History and Overview of the U.S. Healthcare System

LEARNING OBJECTIVES

- Describe the five milestones of medicine and medical education, nursing education, the hospital and healthcare system, public health, and health insurance.
- Identify the differences among primary, secondary, tertiary, and quaternary prevention.
- Analyze the concept of the iron triangle as it applies to health care.
- Discuss the importance of health literacy to health consumers.

DID YOU KNOW THAT?

- When the practice of medicine first began, tradesmen such as barbers practiced medicine. They often used the same razor to cut hair as to perform surgery.
- In 2020, the United States spent 19.7% of the gross domestic product [the amount of monetary or market value of services or goods produced in the country during a year] on healthcare spending, which is the highest in the world.
- The United States is the only major country that does not have universal healthcare coverage.
- In 2002, The Joint Commission issued hospital standards that required facilities to inform their patients if their results were not consistent with typical care results.

Introduction

It is important as healthcare consumers to understand the history of the U.S. healthcare delivery system, how it operates today, who participates in the system, what legal and ethical issues arise as a result of the system, and what problems continue to plague the healthcare system. We are all consumers of health care. Yet, in many instances, we are ignorant of what we are actually purchasing. If we were going to spend $1000 on an appliance or a flat-screen television, many of us would research the product to determine if what we would be purchasing is the best product for us. This same concept should be applied to purchasing healthcare services.

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

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And last, from a personal standpoint, you should have the knowledge from a consumer point of view, so you can make informed decisions about what matters most—your health. The federal government agrees with this philosophy. As the U.S. population's life expectancy continues to lengthen—increasing the "**graying of the population**"—the United States will be confronted with more chronic health issues because, as we age, more chronic health conditions develop.

The U.S. healthcare system is one of the most expensive systems in the world. The United States is the only major country that does not offer a **universal healthcare program**, which means access to all citizens. Many of these systems are typically run by the federal government, have centralized health policy agencies, are financed through different forms of taxation, and payment of healthcare services is by a single payer—the government (Shi & Singh, 2019). France has been discussed as one possible model for the United States to follow to improve access to health care, but universal healthcare programs also have problems and may not be the ultimate solution for the United States. However, because the United States does not offer any type of universal healthcare coverage, many citizens who are not eligible for government-sponsored programs are expected to provide the service for themselves by purchasing **health insurance** or the actual health services that are considered **out-of-pocket expenses**. Many citizens cannot afford these options, resulting in not going to a healthcare provider for routine medical care. The **Patient Protection and Affordable Care Act of 2010 (PPACA)**, more commonly called the **Affordable Care Act (ACA)**, attempted to increase access to affordable health care. One of the mandates of the Act is the establishment of electronic health insurance marketplaces, which provide opportunities for consumers to search for affordable health insurance plans. The ACA's health insurance marketplaces provide cost and service data, so consumers can determine the best healthcare insurance to purchase and what services they will receive for that purchase. Recently, the **Centers for Medicare and Medicaid Services (CMS)** used its claim data to publish the hospital costs of the 100 most common treatments nationwide. The purpose of this effort is to provide data to consumers regarding healthcare costs because the costs vary considerably across the United States. This effort may also encourage pricing competition of healthcare services. The U.S. Department of Health and Human Services provides funding to states to increase their healthcare pricing transparency (Bird, 2013).

Like other countries, the government plays a significant role in **public health**. This was especially true during the COVID-19 pandemic, which was a catastrophic health event that resulted in millions dying worldwide. The U.S. government at each level played a role in developing and implementing public health measures such as mask wearing and vaccines, with the hopes of reducing the mortality rate of COVID-19. Unfortunately, there was much misinformation and disinformation about the disease and treatments, which confused healthcare consumers, ultimately diluting factual information about COVID-19. Although many consider the pandemic to be over, current predictions indicate there will continue to be a prevalence of COVID-19 cases, co-mingling with outbreaks of flu and respiratory syncytial virus (RSV), a respiratory disease particularly affecting young children.

Consumer Perspective on Health Care

What Is Health?

The World Health Organization (WHO) defines health as the "state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (WHO, n.d.-b, para. 1). The Institute of Medicine (IOM) defines health as "a state of well-being and the capability to function in the face of changing circumstances. [It is] a positive concept emphasizing social and personal resources as well as physical capabilities" (Durch et al., 1997, p. 2). According to the Society for Academic Emergency Medicine (SAEM), health is "a state of physical and mental well-being that facilitates the achievement of individual and societal goals" (SAEM Ethics Committee, 1992, p. 1382). The Robert Wood Johnson Foundation focuses on health equity, stating that "Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care" (Braveman et al., 2017, para. 1). It believes that being healthy provides an opportunity for everyone to strive and thrive. All of these definitions focus on the impact an individual's health status has on their quality of life and how being healthy is impacted by their environment and other determinants of health.

What Is Health Literacy?

Title V of the ACA defines health literacy as the degree to which an individual has the ability to obtain and absorb basic health information to make the best

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health decision for themselves (Centers for Disease Control and Prevention [CDC], n.d.-b). Individual health literacy is impacted by culture, the complexity of the health system, the ability of the health consumer to navigate these systems, and communication by the healthcare providers. It is important that healthcare professionals, both medical and public health, clearly communicate to their patients what they need to accomplish to be healthy by increasing their health literacy levels (CDC, n.d.-b). In 2010, the Department of Health and Human Services (DHHS) created a National Action Plan to Improve Health Literacy. "The plan is based on the principles that (1) everyone has the right to health information that helps them make informed decisions and (2) health services should be delivered in ways that are understandable and beneficial to health, longevity, and quality of life" (DHHS Office of Disease Prevention and Health Promotion, 2010, p. 1). The plan targets both the health consumers as well as healthcare organizations and healthcare providers to ensure that the healthcare message is clear to their consumers (CDC, n.d.-e).

What Is Social Justice in Health Care?

According to the American Public Health Association (APHA):

> Racism is a system of structuring opportunity and assigning value to individuals and communities based on race that unfairly disadvantages some individuals and unfairly advantages others . . . [S]tudies have shown that clinicians tend to have more negative attitudes toward people of color, and unconscious racial bias among clinicians has been shown to lead to poorer communication and lower quality of care. (n.d., paras. 2-3)

Social justice focuses on the right for all individuals to have access to resources, including health care, which means **health equity** for all cultural groups. There is a need for training in cultural competence for both staff and clinicians to ensure that access and treatment is fair to all patients. Medical schools have developed cultural competence training in their curricula to encourage cultural respect in health care (Lockett, 2022).

Determinants of Health

Health has several determinants or influences that impact the status of an individual's health. The individual lifestyle factors, such as age, sex, and **constitutional factors**, are direct determinants of a person's health. A recent focus of the **determinants of health** are the **social determinants of health**, which are factors that influence the conditions we are born in, where we grow and live, and how we age (DHHS, n.d.). In addition to the **social and community networks**, there are general macroenvironmental conditions of socioeconomic, cultural, and environmental conditions that impact health, such as education, work environment, living and working conditions, healthcare services, food production, job status, water and sanitation, and housing. These determinants of health can result in **health disparities** if these conditions are not optimal, such as safe housing and work environments or educational opportunities, which are disadvantages to achieving optimal health. When conditions exist for everyone to have a fair opportunity to be as healthy as possible, health equity exists. Health equity is the result of removing restrictions, such as poverty and discrimination, and providing a healthy environment, quality education, and access to health care (DHHS, n.d.). These social determinants of health tie into the activities of the U.S. healthcare delivery system that can impact an individual's health. These activities are often categorized as primary, secondary, tertiary, and quaternary prevention. These concepts are vital to understanding the U.S. healthcare system because different components of the healthcare system focus on different areas of health, which often results in lack of coordination among these different components.

Primary, Secondary, Tertiary, and Quaternary Prevention

Primary prevention avoids the development of a disease. Promotion activities, such as health education, are primary prevention. Other examples include smoking cessation programs, immunization programs, and educational programs for pregnancy and employee safety. State health departments often develop large, targeted education campaigns regarding a specific health issue in their area.

Secondary prevention activities focus on early disease detection, which prevents progression of the disease. Screening programs, such as high blood pressure testing, are examples of secondary prevention activities. Colonoscopies and mammograms are also examples of secondary prevention activities. Many local health departments implement secondary prevention activities.

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Tertiary prevention reduces the impact of an already established disease by minimizing disease-related complications. Tertiary prevention focuses on rehabilitation and monitoring of individuals with a disease. A person with high blood pressure who is taking blood pressure medication is an example of tertiary prevention. A physician who writes a prescription for that blood pressure medication to control high blood pressure is also an example of tertiary prevention.

Quaternary prevention, a recent concept, focuses on mitigating use of interventions that do not work and providing care that is medically acceptable (Less Is More Medicine, n.d.).

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

In order to understand the current healthcare delivery system and its issues, it is important to learn the history of the development of the U.S. healthcare system. Four major sectors of our healthcare system that have impacted our current system of operations will be discussed in this chapter: (1) the history of practicing medicine and the development of medical education for both physicians and nurses, (2) the development of the hospital system, (3) the history of public health, and (4) the history of health insurance. In **Tables 1.1–1.5**, many important milestones are listed by date and illustrate the historic highlights of each system component. The list is by no means exhaustive but provides an introduction to how each sector has evolved as part of the U.S. healthcare system.

Table 1.1 Milestones of Medicine and Medical Education, 1700–2022

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

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- 1970s–1990s: Patient care dollars surpassed research dollars as the largest source of medical school funding. During the 1980s, third-party payers reimbursed academic medical centers with no restrictions. In the 1990s, with the advent of managed care, reimbursement was restricted.
- 2016: The AMA collaborated with medical schools nationally to advance medical school curricula by creating innovative courses.
- 2017: As a result of the opioid epidemic, medical schools began actively developing curricula that specifically teach ways to manage patient pain management.
- 2022: The American Association of Medical Colleges and the National Academy of Medicine issued a joint statement urging Congress to pass the Safety from Violence for Healthcare Employees Act, which provides hospital grants aimed at violence prevention.

Table 1.2 **Milestones of Nursing Education, 1798–2020**

- 1798: A New York physician developed lectures for nursing education for maternity patients.
- 1854: Florence Nightingale, a British nurse, established the Nightingale Principles for nursing education for British nurses.
- 1861: Civil War: 20,000 nurses provided care, which encouraged more nursing education programs.
- 1869: The first nursing class graduated from the Women's Hospital of Pennsylvania school.
- 1873: Three nursing programs in New York, Massachusetts, and Connecticut based on the Nightingale Principles began operations and became the foundation of nursing education in the United States.
- 1890s: Nurses organized professional associations, which later became the American Nurses Association. State nursing associations organized licensing systems.
- 1914: World War I: 23,000 nurses provided care. There was critical demand for specialty nurses.
- 1920–1930s: As more hospitals were built, nurses were relied on to provide patient care.
- 1939: World War II: 78,000 nurses continued to provide care.
- 1948: The Carnegie Foundation's The Brown Report recommended that nursing schools be placed in academic settings rather than hospitals.
- 1960: 172 college-based nursing programs were operating.
- 1970s: Nurse Practice Act allowed nurses to diagnose and prescribe medication.
- 1990: The US Department of Health and Human Services studied the nursing shortage.
- 2003–2008: Studies indicated patient outcomes improved when nursing staff held a Bachelor of Science in Nursing (BSN).
- 2010: The IOM issued a report called "The Future of Nursing," indicating that 80% of the nursing workforce should hold a BSN and should be leaders in health care.
- 2012: Many employers were providing incentives for nurses to return to school to receive their BSN.
- 2014: In response to the IOM report, the Nurses on Boards Coalition was created to assist nurses in becoming pivotal leaders in the healthcare industry.
- 2020: The American Association of Medical Colleges issued a statement indicating that the need to address and eliminate racism from academic medicine.
- 2022: The American Association of Medical Colleges and the National Academy of Medicine issued a joint statement urging Congress to pass the Safety from Violence for Healthcare Employees Act, which provides hospital grants aimed at violence prevention.

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Table 1.3 Milestones of the Hospital and Healthcare Systems, 1820–2022

- 1820s: **Almshouses** or **poorhouses**, the precursor of hospitals, were developed to serve primarily poor people. They provided food and shelter to the poor and consequently treated the ill. **Pesthouses**, operated by local governments, were used to quarantine people who had contagious diseases, such as cholera. The first hospitals were built around areas such as New York City, Philadelphia, and Boston, and were used often as a refuge for the poor. Dispensaries or pharmacies were established to provide free care to those who could not afford to pay and to dispense medications to ambulatory patients.
- 1850s: A hospital system was finally developed but hospital conditions were deplorable because of unskilled providers. Hospitals were owned primarily by the physicians who practiced in them.
- 1890s: Patients went to hospitals because they had no choice. More cohesiveness developed among providers because they had to rely on each other for referrals and access to hospitals, which gave them more professional power.
- 1920s: The development of medical technological advances increased the quality of medical training and specialization and the economic development of the United States. The establishment of hospitals became the symbol of the institutionalization of health care. In 1929, President Coolidge signed the Narcotic Control Act, which provided funding for the construction of hospitals for patients with drug addictions.
- 1930s–1940s: Once physician-owned hospitals were now owned by church groups; larger facilities; and local, state, and federal government.
- 1970–1980: The first **Patient Bill of Rights** was introduced to protect healthcare consumer representation in hospital care. In 1974, the National Health Planning and Resources Development Act required states to have **certificate of need (CON)** laws to qualify for federal funding.
- 1980–1990: In 1985, the **Emergency Medical Treatment and Active Labor Act (EMTALA)** was enacted, which required hospitals to screen and stabilize individuals coming into emergency rooms, regardless of the consumers' ability to pay.
- 1990–2000s: As a result of the Balanced Budget Act (BBA) cuts of 1997, the federal government authorized an outpatient Medicare reimbursement system.
- 1996: The medical specialty of **hospitalists**, who provide care once a patient is hospitalized, was created.
- 2002: The Joint Commission on the Accreditation of Healthcare Organizations (now **The Joint Commission**) issued standards to increase consumer awareness by requiring hospitals to inform patients if their healthcare results were not consistent with typical results.
- 2002: The CMS partnered with the **Agency for Healthcare Research and Quality (AHRQ)** to develop and assess the HCAHPS (Hospital Consumer Assessment of Healthcare, Providers and Systems Survey). Also known as the CAHPS survey, the HCAHPS is a 32-item survey for measuring patients' perception of their hospital experience.
- 2007: The Institute for Health Improvement launched the **Triple Aim**, which focuses on three goals: improving patient satisfaction, reducing health costs, and improving public health.
- 2011: The ACA created the Centers for Medicare and Medicaid Services' Innovation Center for the purpose of testing "innovative payment and service delivery models to reduce program expenditures … while preserving or enhancing the quality of care" for those individuals who receive Medicare, Medicaid, or Children's Health Insurance Program (CHIP) benefits.
- 2014: In 1974, a federal law was passed that required all states to have CON laws to ensure the state approved any capital expenditures associated with the construction and expansion of hospitals and medical facilities. The act was repealed in 1987, but as of 2014, 35 states still have some type of CON mechanism.
- 2015: The Centers for Medicare and Medicaid Services posted its final rule that reduces Medicare payments to hospitals that have exceeded readmission limits of Medicare patients within 30 days.
- 2017: The AHA and its members developed a Hospitals Against Violence initiative that targets youth and workplace violence, and human trafficking.
- 2022: Effective January 1, 2022, The Joint Commission issued new workplace violence prevention standards for all accredited hospitals.

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Table 1.4 Milestones in Public Health, 1700–2022

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

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

- 1900–1950: In 1920, Charles Winslow defined public health as a focus of preventing disease, prolonging life, and promoting physical health and efficiency through organized community efforts.
- During this period, most states had public health departments that focused on sanitary inspections, disease control, and health education. Throughout the years, **public health functions** included child immunization programs, health screenings in schools, community health services, substance abuse programs, and sexually transmitted disease control.
- In 1923, vaccines for diphtheria and whooping cough were developed. In 1928, Alexander Fleming discovered penicillin.
- In 1946, the **National Mental Health Act (NMHA)** provided funding for research, prevention, and treatment of mental illness.

- 1950–1980: In 1950, cigarette smoke was identified as a cause of lung cancer.
- In 1952, Dr. Jonas Salk developed the polio vaccine.
- The **Poison Prevention Packaging Act of 1970** was enacted to prevent children from accidentally ingesting substances. Childproof caps were developed for use on all medications.
- In 1980, the eradication of smallpox was announced.

- 1980–1990: The first recognized cases of AIDS occurred in the United States in the early 1980s.
- 1988: The IOM Report defined public health as organized community efforts to address the public interest in health by applying scientific and technical knowledge and to promote health. The first **Healthy People Report** (1987) was published and recommended it as a national prevention strategy.

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

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

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

- 2015: There was a nationwide increase of children who had not received vaccines due to parents' beliefs that vaccines were unsafe. As a result, there were measles outbreaks throughout the nation even though measles was considered eradicated decades ago.
- 2017: The **Centers for Disease Control and Prevention (CDC)** received $475 million for opioid overdose prevention to support state efforts.
- 2020: The Coronavirus Preparedness and Response Supplemental Appropriations Act provided $8.3 billion in emergency funding for federal agencies to respond to the COVID-19 outbreak. Over 80% was designated for domestic responses such as vaccine research, state and local response, expansion of telehealth, and Small Business Administration loans to entities financially impacted by the pandemic. The DHHS provided $100 million to U.S. healthcare systems to help them prepare for a surge in COVID-19 patients.
- Passed on March 27, 2020, the Cares Act included funding for Operation Warp Speed, a program that focused on expedited development of vaccines for COVID-19. This program resulted in the development of successful COVID-19 vaccines much earlier than anticipated.

(continues)

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Table 1.4 Milestones in Public Health, 1700–2022 *(continued)*

- 2021: President Biden signed 10 Executive Orders mandating masks on public transportation, increasing testing for COVID-19, and increasing travel restrictions to and from the United States. He ordered the use of the Defense Production Act to mandate companies to manufacture supplies such as personal protection equipment (PPE) and COVID-19 tests and increased funding to state and local governments to expand vaccine programs. He also mandated the CDC establish a data dashboard that showed case rates at the county level in each state. In addition, he established a task force that examined the issues of access to testing and vaccine programs in harder hits areas of communities of color.
- Safer Communities Act of 2022: Although there are state firearms laws, this federal legislation included $750 million for states to run crisis intervention programs such as mental health, drug, and veteran courts. It allowed firearms to be confiscated from individuals who are a danger to themselves or others. It also banned firearms from anyone convicted of a domestic violence crime. These components targeted the issue of gun violence, which is a both a criminal and public health issue.
- 2022: Dr. Lorna Breen Health Care Provider Act addressed the behavioral health and welfare of healthcare professionals.
- In June 2022, the Supreme court overruled *Roe* in the *Dobbs vs. Jackson Women's Health Organization,* indicating that abortion was not considered a right. The *Dobbs vs. Jackson* case challenged the Mississippi 2018 Gestational Age Act, which banned abortions after 15 weeks with exceptions for medical emergencies. The Women's Health Organization filed suit, indicating the 2018 Act violated the previous 24-week established point of viability. The Supreme court upheld the 2018 Act, which overruled *Roe v. Wade*.

Table 1.5 Milestones of the U.S. Health Insurance System, 1800–2022

- 1800–1900: Insurance was purchased by individuals in the same way one would purchase car insurance. In 1847, the Massachusetts Health Insurance Co. of Boston was the first insurer to issue "sickness insurance." In 1853, a French mutual aid society established a prepaid hospital care plan in San Francisco, California. This plan resembled the modern health maintenance organization (HMO).
- 1900–1920: In 1913, the International Ladies Garment Workers began the first union-provided medical services. The National Convention of Insurance Commissioners drafted the first model for regulation of the health insurance industry.
- 1920s: The blueprint for health insurance was established in 1929 when J. F. Kimball began a hospital insurance plan for schoolteachers at Baylor University Hospital in Texas. This initiative became the model for Blue Cross plans nationally. The Blue Cross plans were nonprofit and covered only hospital charges so as not to infringe on private physicians' income.
- 1930s: There were discussions regarding the development of a national health insurance program. However, the AMA opposed the move (Raffel & Raffel, 1994). With the Depression and U.S. participation in World War II, funding required for this type of program was not available. In 1935, President Roosevelt signed the **Social Security Act (SSA)**, which created "old age insurance" to help those of retirement age. In 1936, Vassar College, in New York, was the first college to establish a medical insurance group policy for students.
- 1940s–1950s: The War Labor Board froze wages, forcing employers to offer health insurance to attract potential employees. In 1947, the Blue Cross Commission was established to create a national network of doctors. By 1950, 57% of the population had hospital insurance.
- 1965: President Johnson signed the Medicare and Medicaid programs into law.
- 1970s–1980s: President Nixon signed the HMO Act, which was the predecessor of managed care. In 1982, Medicare proposed paying for hospice or end-of-life care. In 1982, diagnosis-related groups (DRGs) and prospective-payment guidelines were developed to control insurance reimbursement costs. In 1985, the **Consolidated Omnibus Budget Reconciliation Act (COBRA)** required employers to offer partially subsidized health coverage to terminated employees.

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- 1990–2000: President Clinton's Health Security Act proposed a universal healthcare coverage plan, which was never passed. In 1993, the **Family Medical Leave Act (FMLA)** was enacted, which allowed employees up to 12 weeks of unpaid leave because of family illness. In 1996, the **Health Insurance Portability and Accountability Act (HIPAA)** was enacted, making it easier to carry health insurance when changing employment. It also increased the confidentiality of patient information. In 1997, the BBA was enacted to control the growth of Medicare spending. It also established the State Children's Health Insurance Program (SCHIP).
- 2000: The SCHIP, now known as the Children's Health Insurance Program (CHIP), was implemented.
- 2000: The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act provided some relief from the BBA by providing across-the-board program increases.
- 2003: The **Medicare Prescription Drug, Improvement, and Modernization Act** was passed, which created Medicare Part D prescription plans for the elderly.
- 2006: Massachusetts mandated that all state residents have health insurance by 2009.
- 2009: President Obama signed the **American Recovery and Reinvestment Act (ARRA)**, which protected health coverage for the unemployed by providing a 65% subsidy for COBRA coverage to make the premiums more affordable.
- 2010: The ACA was signed into law, making it illegal for insurance companies to rescind insurance on their sick beneficiaries. Consumers can also appeal coverage claim denials by the insurance companies.
- 2013: Individuals could buy qualified health benefits plans from the Health Insurance Marketplaces. If an employer did not offer insurance, consumers could purchase it from the federal Health Insurance Marketplace. The federal government provided states with funding to expand their Medicaid programs to increase preventive services.
- 2015: The CMS posted its final rule that reduces Medicare payments to hospitals that readmit Medicare patients within 30 days after discharge. This rule is an attempt to focus hospital initiatives on quality care.
- 2018: CMS finalized its rule for the 2019 Physician Fee Schedule and the Quality Payment Program, which will promote access to telemedicine services.
- 2018: A federal judge ruled that the ACA's individual mandate to purchase health insurance was unconstitutional.
- 2022: The Inflation Reduction Act extended tax credits for ACA premiums through 2025 and allowed Medicare to negotiate drug prices with pharmaceutical companies and cap monthly insulin costs to $35 for Medicare beneficiaries with diabetes.

Milestones of Medicine and Medical Education

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

In the early history of medical education, physicians gradually established large numbers

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

When the Medicare and Medicaid programs were enacted in 1965, Congress recognized that the federal government needed to support medical education, which resulted in ongoing federal funding to teaching hospitals to maintain medical resident programs. The responsibilities of teaching now included clinical duties. During the 1970s to 1990s, patient care dollars exceeded research funding as the largest source of medical school support. Academic medical centers would be reimbursed without question by third-party payers. However, with the advent of managed care in the 1990s, reimbursement restrictions were implemented (Rich et al., 2002). The AMA has been collaborating with medical schools nationwide to advance medical school curricula by creating innovative courses that include technology, a discussion of health reform, healthcare systems thinking, and ways to address patient pain management. Schools are also focusing on cultural competency training through traditional lecture-based classes, international internships, and immersion classes to increase health equities to marginalized populations (AMA, 2016). Also, in working with the Association of American Medical Colleges, medical schools are developing curricula that focuses on diversity, equity, and inclusion, which encourages health equity in patients (AAMC, 2023; Goodman & Musgrave, 1992).

Milestones of Medicine and Nursing Education

According to Post University's *A Timeline of Nursing Education* (2021), formal nursing education is approximately 150 years old. In the mid-1800s, physicians trained women to perform menial tasks for them. Because nurses held a low position in society, most of the sick were cared for by family members. However, in 1854, Florence Nightingale, a British nurse known as the Mother of Nursing, established the Nightingale Principles, which became the foundation for nursing education. In 1860, the Nightingale Training School for Nurses was started in England and became known as the reason modern nursing exists today. During the Civil War (1861) and World Wars I and II, thousands of nurses provided critical care, which encouraged the development of more nursing education programs. In 1873, based on the Nightingale Principles, three nursing programs were established in Massachusetts, New York, and Connecticut hospitals. There continued to be recommendations that nursing education should be college based.

By 1900, there were 400 hospital-based nursing programs. Unfortunately, there was no standardization of the programs. Finally, in 1909, a college-based nursing program was established in Minnesota, which awarded the first baccalaureate program. The 1923 Goldman Report and the 1948 Brown Report indicated the need for standardization of nursing programs and their placement in a university setting. This is similar to the Flexner Report recommendations for medical school standardization for physicians. By 1960, there were 172 college-based nursing programs, which included both community college and 4-year programs. Currently, the associate degree in nursing is typically offered by community colleges. Many of those students continue their education to receive a BSN degree to increase their career choices (Niles, 2019).

With the passage of the Nurse Practice Act of 1964, which allowed nurses to diagnose and prescribe medications, the role of nurses in society continued to elevate. However, there continued to be recommendations that nurses should be trained to receive a BSN. Studies from 2003 to 2008 indicated that patient outcomes were more positive when a BSN-trained nurse participated in their care. These recommendations continue to be relevant now. Many employers prefer BSN-trained nurses. The Nurses on Board Coalition (NOBC) was created in 2014 as a result of the IOM

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report that indicated more nurses should be leaders with pivotal decision-making opportunities. This Coalition assists in placing nurses in leadership positions (Nurses on Boards Coalition, n.d.). In 2018, CVS Health became a Founding Strategic Partner with NOBC to support nurses and nurse practitioners as leaders. Nurses are an integral component of the healthcare system. They spend more time with patients. However, nurses are also subject to workplace harassment issues such as bullying from other employees and family members of patients. In 2022, The Joint Commission (2021) updated their workplace violence prevention standards for accredited hospitals. Also in 2022, the American Association of Medical Colleges and the National Academy of Medicine issued a joint statement urging Congress to pass the Safety from Violence for Healthcare Employees Act, which provides hospital grants aimed at violence prevention.

Milestones of the Hospital System

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

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

In 1973, the first Patient Bill of Rights was established to protect healthcare consumers in hospitals. In 1974, a federal law was passed that required all states to have certificate of need (CON) laws to ensure the state-approved capital expenditures associated with hospital and medical facility construction and expansion reflected a genuine need. The Act was repealed in 1987, but as of this printing, 35 states and Washington D.C. still have some type of CON mechanism (National Conference of State Legislatures, 2023). The concept of CON was important because it encouraged state planning to ensure their medical system was based on need. In 1985, the Emergency Medical Treatment and Active Labor Act (EMTALA) was enacted to ensure that consumers were not refused emergency treatment. During this period, inpatient hospital use was typical; however, by the 1980s, many hospitals were offering outpatient or ambulatory surgery that continues into the 21st century. The BBA of 1997 authorized outpatient Medicare reimbursement to support these cost-saving measures. Hospitalists, created in 1996, are providers who focus exclusively on the care of patients when they are hospitalized. Creation of this new type of provider recognized the need of providing quality hospital care. Hospitalists often have training in different specialties and may be board-certified in hospital medicine. In 2022, there are 50,000 practicing hospitalists (Macmillan, 2022; Sultz & Young, 2006). The CMS partnered with the AHRQ to develop and assess the HCAHPS (also known as the CAHPS survey). The HCAHPS is a 32-item survey for measuring patients' perception of their hospital experience. In May 2005, the National Quality Forum (NQF), an organization established to standardize healthcare quality measurement and reporting, formally endorsed the CAHPS Hospital Survey. The NQF endorsement represents the consensus of many healthcare providers, consumer groups, professional associations, purchasers, federal agencies, and research and quality organizations. Since 2008, it has been nationally recognized as a standardized measurement for hospital comparisons (AHRQ, n.d.).

In 2007, the Institute for Health Improvement launched the Triple Aim, which focused on the three goals of patient satisfaction, improving public health, and reducing healthcare costs. In 2011, the ACA created the CMS Innovation Center for the purpose of developing innovative care and payment models. Section 3025 of the ACA required the establishment of a Hospital Readmissions Reduction Program (HRPP). In 2015, the CMS also posted its final rule that reduces Medicare payments to hospitals that readmit Medicare patients within 30 days. This rule is an attempt to focus hospital initiatives on quality care (Rau, 2015). As a result of this rule, many hospitals are focusing on the concept of quality improvement processes and performance-driven planning to ensure that these readmissions do not occur. In addition to this quality performance program, the 21st Century Cures

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Act requires CMS to assess penalties on hospitals if their performance is not consistent with other hospitals that treat patients who are both Medicaid and Medicare eligible. In 2017, the AHA and its members developed a Hospitals Against Violence initiative that targets youth and workplace violence, and human trafficking.

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

Milestones of Public Health

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

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

Disease control and health education were also integral components of public health departments. In 1916, the Johns Hopkins University, one of the most prestigious universities in the world, established the first public health school (Duke University Library, 2020). Winslow's definition of public health focused on the prevention of disease, while the IOM defined public health as the organized community effort to protect the public by applying scientific knowledge (IOM, 1988; Winslow, 1920). These definitions are exemplified by the development of several vaccines for whooping cough, polio, smallpox, and diphtheria, and the discovery of penicillin. All of these efforts focus on the protection of the public from disease.

The three most important public health achievements are (1) the recognition by the U.S. Surgeon General that tobacco use is a health hazard; (2) the development of many vaccines that have eradicated some diseases and controlled the number of childhood diseases that exist; and (3) the development of early detection programs for high blood pressure and heart attacks as well as smoking cessation programs, which have dramatically reduced the number of deaths in this country (Shi & Johnson, 2014).

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

The *Healthy People 2000* report, which started in 1987, was created to implement a new national prevention strategy with three goals: increase life expectancy, reduce health disparities, and increase access to preventive services. Also, three categories

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of health promotion, health prevention, and preventive services were identified, and surveillance activities were emphasized. *Healthy People 2000* provided a vision to reduce preventable disabilities and death. Target objectives were set to measure progress (CDC, n.d.-c).

The *Healthy People 2010* report was released in 2000. The report contained a health promotion and disease prevention focus to identify preventable threats to public health and to set goals to reduce the threats. Nearly 500 objectives within 28 focus areas were developed. Focus areas ranged from access to care, food safety, education, and environmental health to tobacco and substance abuse. A key component of *Healthy People 2010* is the development of an infrastructure to ensure public health services are provided. Infrastructure includes skilled labor, information technology, organizations, and research. In 2010, *Healthy People 2020* was released. It contained 1200 objectives that focused on 42 topic areas. According to the CDC, a smaller set of *Healthy People 2020* objectives, called leading health indicators (LHIs), have been targeted to communicate high-priority health issues. The goals are to attain high-quality, longer lives free of preventable disease, disability, injury, and premature death; achieve health equity, eliminate disparities, and improve the health of all groups; create social and physical environments that promote good health for all; and promote quality of life, healthy development, and healthy behaviors across all life stages. There are several new topic areas, including dementias; blood disorders and blood safety; health-related quality of life; sleep health; healthcare-associated infections; and lesbian, gay, bisexual, and transgender health. The planning for Healthy People 2030 began in 2020 (CDC, n.d.-d). The goals for all of these reports are consistent with the definitions of public health in both Winslow's and the IOM's reports. It is important to mention the impact on the scope of public health responsibilities of the terrorist attack on the United States on September 11, 2001; the anthrax attacks; the outbreak of global diseases, such as severe acute respiratory syndrome (SARS), Ebola, and the Zika virus; and the U.S. natural disaster of Hurricane Katrina. As a result of these major events, public health has expanded its area of responsibility. The terms "bioterrorism" and "disaster preparedness" have more frequently appeared in public health literature and have become part of strategic planning. The Public Health Security and Bioterrorism Preparedness and Response Act of 2002 provided grants to hospitals and public health organizations to prepare for bioterrorism as a result of September 11, 2001 (CDC, n.d.-f).

There have been measles outbreaks throughout the world even though measles was considered eradicated decades ago. In the United States, the number of measles cases increased six-fold between 2017 and 2018, reaching nearly 800 cases, although the national measles vaccine rate is 90%. Although claims about health risks from vaccines have been disproven, some parents remain reluctant to vaccinate their children. Therefore, more education is needed to increase the number of children who receive a measles vaccine (Welch, 2019).

The opioid epidemic began in the 1990s when pharmaceutical companies assured physicians that their pain-relief medications were not habit forming, which naturally increased the number of prescriptions for these medications. In 2010, there was an increase in the use of heroin, an illegal opioid, because it was easier to obtain. Deaths from heroin use between 2002 and 2013 increased by 286%. Over 75% of heroin users also abused opioid prescriptions. In 2013, there was an increase in opioid deaths because of the increased use of fentanyl, which is a synthetic opioid. The CDC has issued guidelines on prescribing medications for chronic pain (Liu et al., n.d.). Opioid abuse continues to be a public health problem today.

The COVID-19 pandemic dramatically changed our lives, both personally and professionally. In January 2020, the WHO declared it a Public Health Emergency of International Concern and, in March 2020, declared it a pandemic. It became the fifth documented pandemic since the 1918 flu epidemic. In April 2020, WHO issued guidance on mask wearing. In May 2020, President Trump announced Operation Warp Speed, with its main goal of developing a COVID-19 vaccine as soon as possible, a goal which typically takes years. He authorized $10 billion to contractors to develop vaccines. In March 2020, Moderna began trials on COVID-19 vaccines. In November 2020, trials for the Pfizer vaccine determined it was 90% effective. The CDC became the lead federal government agency to develop and implement public health COVID-19 policy. State and local governments were responsible for implementing these policies, though states developed the procedures on how to implement the mask mandates and vaccine distribution.

In April 2021, 1 billion vaccine doses were administered globally. By December 2022, 2.5 years after the virus was identified in China, there have been 653 million cases worldwide, including nearly 6.7 million deaths. A total of 13.06 billion vaccines have been administered as of the end of 2022. Nearly

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69% of the world has received at least one vaccine dose (WHO, n.d.-a).

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

Milestones of the Health Insurance System

The goal of **group insurance** is to minimize the individual risk of medicals costs by sharing the cost across the members of the insurance company (Buchbinder & Shanks, 2007). Like life insurance or homeowner's insurance, health insurance was developed to provide protection should a covered individual experience an event that requires health care. In 1847, a Boston insurance company offered sickness insurance to consumers (Starr, 1982).

During the 19th century, large employers, such as coal mining and railroad companies, offered medical services to their employees by providing company doctors. Fees were taken from their pay to cover the service. In 1913, the International Ladies Garment Workers union began providing health insurance, which was negotiated as part of the contract (Duke University Library, 2020). During this period, there were several proposals for a national health insurance program, but the efforts failed. The AMA was worried that any national health insurance would impact the financial security of its providers. The AMA persuaded the federal government to support private insurance efforts (Raffel & Raffel, 1994).

In 1929, a group hospital insurance plan was offered to teachers at a hospital in Texas. This became the foundation of the nonprofit Blue Cross plans. To placate the AMA, Blue Cross initially offered only hospital insurance in order to avoid infringement of physicians' incomes (Blue Cross Blue Shield Association, n.d.; Starr, 1982). In 1935, the SSA was enacted; Social Security was considered "old age" insurance. During this period, there was continued discussion of a national health insurance program. However, because of the Depression and World War II, there was no funding for this program. The federal government felt that the SSA was a sufficient program to protect consumers. These events were a catalyst for the development of a health insurance program that included private participation. Although a universal health coverage program was proposed during President Clinton's administration in the 1990s, it was never passed. In 2009, there was a major public outcry at regional town hall meetings opposing any type of government universal healthcare coverage. In 2006, Massachusetts proposed mandatory health coverage for all residents, so it may be that universal health coverage would be a state-level initiative (Shi & Singh, 2019).

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

At the start of the 21st century, cost, access, and quality continue to be issues for U.S. health care. Employers continue to play an integral role in health insurance coverage. The largest public coverage program is Medicare. There are three parts: Medicare Part A, inpatient; Medicare Part B, outpatient; Medicare Part C, managed care; and Medicare Part D, prescription drugs. In 2022, Medicare's government funding was $766 billion with 65 million enrolled in the

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program (Cubanski & Neuman, 2023). The SCHIP, renamed CHIP, was implemented to ensure that children who are not Medicare eligible receive health care. In 2022, there were a total of 42 million children enrolled in the Medicaid CHIP program.The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act provided some relief from the BBA of 1997 by restoring some funding to these consumer programs. In 2003, a consumer law, the Medicare Prescription Drug, Improvement, and Modernization Act, created a major overhaul of the Medicare system (White House, 2003). The Act created Medicare Part D, a prescription drug plan that became effective in 2006 and provides different prescription programs to the elderly, based on their prescription needs. As of September 2022. 50.5 million people are enrolled in Medicare Part D (Center for Medicare Advocacy, 2023). The Act also renamed the Medicare cost plans to Medicare Advantage, which is a type of managed care program. Medicare contracts with private health insurance programs to provide services. This program, called Medicare Part C, provides both Medicare Parts A and B benefits. In 2008, the **National Defense Authorization Act** expanded FMLA to permit families of military service members to take a leave of absence if a spouse, parent, or child was called to active military service. The 2010 ACA required individuals to purchase health insurance or pay a fine. In June 2018, a federal judge ruled this mandate unconstitutional but the remaining program has remained in place and continues to offer health insurance. In 2023, nearly 16 million enrolled in the ACA plans which is a 13% increase from 2022 (DHHS, 2023). The majority of individuals in the United States have private health insurance, while others qualify for federal and state insurance plans. In 2022, the total number of individuals who are considered uninsured in the United States is 8%, the lowest percentage ever.

Current System Operations

Government's Participation in Health Care

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

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

The United States has several federal health regulatory agencies, including the CDC for public health; the **Food and Drug Administration (FDA)** for pharmaceutical controls; and the CMS for the indigent, disabled, and the elderly. The Joint Commission is a private organization that focuses on healthcare organizations' oversight, and the AHRQ is the primary federal source for the quality delivery of health services. The **Center for Mental Health Services (CMHS)**, in partnership with state health departments, leads national efforts to assess mental health delivery services. Although the federal government is to be commended because of the many agencies that focus on major healthcare issues, with multiple organizations there is often duplication of effort and miscommunication that result in inefficiencies (Substance Abuse and Mental Health Services Administration [SAMHSA], 2022). However, several regulations exist to protect patient rights. One of the first pieces of legislation was the **Sherman Antitrust Act of 1890** and ensuing legislation, which ensure fair competition in the marketplace for patients by prohibiting monopolies (Niles, 2019). Regulations such as HIPAA protect patient information; COBRA gives workers and families the right to continue healthcare coverage if they lose their job; the **Newborns' and Mothers' Health Protection Act (NMHPA)** of 1996 prevents health insurance companies from discharging a mother and child too early from the hospital; the **Women's Health and Cancer Rights Act (WHCRA)** of 1998 prevents discrimination against women who have cancer; the **Mental Health Parity Act (MHPA)** of 1996 and its 2008 amendment

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require health insurance companies to provide fair coverage for mental health conditions; the **Genetic Information Nondiscrimination Act of 2008** prohibits U.S. insurance companies and employers from discriminating based on genetic test results; the **Lilly Ledbetter Fair Pay Act of 2009** provides protection for unlawful employment practices related to compensation discrimination; and finally, the ACA of 2010 focuses on increasing access to health care, improving the quality of healthcare delivery, and increasing the number of individuals who have health insurance. All of these regulations are considered **social regulations** because they were enacted to protect the healthcare consumer.

Assessing Your Healthcare System Using the Iron Triangle

Many healthcare systems are evaluated using the **Iron Triangle** of health care, a concept that focuses on the balance of three factors: quality, cost, and accessibility to health care (**Figure 1.1**). This concept was created in 1994 by Dr. William Kissick. If one factor is emphasized, such as cost reduction, it may create an inequality of quality and access because costs are being cut. Because lack of access is a problem in the United States, healthcare systems may focus on increasing access, which could increase costs. In order to assess the success of healthcare delivery, it is vital that consumers analyze the balance among cost, access, and quality. Are you receiving quality care from your provider? Do you have easy access to your healthcare system? Is it costly to receive health care? Although the Iron Triangle is used by many experts in analyzing large healthcare delivery systems, as a healthcare consumer, you can also evaluate your healthcare delivery system by using the Iron Triangle. An effective healthcare system should have a balance among the three components.

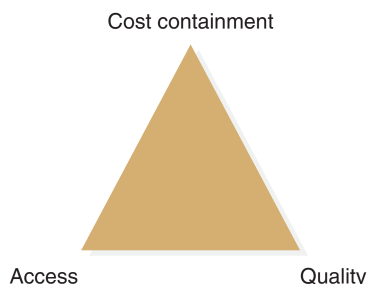

Figure 1.1 The Iron Triangle of Health Care images

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Conclusion

A 2018 Gallup survey indicated that over 55% of Americans are greatly concerned about the availability and rising cost of health care, which marks the fifth year in a row that this issue ranked or tied first for concerns (Jones, 2018). Because the United States does not have universal health coverage, there are more health disparities across the nation. Persons living in poverty are more likely to be in poor health and less likely to use the healthcare system compared to those with incomes above the poverty line. If the United States offered universal health coverage, the per capita expenditures would be more evenly distributed and likely more effective. The major problem for the United States is that healthcare insurance is a major determinant of access to health care. Although there has been a decrease in the number of uninsured in the United States as a result of the individual mandate to purchase health insurance by the ACA, there is still limited access to routine health care. The infant mortality rate is often used to compare the health status of nations worldwide. Although our healthcare expenditures are extremely high, our infant mortality rates rank higher than those of many countries. Racial disparities in disease and death rates continue to be a concern. Both private and public participants in the U.S. health delivery system need to increase their collaboration to focus on health education aimed to reduce the prevalence of obesity and disease and increase patient health literacy. Leaders need to continue to assess our healthcare system using the Iron Triangle to ensure there is a balance among access, cost, and quality. Healthcare employees should receive training in cultural proficiency and social justice to ensure their patients receive equitable care while being respectful of their culture.

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WRAP-UP

Vocabulary

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

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Notes

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Student Activity 1.1

In Your Own Words

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

Group insurance:

Gross domestic product (GDP):

Pesthouses:

Almshouses:

Public health functions:

Primary prevention:

Secondary prevention:

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Tertiary prevention:

Quaternary prevention:

Student Activity 1.2

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

Real-Life Applications: Case Scenario One

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

Activity

Define each of the terms and provide examples of each type of prevention.

Responses

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Case Scenario Two

You have recently heard the term "health literacy," and you are curious about how that applies to you as a consumer of health care.

Activity

Perform an Internet search regarding the concept of health literacy and how it applies to healthcare consumers. Provide examples to your classmates about how to be literate in health care.

Responses

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Case Scenario Three

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

Activity

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

Responses

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Case Scenario Four

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

Activity

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

Responses

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Student Activity 1.3

Internet Exercises

Write your answers in the space provided.

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

Websites

www.ama-assn.org

Organization Name:

Mission Statement:

Overview of Activities:

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Importance of Organization to U.S. Health Care:

www.cdc.gov

Organization Name:

Mission Statement:

Overview of Activities:

Importance of Organization to U.S. Health Care:

www.cms.hhs.gov

Organization Name:

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Mission Statement:

Overview of Activities:

Importance of Organization to U.S. Health Care:

www.hhs.gov

Organization Name:

Mission Statement:

Overview of Activities:

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Importance of Organization to U.S. Health Care:

Student Activity 1.4

Discussion Questions

The following are suggested discussion questions for this chapter.

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

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

3. Why was health insurance developed?

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

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

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

Student Activity 1.5

Current Events

Perform an Internet search and find a current events topic from the last 3 years that is related to this chapter. Provide a summary of the article and the link to the article, and explain how the article relates to the chapter.

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