CHAPTER FOCUS

QUESTIONS TO CONSIDER

After reading this chapter, you will know the answers to the following questions:

1. How did the current U.S. healthcare system evolve to its present form?
2. What is the difference between private and public health care?
3. What are some of the current issues affecting healthcare delivery in the United States, including the implementation of ACA?
4. How do politics and policy influence the healthcare delivery system?
5. What are some of the current and evolving healthcare settings?
6. What impact is managed care having on healthcare delivery?
7. What are some potential roles for nurses within the changing healthcare system?

Health care is one of the largest industries in the United States, employing an estimated 16.4 million workers. The public's healthcare system in the United States includes the most technology-rich facilities and the most advanced practices in the world. The most well-educated physicians, nurses, and other healthcare workers use sophisticated treatments on a daily basis to prolong life and restore function. Less attention and resources have been focused on primary prevention and risk reduction.

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CHAPTER 5

Transforming the Public's Healthcare Systems

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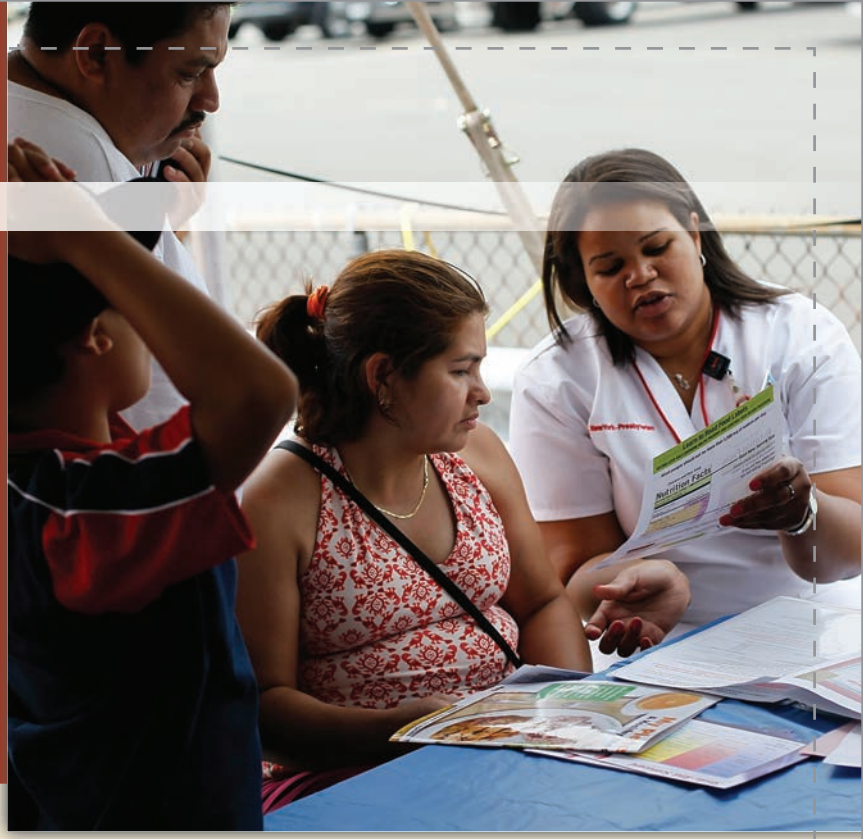

KEY TERMS

Affordable Care Act (ACA)
capitation
defensive health care
diagnosis-related groups (DRGs)
fee-for-service
healthcare delivery system
health maintenance organization (HMO)
integrated healthcare system
long-term care
managed care
managed care organization (MCO)
managed competition
point-of-service (POS) plan
preventive care
primary care
preferred provider organization (PPO)
prospective payment system (PPS)
secondary care
shelter nurse
tertiary care
third-party payer

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REFLECTIONS

What has been your experience with health care in the United States as a nursing student and as a patient? What has it been like as an "insider" compared to your experience before you became a nursing student?

Health care is one of the largest industries in the United States, employing an estimated 16.4 million workers. This number is likely to grow significantly with the passage of the **Affordable Care Act (ACA)** in 2010, as millions more citizens gain access to health insurance and government-sponsored programs, such as Medicaid, beginning in 2014. The U.S. healthcare system is also unique in comparison with other developed countries around the globe. Almost all other comparable developed countries have universal healthcare coverage of some kind, in which the central government plays a central role in providing health care to all of its citizens. Passage of the ACA expands essential healthcare services via private and public reforms for all citizens by federal mandate. Expansion of health insurance and other public funding sources at an acceptable and affordable cost will remain a challenge for the next several years (see Box 5–1).

The U.S. healthcare system includes the most technology-rich facilities and the most advanced practices in the world. The best educated physicians, nurses, and other healthcare workers use sophisticated treatments on a daily basis to prolong life and restore function. As a result of the cutting-edge nature of this health care, the U.S. system is the most costly, in terms of resources, in the world. This chapter reviews components of the present healthcare system, with an emphasis on public and community health services, as prevention-oriented care becomes the economic incentive for major changes in the healthcare system (Shi & Singh, 2013).

The current patterns of healthcare delivery have resulted in an annual cost that exceeds $2 trillion, a figure that is significantly higher than the expenditures of any other industrialized nation. Costs continue to rise at an alarming rate. This figure represents 17.6% of the U.S. gross domestic product (GDP). Approximate expenditures for hospital care accounted for 30% of all national healthcare expenditures in 2011. Physician and clinical services accounted for 20%, prescription drugs for 10%, and nursing home care for 6%. With the extraordinary costs of health care in the United States, many residents have very limited access to even basic care. The Congressional Budget Office (CBO) estimates that 55 million U.S. citizens under the age of 65 are currently uninsured or underinsured (DeNavas-Walt, 2012). Those without access to health insurance are less likely to utilize primary, preventive services and less likely to seek care when hurt or ill until much later in the disease process—if they do at all.

Despite the advances in healthcare technology and high healthcare costs, clinical outcomes are not always significantly better in the United States when compared to other industrialized nations. In the 2011 National Scorecard on U.S. Health System Performance, which measures and monitors healthcare outcomes, quality, access, efficiency, and equity, the United States ranked 64 out of a possible 100. This score is a continuation of the steady decrease seen over 5 years, from the 67 received in 2006 to the 65 received in 2008. For one indicator, preventable mortality, the United States remained in last place among industrialized nations despite significant overall improvements—largely because other nations improved this metric even more (Commonwealth Fund Commission on a High Performance Health System, 2011). Access to health care is believed to be one of the determinants of the less than auspicious health indicators in the United States.

Lack of access to quality healthcare services can take several forms. For example, needed services may simply not be available in an accessible location or during hours when individuals are able to use them. The healthcare site may not be organized in a user-friendly manner so that individuals can obtain timely and acceptable services. For example, providers may not be as culturally sensitive or as multilingual as is needed in certain locations in the United States. Routine health care may also not be accessible because of a lack of personal funds and/or insurance coverage. Medications and special treatments may be beyond the financial resources of the individual despite a provider's carefully developed plan of care. Finally, individuals may not have a regular provider and thus may have to receive care from a variety of providers in a number of unconnected facilities. As a result, care may not be comprehensive or timely.

Although leaders in government, health care, and consumer groups continue to express concern over access issues, inequities in the current system are readily apparent. By most accounts, more than 47 million nonelderly Americans are uninsured (Kaiser Family Foundation, 2013). In addition, many more U.S. citizens are underinsured, and this figure is growing. Individuals working at part-time and minimum-wage jobs make up a large part of the uninsured and underinsured in this country.

A lack of insurance frequently results in a lack of prevention services and early interventions. Lack of adequate

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BOX 5-1 Affordable Care Act (ACA) or "Obamacare": What Is It and Why Is It Necessary?

After decades of attempts to reform the U.S. health care system, in March 2010 President Barack Obama signed into law the Patient Protection and Affordable Care Act (P.L. 111–148) and the Health Care Education and Reconciliation Act of 2010 (P.L. 111–152). The two Acts are collectively known as the Affordable Care Act (ACA), or "Obamacare." The stated purpose of the ACA is to "increase the number of Americans covered by health insurance and decrease the cost of health care."

The American Public Health Association gives the following reasons for why the ACA was necessary:

1. Too many people lack healthcare coverage.
2. High healthcare costs threaten the country's economic stability, hindering our ability to reduce the federal deficit and to spend in other important areas, such as education, housing, and economic development. The United States spends 17.6% of its gross domestic product (GDP) on health care: approximately $2.6 trillion in 2012, which is one and a half times the amount spent by any other comparable country.
3. Despite high spending, our health outcomes are poor when compared with those of similar countries. The United States spends more on medical care than any other industrialized nation but ranks 26th among 36 countries in terms of life expectancy.
4. Our healthcare system emphasizes treatment instead of prevention. Seven in ten deaths in the United States are related to preventable conditions such as obesity, diabetes, high blood pressure, heart disease, and cancer, and three quarters of our healthcare dollars are spent treating such diseases. Only 3 cents per dollar spent (both public and private) on health care go toward prevention.
5. Health disparities exist among numerous vulnerable populations, including those related to income and access to coverage across demographics.

According to the U.S. Department of Health and Human Services, the ACA puts forth a new Patient's Bill of Rights and "gives Americans the stability and flexibility they need to make informed choices about their health." The features include:

1. Coverage
   - Ends pre-existing condition exclusions: Health plans can no longer limit or deny benefits due to a pre-existing condition.
   - Keeps young adults covered: If you are under 26, you may be eligible to be covered under your parent's health plan.
   - Ends arbitrary withdrawals of insurance coverage: Insurers can no longer cancel your coverage just because you made an honest mistake.
   - Guarantees your right to appeal: You now have the right to ask that your plan reconsider its denial of payment.
2. Costs
   - Ends lifetime limits on coverage: Lifetime limits on most benefits are banned for all new health insurance plans.
   - Reviews premium increases: Insurance companies must now publicly justify any unreasonable rate hikes.
   - Helps you get the most from your premium dollars: Your premium dollars must be spent primarily on health care—not administrative costs.
3. Care
   - Covers preventive care at no cost to you: You may be eligible for recommended preventive health services. No copayment for specific screening tests and pregnancy.
   - Protects your choice of doctors: Choose the primary care doctor you want from your plan's network.
   - Removes insurance company barriers to emergency services: You can seek emergency care at a hospital outside of your health plan's network.

Sources: Shi & Singh, 2014; American Academy of Nursing, 2010, Healthcare.gov

prenatal care and infant immunizations, especially for the poor and minority populations, has sometimes led to illness and disability and, ultimately, increased financial demands on the public healthcare system. Statistically, African Americans fare worse in virtually every condition that affects health (Donatiello, Droese, & Kim, 2004). The rates of infectious disease such as tuberculosis, sexually transmitted diseases, and human immunodeficiency virus (HIV) continue to rise, especially within at-risk populations. A lack of accessible community mental health services has also resulted in a number of tragedies and untold stress for families.

Attempts to contain spiraling costs, deal with the dissatisfaction of consumers and providers, and address issues of uneven access and poor clinical outcomes have resulted in cost-containment legislation, new configurations of providers, and new ways of providing care. Because nursing care holds the answer to many of the current dilemmas, the nursing profession appears to be poised on the edge of an exciting and challenging future.

The Evolving U.S. Healthcare Delivery System

The term **healthcare delivery system** refers to a multilevel industry that transforms a variety of resources into essential services designed to meet the healthcare needs of a population. This transformation occurs through a complex set of interactions among consumers, providers, payers, employers, and the government. Resources include physical structures, personnel, technology, supplies, and financing, among

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other things. The system is both guided and, in some instances, undermined by competition, demands for profit, technological innovation, standards, and government regulations.

With growing concerns regarding out-of-control healthcare costs—a factor that further exacerbated the 2008 economic collapse—healthcare reform was once again a major political issue. President Obama signed into law, after a long and contentious legislative debate, the ACA of 2010. All major nursing organizations supported the ACA, including the American Nurses Association (ANA) and the American Academy of Nursing (AAN). Nursing organizations have long supported efforts to reform health care, recognizing their potential to expand access to cost-effective, quality care and to help shift the U.S. health system toward a greater emphasis on primary and preventive care—care that, in the long run, should lower healthcare costs for the population (AAN, 2010).

Many critics suggest that the U.S. healthcare system is not actually a system at all—that is, it is not a coordinated whole with interrelated parts. Instead, health care in this country often occurs as a series of fragmented episodes that may be isolated, unrelated, confusing, or even competing. Furthermore, in the United States there is no single source of oversight, policies, or goals, nor is there a set of shared values and concerns among the various entities in the delivery system.

Services in the United States may be provided in traditional settings, such as hospitals or physicians' offices, and in less traditional settings, such as shelters, specially equipped vans, or shopping malls. Patient care information may or may not be shared among the providers in the subsystems or even between providers at separate sites in a single subsystem. Furthermore, follow-up contact between providers and patients is rare.

CULTURAL CONNECTION

The healthcare system of a nation or society is influenced by the following factors:

- Political values and climate
- Level of economic development
- Technological progress
- Social and cultural values
- The physical environment
- Population characteristics
- Demographics
- Health trends

Source: Shi, L., & Singh, D. A. (2013). *Essentials of the U.S. health care system* (3rd ed.). Burlington, MA: Jones & Bartlett Learning.

Reimbursement may come from one or more of the following sources: private insurance companies, managed care organizations (MCOs), government agencies, foundations, and the patient. The patient is often the one who has to decide who to bill, what to do when reimbursement is denied, or who to talk to when the bill is only partially reimbursed.

Finally, services may need to be accessed in one or more of the following healthcare systems: private, public, and/or the military. Each system has a unique set of rules and requirements. Coverage may be overlapping, costs of care are different, and reimbursement occurs in different ways.

Private Healthcare Delivery

Our complicated private healthcare system has changed dramatically in the last 100 years. In the 19th century, family, servants, or close friends cared for patients in the home, with physicians making visits as needed. Treatment involved medicinal herbs and comfort measures. Medical knowledge was limited, and most medical practitioners in the United States lacked a standardized education. Medical treatments were based on common sense, and physicians often lacked acceptance as professionals. Care was purchased out of private funds or provided on a charity basis. The few hospitals that existed basically served indigent patients (i.e., without family or support) who found themselves at death's door. The medical treatments delivered in these early hospitals were often crude and seldom very effective.

After the middle of the 19th century, large leaps in medical knowledge occurred. These advances paved the way for significant gains in surgical interventions and the treatment of disease. The new, more sophisticated procedures required centralized facilities to house the new technology and train the personnel needed to provide patient care. This resulted in an era of extensive hospital construction, the institutionalization of health care, and the establishment of the hospital as the center of healthcare delivery (see **Box 5-2**).

BOX 5-2 Phases of Healthcare System Development

Development of the private healthcare delivery system occurred in several phases:

1. Prior to the 1850s: Illness and disability were handled at home. Few hospitals and clinics existed, and they provided mostly indigent care.
2. 1850–1930: Significant gains in medical knowledge occurred. Technology advances necessitated an increase in the number of hospitals and nurses.
3. 1930–1980: Health care became more organized. Insurance became available so people were more likely to go to hospitals for care.
4. 1980 to 2000: Soaring costs resulted in reorganization, restructuring, reallocation of scarce resources, and difficult ethical decisions.
5. 2000 to the present: Escalating healthcare costs and economic collapse led to healthcare reform, significantly the ACA, which was passed in 2010.

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After World War I, the medical profession in this country grew in prestige and power. This transformation was based on several trends: movement to cities away from family and friends, advances in medical science and technology, organization of medicine and adoption of state licensing requirements, establishment of worker's compensation and growth of health insurance, and educational requirements for providers (Shi & Singh, 2013).

To ensure that hospital bills would be paid, insurance companies such as Blue Cross were formed. With the establishment of broader health insurance coverage, providers were at less financial risk, and insurance policies provided for the reimbursement of increasing numbers of patients. Patients selected the provider. Providers simply decided on the appropriate course of care for the patient, implemented that care, and then submitted bills at the end of the illness episode. This form of payment was known as fee-for-service.

Fee-for-service is a form of retrospective payment for health care in which a facility or provider submits a bill for services rendered at the completion of the healthcare episode. An advantage of this type of billing is that care is reimbursed according to the acuity of the patient's condition based on the services required. However, some healthcare experts now believe that paying a fee for each service performed encourages unnecessary services and frequent return visits, which in turn increases healthcare costs.

The Hill–Burton Act was passed in 1946 to help communities build hospitals. In the 1950s, the National Institutes of Health (NIH) became a major funding source for healthcare research. The Medicare Act was passed in 1965 to provide hospital insurance for the elderly. Each of these efforts increased the organizational strength of the U.S. healthcare system.

Two acts passed by Congress have significantly affected the methods by which hospitals are reimbursed for care. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) established a cost-per-case basis for Medicare-reimbursed inpatient services. The 1983 amendments to the Social Security Act established a prospective payment method of paying for inpatient services for Medicare patients based on a system of admitting diagnoses known as **diagnosis-related groups (DRGs)**.

Under the **prospective payment system (PPS)**, an annual fixed (prospective) rate was established for reimbursing providers for care based on 467 diagnoses or procedures. The prototype for the prospective payment system was developed at Yale University. Under the Yale program, reimbursement amounts bore "little or no relationship to length of stay, services rendered, or costs of care" (Williams & Torrens, 2008, p. 112). Rules stated that costs above the established amount for a given DRG would be absorbed by the hospital. If the care was delivered for less than the established amount, however, the hospital could keep the difference and make a profit.

Third-party payers are agencies or organizations such as insurance companies or health maintenance organizations (HMOs) that are responsible for all or part of an insured individual's healthcare costs. Third-party payers also adopted the DRG system as a part of their cost-saving measures. It has been suggested that prospective payment legislation introduced a new era of fiscal constraints, demands for accountability, and pressure to provide services in innovative ways. This new era involved the constant evaluation of practices, policies, and procedures to limit costs whenever possible and has resulted in concerns about access, equitable treatment decisions, and quality of care.

As a result of the need to control costs, provide quality care, and meet the needs of increasing numbers of individuals, a variety of creative and innovative healthcare organizations have developed. Often called alphabet health care, acronyms such as HMOs, preferred provider organizations (PPOs), point-of-service (POS) plans, and MCOs have become part of the new healthcare vocabulary (Feldstein, 2007). With these new healthcare models have come some difficult ethical questions. Is health care a right? If a treatment or procedure is available and you want it, should your insurance be required to pay for it? Who should decide on the appropriateness of medical treatment plans, the physician or the insurance company? These questions are probably going to be with us for a long time, because there are no easy answers.

Public Health Care

Public health can be defined as the health outcomes of a group of individuals, including the distribution of such outcomes within the group; the field of population health, which includes health outcomes, patterns of health determinants, and policies; and the interventions that link these two (Kindig & Stoddart, 2003). The U.S. public health system is made up of interwoven local, state, and national governmental agencies designed to look at broad community-based health issues and protect the general public from the hazards that result from living in populated urban areas.

Massachusetts was the first state to establish a state department of health modeled, in part, after the British General Board of Health. Lemuel Shattuck, from Massachusetts, produced a visionary report in 1850 entitled *Report of the Sanitary Commission of Massachusetts*. In that report, Shattuck outlined the health needs of the state and offered recommendations related to the need for sanitary engineers, accurate vital statistics, inspectors, food and drug regulations, public health education, and routine preventative health care for all citizens. Despite its carefully written and documented recommendations, however, this report was virtually ignored for almost 20 years.

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In 1872, the Public Health Association was formed. Its membership focused on interdisciplinary efforts to improve health and developed a number of health promotion and illness prevention materials for the public. In the 1880s, based on work by Pasteur and Koch, public health moved from having a narrow emphasis on environmental sanitation to taking a broader view that included bacteriology and immunology.

ENVIRONMENTAL CONNECTION

While clean drinking water is taken for granted in the United States due to a long-standing commitment to public health and the availability of resources, 85% of the world's people live in the driest half of the planet, and therefore have more limited water access. The United Nations reported in 2013 that more than 780 million of the world's people lack clean drinking water and over 2.5 billion lack sanitation services (UN Water, 2013).

CULTURAL CONNECTION

Immigration issues have always affected health care. Following Hurricane Katrina in 2005, many Hispanic immigrants, documented and undocumented, flowed into the United States seeking work opportunities in the Gulf Coast region. Prior to Katrina, New Orleans' Hispanic population was estimated to be 5% of the city's total population; after Katrina, it was as high as 30%. What are the challenges for community health nurses in caring for this population?

During the first decades of the 20th century, public health services began to expand in the United States. The Social Security Act of 1935 provided federal funding for support of local health departments and marked the first step toward the development of a nationwide network of public health agencies. Public health agencies were responsible for providing healthcare services to special populations such as urban poor, mothers, babies, and Native Americans, among others (Fairbanks & Wiese, 1998).

Today, public health agencies range in size and scope from local health departments to the Centers for Disease Control and Prevention (CDC) in Atlanta and focus on ensuring that the public health of the community is protected, promoted, and restored. To meet that overall goal, public health departments currently have a wide range of population-based goals (see **Box 5-3**). To meet the goal of healthy communities, public health agencies have expanded their core functions to include community assessment, policy development, limited medical services (e.g., immunizations, well-baby check-ups, sexually transmitted disease treatment, and surveillance), and program evaluation (Keck & Scutchfield, 1997).

BOX 5-3 Public Health Goals

The public health system is responsible for the following activities:

- Preventing epidemics and the spread of disease
- Reducing environmental hazards
- Preventing injuries
- Promoting healthy behaviors
- Providing disaster services
- Ensuring the quality and accessibility of health services

Source: Fairbanks, J., & Wiese, W. H. (1998). *The public health primer.* Thousand Oaks, CA: Sage.

RESEARCH ALERT

Many Native American nations, tribes, and bands are at an elevated risk for premature death from unintentional injury. The purpose of this study was to identify and characterize any association between prior injury and/or alcohol use contacts with the Indian Health Service (IHS) and subsequent alcohol-related injury death. Death certificates of Native Americans who died from injury in a rural IHS area over 6 consecutive years were linked to IHS acute care facility records and toxicology reports. Of the 526 injury deaths involving Native Americans in the IHS area studied, 411 (78%) were successfully linked to IHS records. Of these cases, 152 met the inclusion criteria, with an additional 98 cases identified as a comparison group.

No differences in alcohol use at time of death between groups with and without prior healthcare contact (for injury or alcohol) could be determined (81% versus 73%). A significant relationship was found between previous visits for acute or chronic alcohol use and subsequent alcohol-related fatalities ($p = .01$).

Based on these findings, injury-prevention activities in the population studied should be initiated at the time of any health system contact in which alcohol use is identified. Community health nursing interventions should be developed to educate patients and families about the risk of alcohol use and injury risk with any contact at point of service for this at-risk population.

Source: Sanddal, T. L., Upchurch, J., Sanddal, N. D., & Esposito, T. J. (2005). Analysis of prior health system contacts as a harbinger of subsequent fatal injury in American Indians. *Journal of Rural Health, 21*(1), 65–69.

Military Health Care

One of the most important fringe benefits of military life is a system of well-organized, comprehensive healthcare services provided at little or no extra cost (Williams &

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Torrens, 2008). Military personnel are also covered for service-connected problems for life. Health care is always available when needed, although personnel may have little choice of provider. Finally, the military healthcare system emphasizes prevention in addition to illness care. The National Defense Authorization Act for fiscal year 2005 was designed to improve the comprehensiveness of the overall health benefits available to members of the National Guard, reservists, and their families.

Ambulatory care is provided in military base and regional clinics. Simple hospital services, including short-term stays, are available through base dispensaries or sick bays onboard ships. More advanced care is available in regional hospitals. Well-trained medics, nurses, and physicians, working in facilities owned by the U.S. government, provide most of the care. This system of care is well organized, integrated, and sophisticated.

Dependents and families of active-duty personnel are covered by an extensive health insurance plan known as TriCare. This program allows dependents and families to obtain health care from private clinics and practitioners, local hospitals, and HMOs when similar services are not available from a nearby military base.

A second program, the Veterans Administration (VA) healthcare system, is a hospital and long-term care system that exists to care for retired and disabled military personnel. Whereas a hospital clinic system is available for complicated ambulatory services, most simple ambulatory services are obtained through other systems of care. The VA healthcare system is probably the largest long-term care provider in the United States and is funded through an annual appropriation from Congress.

Healthcare Reform

The current U.S. healthcare delivery system is undergoing dramatic changes with the passage of the ACA. Advances in research and technology have resulted in the most sophisticated care in the world, and the most costly. At the same time, millions of Americans have limited or no access to healthcare services. When the uninsured do receive care, it is often in costly emergency departments and after the condition has become unnecessarily complex. Uncompensated care is on the rise, and many providers are limiting their numbers or refusing to care for uninsured or underinsured patients. Patients without a regular provider are often forced to seek care in emergency departments after their conditions have become serious and where care is often fragmented (Squires, 2012). Consequently, it is not surprising that healthcare reform has drawn the attention of many supporters.

Healthcare reform is not a new issue. The administrations of Franklin Roosevelt, Truman, Kennedy, Johnson, Nixon, Ford, Carter, George H. W. Bush, Clinton, and George W. Bush all attempted to design some type of healthcare reform. Only the Medicare Act, supported by President Kennedy before his death and passed by his successor, Lyndon Johnson, became law without undergoing major changes.

Each time, the need for healthcare reform was based on the need to control healthcare costs while providing access to quality healthcare services to increasing numbers of people. Prior to 1993, the prototypes for Clinton's healthcare reform bill had been debated through three elections and defeated by two legislatures because of concerns about increased costs and governmental control.

A massive reorganization attempt was started during the first year of President Clinton's administration under the direction of First Lady Hillary Rodham Clinton. This plan would have guaranteed all individuals access to a basic benefit package of selected primary and preventive services while ensuring cost containment and quality care.

The failure of the Clinton plan is generally attributed to a number of structural, strategic, and tactical mistakes. The opposition was well organized, the president had critics within his own party, the plan was too complex, the drafters of the plans were politically naive, and the president's political base of support was narrow. The arguments that were most often heard were that the plan was too expensive, it was too confusing, and taxpayers did not want to pay for health care for poor people. The failure of the plan left the United States and South Africa as the only major industrialized countries in the world without some form of universal insurance coverage. Although the reform package was never passed, healthcare changes did eventually occur. President Clinton's incremental initiatives, such as the Health Insurance Portability and Accountability Act of 1996, have succeeded.

In his health policy agenda, President George W. Bush focused less on broad, sweeping reform, and more on market-based, individualistic, incremental policies. Bush promoted health savings accounts, which allow people to create tax-free accounts to pay for out-of-pocket medical expenses, efforts to increase transparency in healthcare pricing and quality, and health information technology (Shi & Singh, 2013).

The Current U.S. Healthcare Delivery System

In response to a need for change, a number of new and innovative organizations are emerging, and many traditional components of the system are in transition because of the legal mandates set by the ACA. A single hospital operating independently or a physician/primary healthcare provider in an individual practice is becoming unusual. Hospitals, physicians, clinics, and other providers have been forced into a variety of interrelated systems. Growth and consolidation of smaller providers into larger organizations, horizontal and

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ETHICAL CONNECTION

- According to the Institute of Medicine (IOM), uninsured Americans get about half the medical care of those with health insurance. As a result, they tend to be sicker and to die sooner.
- Approximately 45,000 unnecessary deaths occur each year because of lack of health insurance, according to a 2009 study in the *American Journal of Public Health*.
- When even one family member is uninsured, the entire family is at risk for the financial consequences of a catastrophic illness or injury.
- According to the American College of Emergency Physicians, healthcare costs for both the full-year and part-year uninsured have been estimated to total $176 billion dollars per year. The U.S. government's programs finance approximately 75% of this cost.
- The burden of uncompensated care has been a factor in the closure of some hospitals and the unavailability of services in others. Disruptions in service can affect all who are served by a facility, including those who have health insurance.
- The United States loses the equivalent of $65 billion to $130 billion annually as a result of the poor health and early deaths of uninsured adults, according to a 2004 IOM report.

"In light of the adverse consequences that uninsurance has for individuals, families, communities, and society as a whole, it should be painfully clear that our nation can no longer afford to ignore this problem," said IOM committee co-chair Arthur Kellermann, professor and chair of emergency medicine at Emory University School of Medicine in Atlanta. "We must find a way to cover the uninsured."

The committee's five guiding principles to judge proposed solutions are as follows:

1. Healthcare coverage should be universal.
2. Healthcare coverage should be continuous.
3. Healthcare coverage should be affordable to individuals and families.
4. The health insurance strategy should be affordable and sustainable to society.
5. Healthcare coverage should enhance health and wellbeing by promoting access to high-quality care that is effective, efficient, safe, timely, patient centered, and equitable.

Based on these facts and principles, what are our ethical responsibilities to providing basic health care to our citizens? Who is responsible? Who is most vulnerable?

Sources: Institute of Medicine, Committee on the Consequences of Uninsurance. (2004). *Insuring America's health: Principles and recommendations*. Washington, DC: National Academies Press; Wilper, A. P., Woolhandler, S., Lasser, K. E., McCormick, D., Bor, D. H., & Himmelstein, D. U. (2009). Health insurance and mortality in US adults. *American Journal of Public Health, 99*(12), 2289–2295; American College of Emergency Physicians. (2013). The uninsured: Access to medical care fact sheet. Retrieved from http://newsroom.acep.org/index.php?s=20301&item=30032

vertical integration of services within organizations, changes from government-owned facilities to private nonprofit and for-profit facilities, and diversification of traditional healthcare services are occurring at an amazingly rapid pace (Lee & Estes, 2003). Large purchasers of medical services are demanding wholesale prices for services and even dictating terms to providers. Insurance coverage is constantly changing, and patient choices have been reduced (Squires, 2012).

Levels of Care

The U.S. healthcare delivery system provides six basic levels of care: preventive, primary, secondary, tertiary, restorative, and continuing or long-term health care.

Preventive care includes education and screening programs. **Primary care** includes services directed at reducing the potential for a disease through continuous, coordinated, and comprehensive care. Preventive and primary care generally take place in the primary care provider's office.

Secondary care is concerned with early detection and treatment of acute illness and injury to prevent disability and mortality. This type of care usually occurs in the primary care provider's office or in a community hospital.

Tertiary care is concerned with slowing the progression of established disease, preventing further disability, and improving the individual's degree of functioning. It sometimes occurs in community hospitals and sometimes in large medical referral centers. Restorative care is part of tertiary care and includes hospice and chronic care and occurs in hospitals or special rehabilitation facilities. **Long-term care**, also usually a subset of tertiary care, occurs in long-term care facilities such as nursing homes and hospice facilities. Historically, the United States has focused most of its resources on tertiary care provided in large medical care institutions.

Healthcare Providers

Registered nurses (RNs) and physicians are the two largest groups of healthcare professionals. As health care has become more complex, however, the number and variety of providers has increased proportionately. The Commission on Accreditation of Allied Health Education Programs (CAAHEP) is the largest programmatic/specialized provider of accreditation in the health sciences field. In collaboration with its Committees on Accreditation, CAAHEP accredits more than 2,000 educational programs in 19 health sciences occupations across the United States and Canada (CAAHEP, 2008).

Physicians

Physicians are the second-largest group of healthcare professionals. A total of 921,904 physicians are currently practicing in the United States and its possessions (American Medical

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Association [AMA], 2008). They diagnose and treat patients in an attempt to cure or improve the health of their patients. Physicians may be allopathic (MDs) or osteopathic (DOs).

In the past, most physicians were in solo practice. Today, many physicians are joining group practices or contracting with healthcare corporations. By joining groups, physicians are able to spread out both their workloads and their risks.

Nurses

Nurses are the largest group of healthcare providers. Approximately 3.1 million individuals hold nursing licenses in the United States (ANA, 2011). A nursing degree prepares an individual to work in many areas. For example, in 2011, approximately 57.3% of all registered nurses worked in hospitals; 8.7% worked in physician offices; 14% in home health care, nursing facilities, or outpatient care; and the rest in academic or civil service positions (Robert Wood Johnson Foundation, 2012). Nurses deliver and coordinate health care for patients within settings and across sites, collaborate with physicians, and carry out day-to-day treatments and care.

More than 250,000 registered nurses have the education and credentials to call themselves advanced practice nurses (ANA, 2011). The category of advanced practice nurse contains several different specialty areas, including clinical nurse specialists, nurse practitioners, nurse midwives, and nurse anesthetists. These advanced-level roles have grown over the years, usually in response to a physician shortage or a physician misdistribution. Each role has its own certification, rules and regulations, and state recognition process.

Physicians and nurses work in acute care settings in collaboration to improve health of patients.

Nurses are currently at an important juncture in the development of the profession with the new healthcare reform of the ACA. They currently have the opportunity to show their value in providing quality care at a reasonable cost while obtaining positive patient outcomes (Buerhaus et al., 2012).

NOTE THIS!

The American healthcare bill in 2009, according to the Commonwealth Fund's 2011 report, was approximately $7,960 per person.

Physician Assistants

Approximately 90,000 physician assistants (PAs) are currently practicing in the United States (American Academy of Physician Assistants [AAPA], n.d.b). The first training program for PAs was started at Duke University in 1965. As of 2011, the American Academy of Physician Assistants had accredited 156 PA programs in all 50 states (AAPA, n.d.a). The PA training program is typically the last 2 years of an undergraduate degree program and focuses on medical science and clinical skills. PAs work directly under the supervision and license of physicians, who are responsible for their performance. PAs can provide a variety of medical services as part of their role, such as history and physical examinations, minor medical diagnoses and care, follow-up care for acutely and chronically ill patients, hospital rounds, and surgical assistance, among other things.

Specialized Care Providers

Within the healthcare delivery system, certain groups of professionals provide focused care services. Examples are clinical psychologists, dentists, podiatrists, and optometrists. These professionals are licensed, although standards vary from state to state. They are usually addressed as "doctor," and in some areas they may have prescriptive authority and hospital privileges (i.e., they can admit and treat patients in a hospital setting). Their education is in depth in their specialty areas at a master's level or higher.

Technicians/Therapists

Many people who provide ancillary healthcare services are called technicians or technologists; examples include the medical laboratory technician or medical technologist, the medical record technician, the x-ray technician, and the dietary technician. Other ancillary healthcare professionals are called therapists; examples are respiratory, occupational,

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physical, mental health, and speech therapists. Each is educated and licensed to provide a specific service and is educated at a bachelor's level or higher.

MEDIA MOMENT

Daytime dramas ("soap operas") frequently use the hospital as a setting for plot lines. Millions of people watch these serials every day, which provide an artificial and often inaccurate portrayal of nurses, physicians, and the healthcare system. Rarely, if ever, is the issue of the cost of healthcare services mentioned. People in the series are often faced with near-death catastrophes, only to be saved at the last possible moment by some miraculous experimental treatment.

Other Providers

Other healthcare providers include professionals such as pharmacists and social workers. Pharmacists are specialists in the science of drugs and can make recommendations about drug therapy. Most programs preparing pharmacists are 5 years long and include an internship. Pharmacists are the third largest group of healthcare providers.

Social workers are assuming increasingly important roles in today's healthcare delivery system. These professionals counsel patients and families, often directing them to various healthcare resources. They may also be involved in discharge planning. Chaplains address the spiritual and emotional needs of patients and families from a nondenominational perspective.

Healthcare Settings

Services may be provided in traditional settings, such as hospitals, nursing homes, physicians' offices, ambulatory clinics, and homes. In addition, services may be provided in less traditional settings such as shelters, shopping malls, homeless shelters, pharmacies, schools, and job sites. Refer to the section "Community-Based Healthcare Settings" later in this chapter for more details.

Acute Care Facilities

Hospitals, or acute care facilities, make up the largest component of the U.S. healthcare delivery system and accounted for 31.6% of total U.S. health expenditures in 2012 (Centers for Medicare & Medicaid Services, 2012). Hospitals include federal, state, and local government facilities as well as those owned by private organizations. Privately owned hospitals include voluntary (not-for-profit) or proprietary (for-profit) hospitals. Religious and charitable groups operate voluntary hospitals and may be independent or represent HMOs or cooperatives. Individuals, partnerships, or corporations own proprietary hospitals. The early 2000s have seen an increase in investor-owned hospital corporations; the stock of these large corporations is traded on stock exchanges.

In the current healthcare market, many hospitals have established home health agencies to help patients as they transition from the hospital to the home environment. Community health nurses can provide a critical link between hospital care and home care.

Short-Term Specialized Care Facilities

Some facilities, such as mental health centers, substance abuse facilities, and rehabilitation centers, offer very specialized services. Patients are admitted to these facilities for a short-term stay to learn how to function with their disability. Another example of a short-term facility is a respite care facility that provides temporary inpatient services for individuals who usually are cared for at home. The purpose of respite care is to offer relief to the informal caregiver, usually a family member.

A short-term facility may be part of a network of coordinated services or a single independent entity. Centers may be staffed with a variety of healthcare providers, including physicians, nurses, and social workers. Short-term specialized care facilities discharge patients into the community after short stays. Community health nurses could provide family and home assessments to determine the patient's needs upon discharge and serve as a resource to patients once they are at home.

Long-Term Care Facilities

Long-term care may be defined as a wide range of social, personal, and healthcare services in addition to medical care. These services may include arranging social functions, exercise classes, and shopping trips to improve mental and physical function. Services might also include assistance with eating and bathing, arranging for therapy sessions, dental treatments, and visits by healthcare providers. Such services may be needed by older individuals or individuals who have lost their ability to care for themselves through disease or injury. Long-term care focuses on maintaining as much function as possible and emphasizes activities of daily living (basic needs such as eating, dressing, bathing, and ambulating). Nursing home and home healthcare expenditures make up approximately 8.2% of the total healthcare expenses in the United States (Centers for Medicare & Medicaid Services, 2012).

Most long-term care occurs in nursing homes. However, as the prospective payment system has forced patients to be discharged from hospitals earlier, home health care has become an essential part of the healthcare delivery system. Care may take place in a variety of other ways, such as through assisted living facilities and home healthcare agencies. Care is provided by registered nurses skilled in assessment and practical nurses and aides trained to provide safe patient care. Agencies receiving

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Medicare reimbursement must be certified and must meet specified conditions and federal standards.

Technology previously found only in hospitals is now provided by home care agencies. These treatments may include intravenous feedings and medications, ventilators, portable dialysis machines, and cardiac monitoring, for example. Although home health care has changed dramatically, it is still the traditional practice area for community health nurses. In addition to skilled nursing care, home health care may include physical, occupational, or speech therapy; homemaker services; and home-delivered meals. Community health nurses must have excellent skills related to assessing community resources and individualized patient needs in each of these long-term care modalities.

Ambulatory Care Sites

Patients can receive care for conditions not requiring hospitalization at ambulatory care sites. Physician and clinical services account for 20.2% of the total healthcare expenses in the United States (Centers for Medicare & Medicaid Services, 2012). Many ambulatory care sites are affiliated with hospitals, whereas others operate independently. Traditional "walk-in" clinics have existed for many years and are often supported by government funding or charitable organizations. People often use these clinics in lieu of having a personal physician. Centers may operate on an appointment or drop-in basis. Some clinics are specialized, such as family-planning clinics or those offering only women's healthcare services, and nurse practitioners or PAs frequently provide the care. Community health nurses can provide essential services in assisting patients while they try to meet their healthcare needs and stay at home.

Rural health centers were developed as a result of federal funding and to meet the need for care in rural, impoverished areas with few or no local physicians. Teams of residents and physicians from medical centers, along with nurse practitioners and PAs, frequently provide much of the care in these centers. These providers may cover several clinics on a rotating basis. Community health nurses play an important role in providing continuity in the care of patients who are often seen by many different providers. See the "Ambulatory Care Center Nursing" section in the Research Alert later in this chapter for further discussion on ambulatory care in the community.

Daycare Centers

Daycare centers target specific patient populations. For instance, many daycare centers serve elderly persons who cannot be left alone for long periods of time but who can carry out activities of daily living. Other daycare centers serve patients who are physically or mentally challenged, such as those with cerebral palsy or Down syndrome or those with chemical dependencies. They care for individuals when family members are working and offer services such as meals, rehabilitation, and occupational therapy. Because the primary needs of these patients are in the area of personal care needs, nurses play an important role in these facilities.

The world's healthcare systems have more in common than you might think. For example, in Canada, which has a government-sponsored healthcare system, some 30% of health spending is privately financed. In our supposedly "free-market" U.S. healthcare system, more than 40% of health spending is taxpayer financed (Medicare, Medicaid, military), and the privately financed part is intensely regulated.

Nurse-Managed Health Clinics

Nurse-managed health clinics that provide direct care through professional nursing services are holistic and patient centered and are reimbursed at a reasonable cost. Accountability and responsibility for patient care and professional practice are those of the professional nurse. There are a variety of models that meet the needs of selected populations, such as free-standing clinics and school-based clinics, which may be affiliated with medical centers and schools of nursing. Nurse-managed health clinics are centers that have existed for many years, but with the passage of the ACA of 2010, expectations for growth and expansion of services in these types of community-based clinics are high. This may be especially beneficial for vulnerable populations that often lack access to traditional healthcare services (Hanson-Turton & Kinsey, 2001).

Hospices

A hospice, whether run by a public or private agency, is designed to care for terminally ill patients and their families by providing noncurative, supportive, and palliative services. Many patients receiving these services are suffering from cancer, although conditions such as acquired immune deficiency syndrome (AIDS), multiple sclerosis, or end-stage renal disease may also require hospice care. Although nurses play the major role in hospice care, a team approach including physicians, therapists, volunteers, and clergy is often used. Nursing activities focus on managing pain, treating symptoms, and preparing the patient and family for death and bereavement.

Hospice care has been the fastest-growing segment of Medicare-reimbursed care in recent years. The number of Medicare beneficiaries who used hospice for end-of-life care doubled between 2000 and 2010 (Medicare Payment Advisory Commission [MedPAC], 2012).

Retirement Communities

Since the 1990s, the number of retirement communities in the United States has increased significantly. These communities take many forms, such as entire small towns, retirement subdivisions, apartments or condominiums,

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and continuing-care communities. Although the services vary, retirement communities usually provide a number of levels of care.

In an arrangement known as assisted living, older people live independently with care nearby if needed. A convalescent center may be associated with the facility, and services such as physical and occupational therapy may be provided. Other healthcare services such as dental care may also be available. Residents are guaranteed access to various healthcare services, and the financial responsibilities are spread over the entire community. Some of the fees, such as entry fees, must be prepaid and may be very expensive. Entry fees and monthly maintenance fees are often high, thus limiting access to some of these facilities to the more affluent retirees.

Complementary/Alternative Health Care

Complementary and alternative health care involves nontraditional treatments such as acupressure, acupuncture, therapeutic touch, herbal treatments, hypnosis and imagery, and homeopathy. Complementary and alternative healthcare treatments are now being studied to see how they can be used to support more traditional medical plans of care.

Congress established the Office of Alternative Medicine in 1992 to sponsor research in this field to attempt to determine the value of nontraditional treatments on patient outcomes. Nurses have often been supportive of and practiced alternative health care. Current research has recently focused more attention on some of these modalities and made them more acceptable in mainstream health care.

GOT AN ALTERNATIVE?

The National Center for Complementary and Alternative Medicine (NCCAM) was established by Congress in 1992 to sponsor research into complementary and nontraditional treatments and their effects on patient health outcomes. The NCCAM is one of the 27 institutes and centers that make up the NIH. The NIH is one of eight agencies under the Public Health Service (PHS) in the U.S. Department of Health and Human Services (HHS).

NCCAM is dedicated to exploring complementary and alternative healing practices in the context of rigorous science, training complementary and alternative medicine (CAM) researchers, and disseminating authoritative information to the public and professionals.

Issues Affecting the Delivery of Healthcare Services

Many issues have contributed to the growth, complexity, and expense of the U.S. healthcare delivery system, such as deregulation, consumerism, technology, the graying of America, and our litigious society. (See **Box 5-4**.) Local, state, and federal governments have attempted to address these issues at one time or another. However, short-term fixes for any one factor have had little impact on the overall problem.

BOX 5-4 Key Concepts: Factors Affecting Healthcare Delivery

Failure of competition as a strategy following deregulation of health care
Emphasis on secondary and tertiary health care instead of prevention
Increasing consumerism
Escalating cost of technology
Aging of the population
Cost of defensive medicine
Government regulation and administrative costs

Deregulation

In the last few years, the United States has experienced deregulation of health care. The result has been a proliferation of facilities and technology (e.g., CAT scans and MRIs) in some urban areas, which has resulted in excess capacity and, in turn, increased competition. This expense is inevitably passed along to the patients. Also, the trend leads to misdistribution of essential services in underserved areas. Competition as a price control strategy has not helped to control healthcare costs. Americans still want the specialist, the newest technology, the cutting-edge treatment, and the hospital that looks like a four-star hotel: They simply hope their insurance will pay for it.

Emphasis on Secondary and Tertiary Healthcare Services

Historically, the U.S. healthcare system has allocated the majority of its resources to the care that occurs after the patient has become critically ill. Vast amounts of money have been spent on critical care units, technical procedures, and sophisticated surgical techniques, but little money has been devoted to preventing the illness in the first place. Education and screening services are often not reimbursed by third-party payers and are undervalued by busy providers. Although MCOs frequently say they value what these preventive services can accomplish, the cost is often more than they wish to pay. As a result, managed care often makes decisions about which preventive services are the most valuable and ignores the rest.

Increasing Consumerism

Healthcare consumerism encompasses the public's involvement in determining the type, quality, and cost of their health care. Today, consumers are reading, looking up information, subscribing to newsletters specializing in their healthcare problem, and attending support groups. They are better informed and asserting their right to have an active role in decisions related to their care.

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In the past, the poor often either went without health care or had to be satisfied with a lesser quality of care. Values are changing, and equal access to health care is now viewed by many as a right.

Technological Advances

Advances made in technology have drastically changed health care and altered how physicians treat hospitalized patients. For example, the life expectancy of a person with diabetes has increased considerably in recent decades. New chemotherapy treatments have extended cancer patients' lives and, in some cases, greatly increased the quality of their lives. Heart, lung, and liver transplants—all of which were unheard of decades ago—have become commonplace. The latest antibiotic therapies ward off deadly diseases. Taken collectively, advances have reduced hospital stays and allowed people to live longer.

The new technology is expensive, and some advances have raised formidable ethical questions. If you can extend the life of an 80-year-old man for a short time by putting him on a ventilator, should you do it? If you can keep a premature baby alive on life support, but you know that the child has multiple irreparable problems that will result in incredible future costs, should you do it? For the cost of the care of one elderly man on a ventilator for several weeks, you could provide prenatal care to a large group of pregnant women.

RESEARCH ALERT

Public Not Taking Steps to Protect Their Health

Reeves and Rafferty found in their study of 153,000 Americans that only 3% of Americans follow the four basic healthy lifestyle habits that public health experts consider the cornerstones to a longer and better life: engaging in regular exercise, refraining from smoking, eating five or more fruits and vegetables daily, and maintaining a healthy weight. Many public health authorities believe that a person who follows the big four will have gone a long way toward reducing the risks of life-threatening chronic illnesses. The researchers noted:

> These data illustrate that a healthy lifestyle—defined as a combination of four healthy lifestyle characteristics—was undertaken by very few adults in the United States, and that no subgroup followed this combination to a level remotely consistent with clinical or public health recommendations.

The findings, they added, "support the need for comprehensive primary prevention activities to increase healthy lifestyles and to reduce the prevalence of chronic risk factors at the population level."

The researchers analyzed data from the 2000 Behavioral Risk Factor Surveillance System, which included 164,940 respondents aged 18 to 74 years. Participants were randomly telephoned and questioned about lifestyle habits, such as how often they drank fruit juice, ate green leafy vegetables, and the frequency and duration of physical activity.

Survey results showed the prevalence (95% confidence interval) of participants' four healthy lifestyle characteristics were as follows: nonsmoking, 76% (75.6%–76.4%); healthy weight, 40.1% (39.7%–40.5%); five fruits and vegetables a day, 23.3% (22.9%–23.7%); and regular exercise 22.2% (21.8%–22.6%). The overall prevalence of people engaging in all four healthy habits was a mere 3% (95% CI, 2.8%–3.2%) with little variation among subgroups (range, 0.8%–5.7%).

Researchers noted that one of the drawbacks to this study was its reliance on self-reported data. Still, it suggests healthcare providers have their work cut out for them.

"We believe that these findings serve to illustrate the health promotion crisis in the United States, characterized by excessive caloric intake, inadequate leisure time physical activity, increasing obesity, and high rates of cigarette use," the researchers wrote.

Currently, two-thirds of the entire U.S. population is overweight or obese. According to the Centers for Disease Control and Prevention, 22.5% of all U.S. adults (or 46 million people) smoke cigarettes. More men smoke than women—25.2% compared to 20%, respectively.

Source: Reeves, M. J., & Rafferty, A. P. (2000). Healthy lifestyle characteristics among adults in the United States. *Archives of Internal Medicine, 5*(165), 854–857.

Increasing Longevity of Americans

In the 2010 census, approximately 40.3 million individuals reported that they were 65 years of age or older. This represents 13.7% of the total U.S. population—and an increase of 1.3% from the 2000 census (U.S. Census Bureau, 2011). The fastest growing age group in the United States is people 85 and older. Because the heaviest users of health services are the elderly, more emphasis is being placed on their needs, the need for services has increased, and gerontology has become a significant branch of medicine and nursing. Topics such as living wills and power of attorney are becoming more widely discussed, as people become concerned about their ability to maintain life and the quality of that life.

Defensive Health Care and Government Regulation

Defensive health care is a practice of risk mitigation by physicians. It typically consists of avoiding risky procedures in patients who could potentially benefit from

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them and/or ordering medical tests, procedures, or further consultations that are not medically indicated in order to protect the physician from accusations of negligence (Sonal Sekhar & Vyas, 2013). Physicians are often forced to pay extremely high costs for malpractice insurance and attorneys' fees when they are sued. As a result, some physicians have simply stopped offering high-risk services such as obstetrics or have stopped providing care to indigent patients as a way to increase their profits.

The cost of defensive health care and government regulations has been a major factor affecting the delivery of health care in the United States. In addition, increased government regulation has caused many physicians to increase their office staff, reduce their patient load, or join healthcare systems where billing services are provided. As a result of these increased costs, the physician must become much more cost conscious, and health care has become a business rather than a service.

Managed Care

Total integration of services is expected to be the future economic structure of the U.S. healthcare delivery system. Networks are expected to compete for patients by becoming more efficient, charging lower prices, offering a wider range of services, and ensuring quality care for a fixed cost for the individual. They will maintain a central database to ensure that comprehensive care is delivered as the patient moves from provider to provider within the system. These networks are called managed care.

> "I am interested in getting people to use the healthcare system at the right time, getting them to see the doctor early enough, before a small health problem turns serious."
>
> *—Donna Shalala, president of the University of Miami and former Secretary of Health and Human Services*

The Concept of Managed Care

The concept of managed care encompasses a wide variety of organizational structures and is quickly becoming the dominant management strategy in the U.S. healthcare delivery system. By definition, **managed care** refers to a system that, for a set fee, assumes responsibility and accountability for the health of a population through the use of effective, responsible, and cost-efficient care:

> Managed care integrates the financing and delivery of healthcare services to covered individuals, most often by arrangements with providers. These systems offer packages of healthcare benefits, explicit standards for the selection of healthcare providers, formal programs for ongoing quality assurance and utilization review, significant financial incentives for its members to use providers, and procedures associated with the plan. (ANA, 1998)

Managed care organizations (MCOs) first made their appearance in the 1970s and 1980s, when the insurance industry was faced with employers starting to self-insure and healthcare costs were soaring. The huge reserves of money that insurance companies had previously invested were being depleted. Strategically thinking insurance companies redefined their market and began developing MCOs.

The goals of managed care are achieved by keeping patients healthy and treating them in the lowest cost setting using providers that have also agreed to provide services at a reduced rate. Under this system, primary care replaces the hospital as the center of care. The goal is to keep people out of the hospital—not to keep the hospital beds full. More treatments and care are provided in clinics and physicians' offices. Ambulatory patients go home to recover from surgery rather than upstairs in the hospital for a leisurely recovery in a private room.

Managed care has transformed health care from a service industry into a competitive, market-driven business. The question now is whether healthcare decisions are made based on the patient's needs or on the need to show a profit for the organization and its stakeholders. Who is making the decisions about treatment options, and who is caring for the patient with complex, multisystem problems? Is the cheapest treatment always the best treatment? All of these questions are currently without answers.

> "The care of human life and happiness, and not their destruction, is the first and only object of good government."
>
> *—Thomas Jefferson*

If managed care is considered the long-term answer to patient care questions, the answer lies in the premise that a healthy patient is cheaper to care for than an unhealthy one. Therefore, preventive care is the only answer. If managed care looks at the short-term answer, then cheaper is better.

Managed Care Organizations

The majority of MCOs can be categorized into three basic types: HMOs, PPOs, and POS plans. **Capitation** refers to the amount of money that is paid to an HMO to cover the

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cost of health care for a group of patients. An agency or organization representing a group of individuals seeking healthcare contracts with a group of providers and pays a predetermined fee periodically, usually quarterly.

Health Maintenance Organizations

Federally recognized **health maintenance organizations (HMOs)** are prepaid health management plans that offer an organized system for providing a predetermined set of healthcare services in a geographic area to a voluntarily enrolled group of people for an established fee. This system combines traditional insurance and healthcare delivery in one organization and provides a wide range of services, including inpatient and outpatient hospital care, infertility and mental health services, therapeutic x-ray treatments, alcohol and drug addiction treatment, and physical therapy.

HMOs were first established in 1973 under a federal program. The number of HMOs in existence grew dramatically over the next 30 years. Enrollment is voluntary; members have the option to select another plan. Because the fee paid by members is fixed annually, the organization tries to minimize costs. To do so, HMOs must place greater emphasis on health promotion and disease prevention. Some HMOs hire providers as employees, whereas others contract with providers for services.

Preferred Provider Organizations

A **preferred provider organization (PPO)** is a type of managed care plan composed of a group of physicians, and possibly one or more hospitals, which join forces to offer a prepaid healthcare plan to employers. In preferred provider arrangements, patients select their healthcare providers from the list of preferred providers and receive services at a discounted cost. If a consumer chooses to seek services from a provider who has not contracted with the plan, either a substantial deductible fee is assessed or the service is not covered. In the future, PPOs are likely to grow larger and include a wider range of providers.

Point-of-Service Plans

Point-of-service (POS) plans are also known as open-ended HMOs. POSs provide a set of services that are covered under the established fee, but members are also given the choice of going out of the network for services. Members share in costs with the HMO if they decide to go out of the network for care.

Multilevel Integrated Systems

The **integrated healthcare systems** of the future will consist of a mix of many types of healthcare facilities and providers connected through different types of contractual arrangements. These complex systems will be able to supply a broad range of services, from in-house care to outpatient care, from traditional to nontraditional care, within their own system (vertically integrated) or arrange for the services to be provided by other systems (horizontally integrated). Primary care providers, hospitals, retirement communities, wellness centers, pharmacies, health food outlets, rehabilitation centers, counseling centers, and many other types of providers from a large geographical area will be connected and accessible to members of these systems.

The process of changing traditional systems into new, multilevel integrated systems is often complicated and emotionally difficult. The literature is full of words designed to make the transformation process sound less cold and calculating. The first term to appear was "downsizing," which was immediately changed to "rightsizing." This term simply refers to cutting the number of funded positions to decrease costs. "Redesigning" was the next term to make an appearance; it referred to the process of examining all job descriptions to ensure equitable distribution of activities and reduce role overlap, excess specialization, and waste. The next term to appear was "restructuring," which refers to an assessment of the overall organizational structure in an attempt to improve productivity. Finally, "reengineering" refers to a comprehensive and often radical process to look at jobs and organizational structure as a way to form new relationships and new visions, and to improve functioning and productivity. As the evolution of these terms suggests, future integrated healthcare systems will be larger and more comprehensive.

Patient Care Outcomes

The term "patient care outcomes" refers to the consequences of care that the patient receives or does not receive. Outcome studies are becoming very popular in MCOs as a way to predict and provide effective patient care. These studies look for trends over time in patient status and adverse events. Adverse patient care outcomes are occurrences that are not expected as a result of the patient's disease process or treatment. Data obtained from patient care studies are then used as a basis for decisions, the development of policies and procedures, and changes in healthcare practice.

Efforts to improve patient care outcomes involve assessing individual patients' care and recovery and analyzing large data sets from across the country and world. Large national databases will be used in the future to provide predictive information on which to base treatments, types of care, lengths of care, and level of provider needed to achieve positive outcomes.

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RESEARCH ALERT

> Poor health was not just the result of random acts, bad luck, bad behavior or unfortunate genetics. Deliberate public policy decision about housing, education, parks and streets were the key drivers of racial differences in mortality.
>
> — *David A. Ansell,* County*: Life, Death and Politics at Chicago's Public Hospital (2011)*

Community-Based Healthcare Settings

Shelters in the Community

Another focus of community-based health nursing is that of the **shelter nurse**. Shelters are facilities established to assist people, who for one reason or another have found themselves to be homeless. While some shelters simply provide a place to get out of the weather, other shelters offer a wide range of services, often specializing in the concerns of specific populations such as the homeless, victims of abuse, or runaway youth.

Shelters are usually run by a combination of paid professionals and volunteer staff, including psychologists, nurses, attorneys, and others. Shelters may be sponsored by churches, community governments, and a variety of social agencies and are designed to provide a variety of services to people who often suffer from a variety of problems (Townsend, 2000). There is really no such thing as a typical shelter. The location of many shelters is kept confidential to protect the safety of the residents (Lundy, Sutton, & Foster, 2003).

Abuse Shelters Most cities in the United States now have shelters, or "safe houses," where women can go to obtain protection for themselves and their children. Most battered women who reside in shelters have experienced multiple traumatic events, with some even suffering from post-traumatic stress disorder (Humphreys, Lee, Neylan, & Marmar, 2001). Shelters not only provide a haven of safety to the abused and battered woman; they also provide health care, counseling, a milieu to express the intense emotions she may be experiencing, and a wealth of support including financial, social, and spiritual (Humphreys et al., 2001; Townsend, 2000).

Homeless Shelters In the United States, the homeless population is "among the poorest of the poor" (Zuvekas & Hill, 2000, p. 153) and consists not just of adult men and women, but also more than 1.6 million children (American Institutes for Research, National Center on Family Homelessness, 2010; Huang & Menke, 2001). A large segment of this population faces potential barriers to work, as many have serious mental and physical disabilities and others have single or multiple drug addictions (Hatton, 2001). In addition to meeting the medical and mental health needs of the homeless, shelters provide a safe, supportive environment for individuals who simply have no other place to go. While a small percentage of the homeless use the resources available to improve their lives, others become dependent on the provisions that the shelter offers (Lundy et al., 2003; Townsend, 2000).

Disaster Shelters When major flooding, tornadoes, landslides, and earthquakes strike, thousands of families are often displaced from their homes. For some families, displacement may be on a short-term basis. For others, their homes and all their belongings are gone. The greatest immediate need usually reported by most disaster victims is shelter (Daley, Karpati, & Sheik, 2001). This need is closely followed by food and hygiene requirements. Disaster victims include the young and the very old as well as those who are ill and those who are pregnant. Because of this, there is also a great demand in shelters for medications along with medical and nursing care (Daley et al., 2001).

The community health nurse, as a provider of care and manager of care in shelters, is in a unique position to help meet the needs of those people for whom shelters are their lifeline—the difference between life and death. It is essential that the shelter nurse exhibit the following competencies when working with all persons who enter a shelter in search of help and hope.

Professional behaviors essential to the shelter nurse include crisis intervention and counseling, health promotion and maintenance, screening and evaluation, provision of a therapeutic environment, assisting patients with self-care activities, administering and monitoring treatment regimens, health teaching, and outreach activities including home visits and community action (Townsend, 2000).

Shelter nurses must be able to accurately assess the needs of the population for whom they provide care. Depending on the type of shelter, nurses may care for patients with a multitude of physical needs, ranging from bruises and broken bones to pneumonia, sexually transmitted diseases (STDs), AIDS, substance abuse, tuberculosis, and dysentery.

Too often, however, it is the patient's spiritual and mental needs that are harder to assess. Shelter patients often suffer from mental illness, depression, anger, guilt, poor coping mechanisms, a multitude of stressors, and low self-esteem. Shelter nurses must be able to use therapeutic communication skills to develop a trusting relationship with their patients. It is the shelter nurse who is in the best position to let the shelter patient know that his or her feelings of anger and despair are normal and that others have experienced these same emotions in similar situations (Townsend, 2000). Through collaboration with the healthcare team, the nurse works with the patient in individual and group settings in an effort to develop coping skills that will serve as a stable base upon which the patient can begin to build a future.

One of the most important tasks of the shelter nurse is simply to care for the shelter patient. This starts with being

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nonjudgmental. It probably goes without saying that none of the shelter patients desire to be at the station in life in which they find themselves when they come to the shelter. Among the caring behaviors the shelter nurse must exhibit are listening, providing feedback, helping the patient to recognize available choices, and accepting and supporting the patient in whatever he or she chooses to do. One of the most important roles for nurses who work in shelters is that of educator, with emphasis on providing information about the availability of resources in the community (Townsend, 2000).

In addition to not having a place to live, shelter patients often lack the knowledge and skills that will help them to leave the shelter and function on their own. Patients may need assistance with completing paperwork to get federal or local assistance that will enable them to find a permanent home. They may need training or education to get a job, and many of the mentally ill lack the knowledge as to how to get the medications that will treat their mental illness. The shelter nurse may need to teach parenting skills, methods of building self-esteem, and alternative coping mechanisms to many of the shelter's patients. The mentally ill often need information about their medications to promote compliance. This includes when and how to take their medications as well as ways to reduce troublesome side effects. Some patients need assistance with hygiene and teaching about how to socially interact with others.

Nurses often serve as case managers for a selected group of patients who have been seen in shelters (Townsend, 2000). As case manager, the nurse coordinates services that are required to meet the needs of the patient. This is done in an effort to prevent avoidable episodes of illness—physical and mental—among these at-risk patients. Responsibilities include negotiating with many healthcare providers to obtain whatever services are needed by the patient. This coordination of services by the shelter nurse is done in an effort to optimize patient functioning and problem solving, improve work and socialization skills, promote leisure-time activities, and enhance the overall independence of the individual (Townsend, 2000).

The shelter nurse can participate in the research process at multiple levels. Areas of research involvement include identifying problem areas; collecting, analyzing, and interpreting data; applying findings; helping to evaluate, design, and conduct research; and using research available on the needs of shelter patients to formulate clinical pathways that will help to maximize outcomes for shelter patients (Hitchcock, Schubert, & Thomas, 1999). The shelter nurse can also keep abreast of current literature, share findings with other members of the healthcare team, and, when appropriate, apply findings to the care of shelter patients (Lundy et al., 2003).

Ambulatory Care Center Nursing Perhaps one of the most innovative and dramatic changes in community-based health care is in the diversity in care delivered in ambulatory care centers, from ambulatory surgical centers to ambulatory oncology care settings. These free-standing centers provide acute care to walk-in (ambulatory) patients without the custodial feel of traditional hospital care. These alternative sites for acute care have been very successful because of their efficiency, cost-effectiveness, and high degree of patient satisfaction. They can provide faster service with less paperwork and administrative time involvement. These ambulatory care centers are smaller in size than hospitals, employ fewer personnel, and have less technical equipment, which keeps costs down (Lundy et al., 2003).

Ambulatory Emergency/Trauma and Primary Care Centers These centers, often referred to as "urgent care," "urgicare," "minute clinics," or "walk-ins", do not perform major surgeries. Most are located in urban areas, shopping centers, and, most recently, retail stores. These community-based healthcare services have seen significant growth in the first part of the 21st century due to consumer demands for quick and inexpensive services. For example, when patients are unable to make an appointment with their primary caregiver, they can visit a CVS Minute Clinic or the Clinic at Wal-Mart to get a 5-minute strep test and fill any prescriptions at the same location. Influenza vaccinations are now available and administered at many pharmacies. Referrals can be made, based on diagnosis, to local full-service hospitals when patients need additional care.

As a relatively new resource for immediate and primary care, ambulatory centers are often staffed by family nurse practitioners, family practice physicians, registered nurses, licensed practical nurses, lab technicians, diagnostic technicians, and clerks. Ambulatory care centers try to enhance consumer satisfaction by being convenient, cost-effective, and caring. They do so by providing the four "A"s: They are affable, available, accessible, and affordable. These centers are often open 7 days a week, for 12 to 16 hours per day.

Minor illnesses, such as upper respiratory tract illnesses, impetigo, diarrhea, dehydration, urinary tract infections, asthma, and cellulitis can be easily diagnosed and treated at these clinics. Many also see more serious symptoms and illnesses such as chest pain, back pain, seizures, and anaphylaxis. Pregnancy tests are offered, along with suturing of lacerations, casting and splinting of fractures, and treatment of wounds, burns, and eye injuries. These centers offer limited diagnostic services, such as routine radiological services, complete blood cell counts, bacteriology, electrolytes, and toxicology tests.

The majority of patients are adults, although most centers see children as well. Return visits can be arranged but most customers are referred back to their family physician, nurse practitioner, or a specialist (Seidel, Henderson, & Lewis, 1991).

These relatively new healthcare services have been subjected to considerable criticism, especially from the medical community. Many critics view these "one-stop" services as inappropriate for children and others who need the comprehensive

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and continuous care delivered by a family healthcare provider (Lundy et al., 2003).

Ambulatory Surgery Centers Ambulatory surgery refers to a surgical process in which patients have surgery, recover, and are discharged home on the same day. Approximately 62% of all surgical procedures, whether performed in a hospital or a free-standing center, are now performed safely on an ambulatory basis without compromising the quality of care (Cullen, Hall, & Golosinsky, 2009). Surgical procedures generally do not exceed 90 minutes in length and require no more than 4 hours of recovery time.

Because of advances in anesthesia, surgical techniques, and a desire for convenience, free-standing, non-hospital surgical centers have grown significantly since the early 2000s. A 2006 CDC survey found that such centers perform roughly 43% of ambulatory procedures (Cullen et al., 2009). Cost containment is a major factor in the proliferation of same-day surgical centers. Each center has emergency equipment and trained personnel, including registered nurses. Pharmacy services are also available. Laboratory and radiological services may be performed on site or by referral to nearby facilities.

The American Academy of Ambulatory Care Nursing provides standards and guidelines for ambulatory centers in the community. Because of the brevity of patient contact in these centers, nurses must be focused and well educated as professionals in caring for persons who are frightened, stressed, and quickly discharged. The amount of time during which the ambulatory care center nurse stays with patients in these centers is short, so good communication skills are of special significance, to patients and their families and to other health professionals. Remaining focused and precise, nurses in these settings should communicate with deliberate and yet compassionate purpose due to the short length of time with the patients.

The ambulatory health center nurse conducts assessments, serves as an assistant to physicians as either a scrub or circulating nurse for surgical procedures, and takes histories during admission. Assessments after procedures are especially important at surgical centers because the collected data assist the physician in making the decision to discharge the patient.

The ambulatory center nurse makes quick decisions based on well thought-out clinical assessments and uses multiple interventions depending on the setting and diagnosis. Such a nurse analyzes data and integrates knowledge about the specific risks associated with the illness or procedure and takes appropriate action.

The nurse in the ambulatory care center must possess good interpersonal skills in which complex health and safety information can be conveyed in an understandable and concise manner to patients and their families, and in a respectful way to other workers and administration. Compassion for the patient and family is critical, because they are aware that they will be under medical supervision and care for only a short time. Nurses must promote self-care and confidence in the patient's ability to follow through with post-discharge instructions.

Much of the nurse role in an ambulatory care setting involves teaching of appropriate discharge measures. The nurse often follows up the following day to evaluate the health status of the patient after services have been delivered.

The nurse in the ambulatory care setting collaborates with other health professionals to share and manage critical information about the patient before, during, and after procedures. This team approach provides the patient with comprehensive care so that upon discharge, successful healing is more likely.

The ambulatory care center nurse manages a quick turnaround for patients with acute illnesses, which requires excellent organizational skills and a knowledge of critical information related to the specific illness or injury. Evaluation using outcome measurement can provide vital information about how to make the system work more efficiently while maintaining quality levels (Lundy et al., 2003; Williams, 1993).

Source: Lundy, K. S., Sutton, V., & Foster, B. (2003). The nurse's role in ambulatory health settings. In K. S. Lundy & S. Janes (Eds.), *Essentials of community-based nursing* (pp. 258–295). Sudbury, MA: Jones and Bartlett.

Health Politics and Policy

How did the U.S. healthcare delivery system become so expensive? Who should pay for the ever-increasing costs of health care and hospitalization? These questions have become the basis for untold numbers of legislative reports, articles, studies, and documentaries. The astronomical costs of some forms of treatment have made it impossible for the average patient to pay personally for needed medical, surgical, and nursing services. Single illness/episode bills well above $10,000 are no longer the exception. Many people rely on government interventions to help them deal with soaring costs and inaccessible services.

Government Policy

Health insurance provides protection against the high cost of medical care and hospitalization arising from illness or injury. Most Americans look to their jobs for health insurance, but increasingly insurance benefits are not available at work sites. The number of Americans who are uninsured or underinsured is increasing at an alarming rate. In response, Americans have appealed to their legislators for help.

Government policy focuses on health care on several levels. For example, federal legislation establishes boards to govern the practice of healthcare professionals and healthcare agencies, establishes commissions to examine

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healthcare delivery and make recommendations, and sets guidelines for the payment of Medicare benefits. State guidelines influence Medicaid benefits. Medicare and Medicaid guidelines affect the entire healthcare industry, because the government is the third-party payer for more than 40% of all U.S. expenditures for health care (Centers for Medicare & Medicaid Services, 2012).

The publication of *Healthy People 2020*, based on the progress made under *Healthy People 2000* and *2010* goals, again moved forward the U.S. agenda of disease prevention and health promotion for all citizens. The goals for the year 2020 retain three categories from the 2010 agenda—increasing the healthy lifespan, reducing health disparities, and increasing access to healthcare services—while adding the goal of creating social and physical environments that promote health for all (HHS, 2010). Prior to the publication of *Healthy People 2000*, these goals were not central in health legislation. However, in a time of increasing fiscal austerity, these goals make increasing economic sense: Keeping people well is much less costly than trying to cure or rehabilitate them.

Finally, there have been many debates about whether the United States should adopt a national health insurance plan or support market competition. Under a national plan, taxpayers would pay the government for the coverage, much like the way insurance companies currently collect funds from subscribers, and everyone would be covered at a predetermined basic level of services. The disadvantage is that government plans rarely operate very efficiently and many people feel that it is inappropriate for government to meddle in individuals' healthcare decisions. The ACA represented an attempt at a compromise between the two positions, requiring universal health coverage for all citizens but allowing private carriers to offer a range of policies for citizens to choose from and offering government support for the cost of policies to individuals who fell below a certain income level. Because certain aspects of implementation were left to states, the system is unevenly applied nationwide, and whether it will provide adequate coverage and cost reductions is an open question at the time of this writing.

Managed competition has been promoted as another way to keep healthcare costs at a reasonable level while ensuring quality care. Under this system, the government would allow a rivalry between healthcare providers for the purpose of attracting patients. However, an unequal distribution of the most ill patients might keep corporations from wanting to insure the very patients who need care the most.

Public Opinion and Special-Interest Groups

Public opinion expressed through special-interest groups is very influential in the development of public policy. Many special-interest groups, such as the American Hospital Association, the American Medical Association, and the American Insurance Association, spend huge amounts of time and money providing legislators with information on which to base healthcare decisions. Many legislators lack an in-depth understanding of healthcare issues. As a result, the information provided by special-interest groups often serves as a basis for healthcare decisions. When that happens, decisions may fail to reflect the best interests of the majority.

Nursing and Healthcare Policy

As the largest healthcare provider group, it is important for nurses to be both visible and vocal advocates for quality health care. To meet that important goal, the ANA has worked tirelessly over the years to develop an effective special-interest group infrastructure. In response to the healthcare reform issue, in 2007 the ANA formulated a position paper stating that the U.S. healthcare system needs restructuring, wellness promotion must become our emphasis, and universal access to healthcare services must be developed.

The ANA has been politically active in several other areas, including the area of healthcare rationing. When resources are limited, the question of healthcare rationing must be addressed. Of course, the well-insured individuals will worry about restrictions under such a system, and the uninsured or underinsured will worry that they will be excluded. Rationing can mean limiting access to care or limiting contact to the more expensive providers.

Through the years, ANA and state nurses organizations have continued to support legislation that aims to ensure basic healthcare services for everyone. To influence policy, nurses need to vote, be politically active in their states, and know which bills are being considered. To be politically active, you can work on someone's campaign, run for political office, support candidates financially, or simply stay in contact with elected state and federal officials and provide them with information when needed.

New Nursing Opportunities

As health care changes, the practice of nursing must also change. Nurses must stay knowledgeable about healthcare trends to make decisions about future careers. Those trends include things such as the growth in the healthcare workforce, the role of economics as a driving force, the changing U.S. demographics, the transformation of individual providers into multilevel corporations, the trend of physicians becoming employees, the philosophic move from "everything for a few" to "an adequate amount for many," and the increased importance of ambulatory care

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and home health care (Brennan, 2012; Huston & Fox, 1998). Some of the nursing roles related to these trends are discussed here. However, many future roles are yet to be created, as a result of dramatic changes in the healthcare system due to reform and the ACA (Robert Wood Johnson Foundation, 2012).

Advanced Practice Nurses

Advanced practice nursing is not a new category for nurses, but many of the traditional roles for nurses are changing. Nurse practitioners are moving into specialized areas such as geriatrics, acute care, and health care in correction facilities. Clinical nurse specialists are becoming experts in case management, genetics, and comprehensive cancer care. Nurse anesthetists and nurse midwives are managing patients with specialized needs. Advanced practice nurses are prepared to work with physicians, not for them. As specialties develop, nurses are finding ways to become experts in those areas. As more emphasis is placed on controlling healthcare costs, more providers will look to advanced practice nurses as providers of effective, quality, lower cost care. The doctorate of nursing practice (DNP) has emerged as the entry level for all advanced practice nurses. How this will impact the healthcare delivery system remains to be seen.

RESEARCH ALERT

The WIC (The Special Supplemental Nutrition Program for Women, Infants and Children) program provides food, education, and assistance with public health needs for women and children at nutritional risk. Close to 9.17 million persons participated in the WIC program in 2010. Over the decades, since its creation, WIC has produced many positive health outcomes, such as improved birth weights and childhood nutritional statuses. However, breastfeeding as the preferred method of infant nutrition has had less success in its promotion with the WIC program. WIC mothers are less likely to breastfeed their infants when compared to similar populations not on WIC. WIC prioritizes breastfeeding in its stated goals; however, only 0.6% of its budget is put toward breastfeeding initiatives, while infant formula accounts for 11.6% ($850 million) of WIC's budget. This inconsistency in the program's promotion of breastfeeding as the preferred choice for infant feeding in the first year of life is examined in this article and questions why WIC spends 25 times more on formula than on breastfeeding promotion.

Source: Baumgartel, K. L., Spatz, D. L., & American Academy of Nursing Expert Breastfeeding Panel. (2013). WIC (The Special Supplemental Nutrition Program for Women, Infants and Children): Policy Versus Practice Regarding Breastfeeding. *Nursing Outlook, 61,* 466–470.

APPLICATION TO PRACTICE

A pregnant woman with severe epilepsy has presented to the health department from a local obstetrical practice. She had been working part-time for a local grocer until her seizures became unmanageable, and she is no longer employed. The patient has been referred to the health department so that she can qualify for state funds for high-risk maternity care. The patient's husband works for a local manufacturing company and has HMO coverage for both himself and his wife through a company-sponsored managed care plan. The deductible and copayment are more than the couple can afford to pay, and they would like to find other resources to pay for the additional services needed to manage the epilepsy. The public health nurse checks with the state high-risk maternity care program and finds that the couple exceeds the income criteria and most likely will not qualify.

1. What are possible health and economic consequences if the patient's health is not managed appropriately during pregnancy?
2. Which system problems can you identify from the situation that result in ethical issues of treatment and care?
3. Who is responsible for seeing that this patient receives appropriate care at an affordable cost?

Entrepreneurs

In the future, more nurses than ever before will own nursing businesses, such as independent nursing centers. In areas such as home health, healthcare management, insurance evaluation, environmental evaluation, workplace health care, caregiver support, program evaluation, and respite care, the opportunities are endless. Nurses will be in a position to contract with larger systems for consulting services and the application of specialized knowledge and skills. The emerging role of the nurse coach shows great promise in a reformed healthcare system.

Data Management

Public and private agencies are looking for nurses who are skilled at creating and managing large databases containing patient information, a field known as informatics. Every healthcare organization is struggling with the need to maintain information in a safe, yet easily accessible manner. Data must be available for evaluation and decision making. Nurses with an understanding of patient care data coupled with a working knowledge of computers, the workings of databases, and the use of evaluative statistics will be in the perfect position to fill these critical slots.

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Research

We can no longer make decisions on the basis of what we have done before or what we think will work. Decisions must be based on data that can be seen, measured, and reproduced as needed, and then integrated with sound clinical practice experience based on research. We are moving into an age of evidence-based patient care. Consequently, patient-care research is more important today than at any time in the past. Nurse researchers try to develop an understanding of essential patient-care issues on which to base practice. They may be employees of an organization or working on a research project funded by the government or other organizations that fund research. Their work provides the structure for future practice that will identify efficient and effective healthcare practices that improve the lives of patients.

Conclusion

Some critics suggest that the U.S. healthcare system, which is supposed to guarantee access, innovation, and quality care, has instead become a system in crisis. A crisis exists in several areas: cost, availability, equity, efficiency, and responsiveness to public needs. This chapter discussed the history of the U.S. healthcare delivery system and described the changing components of that system. New roles for nursing are emerging as this healthcare system moves from one that was measured by the cost of its components to a system measured by the effectiveness of the care provided by its components.

ART CONNECTION

Look at paintings of Florence Nightingale. What are the differences in the depiction of her providing health care and that of the nurse today?

AFFORDABLE CARE ACT (ACA)

Healthcare spending in the United States since the 2010 passage of the ACA has risen by 1.3% a year, the lowest rate ever recorded, and healthcare inflation reached the lowest it has been in 50 years in 2013. How do you explain these changes in spending?

LEVELS OF PREVENTION

Primary: Organize an influenza program for senior centers and offer the immunization at convenient times and places.

Secondary: Assist patients with self-help care practices once infected with the flu.

Tertiary: Consider vulnerable populations with chronic conditions such as asthma in the intervention of preventing further permanent damage from influenza infection.

HEALTHY ME

How do you utilize the healthcare system? Do you first seek advice from family and friends or from a healthcare provider? Think about how you stay well to avoid being a part of the acute care healthcare system.

Critical Thinking Activities

1. You are a 28-year-old single mother with three children. You are having pain in your stomach and trouble sleeping. You have no money and no insurance. How will you get someone to help you? What will you do if you need medication?
2. You are a 22-year-old single parent with two children ages 1 and 3 years. Your mother is unemployed and watches the children while you work. Your job does not provide you with insurance. Your state has refused to expand Medicaid to conform to the ACA, so although your pay is too high to allow you to be eligible for Medicaid and too low to allow you to afford insurance, you can't get a federal subsidy to purchase an insurance policy. Which types of services do you need from the Health Department?
3. In a world of limited resources, developing equitable health policies involves many difficult decisions. How would you answer the following questions?
   - Should an 85-year-old man with debilitating emphysema be placed on a respirator?
   - Should a 78-year-old woman with breast cancer be put on chemotherapy?
   - Should major health insurance plans reimburse for experimental treatments?
   - Should an insurance plan be required to pay for a liver transplant for an alcoholic?
   - Should a baby with multiple incurable birth defects be placed in a neonatal intensive care unit?

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