SECOND EDITION

BASICS OF THE U.S. HEALTH CARE SYSTEM

NANCY J. NILES, PHD, MS, MBA, MPH

Associate Professor
Lander University
Greenwood, South Carolina

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5 Wall Street
Burlington, MA 01803
978-443-5000
info@jblearning.com
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About the Author

Nancy J. Niles, PhD, MS, MBA, MPH, is in her 11th year of full-time undergraduate teaching. She is in her 7th year of teaching undergraduate business and healthcare management classes in the AACSB-accredited School of Management at Lander University in Greenwood, South Carolina, having spent 4 years teaching in the Department of Business Administration at Concord University in Athens, West Virginia. She became very interested in health issues as a result of spending two tours with the U.S. Peace Corps in Senegal, West Africa. She focused on community assessment and development, obtaining funding for business- and health-related projects. Her professional experience also includes directing the New York State lead poisoning prevention program and managing a small business development center in Myrtle Beach, South Carolina.

Her graduate education has focused on health policy and management. She received a master of public health from the Tulane School of Public Health in New Orleans, Louisiana, a master of management with a healthcare administration emphasis, and a master of business administration from the University of Maryland University College, and a doctorate from the University of Illinois at Urbana, Champaign in health policy.

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Preface

I am very pleased to be updating this textbook because of the monumental change in the U.S. healthcare system: the passage of the Affordable Care Act (ACA) in 2010. The complicated act has nearly 50 mandates that impact many different components of the system; however, there have already been some delays in the timeline of the implementation of some of the mandates.

The ACA continues to be very controversial. There have been several lawsuits and constant discussions in Congress about repealing several different mandates. As of this writing, there are many mandates that have already been implemented that will impact healthcare consumers, which are discussed in the textbook. Because of the ACA impact, each chapter has been updated as it relates to ACA changes and as the healthcare industry has evolved over the past few years.

I also placed the ACA chapter, which was originally an add-on to the first edition, as the second chapter of this edition. That way, the student can become familiar with the mandates in the early learning process of the course and the textbook. The OECD data, discussed in Chapter 2 of the first edition, has also been updated from 2000–2005 to 2005–2010 data. Although the data reflected are still 3 years old, they are the most current data available.

Recognizing how education delivery has changed, I have modified the crossword puzzles so they can be done online or on-ground. I have also included three additional case studies that can be done on-ground or online. I have developed a glossary that will allow students to review vocabulary and take additional quizzes. I also included discussion boards for each chapter that can be used for both online and on-ground classes. I also wrote each chapter as a standalone chapter that can be included in other courses. I truly hope this textbook will provide a foundation for additional learning about the U.S. healthcare system. I also hope it encourages students to have careers in health care. The healthcare system's growth will continue due to the aging of the U.S. population and the increased focus of providing quality health care to healthcare consumers.

The following is a summary of each chapter:

CHAPTER 1

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

Increasing healthcare consumer awareness will protect you in both the personal and professional aspects of your life. You may decide to pursue a career in health care either as a provider or as an administrator. You may also decide to manage a business where you will have the responsibility of providing health care to your employees. And

lastly, from a personal standpoint, you should have the knowledge from a consumer point of view so you can make informed decisions about what matters most—your health. The federal government agrees with this philosophy. Recently, the Centers for Medicare and Medicaid Services used its claims data to publish the hospital costs of the 100 most common treatments nationwide. The purpose of this effort is to provide data to consumers regarding healthcare costs because the costs vary considerable across the United States. This effort may also encourage pricing competition of healthcare services.

As the U.S. population's life expectancy continues to increase, the United States will be confronted with more chronic health issues because, as we age, more chronic health conditions develop. The U.S. healthcare system is one of the most expensive systems in the world. According to 2010 statistics, the United States spent $2.6 trillion on healthcare expenditures or 17.6% of its gross domestic product. The gross domestic product is the total finished products or services that are produced in a country within a year. These statistics mean that nearly 18% of all of the products made within the borders of the United States within a year are healthcare related. Estimates indicate that healthcare spending will be $4.6 trillion by 2020, which represents nearly 20% of the gross domestic product. In 2011, there were 48.6 million uninsured U.S. citizens, a decrease from 50 million in 2010. The Institute of Medicine's (IOM) 1999 report indicated that nearly 100,000 citizens die each year as a result of medical errors. Although there have been quality improvement initiatives in the healthcare industry such as the Patient Safety and Quality Improvement Act of 2005, recent research indicates that medical errors in hospitals remain high. Employers are offering less healthcare benefits. In 2002, 72% offered health insurance benefits, which has dropped to 67.5% in 2010. In 2010, 58% of employees indicated that their employers did not offer healthcare benefits. This is typical of smaller businesses that have a small number of employees who need benefits.

These rates are some of the highest in the world but, unlike most developed countries, the United States does not offer healthcare coverage as a right of citizenship. Most developed countries have a universal healthcare program, which means access to all citizens. Many of these systems are typically run by the federal government, have centralized health policy agencies, are financed through different forms of taxation, and payment of healthcare services are by a single payer—the government. France and the United Kingdom have been discussed as possible models for the United States to follow to improve access to health care, but these programs have problems and may not be the ultimate solution for the United States. However, because the United States does not offer any type of universal healthcare coverage, many citizens who are not eligible for government-sponsored programs are expected to provide the service for themselves through the purchase of health insurance or the purchase of actual services. Many citizens cannot afford these options resulting in their not receiving routine medical care. The passage of the 2010 Patient Protection and Affordable Care Act has attempted to increase access to affordable health care. A mandate of the Affordable Care Act will require employees with 50 or more employees to offer affordable healthcare insurance effective 2015. There is also a mandate that individuals who do not have healthcare insurance purchase health insurance if they can afford it. States will be establishing health insurance marketplaces for affordable health insurance for both individuals and businesses. Both of these mandates should decrease the number of uninsured in the United States. These programs will be closely evaluated to assess whether their goals will be achieved.

CHAPTER 2

The Patient Protection and Affordable Care Act (PPACA) or, as it is commonly called, the Affordable Care Act (ACA) and its amendment, the Healthcare and Education Affordability Reconciliation Act of 2010, was signed into law on March 23, 2010 by President Barack Obama. The goal of the Act is to improve the accessibility and quality of the U.S. healthcare system. There are nearly 50 healthcare reform initiatives that are being implemented during 2010–2017 and beyond. The passage of this complex landmark legislation has been very controversial and continues to be contentious today.

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

people that Medicare is a federal government entitlement program because when individuals reach 65 years of age, they can receive their healthcare insurance from this program. Millions of individuals are enrolled in Medicare. Medicaid, which is a public welfare insurance program based on income, is a state-based government program for millions of individuals including children that provides health care for their enrollees. So the government already plays a huge role in providing healthcare coverage.

However, regardless of these two programs, many critics felt that the federal government was forcing people to purchase health insurance. In fact, the ACA does require most individuals to obtain health insurance only if they can afford it. But with the healthcare system expenditures comprising 17.6% of the U.S. gross domestic product and with millions of Americans not having the accessibility of health care resulting in poor health indicators, the current Administration's priority was to create mandated healthcare reform. The Congressional Budget Office estimates that the act will enable an additional 32 million Americans or a total of 94% of Americans to have access to healthcare insurance.

CHAPTER 3

The one commonality with all of the world's healthcare systems is that they all have consumers or users of their systems. Systems were developed to provide a service to their citizens. The U.S. healthcare system, unlike other systems in the world, does not provide healthcare access to all of its citizens. It is a very complex system that is comprised of many public and private components. Healthcare expenditures comprise approximately 17.6% of the gross domestic product (GDP). Healthcare costs are very expensive and most citizens cannot afford it if they had to pay for it themselves. Individuals rely on health insurance to pay a large portion of their healthcare costs. Healthcare insurance is predominantly offered by employers. According to a 2011 CDC survey, there were nearly 48.2 million uninsured in the United States with approximately 29 million who are underinsured, which means their health insurance does not adequately cover their medical expenses. (It will be interesting to assess the impact of the Affordable Care Act on this statistic because a major focus is individual insurance coverage nationwide.) The ACA projects there will be a decrease of nearly 70% in these statistics when the ACA is fully implemented.

In the United States, in order to provide healthcare services, there are several stakeholders or interested entities that participate in the industry. There are providers, of course, that consist of trained professionals such as physicians, nurses, dentists, and chiropractors. There are also inpatient and outpatient facilities, the payers such as the insurance companies, the government, and self-pay individuals, and the suppliers of products such as pharmaceutical companies, medical equipment companies, and the research and educational facilities. Each component plays an integral role in the healthcare industry. These different components further emphasize the complexity of the U.S. system. The current operations of the delivery system and utilization statistics will be discussed in depth in this chapter. An international comparison of the U.S. healthcare system and select country systems will also be discussed in this chapter, which provides another aspect of analyzing the U.S. healthcare system.

CHAPTER 4

During the Depression and World War II, the United States had no funds to start a universal healthcare program—an issue that had been discussed for years. As a result, a private sector system was developed that did not provide healthcare services to all citizens. However, the government's role of providing healthcare coverage evolved as a regulatory body to ensure that the elderly and poor were able to receive health care. The passage of the Social Security Act of 1935 and the establishment of the Medicaid and Medicare programs in 1965 mandated government's increased role in providing healthcare coverage. Also, the State Children's Health Insurance Program (SCHIP), now the Children's Health Insurance Program, established in 1997 and reauthorized by the Affordable Care Act through 2019 with extended funding through 2015, continues to expand government's role in children's health care. In addition to the reauthorization of the SCHIP program, the Affordable Care Act has increased government interaction with the healthcare system by developing several government initiatives that focus on increasing the ability of individuals to make informed decisions about their health care.

In these instances, the government increased accessibility to health care as well as provided financing for health care to certain targeted populations. This chapter will focus on the different roles the federal, state, and local governments play in the U.S. healthcare system. This chapter will also highlight different government programs and regulations that focus on monitoring how health care is provided.

CHAPTER 5

There are two important definitions of public health. In 1920, public health was defined by Charles Winslow as the science and art of preventing disease, prolonging life, and promoting physical health and efficiency through organized community efforts for the sanitation of the environment, control of community infections, and education of individuals regarding hygiene to ensure a standard of living for health maintenance. Sixty years later, the Institute of Medicine (IOM), in its 1988 *Future of Public Health* report, defined public health as an organized community effort to address public health by applying scientific and technical knowledge to promote health. Both definitions point to broad community efforts to promote health activities to protect the population's health status. The Affordable Care Act is also emphasizing the importance of prevention and wellness. The establishment of the Prevention and Public Health Fund has supported several community-based public health programs.

The development of public health is important to note as part of the basics of the U.S. healthcare system because its development was separate from the development of private medicine practices. Public health specialists view health from a collectivist and preventative care viewpoint: to protect as many citizens as possible from health issues and to provide strategies to prevent health issues from occurring. The definitions cited in the previous paragraph emphasize this viewpoint. Public health concepts were in stark contrast to traditional medicine, which focused on the sole relationship between a provider and patient. Private practitioners held an individualistic viewpoint—citizens more often would be paying for their services from their health insurance or from their own pockets. Physicians would be providing their patients guidance on how to cure their diseases, not preventing disease. This chapter will discuss the concept of health and healthcare delivery and the role of public health in delivering health care. The concepts of primary, secondary, and tertiary prevention and the role of public health in those delivery activities will be highlighted. Discussion will also focus on the origins of public health, the major role epidemiology plays in public health, the role of public health in disasters, core public health activities, the collaboration of public health and private medicine, and the importance of public health consumers.

CHAPTER 6

Inpatient services are services that involve an overnight stay of a patient. Historically, the U.S. healthcare industry was based on the provision of inpatient services provided by hospitals and outpatient services provided by physicians. As our healthcare system evolved, hospitals became the mainstay of the healthcare system offering primarily inpatient services with limited outpatient services. Over the past 2 centuries, hospitals have evolved from serving the poor and homeless to providing the latest medical technology to serve the seriously ill and injured (Shi & Singh, 2008). Although their original focus was inpatient services, as a result of cost containment and consumer preferences, more outpatient services are now being offered by hospitals.

Hospitals have evolved into medical centers that provide the most advanced service. Hospitals can be classified by who owns them, length of stay, and the type of services they provide. Inpatient services typically focus on acute care, which includes secondary and tertiary care levels that most likely require inpatient care. Inpatient care is very expensive and, throughout the years, has been targeted for cost containment measures. Hospitals began offering more outpatient services that do not require an overnight stay and were less financially taxing on the healthcare system. As U.S. healthcare expenditures have increased as part of the gross domestic product, more cost containment measures have evolved. Outpatient services have become more popular because they are less expensive and they are preferred by consumers. This chapter will discuss the evolution of outpatient and inpatient healthcare services in the United States.

CHAPTER 7

The healthcare industry is the fastest growing industry in the U.S. economy, employing a workforce of 18 million healthcare workers. Considering the aging of the U.S. population and the impact of the Affordable Care Act, it is expected that the healthcare industry will continue to experience strong job growth. When we think of healthcare providers, we automatically think of physicians and nurses. However, the healthcare industry is comprised of many different health services professionals. The healthcare industry includes dentists, optometrists, psychologists, chiropractors, podiatrists, nonphysician practitioners (NPPs), administrators, and allied health professionals. It is important to identify allied health professionals because they provide a range of essential healthcare services that complement the services provided by physicians and nurses. This category of health professionals is an integral component of providing quality health care.

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

With the passage of the Affordable Care Act, it is anticipated there will continue to be a shortage of physicians in certain areas. The Association of American Medical Colleges estimates that by 2015 there will be a shortage of over 60,000 physicians. The number will double by 2025 because of the aging of the population as well as the impact of the Affordable Care Act. Medicare officials predict that Medicare enrollment will increase by nearly 45% by 2025, which will further place strain on physician shortages. This chapter will provide a description of the different types of healthcare professionals and their role in providing care in the U.S. system.

CHAPTER 8

The percentage of the U.S. gross domestic product (GDP) devoted to healthcare expenditures has increased over the past several decades. In 2010, the United States spent $2.6 trillion on healthcare spending or 17.6% of the gross domestic product, which is the highest in the world. In 2011, U.S. Census data indicates there were 48.6 million uninsured U.S. citizens, which is a decrease from 50 million in 2010. The Centers for Medicare and Medicaid Services (CMS) predicts annual healthcare costs will be $4.64 trillion by 2020, which represents nearly 20% of the U.S. gross domestic product. The increase in healthcare spending can be attributed to three causes: (1) When prices increase in an economy overall, the cost of medical care will increase and, even when prices are adjusted for inflation, medical prices have increased; (2) as life expectancy increases in the United States, more individuals will require more medical care for chronic diseases, which means there will be more healthcare expenses; and (3) as healthcare technology and research provide for more sophisticated and more expensive procedures, there will be an increase in healthcare expenses.

There are four areas that account for a large percentage of national healthcare expenditures: hospital care, physician and clinical services, prescription drugs, and nursing and home healthcare expenditures. Unlike countries that have universal healthcare systems, payment of healthcare services in the United States is derived from (1) out-of-pocket payments from patients who pay entirely or partially for services rendered; (2) health insurance plans, such as indemnity plans or managed care organizations; (3) public/government funding such as Medicare, Medicaid,

and other government programs; and (4) health savings accounts (HSAs). Much of the burden of healthcare expenditures has been borne by private sources—employers and their health insurance programs have borne much of the cost. Employers are offering less healthcare benefits. In 2002, 72% offered health insurance benefits, which has dropped to 67.5% in 2010. When people are downsized, individuals may continue to pay their health insurance premiums through the Consolidated Omnibus Budget Reconciliation Act (COBRA) once they are unemployed but most individuals cannot afford to pay the expensive premiums. As a result of the passage of the Affordable Care Act of 2010, the government is playing a proactive role in developing a healthcare system that is consumer oriented. The act is requiring more employers to offer health insurance benefits and individuals to purchase healthcare insurance if they can afford it so these statistics may increase.

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

CHAPTER 9

Managed care refers to the cost management of healthcare services by controlling who the consumer sees and how much the services cost. Managed care organizations (MCOs) were introduced 40 years ago, but became more entrenched in the healthcare system when the Health Maintenance Organization Act of 1973 was signed into law by President Nixon. Healthcare costs were spiraling out of control during that period. Encouraging the increase in the development of HMOs, the first widely used managed care model, would help to control the healthcare costs. MCOs' integration of the financial industry with the medical service industry resulted in controlling the reimbursement rate of services, which allowed them more control over the health insurance portion of health care. Physicians were initially resistant to managed care models because they were threatened by loss of income. As the number of managed care models increased, physicians realized they had to accept this new form of healthcare delivery and, if they participated in a managed care organization, it was guaranteed income. Managed care health plans have become a standard option for consumers. Medicare Part C or Medicare Advantage offers managed care options to their enrollees. Many employers offer managed care plans to their employees. This chapter will discuss the history of the evolution of managed care and why it developed, the different types of managed care, the MCO assessment measures used for cost control, the issues regarding managed care, and how managed care has impacted the delivery of healthcare services.

CHAPTER 10

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

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

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

CHAPTER 11

To be an effective healthcare manager, it is important to understand basic legal and ethical principles that influence the work environment, including the legal relationship between the organization and the consumer—the healthcare provider and the patient. The basic concepts of law, both civil and criminal healthcare law, tort reform, employment-related legislation, safety in the workplace, and the legal relationship between the provider and the patient will be discussed in this chapter.

CHAPTER 12

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

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

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

This chapter will focus primarily on **bioethics**, which emerged as a field in World War II when Nazis in Germany used prisoners in war camps as medical experiments, illustrating the rights of human subjects in medical research. This field of study is concerned with the ethical implications of certain biologic and medical procedures and technologies, such as cloning; alternative reproductive methods, such as in vitro fertilization; organ transplants; genetic engineering; and care of the terminally ill, which will be discussed in this chapter. Additionally, the rapid advances in medicine in these areas raised questions about the influence of technology on the field of medicine.

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

CHAPTER 13

According to the World Health Organization, mental wellness or mental health is an integral and essential component of health. It is a state of well-being in which an individual can cope with normal stressors, can work productively, and is able to make a contribution to his or her community. Mental health behavioral disorders can be caused by biological, psychological, and personality factors. By 2020, behavioral health disorders will surpass all physiological diseases as a major cause of disability worldwide. Mental disorders are the leading cause of disability in the United States. Mental illnesses can impact individuals of any age, race, religion or income. In 2011, an estimated 10 million adults ages 18 and older had a serious mental illness. Two million youths ages 12–17 had a major depressive episode during a year. Although mental health is a disease that requires medical care, its characteristics set it apart from traditional medical care.

U.S. Surgeon General David Satcher released a landmark report in 1999 on mental health illness, *Mental Health: A Report of the Surgeon General*. The Surgeon General's report on mental health defines **mental disorders** as conditions that alter thinking processes, moods, or behavior that results in dysfunction or stress. It can be psychological or biological in nature. The most common conditions include **phobias**, which are excessive fear of objects or activities; substance abuse; and affective disorders, which are emotional states such as depression. Serious mental illness would include schizophrenia, major depression, and psychosis. Obsessive–compulsive disorders (OCD), mental retardation, Alzheimer's disease, and dementia are also considered mentally disabling conditions. According to the report, mental health ranks second to heart disease as a limitation on health and productivity. People who have mental disorders often exhibit feelings of anxiety, or may have hallucinations or feelings of sadness or fear that can limit normal functioning in their daily life. Because the cause or etiology of mental health disorders are less defined and less understood compared to traditional medical problems, interventions are less developed than other areas of medicine. This chapter will provide a discussion on the following topics: the history of the U.S. mental healthcare system, a background of healthcare professionals, mental healthcare law, insurance coverage for mental health, barriers to mental health care, the populations at risk for mental disorders, the types of mental health disorders as classified by the American Psychiatric Association's ***Diagnostic and Statistical Manual of Mental Disorders (DSM)***, liability issues associated with mental health care, an analysis of the mental healthcare system, and guidelines and recommendations to improve U.S. mental health care.

CHAPTER 14

The U.S. healthcare system has long been recognized as providing state-of-the-art health care. It has also been recognized as the most expensive healthcare system in the world and the price tag is expected to increase. Despite offering two large public programs—Medicare and Medicaid for the elderly, indigent, and disabled—current statistics indicate that over 48 million individuals are uninsured.

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