



SOCIAL ASPECTS OF HEALTHCARE DELIVERY

Healthcare Delivery in America: Historical and Policy Perspectives

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Case Scenario

The Palmers, a large, extended family, immigrated to New England in the early 1700s. In the 18th and early 19th centuries, the family and their descendants lived on farms in New England. They prospered through farming and some occasional work in small factories in nearby towns. Around 1860, family members moved to the growing cities. A number took jobs in factories; others were fortunate enough to go to high school and even college and found positions in the new professions of teaching, business, and health care. In the 20th century, some family members thrived, especially in the period of rapid economic growth after World War II. Others were barely able to make ends meet, relying at times on government programs and private charities.

One constant in the extended Palmer family is that from the time of their arrival in New England in 1740, various family members kept journals and wrote letters (and later emails or Facebook entries) recording information about their extended family members' daily lives. Suppose that in the 21st century, you have found some of these records spanning several centuries. As a future health professional, you learn about the health and disease history of the Palmer family members: what they thought caused disease and what their philosophies of health and disease were when they made their choices to seek health services; what kinds of diseases family members confronted; the differences public health improvements and technological changes made in their lives; how their health services were paid for; from whom and where they got or didn't get their health services and why; and what they thought about different healthcare policies presented by politicians and branches of government as these policies changed over time in the United States. The written or electronic record covers much of what appears in this chapter.

Based on the material in this chapter, what might you find out about the health experiences and beliefs of the Palmer family members, given their differing socio-economic backgrounds over time? What might you think about how much or how little healthcare services and their models of delivery have improved over time for American populations?

LEARNING OBJECTIVES

Upon completion of this chapter, the student shall be able to:

- Explain paradoxes of the U.S. healthcare system
- Explain health conditions in 18th- and 19th-century America in relation to disease patterns and causation theories
- Explain types of health practices and practitioners and factors explaining access to health care in 19th-century America
- Explain the various roles of government in healthcare delivery in 18th- and 19th-century America
- Explain the differences between orthodox and sectarian practitioners and their patients in relation to their perspectives on therapeutics and the delivery of health care
- Explain changes in the character, organization, and purposes of hospitals as health delivery sites from the early 19th century through the early 21st century
- Describe reforms in medical education at the turn of the 20th century and the consequences of the Flexner report of 1910
- Identify the golden age of medicine and describe what replaced it in the late 20th and early 21st centuries
- Explain the ways in which medicine and pharmacy pursued professionalization in the late 19th and 20th centuries and how these professions define themselves in the 21st century
- Explain how the factors of public health, lifestyle (diet, housing, personal hygiene), and medical practice influenced the decline of infectious diseases and increase in life expectancy at the turn of the 20th century
- Discuss the occurrences of infectious and chronic diseases in the 21st century
- Discuss the types of government policy that affected healthcare delivery in the 20th and early 21st centuries, particularly in relation to the implementation of public and private health insurance
- Discuss the implementation of Medicare and Medicaid in the 1960s, the 1973 Health Maintenance Organization Act, the 1996 Health Insurance Portability and Accountability Act, the 1997 Children's Health Insurance Program, and the 2010 Patient Protection and Affordable Care Act
- Explain the benefits and costs of the Medicare Part D Drug Plan
- Explain problems associated with incremental healthcare reform

CHAPTER QUESTIONS

1. What kinds of health beliefs did Americans hold in the 18th and 19th centuries?
2. What factors account for the decline in mortality rates and increases in life expectancy at the turn of the 20th century?
3. What were the benefits and drawbacks of the reforms in education that pharmacists and physicians implemented in the early 20th century as part of the professionalization process?
4. Who provided healthcare services for Americans and in what kinds of settings during the 18th, 19th, 20th, and 21st centuries?
5. What kinds of changes in private and public health insurance plans were considered by Americans in the past?

6. What is the potential for improved healthcare delivery in implementing patient-centered care, interdisciplinary care, and the medical home model of care?
7. How is the 2010 Patient Protection and Affordability Act characteristic of incremental healthcare reform?

INTRODUCTION

Taking a historical perspective, this chapter examines the evolution of health care and health services in the United States. Emphasis is placed on the changes in social spaces where Americans experience healthcare services—from the home, physician’s office, neighborhood dispensary, or hospital—to the outpatient clinic, multigroup specialty practice, community pharmacy, or federally qualified community health center. Patterns of health and illness in the United States are examined in the context of mortality and life expectancy and the occurrence of infectious and chronic diseases. The changing social meanings of health and disease, the roles of health professionals, such as pharmacists and physicians, and the expectations of citizens as patients and consumers in an increasingly complex healthcare delivery environment are explored. Of particular concern is the context of changes in attitudes and practice toward individual and social responsibility in the delivery of healthcare services.

PARADOXES OF THE U.S. HEALTHCARE SYSTEM

The U.S. healthcare system is characterized by many paradoxes. The United States has the best, most advanced technology available—yet we have a very high rate of medical errors. There are gaps in who has access to health care, with 21.1% of persons aged 18–64 in 2009 lacking health insurance (Cohen, Martinez, & Ward 2010, p.1). Compared to other industrialized nations, the level of spending in the United States means that the country has one of the most expensive healthcare systems, especially in terms of administrative costs. The U.S. healthcare system is also fragmented in terms of how it is financed and how healthcare services are organized and delivered. The following overview highlights the paradoxes of health in America and some key components influencing the continuing crisis.

Technology

Magnetic resonance imaging systems, new diagnostics, transplant surgeries, biotechnology-based products, genetic engineering, telemedicine, new reproductive technologies, and health information technology are just a few of the rapid technologic advances that have emerged in recent years in the United States. These developments offer hopes for improved quality of life, quicker diagnoses and better treatments, and increased life expectancy. Reliance on technologic innovation also creates problems. Most Americans expect to receive only the best technical care available, which often leads to overuse of technologic advances. New technologies tend to be updated quickly, often without sufficient examination of cost and effectiveness or patient safety threat issues. While the meaningful use of electronic health records offers opportunities for cost savings, reduction in medical errors, and improved patient access and outcomes, health

professionals raise concerns that in implementing electronic medical records they may lose focus on the interaction between the sick and the healer, thereby leading them to “suspend thinking, blindly accept diagnoses, and fail to talk to patients in a way that allows deep, independent probing” (Hartzband & Groopman, 2008, p. 1656; Ralston, Coleman, Reid, Handley, & Larson). While many Americans regard access to medical imaging as a sign of the superiority of the U.S. healthcare system, recent health research has focused on the avoidable public health threat that arises from investing so many resources in performing so many procedures as well as the dangers of radiation overdoses in single procedures (Bogdanich, 2010, p. A1; Lauer, 2009, pp. 842, 843). And finally, technology is not equally distributed among patient populations—significant disparities exist based on insurance status, income, and race (Weiss & Lonnquist, 2006, pp. 332–333).

Health Expenditures

The United States easily surpasses all other countries in spending, yet millions of its citizens lack adequate access to health care. In 2008, a total of \$2.3 trillion, representing an increase of 4.4% from the previous year, was spent on healthcare goods and services (amounting to \$7,681 per person). The federal government and health researchers pointed out that health spending growth was the slowest in 48 years, attributing this downturn as most likely connected to the economic recession (Hartman, Martin, Nuccio, & Catlin, 2010, pp. 147–149). Yet the United States also continues to spend more money for health care with the percentage of U.S. gross domestic product spent increasing from 15.9% in 2007 to 16.2% in 2008. A cost that individual households saw was in the share of personal income spent on health, which increased from 5.3% in 2001 to 5.9% in 2008 (Centers for Medicare and Medicaid Services, 2010; Hartman, Martin, Nuccio, & Catlin, 2010, pp. 147–149). The Kaiser Family Foundation also reported in 2007 that the average premium for family health coverage was \$12,106 with American workers paying \$3,281 of this cost (Fletcher, 2008).

According to a study comparing the United States with other developed nations, the country spends a higher share of gross domestic product on health care. The 2009 Health Care at a Glance Organization for Economic Co-Operation and Development (OECD) report compared 2007 healthcare spending of the United States (16.0%) to France (11%), Switzerland (10.8%), United Kingdom (8.4%), and Canada (10.1%). U.S. spending is higher than other developed countries in the areas of inpatient and outpatient care, as well as administrative costs, pharmaceuticals, and long-term care (OECD, 2009; Reinhardt, Hussey, & Anderson, 2004).

Health Insurance

In a 2009 Centers for Disease Control and Prevention national health interview survey, 46.3 million Americans of all ages were without health insurance. Between 2008 and 2009, there was an increase in the percentage of adults (18–64 years) lacking health insurance coverage from 19.7% to 21.1%. The survey indicated 10.9% of the 46.3 million had been without health insurance for more than 1 year. Lack of insurance varied by state, with one in five adults lacking insurance in Georgia and California, and one in four in Texas and Florida. Due to passage of health reform legislation that sought to achieve near-universal coverage, Massachusetts had a 3.7% rate of uninsured adults. Variability in the numbers of those insured across states relates to such factors as employment rates, cost of private insurance provided by employers or individual health

insurance, and access guidelines for public programs such as Medicaid. Studies have shown that many Americans are uninsured for parts of the year with the numbers highest for those living in families with lower incomes. In addition, the Commonwealth Fund estimated that nearly 25 million Americans had insurance policies in 2007 but were underinsured, meaning their policies often don't cover important aspects of care including such items as preventive care health practitioner visits, prescription drug costs, medical tests, surgery or other medical procedures, or catastrophic medical conditions, and/or they usually require significant out-of-pocket payments for services (Cohen, Martinez, & Ward, 2010, p. 1; Gabel, McDevitt, Lore, Pickreign, & Whitmore, 2009; Johnson & Johnson, 2010; National Center for Health Statistics, 2009).

Health Standards

While health care in the United States is the most expensive across the globe, inadequate, improper, and even dangerous care is all too prevalent. In reports on the performance of healthcare systems internationally, the Commonwealth Fund has found that the United States “consistently underperforms on most dimensions of performance” including in areas of “access, patient safety, coordination, efficiency, and equity” (Bodenheimer, Chen, & Bennett, 2009, pp. 69, 72). Major problems for U.S. patients occur in health worker shortages and the ratio of healthcare clinicians to patients, especially in regard to physicians, nurses (including nurse practitioners), physician assistants, pharmacists, and community health and public health workers providing primary care services in rural and underrepresented areas. With increasing numbers of Americans needing primary care for chronic care services, researchers have called for such new national workforce policies as those fostering interdisciplinary and multidisciplinary care delivered in primary care settings, new financial payment systems for primary care practices and clinics, and increased education of health professionals from underrepresented population groups (Davis, Schoen, & Stremikis, 2010).

In 1999, the Institute of Medicine issued a major report, *To Err Is Human: Building a Safer Health System*, presenting data that showed 44,000 to 98,000 people die each year from medical errors, a higher number than those dying from breast cancer or auto accidents. The report outlined ways to reduce medical errors and urged Congress to create a national patient safety center. In 2005, the federal government enacted the Patient Safety and Quality Improvement Act to continue the effort to foster safety cultures in healthcare institutions. A study commissioned by the Society of Actuaries based on insurance claims data reported that medical errors and the problems that ensued from them resulted in costs of \$19.5 billion to the U.S. economy in 2008 (Hobson, 2010). For the same year, the Henry K. Kaiser Foundation stated that “serious medication errors occur in the cases of five to 10 percent of patients admitted to hospitals” (Woo, Ranji, & Salganicoff, 2008, p. 1).

Those studying patient safety disagree on what progress has been made. Some argue that progress has been made in developing new adverse event reporting systems with the introduction of health information technology systems, advancing national data collection and accreditation standards, and promoting new patient safety initiatives supported by such groups as the Joint Commission and the Institute for Healthcare Improvement. Others, including Donald Berwick, an author of *To Err Is Human* and the new director of the Center for Medicare and Medicaid Services, have seen a change in awareness of medical safety but not fundamental change in the nature of the American healthcare industry (Beresford, 2010; Furukawa, Raghu, Spaulding, & Vinze, 2008;

Bosc, Dixon-Woods, Goeschel, & Pronovost, 2009; Gawande, 2010; National Healthcare Quality Report, 2009; Wachter, 2010). Berwick wanted safety responsibility relocated in “the offices and work of leaders of healthcare institutions” and “new safety initiatives . . . fostered by teams working at unprecedented levels of collaboration, reaching across traditional boundaries” (Berwick quoted in Beresford, 2010, p. 2). Government agencies and private foundations studying healthcare quality standards in U.S. health facilities agree that much more work is necessary to ensure safe care for the American population.

An Example: Healthcare-Associated Infections

Healthcare-associated infections were hardly discussed in the *To Err Is Human* report. Still, the 1990s saw growing concerns in healthcare facilities about antimicrobial drug-resistant nosocomial bacterial infections, including methicillin-resistant *Staphylococcus aureus*, *Clostridium difficile*, and the more recently reported multidrug-resistant NDM-producing Enterobacteriaceae (McKenna, 2010; Pitout, 2010, p. 1). The 2009 *WHO Guidelines on Hand Hygiene in Health Care* stated that “HCAI [healthcare-associated infections] concerns 5–15% of hospitalized patients and can affect 9–37% of those admitted to intensive care units (ICUs)” (p. 6). The U.S. Centers for Disease Control and Prevention reported approximately 1.7 million healthcare-associated infections and 99,000 associated deaths and cited HCAI as “one of the top-ten leading causes of death in the United States” (Agency for Healthcare Research and Quality, 2011, p. 1).

The hands of health providers and other health workers were identified as major culprits for healthcare infections. In 2000, the Centers for Disease Control and Prevention asserted that hygiene, especially hand washing, was “the single most effective way to prevent the transmission of disease” (Centers for Disease Control and Prevention, p. 1). Atul Gawande, a 2006 MacArthur fellow and research director of the Center for Surgery and Public Health at the Brigham and Women’s Hospital in Boston, wrote about the hand-washing problem in *The New England Journal of Medicine* in 2004. On a tour of the Brigham and Women’s Hospital with its infection-disease specialist, he learned that the biggest problem in infection control was “getting clinicians like me to do the one thing that consistently halts the spread of most infections: wash our hands” (Gawande, 2004, p. 1283).

In the United States, national guidelines for hand washing were first published by the Centers for Disease Control and Prevention in the 1980s. The 2009 *WHO Guidelines on Hand Hygiene in Health Care* defined alcohol-based hand rubbing, where available, as the standard of care for hand hygiene practices in healthcare settings with hand washing reserved for such situations as medication handling (WHO, 2009, p. 9). Yet in the first decade of the 21st century, hand-washing adherence among healthcare workers, including doctors and nurses, was not high, with “mean baseline rates ranging from 5% to 89% and an overall average of 38.7%” (WHO, 2009, p. 66).

The 2009 *National Healthcare Quality Report* notes healthcare-associated infections increased rather than declined with an increase of 8% seen in postoperative sepsis and an increase of 3.6% seen in postoperative catheter-associated urinary tract infections (*National Healthcare Quality Report 2009*, pp. 107–112). Healthcare institutions have implemented a number of interventions to address these issues (Pronovost et al., 2006). Increasingly in the 21st century, hospitals have pursued formal hand hygiene improvement programs. For example, Massachusetts General Hospital developed an

extensive hand hygiene strategy, organizing a multidisciplinary task force called Stop the Transmission of Pathogens aimed at collaboratively involving hospital employees, patients, and visitors. The program developed by the task force, “Clean Because We Care,” included the recruitment and training of volunteer champions (e.g., nurses, physicians, and housekeeping staff who implemented various motivational programs). In addition, the linking of a hospital-wide hand-hygiene compliance rate of above 90% to an annual employee bonus was used to incentivize employees. In early 2009, Massachusetts General Hospital reported improvement in its compliance rates with 93% of healthcare workers washing their hands before contact with patients and 96% after contact with patients (Hooper, 2009).

Health Outcomes

Health professionals and ordinary Americans have consistently been preoccupied with the state of American health through the examination of various outcomes. A recent study comparing health outcomes in populations with diabetes, hypertension, heart disease, myocardial infarction, strokes, lung disease, and cancer in the United States and the United Kingdom concluded that “based on self-reported illnesses and biological markers of disease, U.S. residents are much less healthy than their English counterparts” (Banks, Marmot, Oldfield, and Smith, 2006, p. 2037). In this study, differences existed at all levels of socioeconomic status, although health disparities were largest for those with the least education and income. The paradox: The United States spends far more on medical care than the United Kingdom does on a per capita basis (Banks et al., 2006, p. 2037).

An often-cited statistic is that the United States ranks lower than many other nations—especially such industrialized nations as Germany, Sweden, and Canada—in terms of infant mortality rates while spending more to prevent infant deaths. In the early years of the 21st century, 43 of the 224 countries reporting infant mortality statistics had lower mortality rates than the United States (Central Intelligence Agency, 2010). Despite the 27% decline in infant mortality rates between 1990 and 2007 among all groups in the United States, there are a number of reasons to account for the United States’ relatively low standing among other nations. For instance, the United States still has significant disparities in infant mortality rates based on race and ethnicity due to such factors as less access to prenatal care. In 2007, the overall infant mortality rate was 6.77 infant deaths per 1,000 live births while the rate for infants born to non-Hispanic black mothers was 13.63 deaths and 8.06 deaths for American Indian or Alaska Native mothers (Central Intelligence Agency, 2010; National Center for Health Statistics, 2009, pp. 6–7).

Programs such as “Every Child Succeeds” in Cincinnati, Ohio, have achieved success in improving infant mortality rates. In seven counties in the Cincinnati area, 8.3 of every 1,000 infants die before the age of 1 year, but for those in the “Every Child Succeeds” program, the infant mortality rate was 2.8, which is a rate that is lower than those reported in every industrialized country. Although the program enrolled 1,800 mothers, its funding allowed only one fifth of the needy women in the Cincinnati area to participate (Naik, 2006).

In another example, health officials in Dane County, Wisconsin, reported a dramatic decline between the early 1990s and 2009 in the rate of infant deaths among black mothers (fewer than 5 deaths per 1,000 live births from an average of 19 deaths), citing factors outside a medical model as an explanation. The county addressed issues

affecting the well-being of mothers—their mental and physical health, social connections, and exposures to stress in their environments, including racism. In other parts of Wisconsin during the same time period, however, the black infant death rate compared to the highest rates in other parts of the United States, at more than 20 deaths per 1,000 live births (Eckholm, 2009).

Comparisons of life expectancy show similar race-based disparities. In 1900, the life expectancy in the United States for women was 51.1 years, and for men it was 48.3 years. In 2006, life expectancy for all Americans was 77.7 years—80.2 years for women and 75.1 years for men. In comparing race-based data, life expectancy for white women compared to black women was 80.6 and 76.5 years, respectively, and for white men and black men, 75.7 and 69.7 years of age. Many factors account for disparities in life expectancy, including differences in the quality of neighborhood living environments and access to preventive care services (Epstein, 2003; Kinsella, 1992, p. 1197S; U.S. Census Bureau, 2010).

According to the 2009 *National Healthcare Disparities Report*, racial, ethnic, and socioeconomic disparities have increased in the United States since the report was first issued in 2003. The 2009 report cited lack of insurance, underinsurance, and lack of access to quality care, especially for those with cancer, pneumonia, and heart failure, in explaining the differences in how various populations experience health care in the United States (*National Healthcare Disparities Report*, 2010).

Based on outcomes as measures of healthcare risks in the United States, several major concerns were highlighted in the 1st decade of the 21st century. In examining targets that the Department of Health and Human Services set in *Healthy People 2010*, the incidence of smoking among adults decreased between 1998 (24%) and 2008 (21%), but did not reach the 12% target decrease that had been set in 2000. In addition, the small progress made was threatened with recent decreases in funding for prevention efforts.

Nearly one third of Americans 20 years or older have been identified as obese in 2010. In connecting this obesity statistic to understanding the importance of decreasing the incidence of diabetes, *Healthy People* focused on this disease state and identified a baseline in 1997 of 40 cases of clinically diagnosed diabetes per 1,000 population. Unfortunately, in 2008 the rate of cases increased to 59 per 1,000 population. The *Healthy People* target of 25 cases per 1,000 population for reducing diabetes prevalence in the United States was obviously not achieved, and increased evidence-based diabetes interventions will need to be made by multidisciplinary health professionals in a variety of healthcare settings to assist in caring for these individuals. Thus, the *Healthy People 2020* plan has included the addition of the following two new goals: first, “promoting quality of life, healthy development, and healthy behaviors across life stages; and second, creating social and physical environments that promote good health” (Koh, 2010, p. 1656).

All of these existing paradoxes in the U.S. healthcare system are important to consider when reviewing the evolution of health care and the delivery of healthcare services in a variety of settings within American communities over time.

HEALTH, DISEASE, AND HEALTH PRACTITIONERS IN COLONIAL AMERICA

As different groups of European settlers arrived in the Americas in the 16th and 17th centuries, they found a variety of societies and cultures. Some of the indigenous inhabitants of North America only hunted and gathered. Other groups occupied more per-

manent settlements and subsisted through both agricultural production and hunting and gathering. Contrary to the belief of many Europeans that the Americas promised a new Eden of good health, Native Americans endured significantly high mortality rates. Malnutrition, violence, accidents, fungal infections, anthrax, tapeworms, tuberculosis, and syphilis were common causes of death. European settlers brought influenza—which may not have been seen previously in the Americas—and other new illnesses—including yellow fever, malaria, smallpox, and measles—against which Native Americans had no immunity. Thus, as the historian of medicine, Gerald Grob, notes, the result of early contact between Europeans and Native Americans “was a catastrophe of monumental proportions that resulted in the destruction of a large majority of the indigenous population and facilitated European domination of the Americas” (2002, p. 27).

Arriving debilitated from sea travel, settlers of England’s North American colonies did not encounter an Edenic or a utopian environment. Rather, in the early years, many fell victim to malnutrition and dysentery—the consequences of poor food and insufficient clean water supplies. The colonists suffered from a wide range of endemic and epidemic infectious diseases such as yellow fever, measles, smallpox, and malaria. The British government did not implement broad public policies to address problems of health and illness or encourage the establishment of health practitioners or institutions (Cassedy, 1991). Colonial officials addressed such public health problems as garbage disposal, street maintenance, and the regulation of water supply and sanitation occasionally, and with little success in enforcement. Partially because of health emergencies (especially such epidemic outbreaks as smallpox or measles), towns and cities did become accustomed to governments enacting more extensive public health regulations. Examples included quarantines of ships arriving from areas affected by epidemic diseases, setting up isolation or pest houses, and fumigating houses where victims of smallpox or other infectious diseases had lived. Still, the medical historian James Cassedy argued that the application of these public health benefits was “so irregular, tentative, and inconsistent that the benefit to the public health must have been negligible” (1991, pp. 13–14).

When colonists became sick, they depended on various members of the community for access to the healing arts, looking as much for simple human and religious comforts as for therapeutic services. Although physicians, apothecaries, midwives, clergy, and public officials responded to individual or community health needs, it was just as common for family members or neighbors, often the females in the household, to diagnose, make medicines, and physically support the sick. Until at least 1825, women commonly depended on their female friends and relatives, and midwives when they were available, to attend to them in childbirth in their homes (Bogdan, 1992). European physicians did not look to the colonies, which had small and widely scattered populations, as locations that offered great professional or economic opportunity. Few physicians emigrated, and since medical education in the North American colonies was not considered a priority of government or private agencies, only a minority of physicians or apothecaries completed formal training. Physicians often compounded and dispensed medicines in shops next door to their medical practices. Apothecaries appeared only in small numbers as compounders, dispensers, or sometimes manufacturers and wholesalers of medicines.

In the growing colonies, all of these practitioners of the healing arts shared health beliefs that relied on a combination of folklore; mineral, plant, and vegetable herbal

remedies; and magic as well as improvisation based on what they found in their environments. The colonists used health practices and medications that were common in Europe and England, such as mercury and opium preparations. They also adopted such Native American health remedies as cinchona bark, which contained quinine (Christianson, 1987; Duffy, 1993; Tannenbaum, 2002).

AMERICA IN THE 19TH CENTURY: THE HEALTHCARE ENVIRONMENT

As the nation expanded westward and its population grew in the early 19th century, Americans exhibited a local outlook on health care that was similar to their attitudes toward economic and political life. A person's health experience as a resident of a town or city on the eastern seaboard was different from the health experience of a farmer in the rural southern or midwestern areas or of an immigrant traveling west into the new territories.

Rural and Urban Health

Self-reliance was a necessity for farmers and travelers. Poverty, loneliness, exhaustion, accidents, exposure to the elements, and dangerous plant and animal life took their toll. Family members and midwives who also functioned as social healers within communities played the most important roles in caring for ordinary people in times of illness. From a beginning in the era of the American Revolution, the number of physicians who practiced medicine in their own homes and traveled to make house calls in the homes of their patients increased significantly in the 19th century in rural areas and small towns. Both midwives, or social healers, and physicians treated entire families—men, women, and children—and juggled the responsibilities of their health practices with their domestic and community responsibilities. Payment for services was in cash and often in kind, or what families produced by their labor. Many patients could not pay, however, so midwives and physicians needed to rely on other sources of income. Rural and small-town residents could request compounded and proprietary medicines through both physicians and apothecaries. They could also purchase proprietary medicines in the general store and from itinerant healers or medicine men who regularly traveled from town to town (Cassedy, 1991; Leavitt, 1995, p. 4; Ulrich, 1990; Young, 1992).

In urban areas, in the 19th century, social class largely affected a person's quality of life and access to health care. The wealthy and growing upper middle class, including those members of the Palmer family (introduced in the case scenario at the beginning of the chapter) who were well off, had servants, lived in neighborhoods that provided clean air and water, gardens and parks, and health practitioners of their choice. The lower middle classes—including skilled workers, clerks, tradesmen, and widows—could afford food and housing and occasional visits to public parks. They tried to keep their domestic spaces clean despite the unsanitary living conditions offered by tenement landlords. They could pay minimal amounts for self-dosing remedies, medicines, or doctor bills. Most major towns and cities began to provide dispensaries that offered such services as the writing of prescriptions, minor surgeries for fractures, and vaccinations for workers who could pay little or nothing at all (Rosenberg, 1974).

The working classes shared problems with the poor, including lack of such basic municipal services as garbage and sewage removal. As part of the Industrial Revolution, members of the working classes breathed air polluted by coal dust from the factories

and railroads that were next to their residences. Congestion, noise, the frenetic pace of commercial life, and the accelerated influx of new waves of immigrants led to a rapid accumulation of new and old health problems, especially rising mortality rates due to infectious diseases. In addition, African Americans confronted even higher degrees of difficulty in relation to quality of life indicators because of slavery and discrimination. They experienced lack of access to health education, health facilities, and basic public health services (Byrd and Clayton, 2000; Cassedy, 1991; Hoy, 1995)

Health Values, Therapeutics, and Practitioners

Health practitioners and the general public have long disagreed about theories regarding the causes of disease and the public policies needed to address them. Some believed that supernatural forces inflicted disease because of human sin. Some believed in contagion or environmental (miasmatic) theories of disease. Still others believed that the individual who did not take precautions to lead a healthful life was responsible for disease (Tesh, 1988).

Regardless of their beliefs about disease causation, most Americans generally shared the same values when it came to health, disease, and the body—that is, they looked to Galen’s 2nd-century concept of humoralism. The body was an interconnected whole with a natural balance (Warner, 1997, p. 87). As Charles Rosenberg (1985) noted, “every part of the body was related inevitably and inextricably with every other. In health, the body’s system was in balance; in disease, the body lost its balance and suffered disequilibrium. If health practitioners were to treat disease effectively, they needed to know about individual patients and their body’s system of ‘intake and outgo’” (p. 40). What could be observed empirically happening to the patient’s body was therapeutically important.

Orthodox physicians (also referred to as allopathic, regular, or mainstream physicians), who had some didactic medical education or at least an apprenticeship under a practicing physician, offered their mostly middle- and upper-class patients heroic medical therapy. They adopted mostly depletive measures, whereas members of the lay public—drawing upon popular domestic medical texts and almanacs—more often employed both depletive and strengthening measures (tonics and astringents) (Horrocks, 2003). Orthodox physicians assumed an active, aggressive role whereby the patient and the family could see very visible changes in secretions and excretions in the body as a result of the physician’s interventions. Using leeches, medical instruments, and a variety of drug therapies, orthodox physicians bled, purged, puked, and sweated their patients. Because cures were not often the result of a physician’s care during serious illnesses, patients and families could at least share in the knowledge that they had observed the physician’s efforts to do something. Rosenberg has noted the ways in which depletive drugs were used in this system:

Drugs had to be seen as adjusting the body’s internal equilibrium; in addition, the drug’s action had, if possible, to alter these visible products of the body’s otherwise inscrutable internal state. Logically enough, drugs were not ordinarily viewed as specifics for particular disease entities; materia medica texts were generally arranged not by drug or disease, but in categories reflecting the drug’s physiological effects: diuretics, cathartics, narcotics, emetics, diaphoretics. (1985, p. 41)

Orthodox physicians competed with sectarians (also called irregulars), who offered a variety of alternative practices, cures, and remedies that were less heroic, including

folk medicines, strengthening tonics, and astringents sold by both itinerant quacks and druggists. Sectarians advocated temperance from alcohol; homeopathy, the infinitesimal dose therapeutic that differed significantly from the usually higher levels of medicines required by heroic dosing (Kaufman, 1971); and regimens of fresh air, exercise, and water cures (hydropathy) taken in what Susan E. Cayleff has referred to as comfortable “cure establishments,” situated in “natural surroundings” in “country settings” (1987, p. 77). In his popular *Thomson’s Almanac*, Samuel Thomson vigorously attacked the orthodox physician’s primary reliance on what he deemed excessive depletive measures and advocated his own medical philosophy primarily emphasizing self-treatment through the use of his regimen of herbal medicines, sweating baths, emetics, and purgatives (Haller, 2000; Horrocks, 2003, p. 120). Sylvester Graham worried about the sexual passions and advocated a vegetarian and high-fiber diet and exercise regimen that forbade spices, alcohol, tea, and coffee, in an effort to control those passions (Nissenbaum, 1980).

The commercial manufacture of proprietary medicines developed rapidly during the first half of the 19th century, replacing the functions of the domestic practitioner who formulated the family’s home remedies over the hearth fire. Physicians dispensed drugs in their offices and on home visits while “pharmacists began to open stores in towns and cities to fill prescriptions for patients of physicians and to compound drugs requested by their customers” (Rothstein, 1996a, p. 376; Cowen & Kent, 1997). Gregory Higby has observed that pharmacists, as part of a shift of “allegiance from physicians to their customers,” also began counter prescribing—that is, “refilling prescriptions without physician authorization, and diagnosing and treating customers” (1992, p. 5). By 1860, many Americans could buy relatively cheap commodities called patent medicines, which were manufactured in small factories, advertised in newspapers, and delivered to any town or city through improved transportation systems. As the 19th century progressed, pharmacists “sold bottles of their own or physicians’ concoctions” and became retailers of the prepared drugs (Rothstein, 1996a, p. 376).

At the same time, social reformers and public officials sought to label the production and distribution of patent medicines as “quackery” and warned the consuming public that patent medicine products were dangerous and fraudulent in their claims. Reformers were unsuccessful in their efforts to pass national legislation regulating the industry until the enactment of the Pure Food and Drug Act (1906), which addressed accurate labeling. Nevertheless, such patent medicines as Lydia Pinkham’s Vegetable Compound remained popular among middle-class women as a treatment for female complaints because it was seen as an “alternative to orthodox treatments they believed to be unsafe” (Cayleff, 1992, p. 317).

Americans sought out a variety of alternative therapies because they often viewed orthodox (regular) physicians as elitist practitioners who sought to monopolize health care. Many Americans accepted the egalitarian view that a variety of philosophies of healthcare practice should be available to all people. Thus, healthcare services were most commonly delivered in the home, physician’s office, drugstore, and cure establishment for the middle and upper classes. The working classes and the poor did not participate in the world of these healthcare services on a regular basis because of the necessity to pay out of pocket at the moment of receiving services. Instead, when most ordinary Americans became sick, they first sought treatment from someone in their own household. They often dosed themselves with self-help remedies that they could afford in an attempt to avoid the cost of treatment from an orthodox physician or one of the many sectarian physicians (Stage, 1979).

The Rise and Transformation of the Hospital: 19th to 21st Centuries

The early 19th-century hospital had its origins in the almshouse or poorhouse, identifying it as an institution with charitable and welfare functions. Most Americans saw the almshouse and hospital as a place that protected the community from those taken in and as a place where patients usually died. Aseptic practices were not commonplace. Generally, admittance for care could be gained only if a prominent member of the community was willing to vouch for the prospective patient's moral character. Patients entering the hospital throughout most of the 19th century were those with the least resources—the “deserving” poor, with so few ties to family or community that no one could care for them. Often they were recent immigrants; however, charitable hospitals sometimes refused certain immigrant populations, particularly the Irish in eastern seaboard cities, and categorically denied admission to African Americans (Vogel, 1979).

Male and female custodial caretakers of the sick were former patients who worked for room and board or local wage-earning residents from the community who had no formal training. Distinguished members of the community served as trustees who financed the institutions, and physicians from upper-class families provided free care to patients, developing new knowledge from the treatment of the very sick (Rosenberg, 1987; Vogel, 1979).

Charitable dispensaries were used by the poor and lower classes, including the poorer members of the Palmer family mentioned in this chapter's case scenario, far more than hospitals from the late 18th century until around 1920. These autonomous, freestanding institutions were located primarily in urban, often new, immigrant neighborhoods and provided such outpatient services as prescribing medication therapies, dental work, and minor surgery. There were few employees: a steward, a house physician, and sometimes a druggist, although the house physician might also act as druggist. Later in the 19th century, established consulting physicians volunteered from the local community (Rosenberg, 1985; Starr, 1991).

Over a 50-year period after the Civil War, the number of U.S. hospitals grew from fewer than 100 to more than 6,000 general and specialty institutions including mental facilities, children's hospitals, and tuberculosis sanitariums. The new hospitals were sponsored and financed by such disparate groups as religious organizations, ethnic associations, women's groups, physician groups (including African American physician associations), and such medical sectarians as homoeopaths and eclectics.

As the 19th century drew to a close, the chiefly welfare or charitable nature of the hospital declined. Orthodox physicians and trustees sought private, paying patients from the middle and upper classes. Physicians grew to reject Galen's system of therapeutics with its heroic remedies, replacing it with an increasing acceptance of the germ theory of disease (whereby specific microorganisms were believed to be responsible for the spread of disease). Hospitals introduced new approaches to care, including the enforcement of new aseptic and antiseptic techniques; new technologic methods, including regular anesthetization in surgery and the initial medical application of X-rays; and applied nursing methods patterned on the model developed by Florence Nightingale in England (Kevles, 1997; Pernick, 1985; Reverby, 1987). Architectural designs of hospitals were planned to provide personal service in a pleasant, clean decor with comfortable furnishings.

General practitioners, as well as elite physicians, sought to admit patients to these hospitals to enhance the growth of their private medical practices. Hospitals

continued to take charity patients, but the numbers decreased and these individuals received a lesser level of care. By the end of the 19th century, hospitals were well on their way in a journey from charitable guest houses to biomedical showcases, with the wealthier members of the Palmer family having the greatest access to the new technological miracles (Ludmerer, 1999; Risse, 1999, p. 4; Rosenberg, 1987, p. 47; Rosner, 1979, p. 127).

The growth of the modern hospital as an indispensable element in American health care was ensured by the 1946 National Hospital Survey and Construction Act (Hill-Burton Act) and subsequent amendments, which provided federal funding for planning and assisting in the construction of new hospitals and public health centers (Rosenberg, 1987, p. 343). While the Hill-Burton Act led to an overabundance of hospital beds with funds disproportionately going to middle-income communities, Rosenberg noted that technological innovation, increasing application of business management policies, and establishment of the principles of local initiative, state review, and federal support sharing provided for some degree of planning on a state level. Hospitals in the post-World War II era organized the financing and delivery of care around an acute disease model.

While the operation of hospitals and the conduct of medical education and research were more dependent on federal government funding, the government became more interested in pursuing service programs from the 1970s through much of the 1990s. This was particularly connected to the federal funding of Medicare and Medicaid programs beginning in the 1960s. A new emphasis also was placed on encouraging preventive health and pursuing cost-cutting and efficiency measures at the same time that hospitals struggled with the possibility of fulfilling the role of exemplary social institutions to the local community (Fox, 1993, p. 17; Litman, 1997, p. 3; Starr, 1982; Stevens, 1989, p. 364).

In the 1990s, some community hospital mergers and nonprofit to for-profit hospital conversions resulted in the maintenance of clear social missions to local communities, while others led to the closing of many community hospitals that had previously treated the poor and less well off (Bell, 1996; Blumenthal & Weissman, 2000; Cahill, 1997; Lukas & Young, 2000; Opdycke, 1999; Young, Dasai, & Lukas, 1997). In the context of thinking of the patient as a consumer, the hospital as a part of an industry sought to attract the sufficiently insured through “a patient-centered care scheme designed to achieve customer satisfaction by striving to make hospitals more pleasant, comfortable, and user friendly” (Essoyan, 2000, p. A19; La Ferla, 2000, p. 4; Risse, 1999, p. 681). Hospitals were redesigned to streamline healthcare delivery, enhancing efficiency and cost savings by using such strategies as placing patients in focused settings with a satellite pharmacy, a laboratory, and radiologic facilities, and employing “cross-trained multidisciplinary caregiving teams” (Risse, 1999, pp. 682–683).

At the turn of the 21st century, the lay public and healthcare professionals, including the physician, had confronted identity dilemmas with the use of new language in healthcare settings. When someone is sick or seeks wellness care, is he a client, patient, or consumer, and what is the connotation of the word *consumer*? Are physicians, nurses, or pharmacists health professionals, caregivers, or mere health providers (Tomes, p. 84, 2006; Risse, 1999, p. 682)? Finally, given the increasing focus on financial incentives and customer orientation, scholars, journalists, the public, health professionals, and government officials have expressed concerns about the meaning of

healing and the 21st century hospital as a “a place of repairing and damaging, birthing and dying—and red tape and budgets and stress—but also a community struggling with the thorny social forces changing the world around it” (Gordon, 2010; Risse, 1999; Salamon, 2010, p. 9).

Major changes in the early 21st century in the hospital are in process. Among them are electronic record keeping and interprofessional education in the academic hospital setting as methods to improve health quality and efficiency and to reduce medical errors (including adverse drug events). In addition, the roles of primary care physicians, specialists, and hospitalists are evolving in provision of coordinated care in healthcare delivery between inpatient and outpatient settings. Concerns revolving around these changes include potential workforce shortages, the future of medical mecca academic health centers, competing specialized health facilities in the community, and financial imperatives related to private health plan and government hospital reimbursements (Berensen, Ginsburg, & May, 2006; Blue, Mitcham, Smith, Raymond, & Greenberg, 2010; Buring et al., 2009; Casalino, November, Berenson, & Pham, 2008; Crossen & Tollen, 2010; DesRoches et al., 2010; Hamel, Drazen, & Epstein, 2009; Mechanic, 2003).

One of the most discussed changes has been the effort to implement patient-centered care. This term was first introduced in 2001 as a goal for quality care in the Institute of Medicine’s report, *Crossing the Quality Chasm*. In this report, patient-centered care is defined as “respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions” (Institute of Medicine, 2001, p. 3). Various hospitals initiated efforts to institute aspects of patient-centered care, including approaches that involved family members. In 1996, Dana Farber Cancer Institute and Brigham and Women’s Hospital began a joint venture to change their paradigm of care to a patient-centered model to involve all parts of the hospital organization including “high-performing teams in which communication, collaboration, transparency, and joint decision-making” (Ponte et al., 2003, p. 84) with hospital executive leadership playing a lead role (Ponte et al., 2003).

In 2006, the American Hospital Association and the Institute for Family-Centered Care developed a tool kit that comprised a video with discussion and resource guides and self-assessment tools that could be used by patients, families, and health practitioners to improve patient care in hospitals through partnerships among the above constituencies (American Hospital Association and Institute for Family-Centered Care, 2006). Late in the 1st decade of the 21st century, critics of patient-centered care argued for bolder meanings. Donald Berwick, president and chief executive officer of the Institute for Healthcare Improvement and appointed by President Barack Obama in 2010 as administrator of the Centers for Medicare and Medicaid Services, proposed a model for hospitals that included patient and family member participation in rounds, patient decision making on food and clothing (as allowed by health status), and patient ownership of medical records with clinicians needing to have permission to gain access to them (Berwick, 2009, p. w561). Implementation of patient-centered care has been identified as a way to prevent a fragmented healthcare experience that often occurs for patients, especially those with serious or chronic illnesses, as they need care in hospitals, other health organizations, and their homes (Epstein, Fiscella, Lesser, & Stange, 2010). Efforts to incorporate patient-centered care into the hospital clearly reflect the idea of hospitals as exemplary social institutions.

CONTINUITY AND CHANGE IN HEALTH INSTITUTIONS AND PROFESSIONS

As part of a continuing process during the early years of the 20th century, medicine and pharmacy instituted important changes in their pursuit of modern, credential-based professionalization. As self-defined members of individual professions, physicians and pharmacists sought to strengthen their positions in society by employing a variety of strategies. These professions placed new emphasis on their special expertise within their own field of study and practice: increasing the authority and purview of professional organizations, licensing and self-regulation standards; the pursuit of rigorous educational reform and professional autonomy; and a commitment to altruism that placed their clientele above any commercial concern for profit.

Medicine

Beginning in 1908, at the urging of the American Medical Association (AMA), Abraham Flexner conducted a study of medical schools sponsored by the Carnegie Foundation. He published *Medical Education in the United States and Canada* in 1910, recommending numerous changes in the focus, education, and practice of medicine in the 20th century (Flexner, 1910). The Flexner report paved the way for effectively making allopathic medicine the legally sanctioned form of practice and abandoning the apprenticeship model of medical education and the primarily commercial financing of medical schools by physician-entrepreneurs. In the early 1900s, medical educators and leaders had already reached some consensus on the direction of change as proposed in the Flexner report, and by 1930, many reforms were in place. Chiefly, these reforms included most states' acceptance that medical schools would be accredited under the control of the American Medical Association; the graduation of fewer students; and the closing of weaker medical schools with the remaining stronger institutions obtaining funding from such sources as state governments and philanthropists to pursue further discoveries in bacteriology and other biomedical sciences and to produce trained clinicians and specialists in such areas as obstetrics, cardiology, and surgery. These reforms also resulted in the reduction of the number of students admitted from the lower classes, ethnic minorities, and women. Their numbers did not reappear in any strength until the 1970s and 1980s, when the number of African Americans and women admitted to medical schools began to increase (Ludmerer, 1985; Markowitz & Rosner, 1979; Morantz-Sanchez, 1992; More, 1999; Starr, 1982). Still, in the early 21st century, “[t]he complexion of the health professions in the United States little resembles the nation’s ethnic and racial composition” (Grumbach & Mendoza, 2008, p. 413) despite business arguments that there are “customer service and competitive advantages to the health industry of having a workforce that is culturally and linguistically attuned to the increasing diversity of the nation’s health care consumers” (Grumbach & Mendoza, 2008, p. 414). Women have made significant inroads in the early 21st century in relation to increased admissions to medical schools, generally approaching half of students admitted annually. However, concerns have remained in relation to career advancement, sexual harassment and discrimination, fears expressed about the feminization of medicine, and the concentration of women physicians in only a few lower income medical specialty areas (Boulis, Jacobs, & Veloski, 2001; McGuire, Bergen, & Polan, 2004; Sullivan & Mittman, 2010).

Nonetheless, the medical reform of the early 20th century ushered in what John C. Burnham has termed a *golden age* in which “American physicians enjoyed social esteem and prestige along with an admiration for their work that was unprecedented

in any age” (Burnham, 1982, p. 284). In post–World War II America, the biomedical model predominated in research and in areas of clinical care. An emphasis was placed on the “subcellular and molecular level, and life processes were increasingly understood in physical and chemical terms” (Ludmerer, 1999, p. 148). This golden age did not begin to be seriously challenged until the 1960s, when questions were raised both from within the profession and by the public about the physician’s priestly pretension and technical performance (Burnham, 1982, p. 291).

From the 1970s through the 1990s, medical education and academic health centers came under increasing duress. Some social inequities were addressed as increasing numbers of women and minorities were admitted to medical schools and such new pedagogies as problem-based learning were widely introduced in medical school curricula to improve clinical skills. At the same time, the new managed care practice made inroads against the pursuit of academic research and the provision of “the importance to the physician’s work of having sufficient time with patients” (Ludmerer, 1999, p. 383).

As the 20th century ended, physicians continued to express concern about their roles in managed care systems. They showed a willingness to treat patients in new ways; including group visits where patients with chronic illnesses, such diseases as diabetes, hypertension, and arthritis; and attend seminars led by physicians (Martinez, 2000). They also raised concerns about whether the quality of patient care and their decision-making autonomy were unduly threatened by managed care’s increased emphasis on linking the number of patients whom physicians treat to their fees and salaries (Kowalczyk, 2000). Deborah A. Stone argued that the “doctor has been reconceived as an entrepreneur who is now in the business of insuring patients as well as caring for them” (1997, p. 534).

In the early 21st century, many medical schools have been making changes in the education of students to respond to evidence showing that American populations, including socially disadvantaged ones, benefit from increased primary care practices in their communities. In addition, the delivery of improved primary care reduces health spending and responds to the needs of large numbers of patients increasingly living with chronic illnesses. The patient-centered medical home model of primary care has been the chief way in which policymakers have supported efforts to expand primary care. In 1967, the concept of a medical home originally was explained by the Academy of Pediatrics and demonstrated as more effective in the delivery of good health care to children with special needs. In the intervening years a “movement” to implement the medical home developed. By 2007, health care professional organizations, national health plans, labor unions, consumer organizations, and major corporations expressed support of the medical home model.

While there is not a consensus definition of the patient-centered medical home concept, it incorporates a number of elements. Patients are whole persons rather than disease states. They are active, prepared, knowledgeable participants who work with an interdisciplinary team of caregivers that is led by a primary care physician. Over the course of lifetimes, the team coordinates patients’ preventive, acute, and chronic care across settings in the healthcare system and community. The team draws upon effective information technology, including electronic health records, to support communication and quality outcomes (Colwill, 2010; Iglehart, 2008; Larson & Reid, 2010). The hope for the future is that payment will be provided based on the added value that the medical home and its practitioners provided, a combination of “fee-for-service, pay-for-

performance, and a separate payment for coordination and integration” (Rittenhouse & Shortell, 2009, p. 2039).

A number of demonstration projects have been funded to experiment with the patient-centered medical home model of care for the future (Kilo & Wasson, 2010; Reid et al., 2010). A single clinic multidisciplinary team practice (including a pharmacist) that is part of a group health cooperative in the Seattle, Washington, area reorganized itself along a medical home model in 2006. A 1-year study of this prototype practice showed that the clinic achieved measurable positive outcomes. In comparison to other clinics in the group health cooperative, the clinic model was able to show 29% fewer visits to the emergency room and 6% fewer hospitalizations with cost savings achieved. In addition, patients reported improvement in their experiences of care and in the quality of care they received. Health practitioners noted more job satisfaction and less burnout (Reid et al., 2010). Other medical schools have begun to implement curricular changes and to study how medical students are currently exposed to patient-centered approaches to care as they learn in hospital and ambulatory care settings (Morrison, Goldfarb, & Lanken, 2010; Saultz et al., 2010). As the 100th anniversary of the Flexner report was celebrated in 2010, medical education in the United States was once again experiencing significant transformation.

Pharmacy

As the 20th century began, pharmacists pursued several approaches in an effort to change their practice to modern credential-based professionalization. Challenges to the apprenticeship model of training pharmacists had already occurred in the 1860s and 1870s, when state universities, especially in the Midwest and West, established a pharmacy curriculum based primarily on study in the physical sciences and laboratory instruction. By the turn of the 20th century, there were more than 50 colleges and departments of pharmacy in the United States. Most, however, had minimal standards for admission and length of study, with a combination of the scientific and apprenticeship models too often providing minimal education or training.

In 1900, more than 38,000 U.S. drugstores served a population of 76 million, translating to one store per 2,000 people (Deno, Rowe, & Brodie, 1959). Few practitioners operated in individual establishments devoted exclusively to professional services. Instead, most worked in commercial enterprises—independent, druggist-owned stores or shops—that provided a variety of services and products, including soda fountains, perfumes, telephone booths, magazines, candy, and popular books. Chain drugstores, with the same ownership and the same product lines, began to appear in the early years of the 20th century and quickly expanded regionally and nationally across the United States.

In their effort to professionalize, pharmacists confronted several difficult problems. In 1915, Abraham Flexner asserted that the pharmacist was not a professional in a speech at the National Conference of Charities and Corrections in Baltimore, Maryland. Whereas the physician “thinks, decides, and orders; the pharmacist obeys—obeys of course with discretion, intelligence, and skill—yet in the end obeys and does not originate. Pharmacy, therefore, is an arm added to the medical profession, a special and distinctly higher form of handicraft, not a profession” (Flexner, 1915, p. 158). In addition, the U.S. military decided to train its enlisted soldiers to dispense medications in World War I rather than recruit and appoint pharmacists as officers. The 1922 Code of Ethics established by the American Pharmaceutical Association (currently the American Pharmacists Association, APhA) was unfortunately compatible with

Flexner's perspective. Pharmacy's primary object was "the service it can render to the public in safeguarding the handling, sale, compounding and dispensing of medicinal substances" (APA, 1922, p. 728). Ordinary Americans encountered the pharmacist as customers in the neighborhood drugstore, a commercial enterprise identified with a for-profit motive. In the 1920s, hospital pharmacy, although devalued by community druggists and often by the institutional administrations where they were located, was the area where pharmacy thrived as a "bastion of high pharmaceutical technology, art, and science" (Higby with Gallagher, 1992, p. 507).

In response to the aforementioned problems, pharmacy colleges organized their own association, the American Conference of Pharmaceutical Faculties (later renamed the American Association of Colleges of Pharmacy) in the 1920s and struggled to reach their goals of establishing more rigorous standards of education and practice. The American Association of Colleges of Pharmacy instituted the requirement of high school graduation for admission, and by 1932, it mandated 4 years of study for graduation (Deno, Rowe, & Brodie, 1959; Higby & Gallagher, 1992; Higby, 1996; Sonnedecker, 1976). Some practicing pharmacists also saw the value of education in improving their image in the community. For instance, when the consumer market for vitamins increased from \$12 million to over \$130 million in sales during the 1930s, pharmacists argued that purchases of these over-the-counter products should be made in drugstores rather than grocery stores because of the pharmacist's specialized knowledge and professional training (Apple, 1996).

In World War II, pharmacists were again denied a commission in the U.S. military while these were given to 1st-year medical students and nurses. Pharmacy organizations responded by contributing funding to a self-study, the 1946 *Pharmaceutical Survey*. This study made recommendations, chief of which was the expansion of the pharmacy curriculum to 6 years. The American Association of Colleges of Pharmacy proposed a 5-year program of study, with a curriculum that continued to focus on the science and technology of pharmaceutical products. Pharmacists in community drugstores in the new age of miracle drugs that followed the discovery of penicillin were relegated to a count and pour role under 1952 federal regulations and the newly promulgated American Pharmaceutical Association's Code of Ethics, which asserted that "the pharmacist does not discuss the therapeutic effects or composition of a prescription with a patient" (APhA, 1952, p. 722).

The 1960s have been defined as years of revolution in pharmacy. During this decade, ordinary community and hospital pharmacists began a push for a new identity in clinical pharmacy, where the pharmacist is the drug expert and is responsible for being a therapeutic advisor for patients and other health professionals. In another revision of the APhA Code of Ethics in 1969, the pharmacist was required to "render to each patient the full measure of his ability as an essential health practitioner" (Higby, 2002, p. 12;). For the community pharmacist, this would mean a new perception of the people that the pharmacist spoke with across their counters—going from customers to patients. A culminating point in the expression of educational reform was presented in 1975 in *Pharmacists for the Future: The Report of the Study Commission on Pharmacy* (Millis, 1975). This report called for a 6-year curriculum culminating in an entry-level doctor of pharmacy degree that was intended to provide a general education for the whole person, educating pharmacists rather than training them, and to incorporate clinical therapeutics and clerkship opportunities in healthcare workplaces (Higby, 1997; Knowlton, 2009; Worthen, 2006; APhA, 1969).

The underpinning for the new program of study and practice was the concept of *pharmaceutical care*, to be implemented in communities and such institutional settings as hospitals where pharmacists would be equal members of the healthcare team. Charles D. Hepler and Linda Strand identified pharmaceutical care as connecting the pharmacist's responsibilities with therapeutic outcomes (Hepler & Strand, 1990). While similar to the widely accepted definition, the 2004 construction states that “[P]harmaceutical care is a patient-centered practice in which the practitioner assumes responsibility for a patient’s drug-related needs and is held accountable for this commitment” (Cipolle, Strand, & Morley, 2004, p. 26). This concept was a reflection on the Omnibus Budget Reconciliation Act of 1990 (OBRA), which mandated evaluation of drug therapy in the review of patient profiles and established standards of medication counseling for Medicaid patients (Higby, 2002; Elenbaas & Worthen, 2009; McGivney et al., 2007). The 1994 Pharmacist Code of Ethics also emphasized such principles as a “covenantal” relationship between patient and pharmacist; promotion of “the good of every patient in a caring, compassionate, and confidential manner” service to “the individual, community and societal needs”; and the pursuit of “justice in the distribution of health resources” (APhA, 1994, p. 1).

Unfortunately, the bureaucratic and cost-cutting demands of third-party payers and managed care organizations greatly inhibited the ability of pharmacists to actually practice pharmaceutical care in healthcare settings (Navarro, 1999). Despite the presence of more pharmacy technicians and robotics in some cases, pharmacists spent most of their time in dispensing roles and reported dissatisfaction with their general lack of opportunities to more effectively fulfill pharmaceutical care roles. Nonetheless, some community pharmacists became more deeply involved in providing expanded pharmaceutical-care services. They documented their care for patients in computerized patient profiles to improve quality of care and to provide evidence of outcomes for compensation for pharmaceutical care services. In a project begun in 1997 in Asheville, North Carolina, for instance, community pharmacists successfully worked with patients with such chronic health problems as diabetes, hypertension, high cholesterol, and asthma, and reported positive clinical and cost-saving outcomes (Smith, Bates, Bodenheimer, & Cleary, 2010; Brock, Casper, Green, & Pedersen, 2006; Kreling, et al., 2006). In another case, an owner of an independent drugstore in Augusta, Georgia, explained: “We are not just going to dispense your drugs . . . We are going to partner with you to improve your health as well” (Abelson, & Singer, 2010, p. A1).

In the 1st decade of the 21st century, pharmacists along with physicians and other health professionals have been engaged in determining their roles in the medical home model. As providers of pharmaceutical care, pharmacists had already begun to articulate their roles in incorporating medication therapy management services into institutional and community settings in a major way as part of the context of the Medicare Modernization Act of 2003 and Medicare Part D (McGivney et al., 2007). In Chapter 3 of this text, Shane P. Desselle explains in detail the movement away from pharmaceutical care to medication therapy management and its potential for incorporation in medical home models of primary care in the future.

A number of demonstration projects have also documented the value of including pharmacists in the interdisciplinary care team working in the primary care medical home. A project in six Minnesota ambulatory clinics incorporated employed pharmacists who collaborated with primary care practitioners, resolved patient drug therapy problems, and contributed to reduced costs (Smith et al., 2010; Hepler, 2010).

Pharmacists, physicians, and public health professionals have argued for the place of pharmacists in the medical home of the future because of their expertise in providing services, including comprehensive therapy reviews of prescribed medications and over-the-counter or herbal products, design of adherence programs for patients with asthma, diabetes, or hypertension, personal medication care plans (lists that include actions that patients can take to keep track of managing their own medications), and recommendations for therapies that are cost-effective (American Pharmacists Association & National Association of Chain Drug Stores, 2008; Smith, et al., 2010). The 2010 Patient Protection and Affordable Care Act has embraced the notion of an expanded patient care role for pharmacists in the medical home with the possibility that community pharmacists may obtain funding for new demonstration projects (Traynor, 2010). Finally, pharmacy leaders have been involved in the Patient-Centered Primary Care Collaborative publication of the task force report, *The Patient-Centered Medical Home (PCMH): Integrating Comprehensive Medication Management to Optimize Patient Outcomes*, which supports the pharmacist role. The collaborative involves various healthcare groups, including government officials, insurance companies, and health professionals, who are committed to working together to improve the quality of health care. The report is the third in a series of reports produced by the collaborative that emphasized the need for payment reform for medication management and that “was developed to provide a framework for integrating medication management in the PCMH (patient-centered medical home) as part of the practice redesign that needs to occur when individual and group practices transform into the PCMH (Patient-Centered Primary Care Collaborative, 2010, p. 4).

Pharmacy has also seen change in the arrival of the retail clinic, which has appeared in chain pharmacies, grocery stores, and superstores that also include pharmacies. These clinics usually offer walk-in visits for convenient, lower-cost care for such acute health problems as sore throat or ear infection symptoms. Staffed by such primary care health professionals as nurse practitioners, there has generally been no formal teaming with pharmacy staff. Community-based pharmacies have also begun to offer vaccinations given by pharmacists who have acquired certification. These innovations offered possibilities for expansion of pharmaceutical care but also raised issues about constructive coordination of health care and confusion over commercial and professional healthcare roles (Farley, Devine, & Hadsall, 2007; Martin, 2010; Pollack, Gidengil, & Mehrotra, 2010).

HEALTH AND SICKNESS PATTERNS IN HISTORICAL PERSPECTIVE

Definitions of Health and Disease

Elliot Mishler notes that broader definitions of health “are neither obsolete, nor of historical and esoteric interest only,” (1981, p. 3) when he refers to the World Health Organization’s definition of health as a “state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (Mishler, 1981, p. 3). In addition, Charles Rosenberg argues for not thinking in narrow constructs:

Disease is at once a biological event, a generation-specific repertoire of verbal constructs reflecting medicine’s intellectual and institutional history, an occasion of and potential legitimization for public policy, an aspect of social role and individual—intrapsychic—identity, a sanction for cultural values, and a structuring element in

doctor and patient interactions. In some ways disease does not exist until we have agreed that it does, by perceiving, naming, and responding to it. (1992, p. xiii)

In studying healthcare delivery in the United States, how we perceive, name, and respond to health and disease and what we make the primary focus of the healthcare system are major focuses of concern (Brandt, 1997; Tesh, 1988).

Each year the mass media reports statistics from government and research institutions about health and disease levels, mortality and life expectancy, and causes of death both globally and within the United States. Historians have also sought, within biomedical, cultural, social, economic, and political contexts, to account for increases in life expectancy, declines in mortality rates, and changes in causes of death from acute and infectious diseases to, more recently, chronic illnesses.

Health Demographics and Causes of Death

Native Americans and European settlers in the 1600s and 1700s confronted malnutrition daily, making them susceptible to endemic and epidemic infectious illnesses. Such endemic illnesses as dysentery, malaria, and respiratory infections, with occasional epidemics, including smallpox and yellow fever, were prevalent in the 18th century. As the 19th century progressed, people became more concerned with illnesses related to the increasing population that lived in rapidly urbanizing and industrializing cities. Deaths continued to result from dysentery and respiratory infections, but also increasingly from cholera, scarlet fever, whooping cough, measles, diphtheria, smallpox, and—above all—tuberculosis. Improvements in public health could be noted as the 19th century ended. In particular, death rates declined—especially infant mortality rates—and life expectancy increased, as noted earlier in this chapter (Leavitt & Numbers, 1997).

Causes of Death and Disease

In 1900, the leading causes of death were infectious diseases, both epidemic and endemic diseases, including influenza and pneumonia, tuberculosis, gastritis, enteritis, diphtheria, measles, scarlet fever, and whooping cough. Some chronic diseases, such as heart and cerebrovascular disease and cancer also were among the top 10 causes of death in the United States (Lerner & Anderson, 1963, p. 16). In the 1st decade of the 21st century, the 10 leading causes of death reported in the United States were heart disease, cancer, stroke (cerebrovascular disease), chronic lower respiratory diseases, accidents, Alzheimer's disease, diabetes mellitus, influenza and pneumonia, nephritis, nephritic syndrome, nephrosis, and septicemia (CDC, 2009). Obviously, causes of death were increasingly attributed to chronic illnesses both in the United States and worldwide.

The 10-volume *Global Burden of Disease* project, edited by Christopher J. L. Murray of Harvard University and Alan D. Lopez of the World Health Organization, estimated that from 1990 to 2020, infectious, nutritional, and childbirth-associated deaths will decrease from 17.2 million to 10.3 million (Murray & Lopez, 1996). Noncommunicable diseases, including unipolar major depression, ischemic heart disease, and cerebrovascular and chronic obstructive pulmonary diseases, however, will increase by 77%, with the number of related deaths increasing from 28 million to nearly 50 million annually (Knox, 1996a). However, critics have pointed out that developing nations struggle with health problems and diseases linked to poverty, such as malnutrition, dysentery, malaria, and tuberculosis (Farmer, P. 1999). With the increase in global

travel and the lack of funding for public health infrastructure, reemergent diseases, as well as AIDS, West Nile, Avian flu, and the H1N1 flu pandemic, have caused the United States to take note of the changes in patterns of infectious diseases outside its national borders and to question the capability of public health agencies to deliver appropriate services when needed within the United States (Markel, 2004; Gandy & Zumla, 2003; Garrett, 2000). In the aftermath of the terrorist attacks on September 11, 2001, the United States also became concerned about bioterrorist threats to health, including the possibility that smallpox could be used as a bioterrorist weapon (Colgrove, Markowitz, & Rosner, 2008; Rosner & Markowitz, 2006).

Factors Explaining Health Demographic Change

To understand the meaning of statistics that report declines in infant mortality rates, increases in life expectancy, declines in communicable diseases, and increases in chronic, degenerative illnesses, historians have analyzed the possible factors that account for the changing numbers and have explored public authorities' explanations for these changes. Three factors are generally cited as explanations, which are: (1) changes in standard of living or lifestyle, including improvements in personal hygiene, diet, nutrition, and housing; (2) advances in public health measures; and (3) progress in medical practice, including therapeutic interventions in the treatment of patients.

In examining the evidence, healthcare historians have found that changes in public health measures and lifestyle contributed more to health improvements than therapeutic interventions by physicians in the 19th and early 20th centuries (Leavitt & Numbers, 1997; Rothstein, 1996b). In the later half of the 19th century, cities recognized the importance of connecting the city's environment and its people's health, including improved sanitation, water supply and delivery, and refuse collection and waste removal (Melosi, 2000). In 1865, New York commissioned a report on public health and later formed a board of health with responsibilities to include enforcing sanitary regulations and controlling epidemics. By 1912, as David Rosner has noted, "garbage collection, meat and milk inspections, pure water, and sewerage systems had been installed throughout the city. Dead animals were now regularly picked up off the streets, and fire safety codes augmented stricter enforcement of housing laws" (1995, p. 15). The department of health, in its annual report, attributed "over the course of just forty-five years ... a decrease of over 50 percent" in the death rate to public sanitation measures (1995, p. 15).

William Rothstein emphasizes the importance of educating the public about specific personal behaviors related to standards of living and public health:

Until well into the 20th century, millions of Americans drank from metal drinking cups kept next to fountains for all to use, did not sterilize bottles or take other measures necessary for hygienic feeding of infants, let their children sleep in the same bed and play with siblings with contagious diseases like diphtheria and scarlet fever, purchased unrefrigerated and bacteria-laden milk and meat, used polluted wells and water supplies without boiling the water, and took baths in bathtubs after others had used the same water. These and many other similar behaviors have disappeared because the public has been educated about personal hygiene. (1996b, pp. 77–78)

At the same time, public health campaigns in the late 19th and early 20th centuries against specific diseases must be seen within the context of how health professionals, public officials, and the general public felt that disease and outsiders threatened

the civic order. They often linked epidemics of infectious diseases—including smallpox, tuberculosis, bubonic plague, typhoid, and polio—to new immigrant populations. Some public health efforts focused on isolation, quarantine, and destruction of housing, often using violence to implement these policies. On the other hand, founding of ethnic and religious hospitals; the establishment of visiting and public health nursing, neighborhood clinics, and settlement houses; health advocacy programs to foster individual efforts to improve domestic hygiene; and struggles for effective public health legislation and enforcement were all examples of efforts to assist immigrants in preventive health measures, in improving the living conditions in urban housing, and in occupational safety and health on the job (Kraut, 1994; Leavitt, 1996; Ott, 1996; Tomes, 1998).

Health care historians have also discussed the role of clinical medicine and therapeutic or technological intervention in contributing to the decline of mortality rates in infectious diseases at the turn of the 20th century. Very few physician efforts, especially those who employed “heroic” measures, were helpful to patients. Such 19th century discoveries as anesthesia and X-rays were very important, but general practice physicians could often use these technological improvements in ways that caused more harm than good. The most striking example of therapeutic intervention success did not occur until the mid-20th century with the introduction of antibiotics. Historian John Parascandola has pointed out that “within a decade after penicillin was first made freely available for civilian use in the United States in 1945, antibiotics had become the most important class of drugs in the treatment of infectious disease. In 1948, antibiotics prescriptions accounted for only 1.5% of the total number written in the United States; by 1952, that figure had risen to 13.7%” (1997, pp. 108–109). Parascandola also cited a Federal Trade Commission report from 1958, which indicated a decrease of 56.4% in the total number of deaths from 1945 to 1955 for eight major diseases responsive to antibiotic therapy, versus a decline of only 8.1% for all other causes of death. In the 21st century, major public health efforts have continued to focus on when and how to implement programs using appropriate antibiotic therapy and on how to educate the public about the misuse and overuse of antibiotics, stressing the limitations of wonder drugs (Parascandola, 1997, pp. 109, 110).

Successful public health measures have often been cited to help explain some decline in infant death rates in various U.S. cities in the late 20th century. These measures included better access to stable housing and prenatal care for low-income pregnant women. Conversely, when funding decreased in a community for various programs aimed at healthy mothers and babies, infant mortality rates rose (Steinhauer, 2000). Recommendations from health professionals across disciplines for improving children’s health in the beginning of the 21st century continue to include such public health measures as community and school-based clinics and education programs on diverse health populations that are public-health based and present in health professional curricula (Markel & Golden, 2004).

Chronic Illness

Since the 1920s, government agencies, biomedical health researchers, and health professionals have recognized that chronic disease must be a health policy priority in the United States (Fox, 1988). In discussing how the United States should address the fact that chronic illnesses afflict close to half the population, costing nearly \$470 billion in 1990, a number of issues related to public health measures, environmental

factors, standard of living, lifestyle, and therapeutic interventions are raised. Medical researchers cite such “diseases of affluence” as sedentary lifestyle, poor diet, smoking, and alcohol abuse as major causes of chronic illness (Knox, 1996b, p. A11). Other researchers documented concerns about the lack of good management of chronic disease and people’s inability to receive the help they need to live on an everyday basis with chronic health conditions. Dr. Halstad R. Holman, director of an arthritis center at Stanford University, noted, “Our health care system—its structure, practices, education, and even research agendas—was developed for acute disease. We have a profound mismatch between our entire health care system and what it’s structured to do and what we need it to do” (Knox, 1996b, p. A11). In the early 21st century, the United States faced a crisis in treating chronic illness far more costly than in 1990, with three fourths of the more than \$2 trillion spent on health care directed toward the treatment of chronic illnesses, especially those connected to worsening health habits. Thus, the emphasis has been put on health promotion and disease prevention regardless of whether the provision of preventive care is more or less expensive (Goetzel, 2009, p. 41; Maciosek, Coffield, Edwards, Flottesmesch, Goodman, & Solberg, 2006).

HEALTH POLICY OVERVIEW: 1900–1950

New Legislation in the Early 20th Century

The major hallmark of 20th-century health care was the increased role of government policy making at the local, state, and especially the federal level. During the first 2 decades of the 20th century, the federal government assumed a more vigorous role in public health, symbolized by its renaming of the Marine Hospital Service as the U.S. Public Health Service in 1912. Partially as a consequence of muckraking journalists’ exposure of dangerous practices in the food and drug industries, the U.S. Congress enacted the Pure Food and Drug Act in 1906 and then significantly strengthened its oversight of this industry with more comprehensive legislation under the 1938 Federal Food, Drug and Cosmetic Act. In addressing the plight of America’s poor children, many of whom lacked good nutrition and housing and were forced to work in dangerous conditions, Congress established the Children’s Bureau in 1912. This legislation was followed in 1921 by the Sheppard-Towner Maternity and Infancy Act, which provided federal funding to support children’s health clinics until 1929. In 1930 the National Institutes of Health and the Veterans Administration were established and the National Cancer Act in 1937 helped launch biomedical research (King, 1993; Patterson, 1987; Temin, 1980).

Public and Private Health Insurance

Twentieth-century changes in health insurance can be traced back to at least 1798, when government hospitals were established in some coastal cities to provide care for merchant seamen. In the 19th century, small numbers of Americans obtained some form of insurance against sickness primarily by gaining income protection through such groups as trade unions, fraternal organizations or their employers (Numbers, 1997, p. 277). Some purchased protection against sickness from commercial insurers. Generally, only mining and lumber companies provided actual medical benefits.

In the early 20th century, progressive reformers and labor unions began to talk about some form of government-sponsored health insurance. In 1914, workers’ compensation

or compulsory sickness insurance programs appeared. Operating on a state level, they generally provided cash payments for injuries or disease related to the workplace. In later decades, payments were made for medical expenses and death benefits. Employers usually purchased these programs from commercial insurers. In 1912, the American Association for Labor Legislation's Committee on Social Insurance put forward a model bill for state legislatures to consider. Until 1917, many medical leaders and associations expressed support for compulsory health insurance efforts. Opposition developed from physicians concerned about seeing their incomes decrease rather than increase. During World War I, many began to perceive social insurance proposals as un-American since the German enemy had employed compulsory insurance for industrial workers since 1883 (Numbers, 1997, pp. 269-271; Starr, 1982; Stevens, 1971).

Following the significant drops in physician and hospital income that occurred in the wake of the Great Depression, hospitals reconsidered insurance plans. In 1929, Baylor University Hospital enrolled public school teachers in a plan covering hospital costs. The American Hospital Association in 1939 approved Blue Cross insurance to cover costs of care in whichever hospital patients chose to enter. In the same year, the Blue Shield insurance plan was first approved by the California Medical Association to help cover fees physicians charged for their services. These insurance programs, which served as a third-party payment system, presented an attractive alternative to the tradition of patients paying health practitioners directly for health services. The AMA and medical associations such as the State Medical Society of Wisconsin expressed support for implementation of voluntary private insurance plans, rather than "wait for a state controlled compulsory plan" (Numbers, 1997, p. 274).

During the Franklin D. Roosevelt administration, Congress considered the Murray-Wagner-Dingall bill, which proposed to provide health care for the poor primarily through federal grants given to the states. Ultimately, this national health effort was defeated (Numbers, 1997). Private insurance, though greatly fragmented, rapidly expanded in the next 2 decades with some form of health insurance held by 51% of the civilian population" by 1951 and 737 health insurance companies selling some kind of insurance by 1959 (Stevens, p. 467, 2008; Richmond & Fein, 2005).

POST-WORLD WAR II HEALTHCARE CHANGES

In the second half of the 20th century, President Harry Truman spoke forcefully in favor of national health insurance that offered protection to all Americans (Poen, 1979). Nonetheless, legislative proposals failed largely because they evoked strong opposition from the AMA. As part of its effort to defeat the Truman proposal, the AMA undertook a \$4.5 million national education campaign, warning that "national health insurance would lead to federal control of health care" (Johnson & Broder, 1996, p. 66). In the Cold War era, which was characterized by a virulent anticommunism movement, the AMA's public relations campaign equated national health insurance with socialized medicine.

In the 1950s, with support from the federal government through tax-deductibility rulings, employers and labor unions increasingly offered U.S. workers healthcare plans as part of their benefits programs. In the 1960s, the federal government established two governmental purchasing programs—Medicare and Medicaid. While a push for these programs began under the John F. Kennedy administration, President Lyndon Johnson was successful in achieving their passage with his landslide victory in the

1964 presidential election and his leadership in advancing Great Society legislation through Congress. Medicare was initially designed in two parts: Part A for hospital insurance coverage and Part B for medical care insurance including physicians and various medical services. In 1972, Medicare insurance was extended to those of any age with proven disabilities or to those with end-stage renal disease to pay for dialysis or transplant costs. Medicaid was established as a joint federal and state program to provide health care for the low-income elderly and other categories of people, including the disabled and families with children (Patel & Rushefsky, 1995; Stevens, 2008, p. 471). See Chapter 18.

Despite these incremental reforms, healthcare costs continued to rise in the 1960s and 1970s, and problems of access to services for the uninsured increased. Once again raising the possibility of a comprehensive national health policy, Senator Edward Kennedy and President Jimmy Carter launched unsuccessful attempts in the 1970s to pass such legislation as Kennedy’s Health Security Act, which was designed to provide quality health care for all Americans at affordable prices (Kennedy, 1972). By 1980, the mostly private model of a healthcare system best described how most Americans were covered—that is, by private insurance programs purchased through plans offered by their employers. Coverage of the healthcare costs of only a few needy groups (e.g., veterans and the elderly) was provided through government-sponsored public insurance programs (Patel and Rushefsky, 1995, p. 25).

Prepaid Health Care, Health Maintenance Organizations, and Managed Care

While Congress did not adopt broad health insurance coverage, in 1973 it passed the Health Maintenance Organization (HMO) Act. This legislation represented a form of prepaid health coverage. Prepaid health plans were first introduced in the United States in isolated rural areas where workers needed health care in the 19th century. In the building of the Grand Coulee Dam in 1938, the highly successful Kaiser Permanente Medical Care Program initially offered healthcare services to workers employed by Henry F. Kaiser. The prepaid plan expanded its provision of comprehensive health care to workers in his steel mills and shipyards, and eventually to the general public on the West Coast and to a lesser extent in the Midwest. Unlike their strong opposition to compulsory health insurance legislative initiatives, medical organizations did not oppose Kaiser’s effort because individual physicians involved in the programs economically benefitted. The 1973 Health Maintenance Organization Act required every employer with more than 25 employees that offered a health plan to include at least one HMO plan providing comprehensive medical care for a fixed fee to its enrollees. A companion bill “requiring employers to provide a basic minimum package of benefits to all their employees” (Johnson & Broder, 1996, p. 67) failed, with the AMA and the health insurance industry lobbying against the bill (Hendricks, 1993).

Rapid growth of HMOs did not become pronounced until the 1990s and a backlash against the movement developed with the public expressing concerns about access to health care and payment for services provided if a patient became very ill. In 1995, HMOs covered nearly 60 million individuals, and the less structured preferred provider organizations (PPOs) covered an additional 91 million people, including Medicare and Medicaid recipients (Anders, 1996; Blendon et al., 1998; Peterson, 1997); see Chapter 21. By 1998, 77 million Americans were enrolled in an HMO, and the number of Americans in some form of managed care had reached 135.37 million in 2010 (U.S. DHHS, 1999; Managed Care On-Line, 2010); see Chapter 17.

Renewed Efforts for National Health Insurance

As the 20th century ended, the American public experienced significant social, economic, and political changes that affected both the U.S. healthcare system and the delivery of healthcare services. In 1991, the Democratic presidential candidate, Bill Clinton, made health care a major issue in his presidential campaign, offering a step-by-step plan to achieve healthcare coverage for all Americans through his health security plan. Despite the AMA dropping its opposition to national health insurance, in 1994, Congress defeated proposals for implementing national health insurance, including President Clinton's health security plan, which was successfully lobbied against by the pharmaceutical, hospital, and health insurance industries (Hacker, 1997; White House Domestic Policy Council, 1993).

Incremental Policy Proposals

Later in the decade, however, other pieces of incremental health legislation affecting Americans' access to health care were passed. In 1996, the Health Insurance Portability and Accountability Act specified in its Title I section that employers or insurers of new employees could impose a waiting period of no more than 12 months before covering them under the employer's health plan. Title II of the Health Insurance Portability and Accountability Act addressed issues of healthcare fraud and abuse and set standards for using and disseminating health information (leading to electronic health records) to increase efficiency in the healthcare system. Congress also passed the Children's Health Insurance Program as part of the Balanced Budget Act of 1997 with the intent that it would provide health insurance for at least half of the 11 million children who lacked such coverage. In 2009, the Children's Health Insurance Program was extended by Congress with the passage of the Children's Health Insurance Program Reauthorization Act (Atchinson & Fox, 1997; Castellblanch, 1996; Goldstein, 1999; Pear, 1997; Fairbrother, Carle, Cassedy, & Newacheck, 2010).

At the beginning of the 21st century, Congress considered several bills to reduce drug prices and to expand Medicare coverage by including prescription medications. The Medicare Prescription Drug, Improvement, and Modernization Act, the largest revision of Medicare in its 38-year history, was passed in 2003. Its most important provision was Medicare Part D, which provided a voluntary prescription drug benefit program. Medicare beneficiaries could choose to enroll in the program that took effect on January 1, 2006. Many reported confusion in trying to choose a program and how to join, especially in regard to the Medicare Advantage plans offered. By June 2006, 22.5 million senior American citizens had enrolled in the program. Recent research indicated that there was an 18.4% reduction in spending on medications out of pocket by the elderly and a 12.8% increase in drug utilization as a result of the legislation (Lichtenberg & Sun, 2007; Pear, 2006; Schneeweiss et al., 2009; Yin et al., 2008); see Chapter 18.

HEALTHCARE REFORM: A CONTINUING PARADOX

Despite its outstanding achievements, a majority of Americans have repeatedly reported dissatisfaction with the U.S. healthcare system and "have favored addressing problems in the health care system since at least the mid-1980s" (Brodie, Altman, Deane, Buscho, & Hamel, 2010, p. 1127). They have thought about healthcare reform

in the context of how it affects the country as a whole and how it relates to their own lives and futures. Many have expressed serious concerns about the number of uninsured or underinsured Americans and called for comprehensive reform of the U.S. healthcare system that would extend health coverage to all Americans. Others have theoretically endorsed universal health insurance yet feared the loss of their own private insurance if a comprehensive plan was established to include those without any health insurance (Blendon & Benson, 2009; Hacker, 2008; Johnson & Johnson, 2010; Sered & Fernandopulle, 2005).

Following the 2009 presidential election year where healthcare system reform was a major campaign issue, the U.S. Congress began consideration of new health legislation. With constant and often trenchant media coverage and intense partisan and sometimes volatile conflict among Democrats and Republicans, the Patient Protection and Affordable Care Act, designed to provide an additional 32 million Americans with some form of health insurance by 2018 (with the establishment of competitive health insurance exchanges in 2014), was enacted into law in March 2010 (Krugman, 2010; Mackey, 2010). President Obama said that the legislation embodied “the core principle that everybody should have some basic security when it comes to their health care” (The White House, 2010, p.1). This new reform represented incremental health reform because it did not change the fundamental structure of the U.S. healthcare system.

While the law did not include a public option whereby Americans would be provided a low-cost alternative to private health insurance—similar to the existing Medicare model—the health bill did provide a number of significant changes. Its provisions included mandating health insurance for most legal residents (reducing those uninsured from 15.6 % in 2010 to about 6% of the population by 2018); stopping insurers from imposing lifetime limits on health benefits; providing tax incentives for small businesses to provide health coverage to their employees; and imposition of new fees on large insurers to ensure that they help pay for employees’ health insurance. In addition, it mandated eliminating preexisting condition clauses for children under 19 years of age beginning in 2010 and for all U.S. citizens by 2014, as well as stopping arbitrary rescissions of health insurance when people file a first major claim for sickness. The act also removes barriers, especially financial ones, placed by health insurers on emergency room services; invests in education and training for an expanded health workforce; and supports pilot projects to reform Medicare and Medicaid healthcare delivery and payment. Implemented through the secretary of Health and Human Services office, various projects also include the fostering of the patient-centered medical home model and supporting the expansion of electronic health records (HealthCare.gov, 2010; Iglehart, 2010; Oberlander, 2010). The new healthcare reform legislation will be phased in between 2010 and 2015. The White House has provided a website that provides information about the health reform bill and a timeline that shows when different parts of the legislation will be implemented (<http://www.whitehouse.gov/health-care-meeting/proposal>).

Given the partisan conflict that occurred during the debate over the new legislation, officials in 21 states had instituted lawsuits within the courts to fight implementation of the new healthcare law within 6 months after the act’s passage. Other public officials and health policy experts hailed the new law for its potential to make health care available to more Americans, more affordable, and higher in quality (Sack, 2010a; 2010b).

Jonathan Oberlander, a professor of social medicine, health policy, and management, noted that “[E]ven with all its shortcomings, the Patient Protection and Affordable Care Act is a great leap forward for the American health care system” (Oberlander, 2010, p. 1116).

CONCLUSION

In looking at healthcare changes over time, the people of the United States have seen significant decreases in mortality rates and increases in life expectancy and some improvements in quality of life for those who live an increasingly longer life span. We have also seen that factors accounting for these changes have involved, most importantly, public health, housing, diet, and hygiene improvements, as well as therapeutic and technologic interventions. Chronic rather than infectious illnesses have become more prevalent reasons for Americans’ need to access the healthcare system, although new and reemerging infectious diseases are more widespread in the 21st century than many experts expected following the discovery of miracle drugs in the mid-20th century.

The U.S. government has consistently attempted to improve access, cost, and quality of health care for American citizens chiefly through implementing incremental health reforms (Vladek, 2003). What will be the long-term effects of the most recent effort at health reform? Will the implementation of more patient-centered care in interdisciplinary medical home settings improve healthcare delivery for many Americans and find acceptance among ordinary Americans as a better way to experience health care? Will the new laws make health care more affordable and more accessible? Will the reforms decrease disparities in care among different groups of Americans? Will health outcomes for most Americans improve? The United States faces very hard economic and social choices related to healthcare delivery in national and global contexts. The need for accessible, humane health care will increase significantly as the 21st century advances.

QUESTIONS FOR FURTHER DISCUSSION

1. How will the conflict between the entrepreneurial role of health delivery organizations and the health professional’s responsibility to serve the community be resolved in the future?
2. Lifestyle improvements, public health measures, and therapeutic interventions all affect health and disease patterns. How much money and effort should be devoted to these areas to address the health problems of Americans? What should the priorities be among the three areas? What roles should private and public institutions play? What roles should health professionals play?
3. To what degree is the healthcare system in crisis in the 21st century?

KEY TOPICS AND TERMS

Blue Cross
 Blue Shield
 Charitable hospitals
 Children's Health Insurance Program
 Children's Health Insurance Program Reauthorization Act
 Chronic disease
 Comprehensive health care
 Dispensary
 Flexner report
 Health Insurance Portability and Accountability Act
 Health Maintenance Organization Act
 Heroic medical therapy
 Hill-Burton Act (National Hospital Survey and Construction Act)
 Humoralism
 Incremental healthcare reform
 Infectious disease
 Medical home
 Medicare
 Medicare Part D
 Medicare Prescription Drug, Improvement, and Modernization Act
 Medicaid
 Medication therapy management
 Orthodox physicians
 Patent medicines
 Patient-centered care
 Patient Protection and Affordable Care Act
 Pharmaceutical care
 Quackery
 Sectarians
 Self-dosing
 Social healers

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