
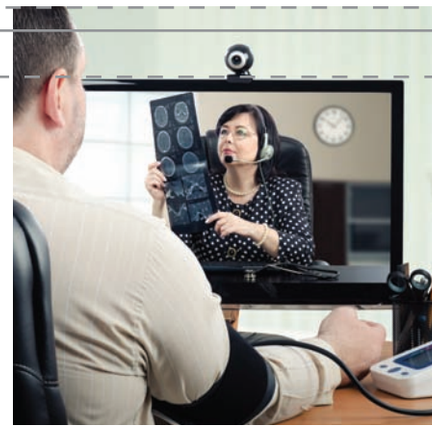
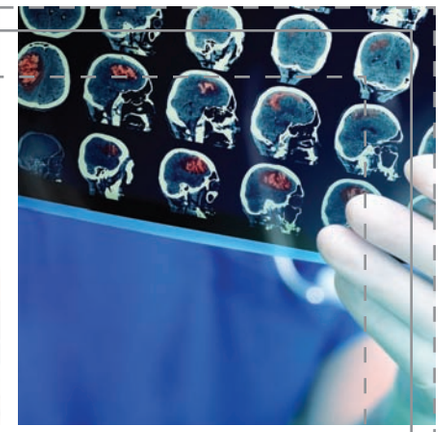

CHAPTER 1

History of the U.S. Healthcare System

LEARNING OBJECTIVES

The student will be able to:

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

DID YOU KNOW THAT?

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

Introduction

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

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

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

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

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

Consumer Perspective on Health Care

What Is Health?

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

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

Primary, Secondary, and Tertiary Prevention

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

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

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

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

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

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

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

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

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

TABLE 1-3 Milestones in Public Health 1700–2015

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

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

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

- 1900–1950: In 1920, Charles Winslow defined public health as a focus of preventing disease, prolonging life, and promoting physical health and efficiency through organized community efforts.

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

  In 1923, a vaccine for diphtheria and whooping cough was developed. In 1928, Alexander Fleming discovered penicillin. In 1933, the polio vaccine was developed. In 1946, the **National Mental Health Act (NMHA)** provided funding for research, prevention, and treatment of mental illness.

- 1950–1980: In 1950, cigarette smoke was identified as a cause of lung cancer.
  In 1952, Dr. Jonas Salk developed the polio vaccine.

  The **Poison Prevention Packaging Act of 1970** was enacted to prevent children from accidentally ingesting substances. Childproof caps were developed for use on all drugs. In 1980, the eradication of smallpox was announced.

- 1980–1990: The first recognized cases of AIDS occurred in the United States in the early 1980s.

  1988: The IOM Report defined *public health* as organized community efforts to address the public interest in health by applying scientific and technical knowledge and promote health. The first Healthy People Report (1987) was published and recommended a national prevention strategy.

- 1990–2000: In 1997, Oregon voters approved a referendum that allowed physicians to assist terminally ill, mentally competent patients to commit suicide. From 1998 to 2006, 292 patients exercised their rights under the law.

- 2000s: The second Healthy People Report was published in 2000. The terrorist attack on the United States on September 11, 2001, impacted and expanded the role of public health. The Public Health Security and Bioterrorism Preparedness and Response Act of 2002 provided grants to hospitals and public health organizations to prepare for bioterrorism as a result of September 11, 2001.

- 2010: The ACA was passed. Its major goal was to improve the nation's public health level. The third Healthy People Report was published.

- 2015: There has been an increase nationally of children who have not received vaccines due to parents' beliefs that vaccines are not safe. As a result, there have been measles outbreaks throughout the nation even though measles was considered eradicated decades ago.

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

- 1800–1900: Insurance was purchased by individuals in the same way one would purchase car insurance. In 1847, the Massachusetts Health Insurance Co. of Boston was the first insurer to issue "sickness insurance." In 1853, a French mutual aid society established a prepaid hospital care plan in San Francisco, California. This plan resembles the modern health maintenance organization (HMO).

- 1900–1920: In 1913, the International Ladies Garment Workers began the first union-provided medical services. The National Convention of Insurance Commissioners drafted the first model for regulation of the health insurance industry.

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

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

Milestones of Medicine and Medical Education

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

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

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

Milestones of the Hospital System

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

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

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

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

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

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

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

Milestones of Public Health

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

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

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

whooping cough, polio, smallpox, diphtheria, and the discovery of penicillin. All of these efforts focus on the protection of the public from disease.

The three most important public health achievements are (1) the recognition by the U.S. Surgeon General that tobacco use is a health hazard; (2) the development of many vaccines that that have eradicated some diseases and controlled the number of childhood diseases that exist; and (3) the development of early detection programs for high blood pressure and heart attacks and smoking cessation programs, which have dramatically reduced the number of deaths in this country (Novick, Morrow, & Mays, 2008).

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

The ***Healthy People 2000*** report, which started in 1987, was created to implement a new national prevention strategy with three goals: increase life expectancy, reduce health disparities, and increase access to preventive services. Also, three categories of health promotion, health prevention, and preventive services were identified and surveillance activities were emphasized. *Healthy People 2000* provided a vision to reduce preventable disabilities and death. Target objectives were set to measure progress (CDC, 2016a).

The ***Healthy People 2010*** report was released in 2000. The report contained a health promotion and disease prevention focus to identify preventable threats to public health and to set goals to reduce the threats. Nearly 500 objectives within 28 focus areas were developed. Focus areas ranged from access to care, food safety, education, environmental health, to tobacco and substance abuse. An important component of *Healthy People 2010* is the development of an infrastructure to ensure public health services are provided. Infrastructure includes skilled labor, information technology, organizations, and research. In 2010, ***Healthy People 2020*** was released. It contains 1,200 objectives that focus on 42 topic areas. According to the **Centers for Disease Control and Prevention (CDC)**, a smaller set of *Healthy People 2020* objectives, called leading health indicators (LHIs), have been targeted to communicate high-priority health issues. Healthy People 2020 Progress Review webinars began in early 2013 and are scheduled to run through mid-2017 (CDC, 2016a). The goals for all of these reports are consistent with the definitions of public health in both Winslow's and the IOM's reports.

It is important to mention the impact on the scope of public health responsibilities of the terrorist attack on the United States on September 11, 2001; the anthrax attacks; the outbreak of global diseases such as severe acute respiratory syndrome (SARS); Ebola; the Zika virus; and the U.S. natural disaster of Hurricane Katrina. As a result of these major events, public health has expanded its area of responsibility. The terms "bioterrorism" and "disaster preparedness" have more frequently appeared in public health literature and have become part of strategic planning. The **Public Health Security and Bioterrorism Preparedness and Response Act of 2002** provided grants to hospitals and public health organizations to prepare for bioterrorism as a result of September 11, 2001 (CDC, 2009).

Public health is challenged by its very success because the public now takes public health measures for granted: Several successful vaccines targeted almost all childhood diseases, tobacco use has decreased significantly, accident prevention has increased, there are safer workplaces because of the Occupational Safety and Health Administration (OSHA), fluoride is added to the public water supply, and there is decreased mortality from heart attacks (Turnock, 1997). When major events like the Ebola crisis, *Escherichia coli* outbreaks, or the Zika epidemic occur, people immediately think that public health will automatically control these problems. The public may not realize how much effort, dedication, funding and research takes place to protect them.

Milestones of the Health Insurance System

There are two key concepts in **group insurance**: "risk is transferred from the individual to the group and the group shares the cost of any covered losses

incurred by its member" (Buchbinder & Shanks, 2007). Like life insurance or homeowner's insurance, **health insurance** was developed to provide protection should a covered individual experience an event that requires health care. In 1847, a Boston insurance company offered sickness insurance to consumers (Starr, 1982).

During the 19th century, large employers such as coal mining and railroad companies offered medical services to their employees by providing company doctors. Fees were taken from their pay to cover the service. In 1913, the International Ladies Garment Workers union began providing health insurance, which was negotiated as part of the contract (Duke University Library, 2016). During this period, there were several proposals for a national health insurance program but the efforts failed. The AMA was worried that any national health insurance would impact the financial security of its providers. The AMA persuaded the federal government to support private insurance efforts (Raffel & Raffel, 1994).

In 1929, a group hospital insurance plan was offered to teachers at a hospital in Texas. This became the foundation of the nonprofit Blue Cross plans. In order to placate the AMA, Blue Cross initially offered only hospital insurance in order to avoid infringement of physicians' incomes (Blue Cross Blue Shield Association [BCBS], 2007; Starr, 1982). In 1935, the Social Security Act was enacted; Social Security was considered "old age" insurance. During this period, there was continued discussion of a national health insurance program. But, because of the Depression and World War II, there was no funding for this program. The federal government felt that the Social Security Act was a sufficient program to protect consumers. These events were a catalyst for the development of a health insurance program that included private participation. Although a universal health coverage program was proposed during President Clinton's administration in the 1990s, it was never passed. In 2009, there has been a major public outcry at regional town hall meetings opposing any type of government universal healthcare coverage. In 2006, Massachusetts proposed mandatory health coverage for all residents, so it may be that universal health coverage would be a state-level initiative (KFF, 2013).

By the 1950s, nearly 60% of the population had hospital insurance (AHA, 2007). Disability insurance was attached to Social Security. In the 1960s, President Johnson signed into law **Medicare** and **Medicaid**, which assist elderly, disabled, and indigent individuals. President Nixon established the health maintenance organization (HMO), which focused on cost-effective measures for health delivery. Also, in the 1980s, diagnostic-related groups (DRGs) and prospective payment guidelines were established to provide guidelines for treatment. These DRGs were attached to appropriate insurance reimbursement categories for treatment. The **Consolidated Omnibus Budget Reconciliation Act (COBRA)** was passed to provide health insurance protection if an individual changes jobs. In 1993, the Family and Medical Leave Act (FMLA) was passed to protect an employee if there is a family illness. An employee can receive up to 12 weeks of unpaid leave and maintain his or her health insurance coverage during this period. The **Uniformed Services Employment and Reemployment Rights Act (USERRA)**, enacted in 1994, entitles individuals who leave for military service to return to their job. In 1996, the **Health Insurance Portability and Accountability Act (HIPAA)** was passed to provide stricter confidentiality regarding the health information of individuals. The Balanced Budget Act (BBA) of 1997 required massive program reductions for Medicare and authorized Medicare reimbursement for outpatient services (CMS, 2016b).

At the start of the 21st century, cost, access, and quality continue to be issues for U.S. health care. Employers continue to play an integral role in health insurance coverage. The largest public coverage program is Medicare, which covers 55 million people. In 2014, Medicare benefit payments totaled nearly $600 billion (Facts on Medicare, 2015). The State Children's Health Insurance Program (SCHIP), renamed CHIP, was implemented to ensure that children who are not Medicare eligible receive health care. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act provided some relief from the BBA of 1997 by restoring some funding to these consumer programs. In 2003, a consumer law, the **Medicare Prescription Drug, Improvement, and Modernization Act**, created a major overhaul of the Medicare system (CMS, 2016b). The Act created Medicare Part D, a prescription drug plan that became effective in 2006 and provides different prescription programs to the elderly, based on their prescription needs. In 2014, approximately $6 billion in Medicare benefits was spent on Medicare Part D (Facts on Medicare, 2015). The Act also renamed the Medicare cost plans to Medicare Advantage, which is a type of managed care program. Medicare contracts with private health insurance programs to provide services. This program, called Medicare Part C, provides both Medicare Parts A and B benefits. In 2014, approximately

$24 billion in Medicare benefit dollars were spent on the Medicare Part C plan (Facts on Medicare, 2015). In 2008, the **National Defense Authorization Act** expanded the FMLA to permit families of military service members to take a leave of absence if the spouse, parent, or child was called to active military service. The 2010 ACA required individuals to purchase health insurance by 2014. Despite these efforts, health insurance coverage continues to be an issue for the United States.

Current System Operations

Government's Participation in Health Care

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

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

The United States has several federal health regulatory agencies, including the CDC for public health, the **Food and Drug Administration (FDA)** for pharmaceutical controls, and the **Centers for Medicare & Medicaid Services (CMS)** for the indigent, disabled, and the elderly. The Joint Commission is a private organization that focuses on healthcare organizations' oversight, and the **Agency for Healthcare Research and Quality (AHRQ)** is the primary federal source for quality delivery of health services. The **Center for Mental Health Services (CMHS)**, in partnership with state health departments, leads national efforts to assess mental health delivery services. Although the federal government is to be commended because of the many agencies that focus on major healthcare issues, with multiple organizations there is often duplication of effort and miscommunication that result in inefficiencies (KFF, 2013). However, several regulations exist to protect patient rights. One of the first pieces of legislation was the **Sherman Antitrust Act of 1890** and ensuing legislation, which ensures fair competition in the marketplace for patients by prohibiting monopolies (Niles, 2013). Regulations such as HIPAA protect patient information; COBRA gives workers and families the right to continue healthcare coverage if they lose their job; the **Newborns' and Mothers' Health Protection Act (NMHPA)** of 1996 prevents health insurance companies from discharging a mother and child too early from the hospital; the **Women's Health and Cancer Rights Act (WHCRA)** of 1998 prevents discrimination against women who have cancer; the **Mental Health Parity Act (MHPA)** of 1996 and its 2008 amendment requires health insurance companies to provide fair coverage for mental health conditions; the **Genetic Information Nondiscrimination Act of 2008** prohibits U.S. insurance companies and employers from discriminating based on genetic test results; the **Lilly Ledbetter Fair Pay Act of 2009** provides protection for unlawful employment practices related to compensation discrimination; and finally, the **Affordable Care Act of 2010** focuses on increasing access to health care, improving the quality of healthcare delivery, and increasing the number of individuals who have health insurance. All of these regulations are considered **social regulations** because they were enacted to protect the healthcare consumer.

Private Participation in Health Care

The private sector focuses on the financial and delivery aspects of the system. Healthcare costs are paid by a health insurance plan, private or governmental, and the enrollee of the plan. Approximately 34% of 2014 healthcare expenditures were paid by private health insurance, insurance offered by a private insurance company such as Blue Cross; private **out-of-pocket expenses or payments**, funds paid by the individual, were 13.7%; and federal, state, and local governments paid 39%. Out-of-pocket payments are considered the individual's **cost share** of his or her healthcare costs. Approximately 83% of private health insurance premiums are paid for by

the employer for the employee. This type of insurance is a type of **voluntary health insurance** set up by an individual's employer. The delivery of the services provided is through legal entities such as hospitals, clinics, physicians, and other medical providers (National Center for Health Statistics [NCHS], 2016). The different providers are an integral part of the medical care system and need to coordinate their care with the layers of the U.S. government. In order to ensure access to health care, communication is vital between public and private components of healthcare delivery.

Assessing Your Healthcare System Using the Iron Triangle

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

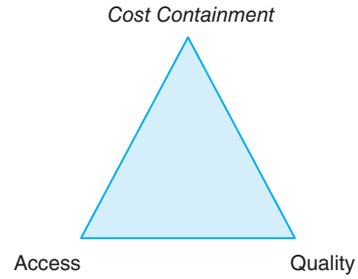

FIGURE 1-1 The Iron Triangle of Health Care

Reproduced from Kissick, William, MD, DR, PH, Medicine's Dilemmas, p. 3. New Haven, CT: Yale University Press, 1994. Reprinted by permission.

Conclusion

Despite U.S. healthcare expenditures, disease rates in the United States remain higher than those of many other developed countries because the United States has an expensive system that is available to only those who can afford it (Regenstein, Mead, & Lara, 2007). Findings from a recent MetLife annual survey indicate that healthcare costs are worrying employees and their employers. Over 60% of employees are worried they will not be able to pay out-of-pocket expenses not covered by insurance. Employers are increasing the cost sharing of their employees for healthcare benefits because of the cost increases (Business Wire, 2013). Because the United States does not have universal health coverage, there are more health disparities across the nation. Persons living in poverty are more likely to be in poor health and less likely to use the healthcare system compared to those with incomes above the poverty line. If the United States offered universal health coverage, the per capita expenditures would be more evenly distributed and likely more effective. The major problem for the United States is that healthcare insurance is a major determinant of access to health care. Although there has been a decrease in the number of uninsured in the United States as a result of the individual mandate to purchase health insurance by the Affordable Care Act, there is still limited access to routine health care. statistic The infant mortality rate is often used to compare the health status of nations worldwide. Although our healthcare expenditures are very high, our infant mortality rates rank higher than those of many countries. Racial disparities in disease and death rates continue to be a concern. However, there has been a decline of 13% in infant mortality rates in the United States from 2000 to 2013. If you compare this statistic to comparable countries worldwide, their rates dropped during the same time period by 26%. The United States has more work to do regarding this issue (CDC, 2016b). Both private and public participants in the U.S. health delivery system need to increase their collaboration to reduce these disease rates. Leaders need to continue to assess our healthcare system using the Iron Triangle to ensure there is a balance between access, cost, and quality.

Wrap-Up

Vocabulary

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

References

American Heritage Dictionary. (4th ed.). (2001). New York: Bantam Dell.

American Hospital Association. (2007). Community accountability and transparency: Helping hospitals better serve their communities. Retrieved from http://www.aha.org/aha/content/2007/pdf/07accountability.pdf

American Medical Association. (2016a). Our history. Retrieved from http://www.ama-assn.org/ama/pub/about-ama/our-history.shtml

American Medical Association. (2016b). Reports of council on medical service. Retrieved from http://www.ama-assn.org/ama1/pub/upload/mm/38/i05cmspdf.pdf

Barton, P. (2003). *Understanding the U.S. health services system*. Chicago, IL: Health Administration Press.

Bird, J. (2013). CMS releases hospital price ranges of 100 most common treatments. Retrieved from http://www.fiercehealthfinance.com/story/cms-releases-hospital-price-comparison-data/2013-05-08

Blue Cross Blue Shield Association. (2016). Blue beginnings. Retrieved from http://www.bcbs.com/about/history/blue-beginnings.html

Buchbinder, S., & Shanks, N. (2007). Introduction to health care management. Sudbury, MA: Jones and Bartlett.

Business Wire. (2013). MetLife study finds six out of ten employees are concerned about out-of-pocket medical costs. Retrieved from http://finance.yahoo.com/news/metlife-study-finds-six-ten-130000050.html

Centers for Disease Control and Prevention. (2001). Trends in hospital emergency department utilization: United States, 1992–1999. Vital and Health Statistics, 13(150 revised).

Retrieved from http://www.cdc.gov/nchs/data/series/sr_13/sr13_150.pdf

Centers for Disease Control and Prevention. (2007). Skin cancer module: Practice exercises. Retrieved from http://www.cdc.gov/excite/skincancer/mod13.htm

Centers for Disease Control and Prevention. (2009). Selected federal legal authorities pertinent to public health emergencies. Retrieved from http://www.cdc.gov/phlp/docs/ph-emergencies.pdf

Centers for Disease Control and Prevention. (2016a). Healthy People 2020: Tobacco use. Retrieved from http://www.cdc.gov/tobacco/basic_information/healthy_people

Centers for Disease Control and Prevention. (2016b). NCHS data brief: Recent declines in infant mortality in the United States, 2005–2011. Retrieved from http://www.cdc.gov/nchs/data/databriefs/db120.htm

Centers for Medicare and Medicaid Services. (2016a). National health expenditure projections. Retrieved from http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/nationalHealthAccountsHistorical.html

Centers for Medicare and Medicaid Services. (2016b). HIPAA: General information. Retrieved from http://www.cms.hhs.gov/HIPAAGenInfo/01_Overview.asp

Chadwick, E. (1842). The sanitary conditions of the labouring class. London: W. Clowes.

Classen, D., Resar, R., Griffin, F., Federico, F., Frankel, T., Kimmel, N., James, B. (2011). Global Trigger Tool shows that adverse events in hospitals may be ten times greater than previously measured. *Health Affairs*, 30(4), 109.

Determinants of health. (2016). Retrieved from http://healthypeople.gov/2020/implement/assess.aspx

Duke University Library. (2016). Medicine and Madison Avenue. Timeline. Retrieved from http://library.duke.edu/digitalcollections/mma/timeline.html

Facts on Medicare spending and financing. (2015). Retrieved from http://kff.org/search/?s=Facts±on±Medicare±spending±and±financing+

Goodman, J.C., & Musgrave, G.L. (1992). *Patient power: Solving America's health care crisis*. Washington, DC: CATO Institute.

HCAHPS Fact Sheet. (2016). Retrieved from http://www.hcahpsonline.org/Facts.aspx

Health, United States, 2014. National Center for Health Statistics. Retrieved from http://www.cdc.gov/nchs/data/hus/hus14.pdf#highlights

Institute of Medicine. (1988). *The future of public health* (pp. 1–5). Washington, DC: National Academies Press.

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

Kliff, S. (2012). Study: Fewer employers are offering health insurance. Retrieved from http://www.washingtonpost.com/blogs/wonkblog/post/study-fewer-employers-are-offering-health-insurance/2012/04/24/gIQAfGH6eT_print.html

Levy, J. (2015). U.S. uninsured rate continues to fall. Retrieved from http://www.gallup.com/poll/167798/uninsured-rate-continues-fall.aspx.

Ludmerer, K. (2004). The development of American medical education from the turn of the century to the era of managed care. *Clinical, Orthopaedics and Related Research*, 422: 256–262.

Nation at a glance: Uninsured Americans. (2016). Retrieved from http://www.cdc.gov/nchs/features/nation_jun2015/nation_at_a_glance_jun2015.htm

National Center for Health Statistics. (2014). *Health, United States, 2014. With special feature on socioeconomic status and health*. Washington, DC: U.S. Government Printing Office.

National Conference of State Legislatures. (2016). Certificate of need: State health laws and programs. Retrieved from http://www.ncsl.org/issues-research/health/con-certificate-of-need-state-laws.aspx

Niles, N. (2013). *Basic concepts of health care human resource management* (pp. 37–50). Sudbury, MA: Jones and Bartlett.

Novick, L., Morrow, C., & Mays, G. (2008). *Public health administration* (2nd ed., pp. 1–68). Sudbury, MA: Jones and Bartlett.

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

Rau, J. (2015). 1,700 hospitals with quality bonuses from Medicare, but most will never collect. Retrieved from http://khn.org/news/1700-hospitals-win-quality-bonuses-from-medicare-but-most-will-never-collect/

Regenstein, M., Mead, M., & Lara, A. (2007). The heart of the matter: The relationship between communities, cardiovascular services and racial and ethnic gaps in care. *Managed Care Interface*, 20, 22–28.

Rich, E., Lebow, M., Srinivasan, M., Parish, D., Wollinscroft, J., Fein, O., & Blaser, R. (2002). Medicare financing of graduate medical education. *Journal of General Internal Medicine,* (17), 4:283–292.

Rosen, G. (1983). *The structure of American medical practice 1875–1941*. Philadelphia: University of Pennsylvania Press.

Starr, P. (1982). *The social transformation of American medicine*. Cambridge, MA: Basic Books.

Stevens, R. (1971). *American medicine and the public interest*. New Haven, CT: Yale University Press.

Sultz, H., & Young, K. (2006). *Health care USA: Understanding its organization and delivery* (5th ed.). Sudbury, MA: Jones and Bartlett.

Turnock, J. (1997). *Public health and how it works*. Gaithersburg, MD: Aspen Publishers, Inc.

Vault Career Intelligence. (2016). Home page. Retrieved from http://www.vault.com/wps/portal/usa

Winslow, C.E.A. (1920). *The untilled fields of public health* (pp. 30–35). New York: Health Service, New York Chapter of the American Red Cross.

Zeroing in on the Triple Aim. (2015). Retrieved from http://www.aha.org/content/15/brief-3aim.pdf.

Notes

Student Activity 1-1

In Your Own Words

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

Group insurance:

Gross domestic product (GDP):

Pesthouses:

Voluntary health insurance:

Public health functions:

Primary prevention:

Secondary prevention:

Tertiary prevention:

Universal healthcare program:

Epidemics:

Student Activity 1-2

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

Real-Life Applications: Case Scenario One

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

Activity

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

Responses

Case Scenario Two

You recently were promoted to assistant to the Chief Executive Officer of the Niles Hospital system. The CEO is interested in building a hospital to expand the Niles healthcare system. She has asked you to investigate the certificate of need (CON) process for this proposal.

Activity

Perform Internet research on the CON process and provide a report on the necessary steps to achieve this CON.

Responses

Case Scenario Three

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

Activity

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

Responses

Case Scenario Four

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

Activity

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

Responses

Student Activity 1-3

Internet Exercises

Write your answers in the space provided.

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

Websites

http://www.ama-assn.org

Organization Name:

Mission Statement:

Overview of Activities:

Importance of Organization to U.S. Health Care:

http://www.cdc.gov

Organization Name:

Mission Statement:

Overview of Activities:

Importance of Organization to U.S. Health Care:

http://www.cms.hhs.gov

Organization Name:

Mission Statement:

Overview of Activities:

Importance of Organization to U.S. Health Care:

http://www.hhs.gov

Organization Name:

Mission Statement:

Overview of Activities:

Importance of Organization to U.S. Health Care:

http://www.jointcommission.org

Organization Name:

Mission Statement:

Overview of Activities:

Importance of Organization to U.S. Health Care:

http://www.ahrq.gov

Organization Name:

Mission Statement:

Overview of Activities:

Importance of Organization to U.S. Health Care:

Student Activity 1-4

Discussion Questions

The following are suggested discussion questions for this chapter.

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

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

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

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

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

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

Student Activity 1-5

Current Events

Perform an Internet search and find a current events topic over the past three years that is related to this chapter. Provide a summary of the article and the link to the article and why the article relates to the chapter.