Basics of the U.S. Health Care System

Third Edition

Nancy J. Niles

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About the Author

Nancy J. Niles, PhD, MS, MBA, MPH, is in her 12th year of full-time undergraduate teaching. She is in her second year of teaching undergraduate and graduate healthcare management and administration courses at Rollins College in Winter Park, Florida. Prior to Rollins College, she taught 8 years of undergraduate business and healthcare management classes in the AACSB-accredited School of Management at Lander University in Greenwood, South Carolina, having spent 4 years teaching in the Department of Business Administration at Concord University in Athens, West Virginia. She became very interested in health issues as a result of spending two tours with the U.S. Peace Corps in Senegal, West Africa. She focused on community assessment and development, obtaining funding for business- and health-related projects. Her professional experience also includes directing the New York State lead poisoning prevention program and managing a small business development center in Myrtle Beach, South Carolina.

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Preface

I am very pleased to be updating this textbook because of the continued changes in the U.S. healthcare system as a result of the passage of the Affordable Care Act (ACA) in 2010. Fortunately, millions of individuals now have healthcare insurance as a result of the Act. Although the Act continues to be controversial, the Act has focused our healthcare delivery on patient centeredness and performance-based outcomes, which has improved the delivery of U.S. healthcare services. Preventable medical errors continue to be a problem but healthcare facilities are developing strategies to reduce these preventable errors.

I continue to review and update the student activities. I also included a section on a current events exercise. My students enjoy this type of exercise because they can apply the textbook information to a current healthcare event. The following is a summary of each chapter.

Chapter 1

It is important as a healthcare consumer to understand the history of the U.S. healthcare delivery system, how it operates today, who participates in the system, what legal and ethical issues arise as a result of the system, and what problems continue to plague the healthcare system. We are all consumers of health care. Yet, in many instances, we are ignorant of what we are actually purchasing. If we were going to spend $1,000 on an appliance or a flat-screen television, many of us would research the product to determine if what we are purchasing is the best product for us. This same concept should be applied to purchasing healthcare services.

Increasing healthcare consumer awareness will protect you in both the personal and professional aspects of your life. You may decide to pursue a career in health care either as a provider or as an administrator. You may also decide to manage a business where you will have the responsibility of providing health care to your employees. And last, from a personal standpoint, you should have the knowledge from a consumer point of view so you can make informed decisions about what matters most—your health. The federal government agrees with this philosophy. The Affordable Care Act's health insurance marketplaces provide cost and service data so consumers can determine what is the best healthcare insurance to purchase and what services they will be receiving for that purchase. Recently, the Centers for Medicare and Medicaid Services (CMS) used its claim data to publish the hospital costs of the 100 most common treatments nationwide. The purpose of this effort is to provide data to consumers regarding healthcare costs because the costs vary considerably across the United States. This effort may also encourage pricing competition of healthcare services. The U.S. Department of Health and Human Services is providing funding to states to increase their healthcare pricing transparency

As the U.S. population's life expectancy continues to lengthen—increasing the "graying" of the population—the United States will be confronted with more chronic health issues because, as we age, more chronic health conditions develop. The U.S. healthcare system is one of the most expensive systems in the world. According to 2014 statistics, the United States spent $2.9 trillion or $9,255 per person on healthcare expenditures or 17.5% of its gross domestic product. The gross domestic product (GDP) is the total finished products or services that are produced in a country within a year. These statistics mean that over 17% of all of the products made within the borders of the United States within a year are healthcare related. Estimates indicate that healthcare spending will be 19.3% of the gross domestic product. The Gallup-Healthways Well-Being Index indicate that in 2014, the number of uninsured Americans has dropped to 16%. Among the states, Hawaii had the lowest percentage of uninsured individuals under age 65 in 2014 (2.5%), followed by Massachusetts (3.2%), Delaware (5.4%), and Iowa (6.4%). The District of Columbia also had a low insurance rate of 3.3%. Texas (21.5%), Oklahoma (21.5%), Alaska (21.2%), and Florida (18.8%) had the highest percentage of uninsured individuals under age 65 in 2014. The rates of uninsured individuals have dropped most among lower-income and black Americans. These drops have been attributed to the

insurance mandate of the Affordable Care Act. The Institute of Medicine's (IOM) 1999 report indicated that nearly 100,000 citizens die each year as a result of medical errors. There have been more recent studies that indicate this estimate is much higher despite many quality improvement initiatives implemented over the years.

Although U.S. healthcare costs are very high, the United States does not offer healthcare coverage as a right of citizenship. The U.S. is the only major country that does not offer healthcare as a right. Most developed countries have a universal healthcare program, which means access to all citizens. Many of these systems are typically run by the federal government, have centralized health policy agencies, are financed through different forms of taxation, and payment of healthcare services are by a single payer—the government. France and the United Kingdom have been discussed as possible models for the United States to follow to improve access to health care, but these programs have problems and may not be the ultimate solution for the United States. However, because the United States does not offer any type of universal healthcare coverage, many citizens who are not eligible for government-sponsored programs are expected to provide the service for themselves through the purchase of health insurance or the purchase of actual services. Many citizens cannot afford these options, resulting in their not receiving routine medical care. The Patient Protection and Affordable Care Act of 2010 (PPACA), more commonly called the Affordable Care Act, has attempted to increase access to affordable healthcare. One of the mandates of the Act was the establishment of electronic health insurance marketplaces, which provide opportunities for consumers to search for affordable health insurance plans. There is also a mandate that individuals who do not have health insurance purchase health insurance if they can afford it or pay a fine. Both of these mandates have decreased the number of uninsured in the United States.

Despite U.S. healthcare expenditures, disease rates in the United States remain higher than those of many other developed countries because the United States has an expensive system that is available to only those who can afford it. Findings from a recent MetLife annual survey indicate that healthcare costs are worrying employees and their employers. Over 60% of employees are worried they will not be able to pay out-of- pocket expenses not covered by insurance. Employers are increasing the cost sharing of their employees for healthcare benefits because of the cost increases. Because the United States does not have universal health coverage, there are more health disparities across the nation. Persons living in poverty are more likely to be in poor health and less likely to use the healthcare system compared to those with incomes above the poverty line. If the United States offered universal health coverage, the per capita expenditures would be more evenly distributed and likely more effective. The major problem for the United States is that healthcare insurance is a major determinant of access to health care. Although there has been a decrease in the number of uninsured in the United States as a result of the individual mandate to purchase health insurance by the Affordable Care Act, there is still limited access to routine health care statistics. The infant mortality rate is often used to compare the health status of nations worldwide. Although our healthcare expenditures are very high, our infant mortality rates rank higher than many countries. Racial disparities in disease and death rates continue to be a concern. However, there has been a decline of 13% in infant mortality rates in the U.S. from 2000 to 2013. If you compare this statistic worldwide to comparable countries, their rates dropped during the same time period by 26%. The U.S. has more work to do regarding this issue. Both private and public participants in the U.S. health delivery system need to increase their collaboration to reduce these disease rates. Leaders need to continue to assess our healthcare system using the Iron Triangle to ensure there is a balance between access, cost, and quality.

Chapter 2

The Patient Protection and Affordable Care Act (PPACA) or as it is commonly called, the Affordable Care Act (ACA), and its amendment, the Healthcare and Education Affordability Reconciliation Act of 2010, was signed into law on March 23, 2010, by President Barack Obama. The passage of this complex landmark legislation has been very controversial and continues to be contentious today.

There were national public protests and a huge division among the political parties regarding the components of the legislation. People, in general, agreed that the healthcare system needed some type of reform, but it was difficult to develop common recommendations that had majority support. Criticism focused in part on the increased role of government in implementing and monitoring the healthcare system. Proponents of healthcare reform reminded people

that Medicare is a federal-government entitlement program because when individuals reach 65 years of age, they can receive their health insurance from this program. Millions of individuals are enrolled in Medicare. Medicaid is a state-established governmental public welfare insurance program based on income for millions of individuals, including children that provides health care for its enrollees.

However, regardless of these two programs, many critics felt that the federal government was forcing people to purchase health insurance. In fact, the ACA does require most individuals to obtain health insurance only if they can afford it. But with healthcare system expenditures comprising 17.9% of the U.S. gross domestic product and with millions of Americans not having access to health care, resulting in poor health indicators, the current administration's priority was to create mandated healthcare reform.

The Affordable Care Act has focused on primary care as the foundation for the U.S. healthcare system. The legislation has focused on 10 areas to improve the U.S. healthcare system, including quality, affordable, and efficient healthcare; public health and primary prevention of disease; healthcare workforce increases; community health; and increasing revenue provisions to pay for the reform. However, once the bill was signed, several states filed lawsuits. Several of these lawsuits argued that the act violates the U.S. Constitution because of the mandate of individual healthcare insurance coverage as well as that it infringes on states' rights with the expansion of Medicaid. The 2012 U.S. Supreme Court decision that upheld the constitutionality of the individual mandates should decrease the number of lawsuits. Despite these lawsuits, this legislation has clearly provided opportunities to increase consumer empowerment of the healthcare system by establishing the state American Health Benefit Exchanges, providing insurance to those individuals with preexisting conditions, eliminating lifetime and annual caps on health insurance payouts, improving the healthcare workforce, and providing databases so consumers can check the quality of their health care. The 10 titles of this comprehensive legislation are also focused on increasing the role of public health and primary care in the U.S. healthcare system and increasing accessibility to the system by providing affordable health care.

Although this legislation continues to be controversial, a system-wide effort needed to be implemented to curb rising healthcare costs although there have been reports that healthcare costs are increasing and consumers are paying higher cost sharing amounts. There are five areas of health care that account for a large percentage of healthcare costs: hospital care, physician and clinician services, prescription drugs, nursing, and home healthcare expenditures. The legislation targets these areas by increasing quality assurance and providing a system of reimbursement tied to quality performance, providing accessibility to consumers regarding the quality of their health care, and increasing access to community health services. Also, the Affordable Care Act has focused on improving the U.S. public health system by increasing the accessibility to primary prevention services such as screenings and wellness visits at no cost. The ACA has mandated that healthcare providers make available certain services with no cost sharing to the healthcare consumer: 15 preventive services for adults, 22 preventive services for women, 25 preventive services for children, and 23 preventive services for Medicare enrollees. Revenue provisions are in place to offset some of the costs of this legislation. With continued controversy, it will be difficult to quickly assess the cost effectiveness and impact of this health reform on improving the health care of U.S. citizens. The President had to veto a repeal of the bill and the House of Representatives have a Task Force to craft an improved ACA. The next major issue is whether typical middle class Americans can afford the high deductibles and increased cost sharing for their healthcare.

Chapter 3

The one commonality with all of the world's healthcare systems is that they all have consumers or users of their systems. Systems were developed to provide a service to their citizens. However, the U.S. healthcare system, unlike other systems in the world, does not provide healthcare access to all of its citizens. It is a very complex system that is comprised of many public and private components. Healthcare expenditures comprise approximately 17.5% of the gross domestic product (GDP). Health care is very expensive and most citizens do not have the money to pay for health care themselves. Individuals rely on health insurance to pay a large portion of their healthcare costs. Health insurance is predominantly offered by employers. The uninsured rate remains at an all-time low with 9.1% of under 65 uninsured as of the end of 2015 according to CDC.gov data. Generally, 2016 saw a rough increase of all the 2015 numbers. The government believes this is the result of the universal mandate for individual health insurance coverage.

In the United States, in order to provide healthcare services, there are several stakeholders or interested entities that participate in the industry. There are providers, of course, that consist of trained professionals such as physicians, nurses, dentists, and chiropractors. There are also inpatient and outpatient facilities; the payers such as the insurance companies, the government, and self-pay individuals; and the suppliers of products, such as pharmaceutical companies, medical equipment companies, and research and educational facilities. Each component plays an integral role in the healthcare industry. These different components further emphasize the complexity of the U.S. system. It is projected that between 2014 and 2024, nearly 10 million jobs will be added in the U.S. healthcare industry. The United States spends the highest proportion of its GDP on healthcare expenditures. The system is a combination of private and public resources. Since World War II, the United States has had a private fee-for-service system that has produced generous incomes for physicians and has been profitable for many participants in the healthcare industry. The healthcare industry operates like traditional business industries. Organizations designated as for profit need to make money in order to operate. The main goal of entities that are designated nonprofit is based on a particular social goal, but they also have to make money in order to continue their operations.

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

It is important to assess the system from an international perspective. Comparing different statistics from the OECD is valuable to assess the health of the United States. Despite the amount of money spent on health care in the United States, the United States ranked lower on many measures than other countries that spend less on their healthcare systems. These statistics may point to the fact that other countries' healthcare systems are more effective than the U.S. system or that their citizens have healthier lifestyles, although obesity rates are increasing globally.

Chapter 4

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

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

The DHS and FEMA now play an integral role in the management and oversight of catastrophic events, such as natural disasters, earthquakes, floods, pandemic diseases, and bioterrorism. The DHS and FEMA collaborate closely with the CDC to ensure that both the state and local health departments have a crisis management plan in place for these events. These attacks are often horrific and frightening with a tremendous loss of life, and as a result, the state and local

health departments need to be more prepared to deal with catastrophic events. They are required to develop plans and be trained to deal effectively with many of these catastrophic issues. Finally, the Affordable Care Act has increased government involvement in the healthcare industry to promote access to a quality healthcare system. This chapter will focus on the different roles the federal, state, and local governments play in the U.S. healthcare system. This chapter will also highlight different governmental programs and regulations that focus on monitoring how health care is provided.

Chapter 5

There are two important definitions of public health. In 1920, public health was defined by Charles Winslow as the science and art of preventing disease, prolonging life, and promoting physical health and efficiency through organized community efforts for the sanitation of the environment, control of community infections, and education of individuals regarding hygiene to ensure a standard of living for health maintenance. Sixty years later, the Institute of Medicine (IOM), in its 1988 *Future of Public Health* report, defined public health as an organized community effort to address public health by applying scientific and technical knowledge to promote health. Both definitions point to broad community efforts to promote health activities to protect the population's health status. The Affordable Care Act is also emphasizing the importance of prevention and wellness. The establishment of the Prevention and Public Health Fund has supported several community-based public health programs. To date, the Fund has invested in a broad range of evidence-based activities including community and clinical prevention initiatives; research, surveillance, and tracking; public health infrastructure; immunizations and screenings; tobacco prevention; and public health workforce and training. As of 2016, funding has been allocated to public health priorities including Alzheimer's disease prevention, chronic disease self-management, diabetes prevention, hospital promotion of breastfeeding, and lead poisoning prevention.

The development of public health is important to note as part of the basics of the U.S. healthcare system because its development was separate from the development of private medical practices. Public health specialists view health from a collectivist and preventative care viewpoint: to protect as many citizens as possible from health issues and to provide strategies to prevent health issues from occurring. The definitions cited in the previous paragraph emphasize this viewpoint. Public health concepts were in stark contrast to traditional medicine, which focused on the relationship between a provider and patient. Private practitioners held an individualistic viewpoint—people more often would be paying for their services from their health insurance or from their own pockets. Physicians would be providing their patients guidance on how to cure their diseases, not preventing disease. As a healthcare consumer, it is important to recognize the role that public health plays in our health care. If you are sick, you go to your physician for medical advice, which may mean receiving a prescription. However, there are often times that you may not go see your physician because you do not have health insurance or you do not feel that sick or you would like to change one of your lifestyle behaviors. Public health surrounds consumers with educational opportunities to change a health condition or behavior. You can visit the CDC's website, which provides information about different diseases and health conditions. You can also visit your local health department. CDC has become very proactive in developing successful social media campaigns regarding public health issues. Traditional medicine has also become entrenched in social media as well. These tools are an effective way to communicate with a society that is so connected with social media applications on a daily basis.

The concept of public health has been more publicized in the 21st century because of the terrorist attacks of 2001, the anthrax attacks in post offices, the natural disasters of Hurricane Katrina and Super storm Sandy, the Boston Marathon bombing, the Ebola and Zika virus epidemics and flooding in the Midwest. Funding has increased for public health activities because of these events. The concept of bioterrorism is now a reality. Because public health is now considered an integral component to battling terrorism and consequently a matter of national security, federal funding dramatically increased. This chapter will discuss the concept of health and healthcare delivery and the role of public health in delivering health care. The concepts of primary, secondary, and tertiary prevention and the role of public health in those delivery activities will be highlighted. Discussion will also focus on the origins of public health, the major role epidemiology plays in public health, the role of public health in disasters, core public health activities, the collaboration of public health and private medicine, and the importance of public health consumers.

Chapter 6

Inpatient services are services that involve an overnight stay of a patient. Historically, the U.S. healthcare industry was based on the provision of inpatient services provided by hospitals and outpatient services provided by physicians. As our healthcare system evolved, hospitals became the mainstay of the healthcare system, offering primarily inpatient with limited outpatient services. Over the past two centuries, hospitals have evolved from serving the poor and homeless to providing the latest medical technology to serve the seriously ill and injured. Although their original focus was inpatient services, as a result of cost containment and consumer preferences, more outpatient services are now being offered by hospitals. Hospitals have evolved into medical centers that provide the most advanced service. Hospitals can be classified by who owns them, length of stay, and type of services provided. Inpatient services typically focus on acute care, which includes secondary and tertiary care levels that most likely require inpatient care. Inpatient care is very expensive and, throughout the years, has been targeted for cost-containment measures. Hospitals have begun offering more outpatient services that do not require an overnight stay and are less financially taxing on the healthcare system. U.S. healthcare expenditures have increased as part of the gross domestic product, and consequently, more cost-containment measures have evolved. Outpatient services have become more prevalent because they are less expensive and they are preferred by consumers.

Although hospitals admit 35 million individuals annually, the healthcare industry has recognized that outpatient services are a cost-effective method of providing quality health care and has therefore evolved into providing quality outpatient care. This type of service is the preferred method of receiving health care by the consumer. In 2015, there were over 900 million visits to doctor's offices, which is the traditional method of ambulatory care. However, as medicine has evolved and more procedures, such as surgeries, can be performed on an outpatient basis, different types of outpatient care have evolved. As discussed previously, there are more outpatient surgical centers, imaging centers, urgent and emergent care centers, and other services that used to be offered on an inpatient basis. There will continue to be an increase in outpatient services being offered. Technology will increase the quality and efficiency of health care for consumers. Telemedicine will also become a more widely used model for health care because of continued advances in technology. The implementation of patient electronic health record systems nationwide will be the impetus for the development of more electronic healthcare services. This chapter will discuss the evolution of outpatient and inpatient healthcare services in the United States.

Chapter 7

The healthcare industry is the fastest growing industry in the U.S. economy, employing a workforce of nearly 20 million healthcare workers. Considering the aging of the U.S. population and the impact of the Affordable Care Act, it is expected that the healthcare industry will continue to experience strong job growth. Job growth in many healthcare sectors is outpacing that in other industries. When we think of healthcare providers, we automatically think of physicians and nurses. However, the healthcare industry is composed of many different health service professionals, including dentists, optometrists, psychologists, chiropractors, podiatrists, nonphysician practitioners (NPPs), administrators, and allied health professionals. It is important to identify allied health professionals because they provide a range of essential healthcare services that complement the services provided by physicians and nurses. This category of health professionals is an integral component of providing quality health.

Health care can occur in varied settings. Physicians have traditionally operated in their own practices but they also work in hospitals, mental health facilities, managed care organizations, and community health centers. They may also hold government positions or teach at a university. They could be employed by an insurance company. Health professionals, in general, may work at many different organizations, both for profit and nonprofit. Although the healthcare industry is one of the largest employers in the United States, there continue to be shortages of physicians in certain geographic areas of the country. Rural areas continue to suffer physician shortages, which limits consumer access to health care. There have been different incentive programs to encourage physicians to relocate to rural areas, but shortages still exist. In most states, only physicians, dentists, and a few other practitioners may serve patients directly without the authorization of another licensed independent health professional. Those categories authorized include chiropractic, optometry, psychotherapy, and podiatry. Some states authorize midwifery and physical therapy. There also continues to be a shortage of registered

nurses nationwide, with the most need identified in the south and west. There is also a shortage of qualified nursing faculty to teach in nursing schools, which limits the number of students enrolled in registered nursing programs. The American Association of Colleges of Nursing (AACN) is discussing this issue with policy makers.

Healthcare personnel comprise one of the largest labor forces in the United States. This chapter provided an overview of the different types of employees in the healthcare industry. Some of them require many years of education; however, some of these positions can be attained upon completion of 1–2 year programs. The healthcare industry will continue to progress as U.S. trends in demographics, disease, and public health pattern change, and cost and efficiency issues, insurance issues, technological influences, and economic factors continue to evolve. More occupations and professions will develop as a result of these trends. The major trend that will impact the healthcare industry is the aging of the U.S. population. The BLS predicts that half of the next decades' fastest growing job categories will be in the healthcare industry. The Affordable Care Act will continue to have an impact on the positive growth for this industry. This chapter will provide a description of the different types of healthcare professionals and their role in providing care in the U.S. system

Chapter 8

The percentage of the U.S. gross domestic product (GDP) devoted to healthcare expenditures has increased over the past several decades. In 2014, the United States spent $2.6 trillion on health care or 17.5% of the GDP, which is the highest percentage of its GDP in the world. The Centers for Medicare and Medicaid Services (CMS) predicts annual healthcare costs will be $4.64 trillion by 2024, which represents nearly 20% of the U.S. GDP.

As healthcare technology and research provide for more sophisticated and more expensive procedures, there will be an increase in healthcare expenses. Three areas account for over 60% of national healthcare expenditures: hospital care, physician and clinical services, and prescription drugs (Health spending explorer, 2016). Unlike countries that have universal healthcare systems, payment of healthcare services in the United States is derived from (1) out-of-pocket payments or cost sharing from patients who pay entirely or partially for services rendered; (2) health insurance plans, such as indemnity plans or managed care organizations; (3) public or governmental funding such as Medicare, Medicaid, and other governmental programs; and (4) health savings accounts (HSAs). Much of the burden of healthcare expenditures has been borne by private sources—employers and their health insurance programs. Individuals may continue to pay their health insurance premiums through the Consolidated Omnibus Budget Reconciliation Act (COBRA) once they are unemployed, but most individuals cannot afford to pay the expensive premiums.

As a result of the passage of the Affordable Care Act (ACA) of 2010, the government has played a proactive role in developing a healthcare system that is more consumer oriented. The Act is requiring more employers to offer health insurance benefits and requiring individuals to purchase healthcare insurance if they can afford it from the health insurance marketplaces. The Act also requires health insurance plans to provide more information about their plans to their members so they can make informed decisions about their healthcare.

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

Chapter 9

Managed care is a healthcare delivery system organized to manage cost, utilization, and quality. Managed care refers to the cost management of healthcare services by controlling who the consumer sees and how much the service costs. Managed care organizations (MCOs) were introduced 40 years ago, but became more entrenched in the healthcare system when the Health Maintenance Organization Act of 1973 was signed into law by President Nixon. Healthcare costs were spiraling out of control during that period. Encouraging the increase in the development of HMOs, the first widely used managed care model, would help to control the healthcare costs. MCOs'

integration of the financial industry with the medical service industry resulted in controlling the reimbursement rate of services, which allowed MCOs more control over the health insurance portion of health care. Physicians were initially resistant to managed care models because they were threatened by loss of income. As the number of managed care models increased, physicians realized they had to accept this new form of healthcare delivery and, if they participated in a managed care organization, it was guaranteed income. Managed care health plans have become a standard option for consumers. Medicare Part C, which is commonly called Medicare Advantage, offers managed care options to their enrollees. Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and MCOs that accept a set payment per member per month (capitation) for these services. Many employers offer managed care plans to their employees.

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

Chapter 10

The general term informatics refers to the science of computer application to data in different industries. Health or medical informatics is the science of computer application that supports clinical and research data in different areas of health care. It is a methodology of how the healthcare industry thinks about patients and how their treatments are defined and evolved. For example, imaging informatics applies computer technology to organs and tissue. Health information systems are systems that store, transmit, collect, and retrieve this data. The goal of health information technology (HIT) goal is to manage the health data that can be used by patients–consumers, insurance companies, healthcare providers, healthcare administrators, and any stakeholder that has an interest in health care.

HIT impacts every aspect of the healthcare industry. All of the stakeholders in the healthcare industry use HIT. Information technology (IT) has had a tremendous impact on the healthcare industry because it allows faster documentation of every transaction. When an industry focuses on saving lives, it is important that every activity has a written document that describes the activity. Computerization of documentation has increased the management efficiency and accuracy of healthcare data. The main focus of HIT is the national implementation of an electronic patient record. Both President Bush and President Obama have supported this initiative.

This is the foundation of many IT systems because it will enable different systems to share patient information, which will increase the quality and efficiency of health care. This chapter will discuss the history of IT, different applications of IT health care, and the status of electronic health records and barriers for its national implementation.

The healthcare industry has lagged behind other industries utilizing IT as a form of communicating important data. Despite that fact, there have been specific applications developed for HIT such as e-prescibing, telemedicine, ehealth, and specific applied technologies such as the PatientPoint, MelaFind optical scanner, the Phreesia Pad, Sapien heart valve, robotic checkups, Electronic Aspirin, Accuson P10, and the Piccolo xpress, which were discussed in this chapter. Healthcare organizations have recognized the importance of IT and have hired CIOs and CTOs to manage their data. However, healthcare consumers need to embrace an electronic patient record, which is the basis for the Microsoft Health Vault. This will enable patients to be treated effectively and efficiently nationally. The patient health record can be integrated into the electronic health records that are being utilized nationwide. Having the ability to access a patient's health information could assist in reducing medical errors. As a consumer, utilizing

a tool like HealthVault could provide an opportunity to consolidate all medical information electronically so, if there are any medical problems, the information will be readily available. The major IT issue in healthcare is the need to establish the interoperability of EHRs systems nationwide. This communication between systems will enable patients to be treated more quickly because there will be immediate access to their most current medical information. Although the federal government has indicated this communication between systems needs is necessary to ensure the full success of electronic health records system, the progress continues to be slow.

Chapter 11

The healthcare industry is one of the most heavily regulated industries in the United States. Those who provide, receive, pay for, and regulate healthcare services are affected by the law. To be an effective healthcare manager, it is important to understand basic legal and ethical principles that influence the work environment, including the legal relationship between the organization and the consumer—the healthcare provider and the patient. The basic concepts of law, both civil and criminal healthcare law, tort reform, employment-related legislation, safety in the workplace, and the legal relationship between the provider and the patient will be discussed in this chapter. I have included some examples of LGBT-related claims that EEOC views as unlawful sex discrimination, which I think is timely.

Chapter 12

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

The concept of ethics is tightly woven throughout the healthcare industry. It has been dated back to Hippocrates, the father of medicine, in the 4th century BC, and evolved into the Hippocratic Oath, which is the foundation for the ethical guidelines for patient treatment by physicians. In 1847, the American Medical Association (AMA) published a *Code of Medical Ethics* that provided guidelines for the physician–provider relationship, emphasizing the duty to treat a patient. To this day, physicians' actions have followed codes of ethics that demand the "duty to treat".

Applying the concept of ethics to the healthcare industry has created two areas of ethics: medical ethics and bioethics. Medical ethics focuses on the decisions healthcare providers make concerning medical treatment of patients. Euthanasia or physician-assisted suicide would be an example of a medical ethics topic. Advance directives are orders that patients give to providers to ensure that, if they are terminally ill and incompetent to make a decision, certain measures will not be taken to prolong that patient's life. If advance directives are not provided, the ethical decision of when to withdraw treatment may be placed on the family and provider. These issues are legally defined, although there are ethical ramifications surrounding these decisions.

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

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

Chapter 13

According to the World Health Organization, mental wellness or mental health is an integral and essential component of health. It is a state of well-being in which an individual can cope with normal stressors, can work productively, and is able to make a contribution to his or her community. Mental health behavioral disorders can be caused by biological, psychological, and personality factors. By 2020, behavioral health disorders will surpass all physiological diseases as a major cause of disability worldwide. Mental disorders are the leading cause of disability in the United States. Mental illnesses can impact individuals of any age, race, religion, or income. According to the Substance Abuse and Mental Health Services Administration's 2014 National Survey, an estimated 43.6 million (18.1%) Americans age 18 or older experienced some form of mental illness. In 2014, 20.2 million adults (8.4%) had a substance use disorder. Anxiety disorders are the most common type of mental disorders, followed by depressive disorders.

Different mental disorders are more likely to begin and occur at different stages in life and are thus more prevalent in certain age groups. Lifetime anxiety disorders generally have the earliest age of first onset, most commonly around age 6. Although mental health is a disease that requires medical care, its characteristics set it apart from traditional medical care. U.S. Surgeon General David Satcher released a landmark report in 1999 on mental health and illness, *Mental Health: A Report of the Surgeon General*. The Surgeon General's report on mental health defines mental disorders as conditions that alter thinking processes, moods, or behavior and result in dysfunction or stress. The condition can be psychological or biological in nature. The most common conditions include phobias, which are excessive fear of objects or activities; substance abuse; and affective disorders, which are emotional states such as depression. Severe mental illness includes schizophrenia, major depression, and psychosis. Obsessive-compulsive disorders (OCD), intellectual disabilities, Alzheimer's disease, and dementia are also considered mentally disabling conditions.

According to the report, mental health ranks second to heart disease as a limitation on health and productivity. People who have mental disorders often exhibit feelings of anxiety or may have hallucinations or feelings of sadness or fear that can limit normal functioning in their daily life. Because the causes or etiologies of mental health disorders are less defined and less understood compared to traditional medical problems, interventions are less developed than in other areas of medicine. This chapter will discuss the following topics: the history of the U.S. mental healthcare system, a background of healthcare professionals, mental healthcare law, insurance coverage for mental health, barriers to mental health care, the populations at risk for mental disorders, the types of mental health disorders as classified by the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, liability issues associated with mental health care, an analysis of the mental healthcare system, and guidelines and recommendations to improve U.S. mental health care. A section on family and caregivers is also included.

Chapter 14

The U.S. healthcare system has long been recognized for providing state-of-the-art health care. It has also been recognized as the most expensive healthcare system in the world and the price tag is expected to increase. Despite offering two large public programs—Medicare and Medicaid for elderly, indigent, or disabled individuals—current statistics indicate that millions of individuals are uninsured, although the Affordable Care Act's individual mandate to purchase health insurance coverage has reduced those numbers.

The U.S. healthcare system continues to evolve. Technology will continue to have a huge impact on health care. Consumers have more information to make healthcare decisions because of information technology. Healthcare providers have more opportunities to utilize technology such as robotic surgery, e-prescribing, and clinical decision support systems that will assist them with diagnoses. The Green House Project is an exciting initiative that may transform how long-term care will be implemented. As our population becomes grayer, more citizens will want to live as independently as possible for a longer period of time, and the Green House Project is an excellent template for achieving this goal. All of these initiatives are exciting for the healthcare consumer. The implementation of an EHR, which will enable providers to share information about a patient's health history, will provide the consumer with the opportunity to obtain more cost-effective and efficient health care. The Veterans Administration hospitals use the EHR system. Duke University Health System also uses an

EHR system in North Carolina. There are hospitals, physician practices, and other healthcare organizations that utilize EHR systems across the country. Even though implementing the system nationally will be extremely expensive—costs have been estimated in the billions—it will eventually be a cost-saving measure for the United States. The Affordable Care Act has provided many incentives to improve the quality of and access to the U.S. healthcare system. The Center for Medicaid and Medicare Innovation has over 40 demonstration projects that focus on different types of financing models that are based on the performance of healthcare providers.

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

This chapter will compare the U.S. healthcare system and the healthcare systems of other countries and discuss whether universal healthcare coverage should be implemented in the United States. This chapter will also discuss trends that may positively impact the U.S. healthcare system, including the increased use of technology in prescribing medicine and providing health care, complementary and alternative medicine use, new nursing home models, accountable care organizations, and the universal-healthcare-coverage programs in Massachusetts and San Francisco, California. The Affordable Care Act (ACA) will also be discussed because of its major impact on the U.S. healthcare system.

CHAPTER 1

History of the U.S. Healthcare System

LEARNING OBJECTIVES

The student will be able to:

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

DID YOU KNOW THAT?

- When the practice of medicine first began, tradesmen such as barbers practiced medicine. They often used the same razor to cut hair as to perform surgery.
- In 2014, the United States spent 17.5% of the gross domestic product on healthcare spending, which is the highest in the world.
- As a result of the Affordable Care Act, the number of uninsured is projected to decline to 23 million by 2023.
- The Centers for Medicare and Medicaid Services predicts national health expenditures will account for over 19% of the U.S. gross domestic product.
- The United States is the only major country that does not have universal healthcare coverage.
- In 2002, the Joint Commission issued hospital standards requiring them to inform their patients if their results were not consistent with typical care results.

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Introduction

It is important as a healthcare consumer to understand the history of the U.S. healthcare delivery system, how it operates today, who participates in the system, what legal and ethical issues arise as a result of the system, and what problems continue to plague the healthcare system. We are all consumers of health care. Yet, in many instances, we are ignorant of what we are actually purchasing. If we were going to spend $1,000 on an appliance or a flat-screen television, many of us would research the product to determine if what we are purchasing is the best product for us. This same concept should be applied to purchasing healthcare services.

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

As the U.S. population's life expectancy continues to lengthen—increasing the **"graying" of the population**—the United States will be confronted with more chronic health issues because, as we age, more chronic health conditions develop. The U.S. healthcare system is one of the most expensive systems in the world. According to 2014 statistics, the United States spent $2.9 trillion or $9,255 per person on healthcare expenditures or 17.5% of its gross domestic product. The **gross domestic product (GDP)** is the total finished products or services that are produced in a country within a year. These statistics mean that over 17% of all of the products made within the borders of the United States within a year are healthcare related. Estimates indicate that healthcare spending will be 19.3% of the gross domestic product (CMS, 2016a). The Gallup-Healthways Well-Being Index indicate that in 2014, the number of uninsured Americans has dropped to 16%. Among the states, Hawaii had the lowest percentage of uninsured individuals under age 65 in 2014 (2.5%), followed by Massachusetts (3.2%), Delaware (5.4%), and Iowa (6.4%). The District of Columbia also had a low insurance rate of 3.3%. Texas (21.5%), Oklahoma (21.5%), Alaska (21.2%), and Florida (18.8%) had the highest percentage of uninsured individuals under age 65 in 2014 (Nation at a glance, 2015). The rates of uninsured individuals have dropped most among lower-income and black Americans. These drops have been attributed to the insurance mandate of the Affordable Care Act (Levy, 2015). The Institute of Medicine's (IOM) 1999 report indicated that nearly 100,000 citizens die each year as a result of medical errors. There have been more recent studies that indicate this estimate is much higher despite many quality improvement initiatives implemented over the years.

Although U.S. healthcare costs are very high, the United States does not offer healthcare coverage as a right of citizenship. The United States is the only major country that does not offer healthcare as a right. Most developed countries have a **universal healthcare program**, which means access to all citizens. Many of these systems are typically run by the federal government, have centralized health policy agencies, are financed through different forms of taxation, and payment of healthcare services are by a single payer—the government (Shi & Singh, 2008). France and the United Kingdom have been discussed as possible models for the United States to follow to improve access to health care, but these programs have problems and may not be the ultimate solution for the United States. However, because the United States does not offer any type of universal healthcare coverage, many citizens who are not eligible for government-sponsored programs are expected to provide the service for themselves through the purchase of health insurance or the purchase of actual services. Many citizens cannot afford these options, resulting in their not receiving routine medical care. The Affordable Care Act's health insurance marketplaces provide cost and service data so consumers can determine what is the best healthcare insurance to purchase and what services they will be receiving for that purchase. Recently, the Centers for Medicare and Medicaid Services (CMS) used its claim data to publish the hospital costs of the 100 most common treatments nationwide. The purpose of this effort is to provide data to consumers regarding healthcare costs because the costs vary considerably across the United States. This effort may also encourage pricing competition of healthcare services. The U.S. Department of Health and Human Services is providing funding to states to increase their healthcare pricing transparency (Bird, 2013). The **Patient Protection and Affordable Care Act of 2010 (PPACA)**, more commonly called the **Affordable Care Act**, has attempted to increase access to affordable healthcare. One of the mandates of the Act was the establishment of electronic health insurance marketplaces, which provide opportunities for consumers to search for affordable health insurance plans. There is also a mandate that individuals who do not have health insurance purchase health insurance if

they can afford it or pay a fine. Both of these mandates have decreased the number of uninsured in the United States.

Consumer Perspective on Health Care

What Is Health?

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

Health has several determinants or influences that impact the status of an individual's health. The individual lifestyle factors, such as exercise, diet and sexual activity are direct determinants of a person's health. Within the immediate environment of an individual, there are social and community networks—external influences on health. In addition to the **social and community networks**, there are also the general **macroenvironmental conditions** of socioeconomic, cultural, and environmental conditions that impact health, such as education, work environment, living and working conditions, healthcare services, food production, job status, water and sanitation, and housing. These **determinants of health** tie into the activities of the U.S. healthcare delivery system and its impact on the determinants of an individual's health. These activities are often categorized as primary, secondary, and occasionally tertiary prevention (Determinants of Health, 2013). These concepts are vital to understanding the U.S. healthcare system because different components of the healthcare system focus on these different areas of health, which often results in lack of coordination between the different components.

Primary, Secondary, and Tertiary Prevention

According to the *American Heritage Dictionary* (2001), prevention is defined as "slowing down or stopping the course of an event." **Primary prevention** avoids the development of a disease. Promotion activities such as health education are primary prevention. Other examples include smoking cessation programs, immunization programs, and educational programs for pregnancy and employee safety. State health departments often develop targeted, large education campaigns regarding a specific health issue in their area. **Secondary prevention** activities are focused on early disease detection, which prevents progression of the disease. Screening programs, such as high blood pressure testing, are examples of secondary prevention activities. Colonoscopies and mammograms are also examples of secondary prevention activities. Many local health departments implement secondary prevention activities. Tertiary prevention reduces the impact of an already established disease by minimizing disease-related complications. **Tertiary prevention** focuses on rehabilitation and monitoring of diseased individuals. A person with high blood pressure who is taking blood pressure medication is an example of tertiary prevention. A physician who writes a prescription for that blood pressure medication to control high blood pressure is an example of tertiary prevention. Traditional medicine focuses on tertiary prevention, although more primary care providers are encouraging and educating their patients on healthy behaviors (Centers for Disease Control and Prevention [CDC], 2007).

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

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

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

- 1700s: Training and apprenticeship under one physician was common until hospitals were founded in the mid-1700s. In 1765, the first medical school was established at the University of Pennsylvania.
- 1800s: Medical training was provided through internships with existing physicians who often were poorly trained themselves. In the United States, there were only four medical schools, which graduated only a handful of students. There was no formal tuition with no mandatory testing.
- 1847: The AMA was established as a membership organization for physicians to protect the interests of its members. It did not become powerful until the 1900s when it organized its physician members by county and state medical societies. The AMA wanted to ensure these local societies were protecting physicians' financial well-being. It also began to focus on standardizing medical education.
- 1900s–1930s: The medical profession was represented by general or family practitioners who operated in solo practices. A small percentage of physicians were women. Total expenditures for medical care were less than 4% of the gross domestic product.
- 1904: The AMA created the Council on Medical Education to establish standards for medical education.
- 1910: Formal medical education was attributed to Abraham Flexner, who wrote an evaluation of medical schools in the United States and Canada indicating many schools were substandard. The Flexner Report led to standardized admissions testing for students called the Medical College Admission Test (MCAT), which is still used as part of the admissions process today.
- 1930s: The healthcare industry was dominated by male physicians and hospitals. Relationships between patients and physicians were sacred. Payments for physician care were personal.
- 1940s–1960s: When group health insurance was offered, the relationship between patient and physician changed because of third-party payers (insurance). In the 1950s, federal grants supported medical school operations and teaching hospitals. In the 1960s, the Regional Medical Programs provided research grants and emphasized service innovation and provider networking. As a result of the Medicare and Medicaid enactment in 1965, the responsibilities of teaching faculty also included clinical responsibilities.
- 1970s–1990s: Patient care dollars surpassed research dollars as the largest source of medical school funding. During the 1980s, third-party payers reimbursed academic medical centers with no restrictions. In the 1990s with the advent of managed care, reimbursement was restricted.
- 2014: According to the 2014 Association of American Medical Colleges (AAMAC) annual survey, over 70% of medical schools have or will be implementing policies and programs to encourage primary care specialties for medical school students.

TABLE 1-2 Milestones of the Hospital and Healthcare Systems 1820–2015

- 1820s: Almshouses or poorhouses, the precursor of hospitals, were developed to serve primarily poor people. They provided food and shelter to the poor and consequently treated the ill. Pesthouses, operated by local governments, were used to quarantine people who had contagious diseases such as cholera. The first hospitals were built around areas such as New York City, Philadelphia, and Boston and were used often as a refuge for the poor. Dispensaries or pharmacies were established to provide free care to those who could not afford to pay and to dispense drugs to ambulatory patients.
- 1850s: A hospital system was finally developed but hospital conditions were deplorable because of unskilled providers. Hospitals were owned primarily by the physicians who practiced in them.

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TABLE 1-2 Milestones of the Hospital and Healthcare Systems 1820–2015 *(continued)*

- 1890s: Patients went to hospitals because they had no choice. More cohesiveness developed among providers because they had to rely on each other for referrals and access to hospitals, which gave them more professional power.
- 1920s: The development of medical technological advances increased the quality of medical training and specialization and the economic development of the United States. The establishment of hospitals became the symbol of the institutionalization of health care. In 1929, President Coolidge signed the Narcotic Control Act, which provided funding for construction of hospitals for patients with drug addictions.
- 1930s–1940s: Once physician-owned hospitals were now owned by church groups, larger facilities, and government at all levels.
- 1970–1980: The first Patient Bill of Rights was introduced to protect healthcare consumer representation in hospital care. In 1974, the National Health Planning and Resources Development Act required states to have certificate of need (CON) laws to qualify for federal funding.
- 1980–1990: According to the AHA, 87% of hospitals were offering ambulatory surgery. In 1985, the EMTALA was enacted, which required hospitals to screen and stabilize individuals coming into emergency rooms regardless of the consumers' ability to pay.
- 1990–2000s: As a result of the Balanced Budget Act cuts of 1997, the federal government authorized an outpatient Medicare reimbursement system.
- 1996: The medical specialty of hospitalists, who provide care once a patient is hospitalized, was created.
- 2002: The Joint Commission on the Accreditation of Healthcare Organizations (now The Joint Commission) issued standards to increase consumer awareness by requiring hospitals to inform patients if their healthcare results were not consistent with typical results.
- 2002: The CMS partnered with the AHRQ to develop and test the HCAHPS (Hospital Consumer Assessment of Healthcare, Providers and Systems Survey). Also known as the CAHPS survey, the HCAHPS is a 32-item survey for measuring patients' perception of their hospital experience.
- 2007: The Institute for Health Improvement launched the Triple Aim, which focuses on three goals: improving patient satisfaction, reducing health costs, and improving public health.
- 2011: In 1974, a federal law was passed that required all states to have certificate of need (CON) laws to ensure the state approved any capital expenditures associated with hospital/medical facilities' construction and expansion. The act was repealed in 1987 but as of 2014, 35 states still have some type of CON mechanism.
- 2011: The Affordable Care Act created the Centers for Medicare and Medicaid Services' Innovation Center for the purpose of testing "innovative payment and service delivery models to reduce program expenditures … while preserving or enhancing the quality of care" for those individuals who receive Medicare, Medicaid, or Children's Health Insurance Program (CHIP) benefits.
- 2015: The Centers for Medicare and Medicaid Services posted its final rule that reduces Medicare payments to hospitals that have exceeded readmission limits of Medicare patients within 30 days.

TABLE 1-3 Milestones in Public Health 1700–2015

- 1700–1800: The United States was experiencing strong industrial growth. Long work hours in unsanitary conditions resulted in massive disease outbreaks. U.S. public health practices targeted reducing **epidemics**, or large patterns of disease in a population, that impacted the population. Some of the first public health departments were established in urban areas as a result of these epidemics.

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TABLE 1-3 Milestones in Public Health 1700–2015 *(continued)*

- 1800–1900: Three very important events occurred. In 1842, Britain's Edwin Chadwick produced the General Report on the Sanitary Condition of the Labouring Population of Great Britain, which is considered one of the most important documents of public health. This report stimulated a similar U.S. survey. In 1854, Britain's John Snow performed an analysis that determined contaminated water in London was the cause of a cholera epidemic. This discovery established a link between the environment and disease. In 1850, Lemuel Shattuck, based on Chadwick's report and Snow's activities, developed a state public health law that became the foundation for public health activities.
- 1900–1950: In 1920, Charles Winslow defined public health as a focus of preventing disease, prolonging life, and promoting physical health and efficiency through organized community efforts.

  During this period, most states had public health departments that focused on sanitary inspections, disease control, and health education. Throughout the years, **public health functions** included child immunization programs, health screenings in schools, community health services, substance abuse programs, and sexually transmitted disease control.

  In 1923, a vaccine for diphtheria and whooping cough was developed. In 1928, Alexander Fleming discovered penicillin. In 1933, the polio vaccine was developed. In 1946, the **National Mental Health Act (NMHA)** provided funding for research, prevention, and treatment of mental illness.
- 1950–1980: In 1950, cigarette smoke was identified as a cause of lung cancer.
  In 1952, Dr. Jonas Salk developed the polio vaccine.

  The **Poison Prevention Packaging Act of 1970** was enacted to prevent children from accidentally ingesting substances. Childproof caps were developed for use on all drugs. In 1980, the eradication of smallpox was announced.
- 1980–1990: The first recognized cases of AIDS occurred in the United States in the early 1980s.

  1988: The IOM Report defined *public health* as organized community efforts to address the public interest in health by applying scientific and technical knowledge and promote health. The first Healthy People Report (1987) was published and recommended a national prevention strategy.
- 1990–2000: In 1997, Oregon voters approved a referendum that allowed physicians to assist terminally ill, mentally competent patients to commit suicide. From 1998 to 2006, 292 patients exercised their rights under the law.
- 2000s: The second Healthy People Report was published in 2000. The terrorist attack on the United States on September 11, 2001, impacted and expanded the role of public health. The Public Health Security and Bioterrorism Preparedness and Response Act of 2002 provided grants to hospitals and public health organizations to prepare for bioterrorism as a result of September 11, 2001.
- 2010: The ACA was passed. Its major goal was to improve the nation's public health level. The third Healthy People Report was published.
- 2015: There has been an increase nationally of children who have not received vaccines due to parents' beliefs that vaccines are not safe. As a result, there have been measles outbreaks throughout the nation even though measles was considered eradicated decades ago.

TABLE 1-4 Milestones of the U.S. Health Insurance System 1800–2015

- 1800–1900: Insurance was purchased by individuals in the same way one would purchase car insurance. In 1847, the Massachusetts Health Insurance Co. of Boston was the first insurer to issue "sickness insurance." In 1853, a French mutual aid society established a prepaid hospital care plan in San Francisco, California. This plan resembles the modern health maintenance organization (HMO).
- 1900–1920: In 1913, the International Ladies Garment Workers began the first union-provided medical services. The National Convention of Insurance Commissioners drafted the first model for regulation of the health insurance industry.

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TABLE 1-4 Milestones of the U.S. Health Insurance System 1800–2015 *(continued)*

- 1920s: The blueprint for health insurance was established in 1929 when J. F. Kimball began a hospital insurance plan for school teachers at Baylor University Hospital in Texas. This initiative became the model for Blue Cross plans nationally. The Blue Cross plans were nonprofit and covered only hospital charges so as not to infringe on private physicians' income.
- 1930s: There were discussions regarding the development of a national health insurance program. However, the AMA opposed the move (Raffel & Raffel, 1994). With the Depression and U.S. participation in World War II, the funding required for this type of program was not available. In 1935, President Roosevelt signed the **Social Security Act (SSA)**, which created "old age insurance" to help those of retirement age. In 1936, Vassar College, in New York, was the first college to establish a medical insurance group policy for students.
- 1940s–1950s: The War Labor Board froze wages, forcing employers to offer health insurance to attract potential employees. In 1947, the Blue Cross Commission was established to create a national doctors network. By 1950, 57% of the population had hospital insurance.
- 1965: President Johnson signed the Medicare and Medicaid programs into law.
- 1970s–1980s: President Nixon signed the HMO Act, which was the predecessor of managed care. In 1982, Medicare proposed paying for hospice or end-of-life care. In 1982, diagnosis-related groups (DRGs) and prospective-payment guidelines were developed to control insurance reimbursement costs. In 1985, the Consolidated Omnibus Budget Reconciliation Act (COBRA) required employers to offer partially subsidized health coverage to terminated employees.
- 1990–2000: President Clinton's Health Security Act proposed a universal healthcare coverage plan, which was never passed. In 1993, the Family Medical Leave Act (FMLA) was enacted, which allowed employees up to 12 weeks of unpaid leave because of family illness. In 1996, the Health Insurance Portability and Accountability Act (HIPAA) was enacted, making it easier to carry health insurance when changing employment. It also increased the confidentiality of patient information. In 1997, the Balanced Budget Act (BBA) was enacted to control the growth of Medicare spending. It also established the State Children's Health Insurance Program (SCHIP).
- 2000: The SCHIP, now known as the Children's Health Insurance Program (CHIP), was implemented.
- 2000: The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act provided some relief from the BBA by providing across-the-board program increases.
- 2003: The Medicare Prescription Drug, Improvement, and Modernization Act was passed, which created Medicare Part D, prescription plans for the elderly.
- 2006: Massachusetts mandated all state residents have health insurance by 2009.
- 2009: President Obama signed the **American Recovery and Reinvestment Act (ARRA)**, which protected health coverage for the unemployed by providing a 65% subsidy for COBRA coverage to make the premiums more affordable.
- 2010: The ACA was signed into law, making it illegal for insurance companies to rescind insurance on their sick beneficiaries. Consumers can also appeal coverage claim denials by the insurance companies. Insurance companies cannot impose lifetime limits on essential benefits.
- 2013: As of October 1, individuals could buy qualified health benefits plans from the Health Insurance Marketplaces. If an employer does not offer insurance, effective 2015, consumers can purchase it from the federal Health Insurance Marketplace. The federal government provided states with funding to expand their Medicaid programs to increase preventive services. MARGIN IS OFF
- 2015: The CMS posted its final rule that reduces Medicare payments to hospitals that readmit Medicare patients within 30 days after discharge. This rule is an attempt to focus hospital initiatives on quality care. The MARGIN IS OFF

Milestones of Medicine and Medical Education

The early practice of medicine did not require a major course of study, training, board exams, and licensing, as is required today. During this period, anyone who had the inclination to set up a physician practice could do so; oftentimes, clergy were also medical providers, as were tradesmen such as barbers. The red and white striped poles outside barber shops represented blood and bandages because the barbers were often also surgeons. They used the same blades to cut hair and to perform surgery (Starr, 1982). Because there were no restrictions, competition was very intense. In most cases, physicians did not possess any technical expertise; they relied mainly on common sense to make diagnoses (Stevens, 1971). During this period, there was no health insurance, so consumers decided when they would visit a physician and paid for their visits out of their own pockets. Often, physicians treated their patients in the patients' homes. During the late 1800s, the medical profession became more cohesive as more technically advanced services were delivered to patients. The establishment of the **American Medical Association (AMA)** in 1847 as a professional membership organization for physicians was a driving force for the concept of private practice in medicine. The AMA was also responsible for standardizing medical education (AMA, 2016a; Goodman & Musgrave, 1992).

In the early history of medical education, physicians gradually established large numbers of medical schools because they were inexpensive to operate, increased their prestige, and enhanced their income. Medical schools only required four or more physicians, a classroom, some discussion rooms, and legal authority to confer degrees. Physicians received the students' tuitions directly and operated the school from this influx of money. Many physicians would affiliate with established colleges to confer degrees. Because there were no entry restrictions, as more students entered medical schools, the existing internship program with physicians was dissolved and the Doctor of Medicine (MD) became the standard (Vault Career Intelligence, 2013). Although there were major issues with the quality of education provided because of the lack of educational requirements, medical school education became the gold standard for practicing medicine (Sultz & Young, 2006). The publication in 1910 of the ***Flexner Report***, which evaluated medical schools in Canada and the United States, was responsible for forcing medical schools to develop curriculums and admission testing. These standards are still in existence today.

When the Medicare and Medicaid programs were enacted in 1965, Congress recognized that the federal government needed to support medical education, which resulted in ongoing federal funding to teaching hospitals to support medical resident programs. The responsibilities of teaching now included clinical duties. During the 1970s–1990s, patient care dollars exceeded research funding as the largest source of medical school support. Academic medical centers would be reimbursed without question by third-party payers. However, with the advent of managed care in the 1990s, reimbursement restrictions were implemented (Rich, Liebow, Srinivaan, Parish, Wollinscroft, Fein, & Blaser, 2002). With the passage of the ACA, which increased the need for primary care providers, more medical schools are focusing on primary care curriculum initiatives (AAMAC, 2016).

Milestones of the Hospital System

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

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

In 1973, the first **Patient Bill of Rights** was established to protect healthcare consumers in hospitals. In 1974, a federal law was passed that required all states to have **certificate of need (CON)** laws to ensure the state approved any capital expenditures associated with hospital and medical facility construction and expansion. The Act was repealed in 1987, but as of 2014, 35 states still have some type of CON mechanism (National Conference of State Legislatures

[NCSL], 2016). The concept of CON was important because it encouraged state planning to ensure their medical system was based on need. In 1985, the **Emergency Medical Treatment and Active Labor Act (EMTALA)** was enacted to ensure that consumers were not refused treatment for an emergency. During this period, inpatient hospital use was typical; however, by the 1980s, many hospitals were offering outpatient or ambulatory surgery that continues into the 21st century. The Balanced Budget Act of 1997 authorized outpatient Medicare reimbursement to support these cost-saving measures (CDC, 2001). **Hospitalists**, created in 1996, are providers who focus exclusively on the care of patients when they are hospitalized. Creation of this new type of provider recognized the need of providing quality hospital care (American Hospital Association [AHA], 2016; Sultz & Young, 2006). In 2002, the Joint Commission on the Accreditation of Healthcare Organizations (now The **Joint Commission**) issued standards to increase consumer awareness by requiring hospitals to inform patients if their outcomes were not consistent with typical results (AHA, 2013). The CMS partnered with the AHRQ to develop and test the HCAHPS (Hospital Consumer Assessment of Healthcare, Providers and Systems Survey). Also known as the CAHPS survey, the HCAHPS is a 32-item survey for measuring patients' perception of their hospital experience. In May 2005, the National Quality Forum (NQF), an organization established to standardize health care quality measurement and reporting, formally endorsed the CAHPS® Hospital Survey. The NQF endorsement represents the consensus of many healthcare providers, consumer groups, professional associations, purchasers, federal agencies, and research and quality organizations. Since 2008, it has been nationally recognized as a standardized measurement for hospital comparisons (HCAHPS Fact Sheet, 2016).

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

In 2011, the ACA created the Centers for Medicare and Medicaid Services' Innovation Center for the purpose of developing innovative care and payment models. In 2015, the CMS also posted its final rule that reduces Medicare payments to hospitals that readmit Medicare patients within 30 days. This rule is an attempt to focus hospital initiatives on quality care (Rau, 2015)). As a result of this rule, many hospitals are focusing on the concept of quality improvement processes and performance-driven planning to ensure that these readmissions do not occur.

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

Milestones of Public Health

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

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

Disease control and health education were also integral components of public health departments. In 1916, the Johns Hopkins University, one of the most prestigious universities in the world, established the first public health school (Duke University Library, 2016). Winslow's definition of public health focuses on the prevention of disease, while the IOM defines public health as the organized community effort to protect the public by applying scientific knowledge (IOM, 1988; Winslow, 1920). These definitions are exemplified by the development of several vaccines for