CHAPTER 2

The Healthcare Climate and Communication

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People create businesses just like themselves.
People make businesses, businesses don't make people.

—Elcha Shain Buckman

The purpose of this chapter is to examine how healthcare insurance and healthcare delivery systems are affected, influenced, shaped, changed, and transformed by the economy. In order to accomplish this, we will look at both ancient and current history, which has influenced the development of medicine and our healthcare delivery system. The existing economic climate, which interfaces with political and medical structures, will continue to change and, therefore, affect the design of these systems of care. We will examine what the future holds and how prevailing influences might affect clinical practice and patient care. All of these issues demand attention to issues related to communication. Finally, specific exercises will facilitate realistic application of theory to practice.

HISTORICAL BACKGROUND

A More Current Event

History is a vast early warning system.

—Norman Cousins

When applied to health care, this statement indicates that the best way to even hope to understand the present healthcare climate and steward its direction is to know the history of the gargantuan and transformational changes that

have happened to the world in general and in the US healthcare delivery system in particular, especially since the early 1900s.

If you don't know where you're going you might wind up someplace else.
When you come to a fork in the road, take it.
It ain't over till it's over.
I never said most of the things I said.

—Yogi Berra

These seminal statements, known as Yogiisms, made by an eighth grade educated, 1940s great and most beloved New York Yankees' baseball catcher and manager, have been embraced by the businesspeople (yes, men and women alike) throughout the United States, particularly when they cannot think of another way to express their feelings.

These Yogiisms unfortunately can also describe what has become our present economic crisis and current state of US healthcare delivery systems. Since 1935 and the advent of Social Security, there exists a confusing mixture of health insurance products and services. Today there are over a dozen different types of delivery systems for health care, and universal health care may be on the horizon.

A Little Ancient History

"Above all else, do no harm," a common phrase when talking about patients and health care, is attributed to Hippocrates (b. 460 BC), the father of medicine. It is said to be from his famous Hippocratic Oath (a code of ethics for physicians) which is still taken by many modern medical, dental, and nursing school graduates around the world. In fact, "Above all else, do no harm" does not appear in The Hippocratic Oath. The confusion may have arisen from the fact that, during the time of Hippocrates, doctors used to administer (for a price) fatal potions to dispatch unwanted individuals to their heavenly reward. Hippocrates strongly disapproved of this practice and did include the phrase "I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect" (Temkin & Temkin, 1967). This cryptic saying effectively conveys the Hippocratic principles. Hippocrates, history's most famous physician, is best known for what today would be referred to as *patient-centered care*. He rejected superstition, which was the prevailing medical practice in terms of both diagnostics and treatment at the time. Rather, he classified diseases according to scientific observation and created moral and professional

standards for physicians. His innovations were so revolutionary and held in such high esteem that virtually no significant medical and healthcare discoveries occurred until 1135 and the birth of Maimonides. This world-renowned Jewish physician was also a rabbi, religious scholar, philosopher, mathematician, and astronomer. Like Hippocrates, his life was entirely focused on improving health conditions and patient care while changing health behaviors and laws. His best known writing is his collection of medical aphorisms: *Treatise on Poisons and their Antidotes*, *Treatise on Hemorrhoids*, *Treatise on Cohabitation*, *Treatise on the Regimen of Health*, *Treatise on the Causes of Symptoms*, *Laws of Human Temperaments*, and *Treatise on Asthma*. Such works have been translated by Jewish medical ethicist Fred Rosner (Battista & McCabe, 1999). In his famous *The Guide for the Perplexed Maimonides*, he provides the view that the ancient Israelite food laws and actions have health benefits and purpose. This work directly led to health food laws, such as kosher dietary laws, and was later adopted by Islam as halal and progressively adopted worldwide.

Not-So-Ancient History

In 1883, poet Emma Lazarus wrote the sonnet *The New Colossus* which was later engraved on the plaque affixed to the lobby of the Statue of Liberty in New York Harbor at its dedication in 1886. The most recognized portion of the sonnet is:

> *Give me your tired, your poor, Your huddled masses yearning to breathe free, The wretched refuse of your teeming shore. Send these, the homeless, tempest-tost to me.*

This poem was written on the pedestal of the Statue of Liberty. It is the most recognized symbol of freedom in the world. It might seem strange to include a poet as an influence on our present day healthcare climate, but her words have not only become a cornerstone in the foundation of our caring about freedom, but have become a commitment for freedom for all people and a cornerstone in our commitment to their health care as well. However, it is Hippocrates whose name and admonishment endures for all healthcare providers: Above all else, do no harm.

Up to Date

It is the likes of Hippocrates, Maimonides, and Lazarus of our medical and world history who posthumously and most significantly resonate for healthcare practitioners; their influence is seen in reflective practice as identified by Harry S.

Sullivan (1953) and Martin Buber (1970); provider–patient relationships as written about by Hildegard Peplau (1952), Ida Jean Orlando (1961), and Elcha Shain Buckman (1994); and self-appreciation espoused by H. L. Dreyfus and S. E. Dreyfus (1986) and Patricia Benner (1984). US citizens are proud of their expansive healthcare system and its expertly prepared advanced healthcare practitioners. Immigrants (legal and illegal) and visitors from abroad have always come to the United States for the opportunities provided by our healthcare delivery systems, freedoms, earning power, and education systems that they and their families can participate and share in. What has previously been the most respected and sought-after healthcare system worldwide, US health care and its multiple choice delivery systems are beginning to disappoint and lag behind other countries, wealthy and poor. Some recent history of the development of our modern yet somewhat flagging healthcare system will bring this into perspective.

Social Security was established as law in 1935 but did not include any healthcare provisions because physician and insurance company lobbies kept them out. It was not until the United States' transition to the Information Age (late 1950s) from the Industrial Era (late 1800s and early 1900s) that the economy began to play a powerful role in shaping the healthcare climate for US citizens and immigrants. Healthcare laws, such as Medicare and Medicaid in 1965, and other economic laws affecting health care, such as the Omnibus Reconciliation Act of 1990 and the Balanced Budget Act of 1997 which included the Children's Health Insurance Program, were created. Coincidentally, from the early 1960s, health care became hostage to the collateral damage of big business forcing the transition from a private-payer system to multipayer and managed care systems and from a medical art and science service industry to a mostly medical science and medico-technology business.

In the late 1970s, healthcare providers were discussing not *whether* medicine was going from high-touch/low-tech to low-touch/high-tech, but *when*. In February 2009, days after his inauguration, President Obama, along with all media outlets and headlines, drove home the messages of economic recession and financial crisis in insurance coverage and medical services.

US health care has been living well for 40 years, but after 50 years of healthcare reform we are on life support. There is continuous threatening talk of Social Security and Medicare running out of money by 2020. On February 24, 2009, President Obama announced a $643 billion bailout for health care over the next 10 years. Hope is high, but the prognosis is extremely grave.

At the beginning of the 21st century, providers find our practice and the system of delivering health care bound to current, yet rapidly changing, economic and political realities. The US healthcare climate has become a conundrum of advancing medical diagnostics, treatments, pharmaceuticals, technologies, and research. For a list of healthcare terms and definitions see Box 2-1.

Box 2-1 Frequently Used Healthcare Delivery Systems Terms and Definitions

Bottom line:	The end result of an analysis; usually refers to financials; can refer to the profit realized by the company.
Beds:	Up to 25% more than the actual number of bed capacity in any given hospital.
Capitation:	After complex cost/benefit and risk analysis based on the number of patients listed with the health maintenance organization (HMO) by the provider, this is the flat-fee payment by the insurer to the contracted provider, without regard to actual health service needs. When a patient requires higher than average level of care, the patient's provider must absorb the extra cost. Conversely, when the lower than average level of care is required, the provider absorbs the savings. This creates financial incentives for the provider to limit care options offered to patients and to shun patients with complex needs while trying to attract young, healthier patients.
The Centers for Medicare and Medicaid Services (CMS):	The government administrators, approvers, and financial overseers of Medicare and Medicaid providers and patient claims.
Cost/Benefit ratio (C/B):	Used in capital budgeting; the formula used to control costs which tells the insurer if they are getting the most from each medical service for every dollar spent; the relationship considered in the analysis of whether the benefit is worth, or greater than, the cost of the medical intervention.
Formulary:	A multitiered prescription program identifying the cost of medications according to the designated areas in which they fall: generic, nonpreferred, and preferred, from the cheapest to the most expensive.

Box 2-1 Frequently Used Healthcare Delivery Systems Terms and Definitions *(continued)*

Heads:	The numbers of individuals receiving care in a hospital, outpatient, or clinic setting; the number of patients a primary care provider carries as a caseload, as dictated by the HMO with whom that provider has a reimbursement contract; used when referring to capitation.
Healthcare Delivery System:	Any insurer, company, or business entity that pays or reimburses a licensed practitioner for providing medical services to a patient; coverage and reimbursement based on a complex internal system of policies, procedures, and finances.
The Health Insurance Portability and Accountability Act (HIPAA):	Defines the standards for electronic healthcare transactions and patient privacy.
Managed care:	An organization that has a paid arrangement for providing health care in which the organization acts as an intermediary between the person seeking care and the physician and providers of other healthcare services; the for-profit side of the business of providing health care to people.
Panel:	A provider who is an accepted member of a managed care organization's network.
Preapproved:	The approval by the insurer for a medically necessary patient treatment, which must be given before the treatment is administered.
Perqs:	Corporate perquisites; benefits provided by an employer to its employees.

Advances in imaging procedures, surgery, and pharmaceuticals are driving up the cost of health care. As the population ages, additional demands will be placed on the system. Increasingly influential and complex lobbying and political systems (some physicians and nurses are now state and national legislators) and permanently powerful financial institutions and investment houses have all become crucial partners in the business of health care.

What would be termed modern and reformed health care began its move in the early 1900s and has pretty much stalled early in the 21st century. What began as an exclusively US, single-payer, private indemnity insurance-based healthcare delivery system has ended in a morass of multipayer, managed healthcare systems. We have shifted from a blue-collar, agricultural–industrial society to a more educated, white-collar, global, and technological society. Health care has shifted from patient-centered care as might be described by Harry S. Sullivan (1953), Carl Rogers (1951), Hildegard Peplau (1952), Ida Jean Orlando (1961), and Elcha Shain Buckman (1994), to economic-centered patient care as determined by Kaiser-Permanente, CIGNA, Tenent, Pacificare, UnitedHealthcare, and Humana.

THE BUSINESS OF US HEALTHCARE: A RESPONSE TO CHANGE

US Healthcare Insurance Models

We are the prisoners of history. Or are we?

—Robert Penn Warren, *Segregation*

No matter what we are told, the present US healthcare insurance industry is not market driven. The development of our healthcare delivery models are designed in response to (1) the current healthcare business climate, (2) the country's prevailing economic situation, and (3) the expectations of its citizens. Therefore, the US healthcare insurance industry can be said to be product driven and/or economy driven. The focus here will be on a review of the development, types, and components of our healthcare delivery models; a review of our unique US healthcare climate as influenced by the design of a prevailing business (i.e., the insurance industry, its healthcare models, and delivery systems); and the effect on and affect by the prevailing economic climate. Later in this chapter we will look at how today's healthcare climate can be affected, controlled, and influenced by communication and what types of communication and actions are needed to make changes for the better.

HEALTH CARE TRANSFORMED: 1935 TO 1980

History is the sum total of the things that could have been avoided.

—Konrad Adenauer

Corporate perquisites (perqs) were the first health insurance products. In the early 1900s, during World War I, the United States entered the Industrial Era,

bringing with it labor unions and increasing corporate responsibilities to and for its employees. The company owners, executives, and board members could easily afford to pay for their health care. Other employees, or line workers, were over worked, under paid, and had no to little access to health care.

Labor unions originated to support line workers and, as such, were and historically remain at odds with management, which is made up of executive (referred to as C level, such as in chief operating officer), management, and supervisory level employees. The rest of the employees, line workers, referred to the importance of manufacturing and products produced in a line. With the advent of labor unions, basic line employees began to see improved working conditions (lighting, air, breaks) and safety improvements, some attention to the health of workers, better pay, a 40-hour work week and overtime pay, child labor laws, and job security. Corporations rewarded loyal workers by giving them regular pay increases, overtime pay, vacation time and pay, and paid for their healthcare costs and provided on-site or neighborhood clinics or provided in-house doctors and nurses who were available during working hours.

Some companies purchased policies covering limited health care. The first insurance plans were administered by new, private insurance companies such as Sears and John Hancock. Line worker employees, in turn, rewarded employers by being hard working, conscientious, reliable, and loyal. Particularly with health care covered, even to a limited extent, loyalty was so high that certain industries like manufacturing or coal mining were known to have multiple, successive generations working for them. Changed labor laws and accompanying healthcare provisions and policies of the late 19th century gave birth to private indemnity insurance, often referred to as 80/20 because 80% of the healthcare bill was paid by the insurance company and 20% was paid by the individual for any and all healthcare services, from doctor's office visits to hospital stays. This system is the original comprehensive healthcare insurance; it can still be found but to a much lesser extent. Private indemnity was the sole type of private healthcare insurance until the 1930s when Kaiser-Permanente, a private HMO, focused on prevention (see HMO section later). The 70 years of coverage by private indemnity insurance policies were also the years that physicians controlled, managed, and led health care and hospitals. These halcyon years provided unprecedented financial prosperity with minimal interference in medical decision making by the payers. During this time, medicine and healthcare services were considered an art and science.

Now that the healthcare climate is a managed care business climate, the private indemnity insurance market share has been reduced to approximately 15%. However, the sales of HMOs' point of service (POS) health insurance plans (see later discussion) and health savings accounts (HSAs) are on the rise. These appear to have structured themselves similarly to parts of private indemnity policies.

The US stock market crashed on October 24, 1929, a day known as Black Thursday. Thousands of people lost nearly or their entire investments with many bankers committing suicide. The losses continued into the following Tuesday. Black Tuesday, October 29, 1929, was the start of the Great Depression, which lasted nearly a decade. Massive levels of poverty, hunger, unemployment, and political unrest followed and spread to Europe and the rest of the world. In an effort to provide financial support for the unemployed, and as a stop-gap measure for poverty and hunger to ever recur, the Social Security Act was ratified on August 14, 1935 by President Franklin D. Roosevelt. Social Security, a uniquely American solution, was established as a system of old-age and disability benefits, becoming the foundation for the establishment of Medicare in 1965 and Medicaid in 1966. Social Security does not require mandatory retirement at any age, but the age of eligibility is reviewed and reset periodically higher by the government. This enables Social Security to be maintained by keeping employment contributions coming in.

The amount one collects in annual Social Security is determined by how many quarters they contribute while working. The maximum of 40 quarters is then calculated on the highest income one earned for those 40 quarters. An individual of retirement age can elect to forego collecting Social Security and continue working and contribute to Social Security until they choose to retire. Opposition by the medical profession and private insurance interests kept health insurance out of the Social Security Act of 1935. Medicare and Medicaid (see following text) were ratified in 1965 and went into effect in 1966, becoming an intrinsic component of our national welfare system. After 30 years of going through various amendments and bitter disagreements, it was clear that health insurance needed to be enacted. The major issues were whether the program would be compulsory or voluntary, serve all incomes or just the poor, and be run by the federal government or the states; also at issue was how public and private agencies would be balanced. The ratified 1965 amendment to the Social Security Act was a compromise: Medicare would be federally run and serve the elderly and disabled of all incomes; Medicaid would serve the poor and be state administered. Medicare is solely a federal trust fund for working US citizens, whose funds are collectable upon retirement. Medicare was originally made up of Part A as mandatory coverage for hospitalization, and Part B as optional coverage that may be deferred if the beneficiary or their spouse is still actively working. There is a lifetime penalty (10% per year) imposed for not enrolling in Part B unless actively working (Kung, Hoyert, Xu, & Murphy, 2008).

The Medicare trust fund is administered by CMS, a component of the Department of Health and Human Services (HHS) in concert with other federal financial departments. In 2007, Medicare provided healthcare coverage for 43 million of the US population, with enrollment expected to reach 77 million by

2031 when the baby boom generation is fully enrolled. Each employee contributes 2.9% of their earnings annually—half by the employee and half from the employer. Medicare was established as a two-part system, Part A (federally funded insurance) and Part B (individually purchased supplemental insurance).

According to the Medicare Information Center, the annual cost of Medicare Part A is prorated on a monthly basis and the amount is deducted from each person's monthly Social Security check. In 2009, that deduction is $96.40 a month which, under Part A, covers limited financial benefits and stays, or both, in hospital, home health, hospice, and skilled nursing facilities (SNFs). Medicare recipients must meet a yearly deductible before Medicare coverage begins. People who have the financial ability can purchase Part B, a private supplementary insurance policy to cover or assist with what costs remain of Part A as the patient's responsibility, covers almost all other necessary medical services including office visits, treatments, and diagnostic tests. A convoluted Part D, purchased separately, became law in 2003 providing limited, proscribed financial assistance with selected prescription drugs, according to a formulary. For individuals who choose an HMO as their supplemental insurance, Part B and Part D become Part C (Medicare choice). In most instances, the monthly $96.40 deduction is the capitation cost for Part C. Medigap is the identifying name and is the federal supplemental equivalent of Medicare for low-income, retired, Medicaid-eligible clients. Permanent Medicaid disability (Supplemental Security Income [SSI]) is converted to Medicare after 2 years and can, in this instance, be collected before full retirement age. In 1965, federal retirement was set at age 65 and was mandatory in most companies; hence, the storied gold watch given at retirement when 65 years old. In 1978 pressure from activist groups, particularly the Gray Panthers, changed the mandatory retirement age from 65 to 70 years old. The Medicare program made a significant step for social welfare legislation and helped establish the growing population of elderly as a pressure group. In 1965, 3.9 million Americans were receiving Medicare benefits and the expected average life span was 68.5 years old for men and 72 years old for women, with 14- to 21-year-olds as the fastest growing segment of the population. The much improved quality of medical care and technological advances have increased life expectancies. In 2005, 50 million Americans were Medicare beneficiaries and the expected life span was 75.2 years for men and 80.4 years for women, with people older than the age of 100 being the fastest growing segment of the population (Ridgway, 2008).

A look at life expectancies, based on the last census taken in 2005, is revealing. It is projected that, in 2010, 70 million Americans will be covered by Medicare and the United States will have a population of 310.3 billion people, growing to 341.4 billion in 2020. The Medicare eligibility age was raised in 2000 from 65 to 67 years old. These foregoing statistics have enormous implications for Medicare and all other healthcare providers and insurers.

The political and financial designers of Medicare were unable to anticipate its present evolution. To lower costs the government periodically redefines retirement age and adds other legislation, thereby enabling the longevity of our Medicare trust fund. Contracted Medicare providers are paid for their services according to the usual and customary charges in their geographical area. The recent additions of HMO-managed Medicare and Part D have severely worsened an already perplexing healthcare climate, to say nothing about the extraordinary lack of public information and understanding. In 1965, prescription medication coverage was not the issue it has become today. Prescribed drugs were given to the patient by the physician who had well-stocked samples from drug representatives and prescriptions were relatively inexpensive to fill.

Since the 1980s, innovative and sophisticated pharmaceutical research and development, pioneering medical technology, reduced coverage by HMOs, and pharmaceutical manufacturers' increased mass marketing and advertising of new and expensive prescription drugs to the public have triggered unbridled rising medication costs for consumers. In 2003 a well-meaning effort to relieve the health-insured consumer of exorbitant medication costs, President George W. Bush complicated the situation by creating and signing into law a convoluted Medicare Part D—incomprehensible to all, even the insurers. In the arena of political healthcare football, many politicians warn of the government's inability to continue Medicare coverage after 2020. From a business standpoint, Medicare, as a healthcare delivery system, is reasonably well organized and is a relatively financially well-managed insurer. Some who are active and knowledgeable in the financial, business, and healthcare industries posit that if universal healthcare coverage is adopted by the federal government then it should be designed like the Medicare/Medicaid model and managed by CMS. These and other proposals to expand competition in (and out of) Medicare are controversial because they are based more on theory than on practice generating apprehension about the risks to beneficiaries. Until then, or until health care and insurance services and costs are strategically investigated and restructured, Medicare will remain only one part of our tangled healthcare quagmire.

Medicaid was instituted in 1966 and is currently the largest healthcare insurer in the United States. It is jointly administered by federal and state governments under Title XIX of the Social Security Act. Medicaid was preceded by the Kerr-Mills Act of 1960, which provided federal support for state medical programs serving the elderly poor. Because the passage of the Kerr-Mills Act and Medicare preceded it, Medicaid was easily passed by Congress but has become the government's most expensive general welfare program. Although state participation in Medicaid is voluntary, all states have participated since 1982. The federal government reimburses states according to per capita income,

with states like New York receiving 50 cents and Mississippi receiving 80 cents for every dollar spent on Medicaid. According to CMS, in 2004, Medicaid payments totaled $295 billion. To help defray rapidly rising costs, a new federal rule was passed on November 25, 2008, that allowed states to charge premiums and higher copayments to Medicaid recipients. The mission of Medicaid is to provide the over 55 million disabled, elderly, low-income, and poverty-level US citizens and resident aliens with access to private-equivalent levels of normal medical health care, including dental care and prescription drug rebates. Medicaid covers in-hospital, SNF, out-patient, and office care. Statistics point to Medicaid enrollment being mostly single women with children (60%), the disabled (20%), and poor elderly (20%) with dual Medicare and Medicaid eligibility. Under federal law, states cannot reduce welfare benefits when individuals become Medicaid eligible. All Medicaid payments are made to providers only and this has created Medicaid's major problem: fraud. Although some successful reforms have been instituted, other problems still persist (Box 2-2).

Medicaid suffers from the same issues and problems as Medicare and all other healthcare insurers: rising costs of health care, increase in eligible individuals, increased use of services by individuals, movement from fee-for-service to managed care contracts compromising assurance of standards of care, stagnation of quality of the health care provided, and expansion of what is considered minimum benefits.

The years after World War II ushered in even more extraordinary advances in the ability of medical care to prevent and relieve suffering through the research and development of powerful diagnostic tools and sophisticated treatments and

Box 2-2 Problems with Medicaid

Being state administered, the quality and range of medical services varies considerably
Because services are contracted with private payers, costs cannot be easily controlled
Because illegal immigrants qualify in many circumstances, this puts extra care and cost burdens on certain states
Hospital emergency rooms are financially vulnerable because illegal immigrants are covered for emergency services
Childless couples and single adults who live at low-income or poverty levels are not covered unless disabled

medicines. We had the polio vaccine and immunosuppressants; we began using computed tomography (CT) scans, positron emission tomography (PET) scans, and magnetic resonance imaging (MRI); we discovered that a naturally occurring water-soluble salt called lithium was the rescue treatment for people suffering from manic-depressive illness; and open-heart surgery, kidney dialysis machines, and organ transplants were saving hundreds of thousands of lives a year. In 1900, the average life expectancy in the United States was 47 years and the major causes of death each year were various infections. By the late 1940s, because of the development of highly developed life support systems, powerful antibiotics, and corticosteroids, chronic diseases such as cancer, stroke, and heart attacks had replaced infections as the major causes of death and, toward the end of the 20th century, life expectancy in the United States had increased to 87 years. Some Americans are now called the *sandwich* generation because they are taking care of their children and their parents now coping with Alzheimer's disease, the scourge of modern medicine, or cancer and dementia. Exceptional scientific advancements, along with the Civil Rights movement, have resulted in profound changes in the US healthcare system. Before World War II most physicians were general practitioners and by 1960, almost 90% chose careers in a specialty area. Solo practice faded and physicians began group practices. Health care became more of right for all citizens, thus increasing the numbers who sought care.

Social and healthcare reforms, Social Security, and Medicare ended segregation in hospitals. Private medical insurance companies, including Blue Cross/Blue Shield, Aetna, and Fireman's Fund, began to offer health insurance to the middle class. Prosperity followed for both providers and hospitals. Medical specialization flourished and yet care became ever more fragmented. Research and technological advances raised ethical issues while disease prevention and health promotion were ignored. Paperwork and red tape began to clog the system. Soaring costs became the major concern, dwarfing the concern about the uninsured and the issue of access to care.

Employers began to realize that their competitiveness in the global market was being lost to foreign companies that paid far less for employee health insurance than they did, and employees feared losing healthcare benefits because of jobs being sent overseas.

The Era of Managed Care: 1985 to Present

This era of rapidly progressing technology advances came roaring on the national scene like a pride of lions in the early 1980s, revolutionizing the field of medical science, research, development, and services in every way possible—

many of which have been welcomed changes. Following this, the cost of health care began soaring out of control in the mid-1980s. In addition, the medical profession's and federal regulator's inability to control costs, combined for a business-imposed approach of *managed care* to take over, resulting in the new business of health care. Managed care is a generic term that refers to a large variety of reimbursement plans in which third-party payers attempt to control costs by limiting the utilization of medical services, in contrast to the hands-off style of traditional fee-for-service payment. Included in this permanent change to healthcare services are:

1. Prescribing medications according to a formulary
2. Mandating preauthorizations before treatments, procedures, surgeries, and hospitalizations are provided
3. Severely restricting the length of time a patient may remain in the hospital and requiring that patients be allowed to see specialists only ifreferred by a *gatekeeper* (the primary care physician or the insurance company)

Some of these changes have had positive outcomes, while others are not without their disadvantages (Table 2-1).

What was first proffered as innovative systems of delivering cost-effective health care quickly became recognized as profit-motivated, investor-owned organizations. So it appears that managed care has unfortunately ushered in a new era of significant vocal public backlash against it and strident patients' rights advocacy. Perqs continue to live and be well and play a stronger role than ever in businesses large and small. As employees, we are a society used to our employer paying for our healthcare insurance (and our family's) since the 1950s; as retirees, we are used to them continuing to pay and provide until we and our spouse die. Or, we expect the same from Medicare. The hottest topics constantly and consistently talked about since 2004 are:

1. Will the company be able to continue to provide healthcare coverage for its working employees? And, if so, what percentage will the company and employee each pay?
2. How can the company legally get out of paying for the healthcare coverage promised to their retirees?
3. Medicare is in a crisis; it is assumed that the government only has money to cover until 2020; the recessive economy (with unemployment and bankruptcies at their highest rate ever recorded) is not allowing for the coffers to continue to be filled. How long will the money really last and how long can it continue to cover today's and tomorrow's retirees?

How's that for the healthcare climate and communication!

Table 2-1 Advantages and Disadvantages of Managed Care

Advantages
Patients are now consumers, leading to such things as better hospital food, previously thought of as complaining or irrelevant
Respect, recognition, and expansion of services by advanced practice nurses and pharmacists
Creation and growth of physician extender programs (physician assistants and medical technicians)
Efficiency of information technologies, providing confidentiality and saving time and space for people, offices, and institutions
The medical profession thinking seriously about costs
Some treatments and procedures safely moved from hospitals to less costly ambulatory settings
Improved business practices regarding healthcare delivery system
Shortcomings
In spite of, or because of, advanced technology, utilization review, and preauthorization there has been a serious erosion of the quality of our health care
A serious loss of trust in doctors and our healthcare system
Triple-digit healthcare inflation
It has not been able to keep its promise of controlling healthcare costs
The *dollar-is-king* and *medicine-is-a-marketplace* business mentality has been seriously detrimental to some areas of healthcare services, medical schools, and teaching hospitals

Health Maintenance Organizations (Managed Care)

All providers must be contracted with the HMO and must accept their capitation rules. HMOs are organized around the following assumption: Control costs by paying less for fewer services. The underlying tenets are stringent utilization

review, cost reduction by reimbursing providers less for services, cost containment by allowing referrals only to in-plan providers, and preauthorization for all procedures and treatments other than in clear emergency situations. In the United States, HMOs caused the demise of virtually all private payer insurances. As much as we may rail against it, we have socialized medicine and it is called HMO. And, we have had it as our major third-party payer since 1980. Socialized medicine is defined as a government-regulated system for providing health care for all by means of subsidies derived from taxation. Universal health care (see later discussion) is defined as healthcare coverage (including medical, dental, and mental health care), which vary in their structure and funding mechanisms and is extended to all eligible residents of a governmental region. With universal health care, typically most costs are met via a single-payer healthcare system or compulsory health insurance. Universal health care is provided in all wealthy, industrialized countries except for the United States and in many developing countries, and is the trend worldwide.

Ironically, the first HMO, nonprofit Kaiser Permanente, had been organized in the 1930s to achieve better coordination and continuity of care and to emphasize preventive medical services. Any cost savings that were achieved were considered a secondary benefit. By the 1980s, however, the attempt to control costs had become the dominant force underlying the managed care movement. HMOs were the new insurance of and for the Information Age. They promised reduced annual policy costs and large cost savings through better utilization of medical services, focus on prevention, and improved management of the healthcare dollar. These promises have not been realized. In fact, since the take over by HMOs, the cost of their annual insurance policies (along with the cost of health care) tripled by 2005.

What first started as merger and management of physician group practices quickly evolved into the addition and management of many healthcare facilities, satellite clinics, and some hospitals and, subsequently, the purchase, control, and restructuring of healthcare insurance companies. So began the era of managing and controlling healthcare delivery systems and healthcare dollars. In 1969, Harvard Community Health Plan (HCHP), established in Boston, fashioned itself after Kaiser-Permanente. Both plans were developed to provide in-house employee health care: Kaiser-Permanente in 1945 for the vast California healthcare system and HCHP for Harvard University and its teaching hospitals' students, staff and faculty, and their families. Kaiser-Permanente, expanding to include other West Coast states, continues to exist as a strong West Coast nonprofit HMO. HCHP, however, after rapid growth to include many off-site health centers, did not fair as well. The 1970s ushered in the age of medical technology and the rapid increase of the cost of health care. This worsening and grossly expensive healthcare climate led to the rise of other HMOs across the country, believing and selling the idea that they could slow the runaway train. In Boston, other universities

with medical schools, such a Tufts, competed by establishing their own internal HMO systems. For a short time, in the late 1970s, the HCHP acronym became loosely known in the Boston healthcare community as Horrible Care for Health People—referring to the decline of their services as it grew through merger and acquisition to include other HMO healthcare delivery systems outside of the huge Harvard University umbrella. In the late 1990s, HCHP was acquired by Pilgrim Health Care, a Boston-based HMO corporation and renamed Harvard-Pilgrim, a for-profit HMO. Across the country, the late 1970s and even 1980s brought the injudicious growth of HMOs (many lawyer-owned for financial expediency and later found to be illegal), especially in the South. Many HMOs became publically owned companies, run by high-paid executives, and, as public companies, were responsible to their stock- and stakeholders first, their contracted providers second, and their contracted customers, the patients, last.

As large companies, HMOs only contract with large groups—businesses, physician groups, healthcare facilities, Medicare, and Medicaid. The bottom-line profit and rising stock prices became primary, and healthcare delivery became secondary. These HMOs became known as cash cows for their owners and executives, and a scourge for physicians who were being financially deprived and professionally controlled through sharply reduced fees paid for preapproved procedures and corporate denial of many usual and customary procedures. Today's patients, who are more educated, informed, and involved in their healthcare decisions, are complaining as well of experiencing a decline in healthcare services, an increase in copayments for preapproved services, and the rising cost of their annual healthcare policies. At the same time, employers are cutting back coverage and the portion they pay of the annual policies, thereby increasing the percentage employees pay for their annual policies. Clearly, we have gotten the message that HMOs are not the answer to our healthcare climate dilemmas. Since the inception of HMOs, recurring incidences of corporate fraud, widespread merger and acquisition activity, pervasive misuse of patient records by healthcare and insurance corporations and some employers, and invasive violations of human rights led to the creation and establishment of HIPAA (see later discussion).

Preferred/Participating Provider Organizations

A preferred/participating provider organization (PPO) is a second, less managed, more expensive managed care organization of medical doctors, hospitals, and other healthcare providers who have contracted with an insurer or HMO as a third-party administrator to provide health care at reduced rates. It allows more flexibility of choice in providers and services than an HMO. A PPO earns money by charging an access fee to the third-party administrator for the use of their network, allowing insurance companies to negotiate directly with hospitals

and physicians for health services at a lower price than would be normally charged. PPOs employ the same utilization review procedures to verify that the recommended procedures or treatments are appropriate for the condition being treated, as well as a near-universal precertification requirement for everything other than emergency services.

PPOs try to combine the best elements of a fee-for-service and an HMO. A PPO provides the subscriber with a greater selection of healthcare service providers—in most cases not requiring a primary care physician referral—and can be viewed as a more traditional plan that uses discounted fees as the cost savings to the managed care company and a perceived increase in services by the subscriber.

Since the proliferation of HMOs and PPOs, the competitive advantages over POS and private indemnity insurance have largely been reduced or almost entirely eliminated. This accounts for medical inflation in the United States again advancing at 150 to 200% the rate of general inflation. Furthermore, the aspects of utilization review and precertification are now widely used even in traditional private indemnity plans, and are widely regarded as being essentially permanent features of the US healthcare system.

Point of Service Insurance

POS plans are a third, most expensive version of an HMO. The POS plan offers two options for the delivery of health care: (1) An open access network allowing the subscriber the right to select a provider within the HMO whenever care is needed without the intervention of a gatekeeper. This option will have a higher physician copayment than its traditional HMO counterpart and may require a deductible as well, plus a designated percentage as a co-insurance requirement. (2) An out-of-network option permits the subscriber to choose a provider outside the HMO network at the time care is required and there is no gatekeeper/director. This option has a high deductible (perhaps $500 or more) before payment is made to a provider for service and an 80/20 co-insurance requirement until the enrollee's out-of-pocket medical expenses reach a high annual deductible (usually $5000), and then the plan would pay all expenses up to a lifetime maximum ($750,000 to $1,000,000).

The Health Insurance Portability and Accountability Act

HIPAA was enacted by the US Congress in 1996. According to the CMS Web site, Title I of HIPAA protects health insurance coverage for workers and their families when they change or lose their jobs. Title II of HIPAA, known as the Administrative Simplification (AS) provisions, requires the establishment of national standards for electronic healthcare transactions and national identifiers for

providers, health insurance plans, and employers. The AS provisions also address the security and privacy of health data. The standards are meant to improve the efficiency and effectiveness of the nation's healthcare system by encouraging the widespread use of an electronic data interchange in the US healthcare system.

Catastrophic Health Insurance Plans

Also known as high deductible health plans (HDHPs), catastrophic health insurance plans (CHIPs) were created as a way to lower overall medical costs by providing a lower monthly premium in exchange for a higher annual health insurance deductible. With CHIPs, you pay for almost all medical care until you reach the annual deductible amount (usually $25,000). After that, traditional, 80/20 private indemnity health insurance coverage begins. If the CHIP is eligible for an HSA, the subscriber can use the funds contributed to help defray the deductible and out-of-pocket expenses. CHIPs have high lifetime maximum benefit payment limits (also known as caps), usually between $1 million and $5 million. Once the cap has been reached, the health insurance company will not pay for any of the subscriber's medical costs and the policy will be cancelled. These health insurance plans can usually be purchased either as an individual plan or as a group, but are very stringent about not covering preexisting conditions. The most common reasons for choosing a CHIP are: (1) you are young and would rather risk getting sick than pay high premiums for full coverage plans, even HMOs; (2) you have enough money to pay for all of your regular health care including short-term surgery and/or hospitalizations; (3) you would use it as a supplementary policy to provide choice of healthcare providers around the world; and (4) you want sufficient coverage for the catastrophic costs associated with diseases such as cancer.

Healthcare Savings Account

This type of healthcare coverage plan is becoming increasingly popular for self-employed individuals and small businesses. As the numbers of unemployed, bankruptcies, and personal and corporate spending cutbacks increase in the recessive 2009 economic climate, it stands to reason that the numbers of HSAs will increase along with the Medicaid roles. HSAs are tax-exempt, tax-deductible ways of saving for the costs of illnesses. There are no withdrawal requirements except that the employee must use the money only for health care. Some believe, especially young healthy people, that it is smart to set aside some money each month to pay for future medical expenses that you may incur, even if you do not use the money until later in life. Personal responsibility and choice are the key concepts upon which this type of healthcare benefits plan is predicated. An HSA is exactly as it states: a personal cash savings account established by an individual or

through his/her company, which is designated solely for the purpose of drawing on these monies to pay for health care. Each state differs in guidelines and tax benefits; certain state and nationally determined tax deductions and/or nontaxable benefits exist. Some states also set an annual minimum balance that must be maintained and/or minimum annual contributions made to the account. An HSA can be established separately along with a CHIP to provide for broader and more comprehensive coverage. The thinking behind this type of nontraditional healthcare savings and payment system is to provide freedom of choice of physicians, treatments, procedures, medications, and healthcare facilities and hospitals. Many physicians, pharmacies, hospitals, and healthcare facilities will provide discounts for services if they are being paid from the accumulated cash in a HSA.

Boutique Physician Practices

These practices are also called concierge, elite, premium, even platinum, practices. Once the pariah of medicine because of its seeming elitist, country club, only-the-wealthy-could-afford aura, boutique practices are now a viable choice for many. Since 2007, there have been continuing education courses designed for physicians, nurse practitioners, and physician assistants to learn the practicalities and legalities of opening boutique practices. Today there are hundreds of physicians in private concierge-type practices. These practices are a response to the confines and restrictions of managed care organizations. Having been a patient for 12 years, your author was one of the first patients in the second-ever boutique practice, started by Robert Colton, MD, in Boca Raton, Florida, in 2000 under the name MDVIP (the first boutique practice, MD2, opened in Seattle, WA, in 1996). MDVIP is now a successful organization with member physicians in 23 states. Since 2000, boutique practices have been started by other physicians independently.

Boutique practices began as a reclaiming by one physician of his professional, and personal, life from the control and dictates of managed care organizations. Physicians open concierge practices as a way of escaping managed care for these reasons:

1. Their incomes have been threatened and compromised.
2. Utilization review, preauthorization, required large caseloads, capitation, and paperwork have severely injured and compromised their ability to provide a high quality of care.
3. To have a personal life. These practices are made up of a limited number of patients (usually 500 to 600) and have a fixed annual membership fee ($1500 to $20,000).

Boutique practices usually provide these types of services:

1. The membership will cover what insurance does not, such as annual wellness exams
2. The time and attention to each patient as an individual and that quality care warrants
3. Your doctor is the only one you see unless he/she is out of town
4. Same-day appointment with a maximum 15-minute wait when needed
5. Each patient is seen for as long as they need and according to their need (an hour for a regularly scheduled annual check-up, half of an hour for other types of appointments)
6. Access to your physician 24/7 by having their email, fax, office, cell, and home numbers and they even will make house calls
7. Personal referral source and liaison for all medical care by other providers
8. A warm friendly staff who knows each patient as an individual
9. Beautifully decorated, comfortable offices with special amenities like beverages, fruit, other healthy snacks

There are lots of good reasons to become a member, but certainly these reasons help to reevaluate our medical care delivery system. Over the last 10 years, I have been following the growth and development of these boutique practices and, unfortunately, because of their attraction, some are gradually evolving into a semblance of our current group medical practices, just at a higher price.

Innovative Ideas for a Better US Healthcare Climate

Universal Health Care

First advocated by Germany's Otto von Bismarck in the 1880s, most German citizens are covered under a mandatory healthcare system. In 1948, the National Health Service (NHS) was established in the United Kingdom and is considered the world's first universal healthcare system provided by government that does include copays for certain procedures. In 1984, the Canada Health Act was passed and, for the most part, is publicly funded; physicians receive a fee per visit or service and are prohibited from extra billing. Most of the services are provided by private enterprises or private corporations, although most hospitals are public. Private pay services are available but carry financial disincentives unless the public system fails to deliver quality or timely service.

Retail Health Care

The United States has always been on the advanced and cutting edge of health care, from the Visiting Nurse Associations, which have all but completely been transformed into a plethora of home health agencies, to Medicare, the groundbreaking program for our elderly. Other very recent innovative healthcare delivery systems have not, as of yet, seen great success, such as physician and advanced practice nurse house call businesses like HouseCalls, MD AM/PM, Sickday, and ACMI/900-ARNPNURSE. What has expanded quickly, but whose longevity has not been tested, are corporate-owned retail medical clinics, the most familiar being MinuteClinic. These retail healthcare clinics, staffed by medical and pediatric nurse practitioners who always collaborate with physicians and can practice independently in most states, are situated in pharmacy chains, grocery stores, and mass markets like Walmart, many of which have in-house pharmacies. The mission of these clinics is to provide sound medical care during regular business hours to relieve the excessive time and costs of unnecessarily using emergency rooms and provide quality care and savings without the long wait at the doctor's office for our millions of Medicaid, Medicare, underinsured, and uninsured citizens who become suddenly sick with common illnesses or sustain non–life-threatening injuries. Corporate America's modern revamping of home and emergency room visits could easily become an integral part of a truly unique comprehensive universal healthcare delivery system for the United States.

Under consideration by the US federal government since 1990, universal health care should not be confused with socialized medicine. The distinguishing characteristics of universal health care are:

1. Government action aimed at extending access to health care as widely as possible
2. Implemented through legislation and regulation which directs what care must be provided, to whom, and on what basis
3. Funded mostly or entirely by taxation, usually a combination of compulsory insurance and tax revenues with some costs assumed by the patient at the time of service
4. In some cases, government involvement also includes directly managing the healthcare system, but many countries use mixed public–private systems to deliver universal health care

The United States is the only wealthy, industrialized nation that does not have a universal healthcare system even though the government directly covers 27.8% of the population via Medicaid, Medicare, and other government subsidized welfare programs. According to a 2007 study by the Kaiser Family Foundation,

since 2001 premiums for private family insurance coverage have increased 78% while inflation has risen 17% and wages have risen 19% (Palosky & Levitt, 2007). With statistics like this, the US government needs to address the cost, quality, and coverage for health care.

There have been numerous proposals to stimulate the current system into extending coverage more universally, rather than through a more comprehensive restructuring. Several studies have examined such market-based reform packages concluding that if market-oriented reforms are not implemented on a systematic basis with appropriate safeguards, they have the potential to cause more problems than they solve. Others have proposed that the whole US healthcare industry must be dismantled and built again from scratch. The author subscribes to a combination, with a heterogeneous team of knowledgeable people from various industries and professions who are both visionaries and strategic who can carefully plan and implement with conviction; can identify, admit, and shift quickly when something is not going correctly; and can rethink and implement again.

On November 5, 2008, President-elect Barack Obama promised to cut waste from the healthcare system and to introduce a universal healthcare plan into law by the end of his first term.

Our attention will next be on using nuggets of information about healthcare economics, identifying the challenges, and using critical and essential communication tools so we may join the wealthiest countries on the globe by creating a better and uniquely US healthcare climate: universal health care.

RECIPROCAL INFLUENCES ON HEALTH CARE

First kill all the lawyers.

√√√—William Shakespeare

Managed care has not proven to be our healthcare delivery system panacea. US citizens are understandably confused about our overabundance of healthcare choices, which has lead to divided sentiment about "should we continue with our private payer systems or convert to a universal health care system?" National universal health care has been bandied about for more than 20 years. Fear of socialized medicine—understood by the general US population as a loss of choices—seems to be the greatest deterrent to the development of a universal healthcare system. Battista and McCabe (1999), researching the "American fear that universal health care would result in government control and intrusion into

health care [would result] in loss of freedom of choice, [concluded that] single payer, universal health care administered by a state public health system would be much more democratic and much less intrusive than our current system. Consumers and providers [businesses and government] would have a voice in determining benefits, rates and taxes [resolving] problems with free choice, confidentiality and medical decision making." Battista and McCabe state that "single payer health care is not socialized medicine, any more than the public funding of education is socialized education, or the public funding of the defense industry is socialized defense." Battista and McCabe (1999) found that repeated national and state polls have shown that between 60 and 75% of Americans would like a universal healthcare system.

The United States spends 50 to 100% more on administration than single-payer systems in other countries. By lowering these administrative costs, the United States would have the ability to provide universal health care without managed care, with an increase in benefits, and still save money. Under a universal healthcare system all citizens could access care because there would be no lines, as in other industrialized countries, mainly because we have an oversupply in our providers and infrastructure and the willingness and ability of the United States to spend more on health care than other industrialized nations.

Now that we have a historical perspective, some interesting tidbits, and can conceptualize our complex and complicated healthcare delivery and practice systems, the following section will concentrate on the political, economic, and social reciprocal influences on our healthcare climate.

Politics

The United States is the only industrialized nation that does not guarantee access to health care as a right of citizenship. We continue to design healthcare delivery systems that support access based on the ability to pay, suggesting that health care is a privilege, often a privilege of the wealthy and the highly educated. Through lobbyists and the political donations allowed by our campaign finance system, corporations are able to buy politicians and control the media to convince people that corporate health care is democratic, represents freedom, and is the most efficient system for delivering health care.

Other than Germany, which has a multipayer universal healthcare system similar to the plan former President Clinton proposed for the United States in 1996, 28 industrialized nations have single-payer universal healthcare systems. The United States ranks poorly relative to other industrialized nations in health care despite having the best trained healthcare providers and the best medical infrastructure of any industrialized nation. Studies of state-administered healthcare

plans by Massachusetts (universal health care was ratified and initiated there on July 1, 2007) and Connecticut (a notably "green" state studying single-payer universal health care) have shown that single-payer universal health care would save $1 to $2 billion per year from the total medical expenses in those states, despite covering all the uninsured and increasing healthcare benefits—due to lower administrative costs. Single-payer health care is not socialized medicine any more than the public funding of education is socialized education, or the public funding of the defense industry is socialized defense.

In the mid-20th century, rapid changes in our US healthcare and accounting systems were advanced by new politicians who were attorneys. This new legislative style led to an excess of amendments that resulted in layered-type changes, rather than substantive resolutions. Consequently, the government has played a greater role in making "ready-fire-aim" decisions for the healthcare industry. Halting the continuation of this political methodology is paramount to repairing our beleaguered healthcare system. Ready, aim, fire action means penetrating questions must come before answers and thoughtful and full analysis must precede planning.

A good start would be to consider these questions:

1. Why does the United States not have a single-payer universal healthcare system when it is apparent to most of the world that single-payer universal health care is the most efficient, most democratic, and most equitable means to deliver health care?
2. Why does the United States remain wedded to an inefficient, autocratic, easily abused healthcare delivery system that makes health care easily accessible to the wealthy and not the poor when a consistent majority of citizens want it to be a right of citizenship?
3. What would it really take for a democratic United States to redesign its antiquated, illness-oriented, corrupted, multipayer healthcare delivery system into a single-payer healthcare system that supports an efficient, fair, and equitable prevention-oriented system of "health" care?

Economics

Healthcare economics consists of a complicated relationship between a number of participants: the consumer, insurance companies, employers, medical professionals, and various government entities. An essential feature of healthcare economics is the spreading of risk, since the cost of health care for catastrophic illness can be prohibitive. This risk may be spread by private insurance companies who seek to make a profit or by government involvement in the healthcare market.

Understanding basic healthcare economics helps us in wisely choosing our personal healthcare insurer and providers, to support or oppose universal health care, and which active roles we might take in the political, business, and social healthcare arenas. The United States uses the gross domestic product (GDP), or what uses our money goes toward, as one benchmark for how the United States is doing economically. One study by global by consulting firm Price Waterhouse Coopers projected that global healthcare spending would triple in real dollars by 2020, consuming 21% of GDP in the United States and 16% of GDP in other Organization for Economic Cooperation and Development (OECD, a 30-member think tank) countries.

Funding models for healthcare delivery systems are extremely complex. Healthcare delivery systems can be funded by any number of models. In most countries with universal health care, funding has been achieved by a mixed model: private or public funds, or both, through a single- or multipayer system or state (municipal) and national funds provided through general taxation.

Risk compensation pools and compulsory insurance in free world economies are usually enforced by legislation that delineates whether one or several funds will provide basic services or extended services, or both. The economics of funding can include private or public and are used to equalize the risks between funds. Medicare is a risk compensation pool. A healthy, younger population pays into the fund and an older, predominantly less healthy population receives the funds. This type of pool competes on price so there is no advantage to eliminate people with higher risks because they are compensated for by means of risk-adjusted capitation payments. These types of funds are not allowed to pick and choose their policyholders or deny coverage, and the basic coverage level is set by the government and cannot be modified by individuals. Taxation in the United States sustains the public portion of healthcare insurance and may contribute, in part, to other forms of the private healthcare delivery system. This effectively meets the cost of insuring those unable to insure themselves via Social Security, as funded from taxation. Some countries, like the United Kingdom, Italy, and Spain, have eliminated insurance entirely and choose to fund health care directly from taxation. Other countries with insurance-based systems fund health care either by directly paying citizens' medical bills or by paying for insurance premiums for those affected.

Adverse selection, in simple terms, refers to those with poor health who are more likely to apply for insurance and more likely to need treatments requiring high insurance company payouts. Those with good health will often remove themselves from the risk pool, becoming the working uninsured, further raising costs. This gives private insurers an economic incentive to use medical underwriting to "weed out" high-cost applicants in order to avoid adverse selection. To avoid adverse selection and the continuous escalating

costs of private healthcare insurance, economists offer, among the potential solutions, a single-payer system (see later discussion) ensuring that health insurance is universal, requiring all citizens to purchase insurance, and limiting the ability of insurance companies to deny insurance to individuals or vary price between individuals.

Single payer is the term used in the US debate over a universal healthcare system to describe the funding mechanism that would meet the costs of medical care from a single fund. Although the fund "holder" is assumed to be the government allocating funding from taxation to pay for health care, its proponents do not rule out the possibility of some other mechanism. It is therefore as of yet undetermined whether a future US single-payer universal healthcare system would be funded from taxation, from compulsory insurance, or a mixture of both. Many countries that have universal healthcare often provide private insurance as a supplement, as done in the United States with Medicare and Medicaid. Since the United States already has a functioning system in place, many of the universal healthcare proponents support adapting the existing system to create US universal health care. Private insurers might cover private rooms (United Kingdom), obtaining treatment more quickly than would otherwise be possible (Canada), or elective cosmetic surgery (Brazil).

From the beginning, the US healthcare delivery system was structured as free economy, multipayer organizations. Since 1970, the number of healthcare administrators has increased 23 times faster than the number of doctors and nurses. As of the early 1980s, the business of health care was taken out of the hands of physician administrators and private insurers (many of which were owned by individual or groups of physicians), and put into the hands of business people whose "ethics" are the bottom line. Since this transition, the ethics of practicing healthcare providers have come under harsh scrutiny. In single-payer universal health care everyone's health care would be paid for out of one publicly administered trust fund that would replace the current multipayer system, thereby eliminating the role of and need for insurance companies. It would provide all residents with comprehensive healthcare coverage that assures the freedom to choose physicians, nurse practitioners, and other healthcare professionals, services, and facilities.

True or False?

The United States has the best healthcare system in the world. Universal health care would be too expensive. Universal health care would deprive citizens of needed services. The problems with the US healthcare system are being solved and are best solved by private, corporate, managed care medicine

because they are the most efficient. Battista and McCabe (1999) conclude that these statements are all false by citing the following:

- The United States ranks 23rd in infant mortality, down from 12th in 1960 and 21st in 1990.
- The United States ranks 20th in life expectancy for women, down from 1st in 1945 and 13th in 1960.
- The United States ranks 21st in life expectancy for men, down from 1st in 1945 and 17th in 1960.
- The United States ranks between 50th and 100th in immunizations, depending on the immunization. Overall the United States is 67th, right behind Botswana.
- Outcome studies on a variety of diseases, such as coronary artery disease and renal failure, show the United States to rank below Canada and a wide variety of industrialized nations.
- The United States ranks poorly relative to other industrialized nations in health care despite having the best trained healthcare providers and the best medical infrastructure of any industrialized nation.
- For-profit, managed care cannot solve the US healthcare problems because health care is not a commodity that people shop for and the quality of care will always be compromised when the motivating factor for corporations is to save money through denial of care and decreasing provider costs.
- Managed care has introduced problems of patient confidentiality and disrupted the continuity of care by having limited provider networks.
- Private, for-profit corporations are the least efficient deliverer of health care. They spend between 20 and 30% of premiums on administration and profits. The public sector is the most efficient. Medicare spends 3% on administration.
- The same procedure in the same hospital, the year after conversion from not-for-profit to for-profit, costs between 20 and 35% more.
- Healthcare costs in the United States grew more under managed care in 1990 to 1996 than any other industrialized nation with single-payer universal health care.
- Since the late 1980s, the quality of health care in the United States has deteriorated under managed care. Access problems have increased and the number of uninsured has dramatically increased—10 million to 43.4 million from 1989 to 1995, 16% in 1996, and increasing each year.
- The level of satisfaction with the US healthcare system is the lowest of any industrialized nation. Eighty percent of US citizens and 71% of US doctors believe that managed care has caused quality of care to be compromised.

According to a 2007 World Health Organization (WHO) report, the United States had the most expensive health care of any OECD country and also had the highest percentage of costs paid privately, with some of the worst health statistics in the free world.

Social

The social facet of our influence is determined by the arena of our target audience. The social aspect of professional healthcare practice refers to our patients and clients, colleagues, students, meetings we attend and present at, locations in which we function professionally, and the professional organizations we actively join. The social part of politics concerns our local and regional state offices and officers, state and national legislators, our President and his executives, our national centers and committees, and the organizations and committees in which we are publically active and about which we speak. The social side of economics is about our relationships with our bankers, investment counselors, financiers, and our state and national legislators and the committees on which they serve. We share our interactions in our social life with our families, friends, and acquaintances at sporting events, parties, and gatherings. Professional practice, politics, economics, and society are intertwined and related to the topic of healthcare reform. It is in the socializing setting of each area that the tools we use to communicate with our target audience matter the most.

In our healthcare practices, we use all the technology and electronic tools at hand: email, fax, phone, Internet information, blogs, and social internet sites; networking; written material for professional journals and books; general interest magazines and books; teaching; photography; and professional and public speaking engagements. In addition to these same contact tools, when in the political and economic fields, we use our verbal assets and face-to-face meetings to their utmost such as networking, educating, lobbying, campaigning, assistance in writing legislation (new amendments, referenda), and participating in activities and meetings. In our social and family circles we count mostly on social gatherings, networking (personal and technological), and informed, hopefully passionate, discussion.

THE FUTURE OF US HEALTH CARE

Future Challenges

The US healthcare system has three primary goals: the provision of high quality care, ready access to the system, and affordable costs. Certain

causes of healthcare inflation are desirable and inevitable, such as the development of new drugs and technologies and an aging population. However, other causes of soaring healthcare costs are clearly less defensible. These include the high administrative costs of the US healthcare system, our litigious culture that results in the high price of defensive medicine, a profligate US practice style in which many doctors often perform unnecessary tests and procedures, the inflationary consequences of having a third party pay the bill (thereby removing incentives from both doctors and patients to conserve dollars), and the existence of for-profit managed care organizations and hospital chains that each year divert billions of dollars of healthcare premiums away from medical care and into private wealth. Clearly, there is much room to operate a more efficient, responsible healthcare delivery system in the United States at a more affordable price.

Today's Issues and Trends Facing US Health Care

Efficient Use of Resources

The wiser and more efficient use of resources is only one challenge to the US healthcare system. In this 21st century, the United States will still face the problem of limited resources and seemingly limitless demand. At some point hard decisions will have to be made about what services will and will not be paid for. Any efforts at cost containment must continue to be balanced with efforts to maintain high quality and patient advocacy in medical care. Better access to the system must also be provided. The US public must maintain realistic expectations of medicine. This can be done by recognizing broad determinants of health like good education and meaningful employment, avoiding the *medicalization* of social ills like crime and drug addiction, and recognizing that individuals must assume responsibility for their own health by choosing a healthy lifestyle. Only when all of these issues are satisfactorily taken into account will the US have a healthcare delivery system that matches the promise of what medical science and practice have to offer.

Fraud, Abuse, and Waste

The multipayer US healthcare system, which is so complex, multilayered, confusing, conflicting, and overrun with unceasing paperwork, provides fertile ground for fraud, abuse, and waste that runs unchecked. A single-payer universal healthcare system by definition could provide the checks and balances missing in the existing healthcare delivery system.

The Joint Commission Monopoly

The Joint Commission is akin to what would be a single-payer healthcare system in that it holds the monopoly on accreditation of hospitals for Medicare. In this case, hospital accreditation among competitive agencies could strengthen standards and streamline the very difficult and anxiety-provoking process of accreditation.

Rural Medicine

In rural areas there is and will continue to be a physician shortage. Medical insurance alone will not solve the health problems of a poor rural community where there are no hospitals, doctors, clinics, or pharmacies. Public health systems and an array of alternative primary care providers often fill in the gaps. Primary care may be provided by nurse practitioners, physician assistants, or home-health nurses. Practice locations include publicly or charitably subsidized comprehensive primary care centers, specialty service clinics, and in patient homes. Advances in medical technology, increasing costs, and market forces contribute to the economic destabilization of many rural healthcare systems and the closings of hospitals. Consequently, rural residents must often travel great distances to access more costly and complex levels of care.

Aging Population

Neither Medicare nor the National Agency on Aging provides plans of care for the elderly. Life expectancy and the quality and costs of care in the United States, and around the globe, are increasing without plans to care for and house the aging population. An opportunity exists for the United States to provide innovative initiatives and cost planning for health care and housing communities for the aging in its healthcare reform.

Healthcare Provider Shortages

A shortage of physicians and advanced practice nurses, an increase in the relatively new positions of physician assistant and nursing technician, and an increase of pharmacists are expected in 2010. Many physicians and nurse practitioners have left health care for the business world and creative endeavors, therefore purging inspired, brilliant, and talented people from health care. Medical providers have seen managed care companies and executives of healthcare businesses making much more money than healthcare providers who save lives

every day. Some healthcare providers feel invalidated and devalued by the predominant managed care companies. Others believe that the managed care mindset and lack of sensitivity and professional ethics have almost eradicated the art of the science and practice of health care. Because most physicians, advanced practice nurses, and patients believe that universal health care and a single-payer system will improve practice conditions for providers and quality of care for patients, US residents must become actively involved in healthcare reform.

Controlling Costs

As costs increase, public and private insurers must struggle to control their expenditures. In the 2009 recession, subscribers are also controlling expenditures—many, unfortunately, are doing so by cutting back on doctor visits and not following or filling prescriptions. Many believe that universal health care with a single-payer system is the answer. Until this hotly debated issue can be settled, cost containment will remain the primary problem of the multipayer healthcare delivery system.

Resurrecting the Healthcare System: The Next Step

The United States has the most expensive health care in the world. US citizens have become a population used to high-priced, over marketed and advertised designer medications and the most current and expensive diagnostic and treatment technology. The present over-65 Medicare population believed that it could well afford these medications and treatments before an economic recession began in earnest in 2007, depositing the United States firmly in the worst economic climate ever recorded. Citizens and government officials overwhelmingly agree that the US system, the most expensive health care system in the world, is broken; I venture that it is irreparably broken and the only solution is a universal healthcare, single-payer system.

A universal healthcare single-payer system appears to be the only solution to saving the future of the US healthcare system. Economic concerns about the constantly escalating costs of healthcare services, scientific research and development, the manufacturing of medical technologies and designer drugs; national worries about a severe economic recession; popular citizen opinion; and support by the healthcare provider community and President Obama make this the second most important agenda item, warranting a solution by the Obama administration. Unless the universal health care dispute is settled in a positive direction, the United States will continue to be plagued by the aforementioned

concerns. The following pros and cons highlight the current universal healthcare and single-payer system debate.

Common arguments by supporters of universal healthcare systems include:

- Ensuring the health of all citizens benefits a nation economically.
- A single-payer system could save $286 billion a year in overhead and paperwork. One estimate put the total administrative costs at 24% of US healthcare spending.
- Wastefulness and inefficiency in the delivery of health care would be reduced.
- The United States spends a far higher percentage of GDP on health care than any other country but has worse ratings on such criteria as quality of care, efficiency of care, access to care, safe care, equity, and wait times, according to the Commonwealth Fund (foundation established 1918 by Anna M. Harkness, "for the welfare of mankind").
- The profit motive adversely affects the cost and quality of health care.
- Universal health care and public doctors would protect the right to privacy between insurance companies and patients.

Common arguments by opponents of universal healthcare systems include:

- Health care is not a right; as such, it is not the responsibility of government to provide health care.
- Unequal access and health disparities still exist in universal healthcare systems.
- The widely quoted healthcare system ranking by WHO, in which the US system ranked below other countries' universal healthcare systems, used biased criteria, giving a false sense of those systems' superiority.
- Large market-based public programs such as the Federal Employees Health Benefits Program can provide better coverage than Medicare while still controlling costs as well.

Communication and the Present Healthcare Climate

I am not a teacher, but an awakener.

—Robert Frost

Business would be great if it weren't for the people.

—Anonymous

Communication and Change

Like the importance of history as a communicator of information about our past accomplishments and mistakes, some psychological history about human communication would be valuable here. For all of our intellectual gifts and verbal abilities, human beings continuously get caught on the spikes of childhood experiences; cultural, religious, and family teachings; personal situations; and emotional encounters that leave us with fears of criticism and rejection—fears of loss of esteem, position, money. People are resilient and courageous. We make mistakes and do our best to learn and communicate our shortcomings, ideas, wishes, needs, wants, and even our assets with the hope of not seeming egotistical.

But change is not easy for us. Some of us welcome and embrace change as the challenge that it is; however, most of us are change averse. Driven by our unconscious, we perceive change as loss in that we have to give up something to gain something else, and the devil we know will always be more comfortable to live with than the devil we do not know. Loss is the bottom-line issue for people; facing the ultimate loss: our own mortality. Change can only happen if we raise our awareness of our motivations, learn from our feelings and actions, and use all the available tools of communication. New learning happens only by careful and strategic examination of our mistakes and accomplishments, curious looks at past motivations and behaviors, analysis of the information, and development of a strategic plan for change. Implementation is the weakest point of any plan, and implementation is communication.

The Communication Imperative

When planning healthcare change, using communication as an imperative creates a whole new culture by raising strategic planning standards and generating decisive actions. Healthcare providers have always embraced change as a challenge to grow, and communication as a teacher and informant for enhanced learning and performance. If we are to change our healthcare system and climate, we must learn to communicate more skillfully with each other. We are graced with an overabundance of tools of communication, both verbal and nonverbal. The first part of great communication is recognizing that there are no dumb questions and that asking is often more important than getting answers. The second part of great communication is functioning successfully in a group or on a team. The third part is the greater communication skill: listening. We listen with all of our senses. Constructive, goal-oriented communication is the sharing of ideas, opinions, thoughts, impressions, and feelings. Attentive, active listening

and observing will often provide more information than actively engaging in passionately heated conversation. Asking, "Do we want to reform, remodel, or rebuild our healthcare delivery system?" provides infinitely more success than struggling over the pros and cons of universal health care and a single-payer system. Discussing whether health care is a right or a privilege is more wasteful of communication energy and time than asking, "How do other countries succeed at having a universal healthcare system that provides both for their citizens?" What we may discover is that we need to think about a system that values fair and equitable versus one that values fair and equal. Is it acceptable for all residents to receive levels of good and more than adequate health care in a financially solvent climate, instead of adequate or excellent care in a financially bankrupt one? Do our principles of free enterprise in our democratically run country conflict with a universal healthcare and single-payer system? Starting with these and other realistic communiqués is the place to begin when designing a fresh and viable healthcare delivery system, be it a universal single-payer or a private multipayer solution.

JOURNALING EXERCISES

1. History Exercise

You are taking a class on History of American Health Care at the local university that began 2 weeks ago. Your professor walks into class last night quoting Konrad Adenauer (chancellor of Federal Republic of Germany, 1949 to 1963, who must rank as the most successful German politician since 1945): "History is the sum total of the things that could have been avoided." Your professor assigns the class to keep a journal this semester. Record responses to questions like:

What does the quote say to you?

What have we learned from healthcare history that should have been avoided?

Why, for we humans, does history repeats itself so often?

What can we do about avoiding history repeating itself?

What does US healthcare history teach us that we need to remain cognizant of so as not to repeat the same mistakes when the US government gets around to designing a universal, single-payer healthcare system?

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2. The Business of Health Care

What are six characteristics that make the US healthcare system and healthcare climate unique?

How do they make the US healthcare delivery system and healthcare climate unique?

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3. Navigating Medicare and Medicaid

Your 20-year-old patient on dialysis and her mother have a first appointment with you in 2 days. As with all first complex appointments, you schedule them for a 40-minute visit with 20 minutes of after time for you to make additional notes in your sourcing journal. This family was referred to you because of your in-depth knowledge about the practices and practicalities of healthcare delivery systems, and your ability to communicate this to patients is legendary in the healthcare community. As this family is new to permanent disability, they require your help in navigating the appropriate systems and maximizing their benefits. You spend 15 minutes creating a patient sourcing journal outline that includes, but is not limited to, the following:

What the family needs to know about:

- Medicaid is their primary insurer and Medicare is the supplemental insurer when the patient is on permanent disability (SSI)
- Filling out the required Medicaid and Medicare forms
- What benefits Medicaid will and will not cover
- What supplemental benefits Medicare covers
- Your ethical guidelines about billing practices
- How you conduct your practice
- The advantages and limits of your credentials and practice
- Your availability during and after office hours

Sideline notes are added according to the needs of the patient and family regarding:

- Your and their communication styles
- Your and their surfacing feelings
- The amount of information that they can absorb, in what time period
- Your impressions of their comprehension levels

- Assessment of all aspects of their levels of functioning
- Assessment of their physical, emotional, social, and financial resources

What are the similarities and differences between managed care reform of the late 20th century and universal healthcare reform of the early 21st century? Take your time and compile a list. Share the list with your legislators and medical associations and the local newspaper and radio talk show program. Write a book.

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4. Healthcare Systems

Because of your many recognition awards for superior public speaking skills and commendations for innovative medical practice, you have been asked by your alma mater to deliver this year's 20-minute graduation address. The dean requested that you speak on (surprise, surprise) innovative healthcare models. You came up with a sexy title, "Universal and retail health care: Strange bedfellows." In planning out the speech, you developed several headings:

What are they?

What do universal and retail health care have in common?

How do they differ?

Explain how retail health care be an integral part of a universal healthcare system.

Fill in the blanks and you have a speech.

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5. Politics and Communication Imperatives

Because of your known interest in becoming actively involved in the politics and legislative process of health care and healthcare reform, you have been invited to participate with a team of healthcare professionals to develop and bring a healthcare reform referendum to the state legislature. Now is your golden opportunity. Having never done this before, you want to go in somewhat prepared so no one will think you are a complete novice. So you ask two other advanced practice colleagues to come over to your house on Wednesday night for 2 hours of drinks (nothing too strong), nibbles (nothing too fattening), and role play for the practice and experience of what it might actually be like to do the job requested of you. You chose John and Marie because they will challenge you and even throw in a little intimidation for the experience—John not too much the expert and Marie not exactly a novice. Lots are drawn for who you each will be impersonating. Marie is the lobbyist with 4 years of experience under her belt. John is the old-school legislative whip with womanizing tendencies—you heard from a very reliable source that, 15 years ago, he salaciously asked an advanced practice registered nurse (APRN) lobbyist what she would do for him if he sponsored her bill and she replied "Not report you" (a tough act to follow!). You are the team's newbie healthcare member and their spokesperson who will be presenting the referendum to the lobbyist and legislator together.

What feelings do you have when initially thinking about this opportunity?

How do you feel about the new dual role as member and spokesperson? How will you approach your role as newest team member? And team spokesperson?

What behaviors do you anticipate will be exhibited toward you as the newbie by the other team members? What might be motivating their behaviors?

What communication tools do you anticipate using at your first team meeting?

What verbal and nonverbal communications are the team members using?

During the role play, how will you communicate with John and Marie about what you need from them to make this role play realistic?

What feelings do you think the role play will bring out about the referendum presentation meeting?

What work will you need to do on your more objectionable feelings? On strengthening your strong points?

What communication tools can you anticipate using when dealing with the lobbyist and legislator?

How will you communicate strength and influence with these political powerbrokers?

What information do you need to have to present an effective, persuasive referendum?

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6. Cost Containment in Health Care

The15 leading causes of death in the United States in 2007 fell into these Seven *International Statistical Classification of Diseases, 10th revision* (ICD-10) diagnostic categories:

1. Diseases of heart (heart disease)
2. Malignant neoplasms (cancer)
3. Cerebrovascular diseases (stroke)
4. Chronic lower respiratory diseases
5. Accidents (unintentional injuries)
6. Diabetes mellitus (diabetes)
7. Alzheimer's disease

Develop a four-module program to educate the public on preventative care and current treatments regarding these disease entities.

Design a simple, cost-effective marketing and advertising campaign and tools to let the public know what the program is, who is teaching it, where it will be held, on what days, what times will it be offered, who the sponsor is (can be for name recognition or funding), and what is the consumer's cost for the program—donate the cost to a medical charity, it is tax deductible and does a lot of good.

Include these aspects of prevention in this program:

- Document that prevention is more cost effective than treatment.
- Teach the steps of preventative medicine that improves health and reduces disease.
- List five signs with which patients can identify each disease process.
- Identify and describe the current treatments for these diseases.
- In what ways do informed and educated healthcare consumers contribute to containment of healthcare costs?

You will need your personal teaching tools and the following supplies at each meeting:

- Good lighting and enough comfortable classroom style seating that preferably can be converted into auditorium and circle seating
- Pads of paper and pens, some colored
- Good drinking water, ice, cups, and trash bags
- Hard sucking candies, some sugar free
- Fruit, napkins, plastic ware, small paper plates
- Anything else you want

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7. Social Influence

Talk to two coworkers, friends, and family members as separate pairs about why single-payer finance and universal healthcare legislation will improve quality, access, and affordability of care. The following are reform issues to be considered during the discussion:

Reduced spending versus reduced utilization

Reduced spending versus raising taxes

Reduced services versus increased beneficiary contributions

Increased services versus increased out of pocket expenditures

Managed care versus universal health care

Fee for services versus access to care

Age eligibility versus benefit income ceiling

Take as long as you want to discuss. Have a third person be a recorder. Compile and organize the data in three concept areas: improving quality, access, and affordability of care. Write a report and submit it for acceptance at a healthcare conference of your choice. Do not give up if rejected by the first conference committee. Remember, if you throw enough, some of it will stick.

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8. Future Challenges

What are the US medical industry's healthcare challenges regarding:

- High administration costs?
- An aging culture and citizenry?
- Defensive medicine to combat a litigious society?
- Continuing numbers of unnecessary tests and procedures?

- Inflationary consequences of third-party payers?
- For-profit managed care?

9. Trends and Issues

Write a succinct one-page letter to your local newspaper urging support of creating a single-payer universal healthcare system in your state. Feel free to cite the successes of Kaiser-Permanente, Massachusetts, Connecticut, Maryland, and California.

Make your points clearly and succinctly because long sentences and long letters are not read or printed unless they are very seductive or controversial.

Name four of the top trends and issues plaguing our present multipayer managed care healthcare delivery systems.

List two describers each for the up and down sides of the four trends and issues you named.

End by concisely stating the case for the healthcare system that you believe will reform and save our flagging healthcare system.

Sign your name and list and fully spell out the names of your credentials with the parenthetical acronym after each credential. Send the letter.

10. Single-Payer Universal Healthcare System

Your department chair has started a study group that meets at her home on Wednesday nights, 7–9 PM. This is the reading list:

1. *The Corrosion of Medicine: Can the Profession Reclaim Its Moral Legacy?* by John Geyman, MD.
2. Publications on healthcare reform by the Massachusetts Nurses Association.
3. Any number of books by Marcia Angell, MD (a past president of the Massachusetts Medical Association and former editor of *The New England Journal of Medicine*).
4. Healthcare books published by Common Courage Press, Monroe, Maine.

She said that these are important publications written by seasoned, experienced physicians and healthcare professionals and they address the ills of the present healthcare system and encourage launching new healthcare reform by supporting a universal healthcare single-payer system.

The topic of the study group for the next 6 weeks is staying current on the issues and questions regarding single-payer universal healthcare as it affects your organization, patients, third-party payers, and the practice of health care.

Participants have been asked to keep a journal of their response to the issues raised and solutions provided and to come to study group prepared to share and discuss them. Twenty to 30 minutes of journaling time per 2 hours of reading is recommended (more if you want), to be divided among the following:

Reactions
Feelings
Thoughts
Questions
Objections
Support
Insights
Other issues
Your solutions

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11. Communication and Change

Friends, family, and colleagues have been bombarding you for years, and more so lately, about running for city office. You are finally weakening, it has been something you have always entertained ever since you can remember. You go to city hall and declare your candidacy for city council member. You have assembled your political strategy committee and it is time to plan and implement a strategy. These are some of the questions that have been raised that need answers to develop your campaign. Your committee wants you to flesh out your ideas and answers by the next meeting in 3 days. Successfully communicating your plans for change are paramount to winning the city council seat.

Why do you want to run?

Whose help do you need to wage a successful run, and why do you need them?

Who is your constituency, your target audience, who do you need to reach?

What platform would you run on regarding these areas and their issues?

- Health care
- Education
- Politics
- Economics
- Business
- Social issues
- Safety

What communication tools do you want to use to convey your platform and ideas for change?

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12. Corporate Culture

Dr. Madeleine Leininger, distinguished nursing researcher and theoretician, recognized for contributing the *cultural diversity and universality theory* to the practice of nursing, has been invited to your hospital to speak to advanced practice clinicians for 1 hour, followed by 40 minutes of coffee and discussion. At the heart of her theory is the "emphasis on the importance of cultural knowledge and of shaping care practices to be culturally congruent and applicable beyond nursing practice [and] can be used in a wide variety of situations" and disciplines (George, 2002, p. 578). You are very excited about attending because you recently started seriously reading about the importance of organizational culture learning and learned that each healthcare delivery system in our multipayer healthcare system has a different corporate culture which informs its ways of communicating that affects the total US healthcare climate. To prepare to get the most out of this lecture you think about and answer these questions yourself; you hope very much to also ask Dr. Leininger some of them.

How would I define my organization's corporate culture?

How would I describe the effects our corporate culture has on the healthcare climate at our organization? On our patients and their families?

How do the different payers' cultures affect the way we do business?

What effect does my hospital's culture have on the way we deliver health care?

How does my organization's culture affect its own healthcare climate and that of the United States?

What are the differences and similarities between my organization's culture and the multipayers' cultures?

In what ways does my organization effectively communicate?

In what ways does my organization communication ineffectively?

In what ways are corporate cultures and communication systems separate yet interdependent variables?

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