs to society include, but are not limited to, the alternative use of hospital resources in a community (e.g., feeding the poor, housing the homeless), consumption of a tax basis (in the case of NFP hospitals) for the same, the costs of ill health for individuals and employers (such as the opportunity cost of lost time and productivity at work), unreimbursed expenses related to caring for the underinsured or the uninsured, and the alternative use of people and technology resources in other employment.

Summary

This chapter offers background information on the nature of competition and why it is important in the market for hospital care. The discussion of profit motive and patient care debunked some myths about why a hospital exists to fulfill its purpose—to satisfy the needs of various stakeholders, such as employees, the community at large, as well as patients and providers, such as physicians and nurses. All of this reflects the complexity of the system.

Some of this monetary analysis is a brand new way of thinking for those who have not studied formally in the fields of economics, accounting, or finance. It is hoped that, through this examination of what it takes for a healthcare firm to survive competitive circumstances, future cohorts of nurses can preserve the practice of professional nursing.

Most of the statements on healthcare firm conditions and the business activities therein are from the domain of positive economics (*what is* or *what exists*), leaving the reader to draw his or her conclusions in the normative economic (*what* should *be*) field of endeavor. Nursing's history has been to embrace the mission of caring, often with less investment in the impact of ideals, such as safe staffing on the hospital's margin. Without a sustainable margin of profit, a healthcare entity, like any business, fails to provide service, employ personnel, pay its suppliers, or fulfill its mission.

Discussion Questions

1. Support or refute the statement "Supply and demand—it just doesn't work in health care!"
2. Discuss how margin and mission are related, or not related, in the hospital environment.
3. Are hospitals competing on the basis of price, quality, or both? Explain.
4. Is hospital care overregulated? Cite some examples to support your argument.
5. What is healthcare regulation and what are some of its costs?
6. Why is the provision of sick care (hospital) services said to be a derived demand?
7. From an economic perspective, describe the cost of regulation in the healthcare environment.
8. What is your definition of profit?

Glossary of Terms

American Nurses Credentialing Center The world's largest and most influential nurse credentialing organization and a subsidiary of the American Nurses Association. The American Nurses Credentialing Center is best known for promoting excellence in practice through its Magnet Recognition Program and Pathways to Excellence Program.

Asymmetric Knowledge A state or condition in which buyers and sellers of a product or service have significantly different sets of information.

Bad Debt Expense Accounts receivable that will likely remain uncollectible and will be written off. It is a line item for which the hospital budgets.

Buyer One who purchases healthcare services; often the health insurance company.

Competition The efforts of two or more parties to gain the business of a third by offering preferably favorable terms.

Cost The dollar value of inputs used in the production of goods and services (output). Types of costs are variously termed and defined. These include direct, indirect, medical, nonmedical, future, intangible, fixed, variable, marginal, and opportunity. Not to be confused with *expenses;* it is a broader term.

Cost Accounting An element of financial management that generates information about the costs of an organization and its components. A subset of accounting, in general. Encompasses the development and provision of a wide range of financial information useful to managers in their roles.

Diagnosis Related Groups (DRGs) Medicare initiated payment to hospitals on this basis beginning in 1984. The prices for the groups are updated yearly by Medicare to reflect changes in reimbursement protocols.

Economics The study of how a society allocates scarce resources and goods.

Economies of Scale Also known as "returns to scale," it is the degree to which the cost of providing a good or service falls as quantity (measured by patient days) increases because fixed costs are shared by the larger volume of units.

Expense A more exact concept than *cost*; the exact dollar amount a firm spends on a unit of production. Divided into two major types on a hospital's income statement, there are operating expenses (direct line items for the cost of inputs) and nonoperating expenses (less directly assigned costs—e.g., overhead).

Financial Accounting System that records historical financial information and provides summary reports to individuals outside of the organization of what financial events have occurred and what the financial impact of those events has been.

Firm The company.

Government Intervention Actions on the part of government that affect economic activity, resource allocation, and especially free choice regarding the purchase of products or services.

Healthcare Economics A branch of economics concerned with issues related to scarcity in the allocation of health and healthcare service provision.

Incentive Reward to an organization or individual for a behavior. Differs from *motive*, which is a psychological term describing an inner state.

Liquidity Ability of a firm to meet its short-term financial obligations—that is, pay bills as they become due.

Macroeconomics A branch of economics concerned with how human behavior affects outcomes in highly aggregated markets, such as the markets for labor or consumer products. In the healthcare context, the behavior of all healthcare firms.

Managed Care A system that manages healthcare delivery with the aim of controlling costs. Typically, reliant on a physician or nurse in advanced practice, the clinical activity is paired with the economic activity that is thought to reduce frivolous expenses and moral hazard.

Managerial Accounting The process of identifying, analyzing, interpreting, and communicating financial information so that an organization can pursue its goals. Differs from financial accounting in that it is an internal process, whereas financial accounting focuses on reporting financial activity to an outside source.