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CHAPTER 2

Categories of Health Services

OBJECTIVES

After studying this chapter, the student should be able to:

- List direct health services provided by the federal government.
- Compare financing and governing of private, public, and volunteer healthcare facilities.
- Identify the five broad types of health services in the United States.
- Compare the population served by federally funded primary care health centers and free clinics.
- Name health agencies within the U.S. Department of Health and Human Services (HHS).
- Summarize the six major points of the Patient Care Partnership.
- Describe public health and mental health services in the United States.

KEY TERMS

Affordable Care Act (ACA)
Almshouse
Ambulatory care
Behavioral Risk Factor Surveillance System (BRFSS)
Centers for Disease Control and Prevention (CDC)
Certified Community Behavioral Health Clinics (CCBHCs)
Chronic care
Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)
Commissioned Corps
Community hospital
Community Mental Health Act
Community Mental Health Centers (CMHC)
Diagnosis and treatment of illness
Disease prevention services

Drug addiction
Essential hospitals and health systems
Federally Qualified Health Center (FQHC)
Free medical clinic (FMC)
Healthcare facilities
Health promotion services
Health Resources and Services Administration (HRSA)
Hospital system
Indian Health Service (IHS)
Informed consent
Mental health services
Mental Health Parity and Addiction Equity Act of 2008
National Association of Free & Charitable Clinics (NAFC)
National Center for Health Statistics
National Health Service Corps
National Institute of Mental Health (NIMH)
Patient-Centered Medical Home (PCMH)
Patient Care Partnership
Protecting Access to Medicare Act of 2014
Rehabilitation
Serious mental illness (SMI)
Social Security Act of 1935
Social Security Act of 1965

OVERVIEW OF THE U.S. HEALTHCARE SYSTEM

The healthcare industry is a complex system of diagnostic, therapeutic, and preventive services. Hospitals, clinics, government and volunteer agencies, pharmaceutical and medical equipment manufacturers, and private insurance companies provide these services. In terms of jobs in the healthcare industry, hospitals employ the largest percentage (39%), followed by offices of health practitioners (26%) and nursing and other residential facilities (20%). Home health services and outpatient, laboratory, and other ambulatory care settings make up the remaining healthcare jobs, at 8% each.[1]

The focus of this chapter is hospitals and outpatient or ambulatory care provided by both private and government institutions as well as the federal agencies responsible for ensuring the health and safety of all Americans under the U.S. Department of Health and Human Services (HHS) through research and financial support. Chapter 4 includes long-term care—nursing home care and other supportive living facilities.

Unlike most developed countries, the United States does not have a centralized healthcare delivery system in which individuals automatically receive health care. Instead, consumers obtain healthcare services—choosing their doctor, clinic, or hospital—from a variety of locations and providers funded by private insurance or government-subsidized insurance. Consumers often are left to coordinate their own care; thus, the quality of health care can vary.

Two countries similar to the United States, Canada and the United Kingdom (UK), have national health insurance systems. Canada implemented a national health insurance system in 1966, and each province or territory has its own unique health insurance plan. The health insurance program is funded by provincial taxes as well as a fixed amount from the federal government. The UK health delivery system—the National Health Service (NHS)—is funded primarily through general taxation. The system emphasizes preventive community services and coordination of primary and acute care. All patients insured through this system are required to register with a local general practitioner or physician who coordinates their care. The federal government owns and operates the hospitals and clinics, and most of the healthcare workers are employed by the government.[2]

In contrast, the U.S. federal government provides very few direct health services, preferring to support new or improved services by providing money to fund expanded services—for example, through the **Affordable Care Act (ACA)**. The exceptions are the health services of TRICARE, through the U.S. Department of Defense (DoD), the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), and the **Indian Health Service (IHS)**. The federal government has no authority to provide direct services; this is a function of the private sector and the states. The federal government is involved, however, in financing research through the National Institutes of Health (NIH) and individual health care for the elderly through Medicare as well as health care for the low-income uninsured through Medicaid. The federal government also funds loans and scholarships for students in the health professions through the **Health Resources and Services Administration (HRSA)**. The most important federal agency concerned with health affairs is the HHS, with 11 operating divisions, including eight agencies in the U.S. Public Health Service and three human services agencies.[3] Congress plays a key role in this federal activity by making laws, allocating funds, and doing investigative work through committees.

CATEGORIES OF HEALTHCARE SERVICES

The healthcare system offers five broad types of services: health promotion, disease prevention, diagnosis and treatment, rehabilitation, and chronic care.

Health promotion services help clients reduce the risk of illness, maintain optimal function, and follow healthy lifestyles. These services are provided in a variety of ways and settings. Examples include hospitals that offer prenatal nutrition classes and local health departments that offer selected recipients prenatal nutrition classes plus a food package that meets their nutritional requirements (the Women, Infants, and Children [WIC] program). Classes at both locations promote the general health of women and children. Exercise and

aerobic classes offered by city recreation departments, adult education programs, and private or nonprofit gymnasiums encourage consumers to exercise and maintain cardiovascular fitness, thus promoting better health through lifestyle changes.

Disease prevention services offer a wide variety of assistance and activities. Educational efforts aimed at involving consumers in their own care include attention to and recognition of risk factors, environmental changes to reduce the threat of illness, occupational safety measures, and public health education programs and legislation. Examples of public health programs are a smoking cessation class offered through the hospital or the local department of public health or a lead abatement program for older homes offered to homeowners by the city health department. An example on the individual level is women participating in screening for breast and cervical cancer. It is evident that preventive measures such as these can reduce the overall costs of health care.

Diagnosis and treatment of illness have been the most used of the healthcare services, most often provided in the hospital or **ambulatory care** setting. Diagnosis of illness involves physician visits and, if necessary, laboratory tests, X-rays, and other technology to make a diagnosis; examples of treatment are surgery, physical and speech therapy, and medications. Recent advances in technology and early diagnostic techniques have greatly improved the diagnosis and treatment capacity of the healthcare delivery system, but the advances have also increased the complexity and price of health care (**FIGURE 2.1**).

Rehabilitation involves the restoration of a person to normal or near-normal function after a physical or mental illness, including chemical addiction. These programs take place in many settings: homes, community centers, rehabilitation centers, hospitals, outpatient clinics, and long-term care facilities. Rehabilitation is a long process, and both the client and family require extra assistance in adjusting to a chronic disability. Common conditions requiring rehabilitation are physical injuries such as strokes and head injuries, hip and knee replacement surgery, and substance use disorders such as alcohol or drug addiction.

FIGURE 2.1 Diagnosis and treatment are the most used healthcare services.

Chronic care is ongoing care for a chronic health condition such as diabetes, which requires long-term monitoring with adjustments in diet, medication, and physical activity to maintain blood glucose levels and the prevention of complications. Most individuals with diabetes have a primary physician or a specialist physician, an endocrinologist, who coordinates care. Nurses, dietitians, and other healthcare professionals who specialize in diabetes care provide patient education. The primary care provider refers patients to other physician specialists when complications of the disease develop—for example, an ophthalmologist for eye health and a nephrologist to monitor kidney function.

HEALTHCARE FACILITIES

A wide variety of **healthcare facilities** are available. These facilities—the places where people involved in the healthcare industry work—are broadly summarized in this chapter but are individually detailed elsewhere. This discussion of numerous healthcare settings should assist students in selecting a health career and becoming knowledgeable about their chosen field.

Expansion of the healthcare system and professional specialization have broadened the range and types of healthcare settings. Medical care settings include offices of health practitioners, nursing and residential facilities, home health services, and outpatient clinics, laboratories, and ambulatory services as well as the primary inpatient setting, hospitals. Public health settings are usually community-based and may be voluntary organizations, such as the American Cancer Society, or government-supported entities, such as the city, county, or state public health department.

Clients requiring diagnosis and treatment can find health care in physicians' offices, ambulatory care centers, and outpatient clinics. In addition, there are freestanding immediate-care clinics staffed by physicians or located inside a pharmacy and staffed by nurse practitioners or physician assistants who provide immunizations and treat minor, acute illnesses such as colds, cuts, or sprains. Although physicians in office practice focus mainly on the diagnosis and treatment of specific diseases, many clinics and ambulatory centers offer health education and rehabilitation as well. For example, outpatient cardiac rehabilitation centers provide classes on nutrition and stress management and the use of exercise equipment to increase strength and endurance while monitoring heart function. Other health professionals who provide rehabilitation services are physical therapists for physical rehabilitation and psychologists, social workers, and behavioral counselors, who provide therapy for chemical addiction and mental illness.

Community-based agencies provide health care within defined neighborhoods. Such diverse facilities include federally supported health centers, adult day care centers, home health agencies, crisis intervention and drug rehabilitation centers, halfway houses, and various support groups. All work in a wide variety of ways to maintain the integrity of the community.

Federally funded primary care health centers—**Federally Qualified Health Centers (FQHC)**—are the largest

comprehensive safety net of primary and preventive care in the country with nearly 1,400 centers in the United States. The health centers are supported by the HRSA within the HHS and are public and private nonprofit healthcare organizations governed by a board, most of whose members are from the community being served by the health center. The centers provide a medical home for medically underserved populations—for example, the homeless, veterans, residents of public housing, and the uninsured—or special, medically underserved populations, such as migrant and seasonal farmworkers. The health centers receive assistance in recruiting and staffing primary care providers through the **National Health Service Corps**, also funded by HRSA.[4] The FQHC manage patients with multiple healthcare needs and use key quality improvement practices, including health information technology—nearly 97% of the centers use electronic health records.[5] The majority of the operating funds come from Medicaid, Medicare, private insurance, and patient fees; services are provided regardless of ability to pay. The quality of care is comparable to private primary care centers.[4]

Comprehensive medical, prenatal, dental, pharmacy, and behavioral health services are available at the health centers. A multidisciplinary team of physicians, physician assistants, nurses and nurse practitioners, midwives, social workers, health educators, behavioral health counselors, and other providers staff the health centers.[5] Supportive services—health education, language translation, and transportation—increase language access and reduce barriers to keeping scheduled appointments because of limited public transportation.[4]

The health centers use the **Patient-Centered Medical Home (PCMH)** model, whereby patient care is coordinated by a primary care provider to ensure that patients receive culturally appropriate care when and where they need it. The centers are able to achieve strong patient outcomes even though the patients are often sicker than the general population. Because of the care received in the clinics, patients have fewer emergency room or hospital visits, resulting in a cost savings to the government.[6]

The first federally funded health centers were established in 1962 for migrant and seasonal farmworkers, and by 1964, two neighborhood health centers were opened in the Boston area. As of 2019, centers provided care to over 28 million patients in all states within the United States, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and the Pacific Basin.[6] The ACA provided funds to expand the number of health centers and increased access to health care for many low-income individuals. In 2019, one in every 12 Americans received health care through one of the health centers[6]; over 60% of those receiving services were members of an ethnic or minority group, and 23% had no health insurance.[5]

The FQHC network addresses public health priorities—for example, the opioid crisis and the HIV epidemic. For example, in 2018, health centers screened and identified over 1 million people for substance use disorder and provided medication-assisted treatment—naloxone, used to prevent death from an overdose—to nearly 95,000 patients. These health centers serve the HIV community with testing and diagnosis of HIV and in 2018 provided testing for over 2 million patients and treated one in six individuals diagnosed with HIV from across the United States.[6]

Privately funded **free medical clinics (FMCs)** are nonprofit, community-based or faith-based organizations that provide health care at little or no charge to low-income individuals—at or below 200% of the federal poverty level—who are uninsured or underinsured and are residents of the county in which the clinic is located. The **National Association of Free & Charitable Clinics (NAFC)** was established in 2001; in 2019, 2 million people received health care at 1,400 clinics and pharmacies.[7] A nationwide survey reported that those who used a free clinic were homeless (42%) and immigrants (40%) and had substance use disorders (18%) or HIV/AIDs (10%). When the ACA was implemented, more people were eligible for health insurance through Medicaid or the Marketplace. However, barriers to health care access persisted for individuals not eligible for government-subsidized health insurance—for example, the undocumented and those who live in states that have not expanded Medicaid programs. Also, FMCs provide services less readily available elsewhere, free or low-cost medications and eyeglasses, and health education (**FIGURE 2.2**).[8]

In contrast to the FQHC, the free clinics receive little or no state or federal funds. FMCs are financially supported by a variety of individuals or organizations such as hospitals, medical associations, secular community organizations, faith-based entities, and foundations as well as fund-raising events. Pharmaceutical companies and other organizations donate low-cost or free medications and medical supplies. Clinics may be housed in temporary physical facilities similar to those used for humanitarian relief in response to disasters such as a hurricane or tornado.[9] For example, from 2009 through 2016, large-scale free clinics were held in several cities including Kansas City, MO; Dallas, TX; New Orleans, LA; Charlotte, NC; Madison, WI; and Tacoma, WA. Permanent clinics are housed in existing physical spaces such as

FIGURE 2.2 Free clinics provide dental services to the uninsured.
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churches.[10] Most FMCs provide medical, dental, pharmaceutical, behavioral health, vision, and health education services to ensure that the uninsured and underinsured have a medical home. Clinics are staffed by a variety of volunteer health professionals: doctors, dentists, nurses, nurse practitioners, social workers, psychologists, optometrists, pharmacists, and non-licensed medical personnel or lay volunteers. Board-certified physicians typically devote one to four half-days per month. Some clinics develop networks with local physician specialists such as cardiologists or endocrinologists or with hospitals to pool resources to enable the uninsured or undocumented to receive specialty care.[9]

There is a popular misconception that free clinics are no longer necessary after the implementation of the ACA. However, an estimated 29 million (11%) of those living in the United States were uninsured in 2019. Nearly half of the uninsured were not eligible for insurance because they lived in a state that did not expand Medicaid, were restricted because of immigration status, or were not eligible for subsidized health insurance premiums because their income was too high. Those without health insurance included noncitizens (23%); undocumented immigrants are not eligible for federally funded health insurance through Medicaid, the Marketplace, or the FQHC.[11] Immigrants are more likely to be uninsured because most work in low-paying jobs that do not include a health insurance benefit. In addition, documented immigrants must have lived in the United States for at least five years to be eligible for federally funded insurance; however, immigrants granted refugee status are eligible.[11]

Individuals who are unemployed or working in low-paying jobs and living in the 12 states that have not expanded Medicaid often are unable to pay for the premiums for health insurance policies through the Marketplace because of the cost. They fall into a coverage gap because they earn too much to be eligible for Medicaid and don't earn enough to be able to pay for health insurance premiums, even when the premiums are subsidized. However, they would be able to receive care in federally supported health centers. Undocumented immigrants often rely on free clinics for health care since they are not eligible for government programs, either Medicaid or services through the FQHC.

HOSPITALS: DEVELOPMENT AND SERVICES

Hospitals are the major agency in the healthcare system and vary greatly in size, depending on the location. A rural hospital may have two dozen beds; a hospital in a large city may have more than a thousand. The hospital is the key resource and center of the U.S. healthcare system. Hospitals not only deliver primary patient care, but some also train health personnel, conduct research, and disseminate information to consumers. Since the turn of the century, hospitals have gradually become the professional heart of all medical practice. Accelerating technological advances and changing societal factors have thrust hospitals into the grasp of big business. Hospitals are the second-largest business in the United States. They employ approximately 40% of healthcare personnel, with a collective payroll that accounts for at least one-third of the nation's health expenditures. Approximately 41% of federal health spending goes to hospitals as reimbursement for patients who are enrolled in Medicare or Medicaid.

American hospitals started around the time of the Civil War in response to urbanization and economic expansion during the Second Industrial Revolution as well as the arrival of large numbers of immigrants. When the country was first settled, most Americans lived in rural areas and received health care in the home. Hospitals emerged from **almshouses**, institutions that cared for the poor who were chronically ill or disabled. The first two hospitals in the United States were originally almshouses; a six-bed almshouse founded in 1736 in New York City later became Bellevue Hospital, and an almshouse founded in the same year in New Orleans later became Charity Hospital. Before the 1920s, the doctors donated their services, and the nurses and other staff received low pay; however, as healthcare staff became more professional, funds were required to operate the hospitals. From these first hospitals developed public hospitals established by cities, counties, or states that were committed to serving all people but especially the poor. The passage of the **Social Security Act of 1965** created the Medicare and Medicaid programs that funded health care for those over 65 years of age through Medicare and for the indigent through Medicaid. These programs provided federal funds to alleviate poverty; Medicare and Medicaid provided a source of funds to hospitals.[12]

The major forces affecting the development of hospitals include the following: (1) advances in medical science, most notably the discovery of antiseptic techniques and sterilization processes and the use of anesthesia; (2) advances in medical education, with predominant use of scientific theory and standardization of academic training for physicians; and (3) transformation of nursing into a profession by requiring training in caring for the wounded and ill, cleanliness and sanitation procedures, dietary instruction, and simple organized care. These effective, although simple, procedures were a great boon to the growth of hospitals, as the public began to see hospitals as a safe, effective place to go when they were ill. The fourth major force was the development of specialized technology such as X-rays, blood typing, and electrocardiograms, which all came into being early in the twentieth century.[13]

The growth of health insurance (which is discussed in Chapter 3) and of the role of government in the hospital industry has had a substantial impact on hospitals. The federal government has financed hospital construction, regulated the type of construction, financed the provision of care, and set policy for the ways in which hospitals are operated.

The complex hospital industry is usually categorized by three methods: function or type of service provided (from those treating a single disease such as cancer to those with multiple specialties, usually teaching hospitals); length of stay (many short-term, with five days being the average length of stay, and fewer long-term, such as psychiatric or chronic disease hospitals,

where the average stay is several weeks to months); and ownership or source of financial support—for example, government (or public), proprietary (private for-profit), or voluntary and religious (private nonprofit) ownership.[13] The majority of hospitals (5,141) in the United States are **community hospitals**, with nearly 3,000 of community hospitals being nonprofit (TABLE 2.1).

Hospitals are either private or public. Private hospitals are owned and operated by groups such as churches, businesses, corporations, and physicians. This type of facility is operated in such a way as to make a profit for the owners. A public hospital is financed and operated by a government agency—for example, by the city, county, or state. Such facilities are termed nonprofit facilities, and they admit many patients who cannot afford to pay for medical care. Patients in private hospitals have insurance, private funds, or medical assistance to pay for their care. Voluntary hospitals are usually nonprofit and often are owned and operated by religious organizations. Community hospitals are independent, nonprofit corporations consisting of local citizens interested in providing hospital care for their community.[13]

Proprietary hospitals or for-profit hospitals are operated for the financial benefit of the persons, partnerships, or corporations that own them. The current trend is toward a buyout of substantial numbers of these smaller hospitals by large investment firms, creating large, for-profit hospital systems. Management contracts are also on the rise, not only in for-profit hospitals but also in community hospitals. Both trends are expected to continue, as will adverse reaction to them, especially in regard to management corporations taking over community-based hospitals. Philosophy, policies, and operations change drastically under management systems—sometimes for the better and at other times with dubious benefit. However, the proliferation of multisystem hospitals (corporation owned, leased, or managed) will probably persist.[13]

Community hospitals are defined as short-term general and specialty hospitals designed to treat specific health problems, which may include obstetrics and gynecology; ear, nose, and throat; rehabilitation; and orthopedic conditions. These may include academic medical centers and teaching hospitals. A **hospital system** is defined as either more than one hospital managed by one organization or a single hospital that includes other healthcare organizations—for example, a single hospital that has ownership in a pre-acute outpatient clinic and/or in a post-acute rehabilitation center. A network is a group of hospitals, physicians, and other providers such as physical therapists or mental health workers, insurers, and other community agencies that work together to coordinate and deliver a broad spectrum of services within a town or geographic region.[14]

Public hospitals are owned by local, state, or federal agencies. Federally owned hospitals are generally reserved for the military, veterans, American Indians and Alaska Natives, or other special groups. State governments usually operate long-term hospitals treating chronic illnesses, such as mental institutions. Local governments have city, county, or district hospitals that are primarily short term and staffed by physicians who also have private practices. These types of hospitals in small cities and towns are generally small and function as community healthcare facilities. Public hospitals in major urban areas are large and are staffed by salaried physicians and resident physicians. They take care of the economically deprived and furnish all types of services—from drug abuse treatment to family planning.[13] Another term used to describe public hospitals is **essential hospitals and health systems** that provide significant levels of care to vulnerable populations with limited or no access to health care because of financial circumstances, insurance status, or health condition.[15]

Every state operates hospitals that provide long-term care (if necessary) for the treatment of the mentally ill or developmentally disabled persons; for example, Lincoln Regional Center is a hospital that provides care for Nebraskans who are mentally ill. These state hospitals are run by state administrative agencies; at the local level, district hospitals are supported by taxes from those who live in the district. These hospitals are not involved with the governments of cities, states, or counties. County and city hospitals provide services for the poor and for private patients. Municipal and county governments usually control city hospitals. An example of a locally governed public hospital is Cook County Hospital in Chicago, IL (now Stroger Hospital), which provided uncompensated care for residents without health insurance for years at a cost to taxpayers.

The federal government operates hospitals and clinics for three agencies—the VA, the DoD, and the IHS. The **Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)** is a comprehensive healthcare program in which the VA shares the cost of covered healthcare services with eligible veterans of the armed services. VA services are organized into regional centers that include hospitals and clinics. TRICARE is a managed healthcare program for active-duty and retired members of the armed services, their families, and survivors. Military retirees and spouses of

TABLE 2.1 Number of Hospitals in the United States by Type of Hospital, 2021[14]

Type of hospital	Number
Community	5,141
Nonprofit	2,946
For-profit	1,233
State and local	962
Federal government	208
Non-federal psychiatric	625

Data from American Hospital Association. *Fast Facts on U.S. Hospitals*, 2021. Accessed August 16, 2021. https://www.aha.org/system/files/media/file/2021/01/Fast-Facts-Hospitals-Infographic-2021-jan21.pdf

FIGURE 2.3 The federal government operates hospitals for the military and VA.

veterans killed in action are also eligible for health services through TRICARE. Walter Reed National Military Medical Center in Bethesda, MD, is one of the largest military hospitals in the United States and provides care for military personnel who are injured or need medical care (**FIGURE 2.3**).[16]

The IHS provides health services to 2.2 million American Indians (AI) and Alaska Natives (AN) who are members of 566 federally recognized tribes. IHS is administered through a system of 12 area offices and 170 IHS and tribally managed service units that include both hospitals and clinics. In addition, there are 33 urban health service programs to meet the needs of AI/AN who live off the reservation.[17]

AMBULATORY HEALTHCARE SERVICES

Care that is provided outside institutional settings is considered ambulatory care and is the most frequent contact that most people have with the healthcare system. Ambulatory care can be any type of care, from simple and routine to complex and specialized. Probably the most familiar kind of ambulatory care, and the one that most people receive, is in the office of either a single practitioner or a group practice or in a non-institutional clinic. The type of service is primary or secondary care, and the principal health practitioners are physicians, dentists, nurses, medical lab technicians, physical therapists, and medical and nursing assistants. If the community can afford an emergency transportation and immediate care system, paramedics and emergency medical technicians are also part of the ambulatory care network. Emergency advice is furnished from community hotlines and poison control centers.

Primary and secondary care is given at neighborhood health centers and migrant health centers as previously discussed in this chapter. Psychologists and social workers staff community mental health centers. Nurses staff home health and school health services and give both primary and preventive care. Public health services include targeted programs such as family planning, immunizations, screening, maternal and child nutrition, and health education. The health practitioners in these settings are physicians, nurses, dietitians, clinical assistants, and aides. The roster may also include environmental health specialists and health inspectors who do inspections of factories, hospitals, and food establishments to ensure the safety of workers and the public. Pharmacies are ambulatory care facilities staffed by registered pharmacists who dispense drugs and health education. Optical shops with optometrists and opticians provide vision care, while medical technicians provide specialized services in medical laboratories. The federal health system, previously detailed, furnishes all types of ambulatory care, as do prison services.

Many of the ambulatory care services evolve into large, highly complex organizations. For example, an executive committee may be elected to administer the service's business and operations functions. Designated group members may form a credentials committee to screen prospective members, or a building committee may be established.

Large group practices usually have a medical director who is responsible for establishing policies regarding the scope and quality of care as well as personnel practices.[13]

Hospitals are expanding their role to include ambulatory services. They have established fully staffed outpatient facilities and clinics. Hospital outpatient clinics include not only primary care but also specialties such as cardiology, neurology, and endocrinology. Teaching hospitals operate many specialty ambulatory clinics that expose medical students and residents to more extensive experiences. Ambulatory surgery centers and emergency medical services have both expanded, with emergency medicine becoming a specialty for physicians, and regional, hospital-based trauma centers have sprung up in many communities. Forces are at work within communities throughout the nation to enhance primary and specialized health care for all citizens.[13]

BEHAVIORAL HEALTH SERVICES

Behavioral health disorders include mental illness and substance use disorders. Mental illnesses are specific, diagnosable disorders characterized by intense alterations in thinking, mood, and/or behavior. Substance use disorders are conditions resulting from the inappropriate use of alcohol and drugs. Behavioral health disorders affect one in five Americans, yet finding affordable services can be a challenge for many.[18] In 2016, only 43% of nearly 45 million adults with any mental health disorder received treatment, and fewer than 11% of those with substance use disorder received treatment.[19]

Behavioral health personnel involved in the delivery of services include psychiatrists, who are physicians who make a diagnosis, prescribe medications, and may provide psychotherapy. Other health professionals include psychologists, clinical social workers, behavioral disorder counselors, and psychiatric nurses who have advanced degrees and who provide case management and/or psychotherapy. Primary care providers—physicians, nurse practitioners, and physician assistants—screen patients for mental health and substance use disorders and frequently prescribe psychotherapeutic medications. A number of allied health fields have developed in response to the growing needs of the community and the availability of funding. These include school counselors, special education teachers, and others such as art, music, and recreational therapists.

Mental health facilities in the United States were developed in the nineteenth century (as was the American Psychiatric Association), but they were little more than warehouses for large numbers of poor, homeless, alcoholics, drug addicts, and social misfits. They were state hospitals in which the primary purpose, instead of treating the patient, was to protect the public. The creation of the **National Institute of Mental Health (NIMH)** in 1946 and the development of psychopharmaceuticals in the 1950s were the major breakthroughs that led to the real treatment of mental illnesses. Psychotropic drugs enabled thousands of people to return to their communities and to be treated on an outpatient basis.[20] On October 31, 1963, President John F. Kennedy signed into law the **Community Mental Health Act,** which led to changes in how **mental health services** were delivered and provided funds for the establishment of comprehensive **Community Mental Health Centers (CMHC)** throughout the United States.[21]

By 1964, over 1,600 CMHC and general hospitals were providing mental health services in the community. General hospitals designated a certain number of beds as psychiatric beds for short-term stays. Grants were provided to finance staffing and conversion, especially in economically depressed areas. The centers provided inpatient, outpatient, and day care as well as emergency services; the centers were required to provide specialized services for the mental health of children and the elderly and offered special preventive, treatment, and rehabilitation programs for behavioral health disorders.[22]

Deinstitutionalization appeared to be an acceptable approach for treating mental illness; most patients who had been living in institutions could be treated in community facilities if a comprehensive program was available. Unfortunately, the government failed to adequately fund the CMHC needed for addressing the needs of those diagnosed with **serious mental illness (SMI)**—schizophrenia and severe bipolar disorder—with serious consequences. In 2017, an estimated 11 million adults (4.5%) over 18 years of age in the United States suffered from SMI, yet nearly half of those needing treatment were not getting it because (1) they could not afford the cost of treatment, (2) they didn't know where to go for treatment, or (3) they thought they could handle the problem on their own.[19] The publicly funded psychiatric system that was originally created to protect both the patients and the public no longer exists. Those with SMI are more likely to be homeless or incarcerated or attempt suicide. The psychiatric care they receive is fragmented and uncoordinated, coming at great cost to taxpayers, often with poor outcomes.[23]

Drug addiction became a public health crisis beginning in 2001 when deaths from drug overdoses needed to be addressed. In 2014, nearly 2 million people in the United States suffered from substance use disorders fueled by addiction to prescription opioids and heroin, with a 200% increase in death from overdose between 2001 and 2014. States addressed the opioid crisis by increasing patient access to medication-assisted treatment (e.g., methadone treatment and naloxone [Narcan]) and behavioral health treatment programs. Naloxone was made available to emergency medical technicians and emergency room staff to reverse an opioid overdose and prevent death.[24]

In response to the opioid crisis and decades of declining federal funding for both mental health and addiction treatment services, the bipartisan **Protecting Access to Medicare Act of 2014** funded **Certified Community Behavioral Health Clinics (CCBHC)** to expand access to comprehensive mental health and substance use disorder services. States applied for grants for Medicaid demonstration projects and were required to meet specific criteria including 24-hour crisis services and rapid response non-crisis services, tailored

services for active duty military and veterans, and access for all regardless of ability to pay. In 2017, eight states received funding for 66 CCBHC, and by 2020, 13 additional states were funded for a total of 113 clinics in 21 states. Other states can use Medicaid waivers to fund CCBHC. The clinics partner with primary care providers, hospitals, and other healthcare providers to coordinate care, integrate mental and physical health, and reduce hospital readmission; clinics also partner with local law enforcement to prevent recidivism.[25]

Hospitals can become "safety nets" for behavioral health care especially when there is a shortage of CMHC and CCBHC in the community. As a way to identify settings more appropriate for providing behavioral health services, hospitals are now partnering with CMHC, CCBHC, FQHC, academic medical centers, churches, community advocacy groups, and other social service agencies to connect those suffering from behavioral health disorders with care and resources. Hospitals are also working with healthcare workers in primary care settings to integrate assessment and treatment for behavioral health disorders.[18] Approximately one in eight emergency department (ED) visits involves a behavioral health condition, the most common being suicide ideation. This occurs in communities where access to behavioral health care is limited. To avoid repeat visits to the ED, hospitals are involving community resources for care.[18]

Many problems exist within the behavioral health system, including a society that stigmatizes mental illness and substance use disorders. One in 5 Americans suffers from mental illness or substance use disorders every year, yet only half of those seek treatment. Mental illness and substance use disorders are leading causes of disability and death. Adequate and appropriate treatment for mental illness has been difficult, especially for long-term treatment, because of lack of public funding. Historically, most private health insurance policies limited the number of days in the hospital and the number of outpatient visits for treating mental illness and substance use disorders. It has only been since 2008 that services began to be covered by health insurance policies as a result of the **Mental Health Parity and Addiction Equity Act of 2008**.[26] In addition, the ACA requires that all health insurance policies include mental and behavioral health services (see Chapter 5). These requirements are expected to increase access to mental health services for Americans. Unfortunately, those with SMI often are unable to seek treatment, including follow-up care, because of the disabling effects of mental illness. The consequences of untreated mental illness too often are unemployment, homelessness, and incarceration. Treatment requires an integrated system of social and medical services and greater awareness of mental health and mental illness, prevention, and early intervention. There are also disparities in behavioral healthcare access for various populations, including racial and ethnic minority groups, the LGBTQ community, military service members and veterans, and rural residents. These disparities continue to result in poorer health outcomes and increased costs across the healthcare system.[27] The CCBHC model addresses these issues, but not all states have these clinics, and as in the past, the federal government may reduce funding for these clinics, leaving those most vulnerable to a behavioral health crisis without the needed services.

THE CONSUMER'S RIGHTS

In 1973, the American Hospital Association (AHA) developed a Patient's Bill of Rights. The bill, although not a legally binding document, stated the responsibilities of the hospital and staff toward the patient and the patient's family. In 1997, President Bill Clinton appointed an advisory commission on consumer protection and quality in the healthcare industry that further refined the Patient's Bill of Rights. In 2003, the AHA developed the **Patient Care Partnership** to replace the Patient's Bill of Rights, which has six expectations for patients during hospitalization: (1) high-quality hospital care, (2) a clean and safe environment, (3) patient involvement in their own care, (4) protection of patient privacy, (5) help when leaving the hospital, and (6) help with billing claims. A brochure is available in several languages in addition to English and is posted on the AHA webpage.[28]

One of the patient's most important legal rights is **informed consent**; that is, the physician must obtain permission from the patient to perform certain actions or procedures. Informed consent must be obtained before beginning any invasive procedure, administering an experimental drug, or entering the patient into any research project. Specific criteria must be adhered to for informed consent to be valid. Important factors are that the client must be rational and competent or be represented by someone (an advocate) and that the document must be written in a language the client can understand, delineate all the risks involved, state that participation is voluntary, and list the benefits of the procedure and alternatives to the procedure. The client's right to informed consent affects how the healthcare system delivers care. It usually results in increased costs from extra paperwork, but it is necessary for the consumer's protection (and may reduce the care provider's vulnerability to malpractice suits).

Healthcare professionals working in such a wide variety of facilities find challenges and diversity that require them to become knowledgeable in specialized areas and to expand their range of services. The healthcare professional who prefers research may choose to work in primary research institutions, such as the NIH and agencies that administer health and welfare programs. Two major agencies are the VA hospitals and clinics and the U.S. Public Health Service (PHS). If you choose to practice in Canada, the Canada Health Care System covers medical care for all residents of Canada.

PUBLIC HEALTH SERVICES

The mission of HHS is to enhance and protect the health and well-being of all Americans by providing for effective health and human services and fostering advances in medicine, public health, and social services. The Secretary, Operating

Divisions, and Regional Offices administer HHS programs including the ACA. Many HHS-funded services are provided at the local level by state or county agencies or through private-sector grantees (TABLE 2.2).[2]

HHS is responsible for Medicare, Medicaid, public health, biomedical research, food and drug safety, disease control and prevention, Indian health services, and mental health services. HHS works closely with state and local governments and provides leadership in public health emergency preparedness in the event of severe weather, infectious disease epidemics, or biological terrorism.[2]

The focus of public health is the community instead of the individual. The community may be limited to a city or may include an entire state, country, or the world. The recent outbreaks of infectious diseases such the coronavirus and Ebola demonstrate the importance of global disease surveillance, pooling of research efforts to help identify pathogens, and international cooperation to develop diagnostic tests, prevention measures, and treatments.

The emphasis in public health is on prevention in contrast to medical care, in which the emphasis is treatment of disease. Public health practitioners are represented by a variety of disciplines such as nursing, medicine, veterinary medicine, dentistry, health education, and nutrition.

Practitioners in public health, including epidemiologists and statisticians, study the nature of new threats and organize public measures to combat them. Because the government is usually involved in the financing and policy-making procedures, the term "public health" has come to include research, assessment, and control measures.

The threats to health change over time. As one set of diseases, epidemics, and conditions is brought under control or eliminated, new diseases appear. The past focus of services, as previously discussed, was to prevent or mitigate the effects of acute infectious diseases such as smallpox, bubonic plague, typhoid fever, childhood infectious diseases, and the 1918 flu pandemic. With the changes in living conditions in the twentieth century, degenerative, debilitative diseases such

TABLE 2.2 Operating Divisions and Functions within the U.S. Department of Health and Human Services (HHS)[2]

Administration for Children and Families (ACF)	Promotes economic and social well-being of families, children, individuals, and communities through educational and supportive programs in partnership with states, tribes, and community organizations.
Administration for Community Living (ACL)	Ensures access to community support and resources to meet needs of older Americans and people with disabilities.
Agency for Healthcare Research and Quality (AHRQ)	Supports research designed to improve quality and patient safety, reduce healthcare costs and medical errors, and broaden access to essential services.
Agency for Toxic Substances and Disease Registry (ATSDR)	Prevents exposure to toxic substances and the adverse health effects and diminished quality of life associated with exposure from waste sites, unplanned releases, and other sources of environmental pollution.
Centers for Disease Control and Prevention (CDC)	Protects the public health of the nation by providing leadership and direction in the prevention and control of diseases and other preventable conditions, and responding to public health emergencies.
Centers for Medicare and Medicaid Services (CMS)	Combines oversight of the Medicare program, the federal portion of the Medicaid program and State Children's Health Insurance Program, the Health Insurance Marketplace, and related quality-assurance activities.
Food and Drug Administration (FDA)	Ensures that food is safe, pure, and wholesome; human and animal drugs, biological products, and medical devices are safe and effective; and electronic products that emit radiation are safe.
Health Resources and Services Administration (HRSA)	Improves access to healthcare services for people who are uninsured, isolated, or medically vulnerable.
Indian Health Service (IHS)	Provides American Indians and Alaska Natives with comprehensive health services by developing and managing programs to meet their health needs.
National Institutes of Health (NIH)	Supports biomedical and behavioral research in the United States and abroad, conducts research in its own laboratories and clinics, trains promising young researchers, and promotes collecting and sharing medical knowledge.
Substance Abuse and Mental Health Services Administration (SAMHSA)	Improves access and reduces barriers to high-quality, effective programs and services for individuals who suffer from or are at risk for addictive and mental disorders as well as for their families and communities.

Reproduced from Department of Health and Human Services, HHS Agencies & Offices. https://www.hhs.gov/about/agencies/hhs-agencies-and-offices/index.html[3]

as chronic obstructive pulmonary disease (COPD), cancer, arthritis, strokes, and coronary heart disease have replaced infectious diseases. That is, until 2020, when the pandemic caused by COVID-19 caught the world unprepared to manage a public health crisis. The virus caused many hospitalizations and deaths comparable to the worldwide 1918 influenza.

The public health system requires cooperation among federal, state, and local governments. Great changes in the roles played by government agencies have occurred over time, with the most important one being the **Social Security Act of 1935**. This act established annual grants-in-aid from the federal government to the states, part of the purpose of which was to fund full-time local health departments. These grants provided for maternal and child health services and extended the services of local public health departments according to the needs of their communities. They were matching-fund grants, in which the states matched federal money on a dollar-for-dollar basis.

Public health at the city and state level now includes such functions as licensing and accrediting health professionals and health facilities, setting standards for automobile safety devices, and supervising the quality of medical payment programs such as Medicaid.

The establishment of public health and social services in the United States has evolved over time. **TABLE 2.3** is a timeline of the HHS beginning in 1798 with an act to provide health care for sick and disabled seamen.[9]

Six basic functions were established for the Public Health Service between 1935 and 1946, and with few revisions they remain the foundation for public health agencies. These are (1) collecting and reporting vital statistics such as birth, death, and incidence of diseases; (2) controlling communicable diseases such as influenza and measles; (3) maintaining a sanitary and safe supply of food and water; (4) ensuring maternal and child health by providing prenatal care; (5) improving health education on common diseases through publications and state and local outreach; and (6) providing laboratory services to track communicable diseases such as HIV/AIDS, COVID-19, influenza, and outbreaks of foodborne illnesses. States conduct annual telephone surveys of residents as part of the **Behavioral Risk Factor Surveillance System (BRFSS)** to evaluate behaviors that increase risk for

TABLE 2.3 Historical Highlights of Health and Human Services in the United States[29]

1798	Passage of an act for the relief of sick and disabled seamen, which established a federal network of hospitals for the care of merchant seamen, the forerunner of today's U.S. Public Health Service.
1862	President Lincoln appointed a chemist, Charles M. Wetherill, to serve in the new Department of Agriculture. This was the beginning of the Bureau of Chemistry, the forerunner to the Food and Drug Administration.
1871	Appointment of the first Supervising Surgeon (later called Surgeon General) for the Marine Hospital Service, which was organized the previous year.
1878	Passage of the National Quarantine Act began the transfer of quarantine functions from the states to the federal Marine Hospital Service.
1887	The federal government opened a one-room laboratory on Staten Island for research on disease, thereby planting the seed that was to grow into the National Institutes of Health.
1891	Passage of immigration legislation, assigning to the Marine Hospital Service the responsibility for the medical examination of arriving immigrants.
1902	Conversion of the Marine Hospital Service into the Public Health and Marine Hospital Service in recognition of its expanding activities in the field of public health. In 1912, the name was shortened to the Public Health Service (PHS).
1906	Congress passed the Pure Food and Drugs Act, authorizing the government to monitor the purity of foods and the safety of medicines, which is now a responsibility of the Food and Drug Administration (FDA).
1912	President Theodore Roosevelt's first White House Conference urged the creation of the Children's Bureau to combat the exploitation of children.
1921	The Bureau of Indian Affairs Health Division was created, the forerunner to the Indian Health Service.
1930	Creation of the National Institute (later Institutes) of Health, out of the Public Health Service's Hygienic Laboratory.
1935	Passage of the Social Security Act.
1938	Passage of the Federal Food, Drug, and Cosmetic Act.
1939	The Federal Security Agency was created, bringing together related federal activities in the fields of health, education, and social insurance.
1946	The Communicable Disease Center was established, forerunner of the Centers for Disease Control and Prevention (CDC).

(*Continued*)

TABLE 2.3 Historical Highlights of Health and Human Services in the United States[29] (*Continued*)

1955	Licensing of the Salk polio vaccine. The Indian Health Service was transferred to the U.S. Department of Health and Human Services from the Department of the Interior.
1961	First White House Conference on Aging.
1962	Passage of the Migrant Health Act, providing support for clinics serving agricultural workers.
1964	Release of the first Surgeon General's Report on Smoking and Health.
1965	Creation of the Medicare and Medicaid programs, making comprehensive health care available to millions of Americans. The Older Americans Act created nutrition and social programs administered by the HHS's Administration on Aging. Head Start program was created.
1966	International Smallpox Eradication program was established; led by the U.S. Public Health Service, the worldwide eradication of smallpox was accomplished in 1977. The Community Health Center and Migrant Health Center programs were launched.
1970	Creation of the National Health Service Corps.
1971	National Cancer Act signed into law.
1975	Child Support Enforcement program was established.
1977	Creation of the Health Care Financing Administration (HCFA) to manage Medicare and Medicaid separately from the Social Security Administration.
1980	Federal funding provided to states for foster care and adoption assistance.
1981	Identification of AIDS. In 1984, the Public Health Service and French scientists identified HIV. In 1985, a blood test to detect HIV was licensed.
1984	National Organ Transplantation Act signed into law.
1988	Creation of the JOBS program and federal support for child care. Passage of the McKinney Act to provide health care to the homeless.
1989	Creation of the Agency for Health Care Policy and Research (now the Agency for Healthcare Research and Quality).
1990	Human Genome Project established. Passage of the Nutrition Labeling and Education Act, authorizing the food label. Ryan White Comprehensive AIDS Resource Emergency (CARE) Act began providing support for people with AIDS.
1993	The Vaccines for Children Program was established, providing free immunizations to all children in low-income families.
1995	The Social Security Administration became an independent agency.
1996	Enactment of welfare reform under the Personal Responsibility and Work Opportunity Reconciliation Act. Enactment of the Health Insurance Portability and Accountability Act (HIPAA).
1997	Creation of the State Children's Health Insurance Program (CHIP), enabling states to extend health coverage to more uninsured children.
1999	The Ticket to Work and Work Incentives Improvement Act of 1999 made it possible for millions of Americans with disabilities to join the workforce without fear of losing their Medicaid and Medicare coverage. Initiative on combating bioterrorism was launched.
2000	Publication of human genome sequencing.
2002	Office of Public Health Emergency Preparedness was created to coordinate efforts against bioterrorism and other emergency health threats.
2003	Enactment of the Medicare Prescription Drug Improvement and Modernization Act of 2003, the most significant expansion of Medicare since its enactment, including a prescription drug benefit.
2010	The Affordable Care Act was signed into law, putting in place comprehensive U.S. health insurance reforms.

Modified from U.S. Department of Health and Human Services. *HHS Historical Highlights*, 2017. http://www.hhs.gov/about/historical-highlights/[29]

chronic disease, including diet, physical activity, smoking, and drug and alcohol use. Individual states report health statistics to the **National Center for Health Statistics**, and the **Centers for Disease Control and Prevention (CDC)** compiles, analyzes, and reports data on disease prevalence. The CDC works in cooperation with infectious disease specialists around the world to track outbreaks of infectious diseases and to develop vaccines and other treatment protocols. In addition, the CDC monitors air and water quality and provides support in emergencies, such as severe weather conditions that impact health and safety (**FIGURE 2.4**).

In the United States, career opportunities in public health exist in the **Commissioned Corps**, an essential component of the largest public health program in the world. Corps officers are eligible for a variety of positions throughout the HHS and certain non-HHS federal agencies and programs in the areas of disease control and prevention; biomedical research; regulation of food, drugs, and medical devices; mental health and drug abuse; healthcare delivery; and international health. Opportunities are also available at the community level in public health departments and professional organizations—for example, the American Heart Association.

The student desiring to go into public health must be aware of the political battles that are being waged over the structure of the system as well as a lack of financial support. New and changed roles for local, state, and federal public health agencies are apparent. The nation will continue to need public health services and leaders who keep abreast of new research and who have a grasp of modern health problems and solving problems from both a preventive and curative standpoint. Also needed is an understanding of the political system and societal expectations and demands. The student who chooses a public health service career will be in a role with changing dynamics while still fulfilling fundamental, long-accepted functions. Table 2.3 lists achievements in public health in the United States.

HEALTH CARE IN THE TWENTY-FIRST CENTURY

From its humble, unscientific, and often haphazard beginnings to the present multibillion-dollar industry, the private U.S. healthcare system has undergone broad and often drastic changes. Its present visibility and highly technical orientation have led to thousands of jobs, created new professions, and provided care to millions of people. It is not without the attendant problems of a giant industry, however, and in the twenty-first century, the system must face and solve yet more problems. Preventive health care will play an important role

FIGURE 2.4 The CDC monitors air and water quality and provides support in weather emergencies.
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in achieving health care for all through recently expanded federally funded primary care clinics and behavioral health clinics in response to the opioid crisis and high rates of incarceration of those with serious mental illness. Although many infectious diseases have been nearly eliminated through vaccination programs, new infectious threats can reappear, as happened in 2019–2020 with COVID-19. American ingenuity will face a difficult challenge in formulating a workable, affordable system for all people.

SUMMARY

Unlike most developed countries the United States does not have a centralized health care delivery system (national health system) in which individuals automatically receive health care. Instead, the majority of Americans obtain health care services from a variety of locations and providers; services are employer-funded private insurance or government-subsidized Medicare or Medicaid. Five broad categories of healthcare services are health promotion, disease prevention, diagnosis and treatment, rehabilitation, and chronic care.

The only direct health services provided by the federal government are TRICARE, through the Department of Defense, CHAMPVA through the Veterans Administration, and the Indian Health Service. The federal government administers public health programs through 11 agencies within Health and Human Services (HHS) responsible for Medicare, Medicaid, public health, biomedical research, food and drug safety, disease control and prevention, Indian health services, and mental health services. HHS works closely with state and local governments and provides leadership in public health emergency preparedness. The role of the U.S. Congress is making laws, allocating funds, and doing investigative work through committees.

Hospitals are the second-largest industry in the United States and the largest employer of healthcare workers. Public hospitals are financed by the government, while private hospitals are financed by businesses, churches, physicians, and others. Hospitals provide patient care, train health professionals, conduct research, and provide public education for consumers and members of the community. The American Hospital Association's Patient Care Partnership informs patients of their rights and responsibilities during hospitalization and after hospital discharge.

Ambulatory healthcare is delivered outside of a hospital setting and employs the second-highest number of healthcare workers to provide care for simple to complex health conditions. Federally Qualified Health Centers are funded by Medicare, Medicaid, and private insurance, and serve high-need and medically underserved people including those with substance use disorders and HIV. Free Medical Clinics are privately funded and serve those who are uninsured—the unemployed and underemployed—as well as undocumented immigrants and the homeless. Certified Community Behavioral Health Clinics are federally funded and provide comprehensive mental health and substance use disorder services.

LEARNING PORTFOLIO

Study Points

1. The healthcare industry is a complex system of hospitals, ambulatory care, laboratories, pharmaceutical and medical equipment manufacturers, and private and government-funded programs. However, the United States does not have a centralized healthcare delivery system common in other countries including Canada and the United Kingdom.
2. Hospitals are the second-largest industry and the largest employer of healthcare workers in the United States.
3. Direct healthcare services provided by the federal government are limited to the U.S. Department of Defense, the U.S. Veterans Administration, and Indian Health Services.
4. Most health care is delivered in ambulatory care settings by a variety of health professionals.
5. Five broad categories of health care are health promotion, disease prevention, diagnosis and treatment, rehabilitation, and chronic care.
6. Nearly 1,400 Federally Qualified Health Centers (FQHC) are funded by Medicare, Medicaid, private insurance, and patient fees. FQHC serve high-need and medically underserved people living in urban and rural areas, including large populations with substance abuse disorders and HIV.
7. About 1,400 privately funded free medical clinics (FMCs) serve those who are uninsured—the unemployed and underemployed as well as undocumented immigrants and the homeless.
8. Inadequate public funding for treating serious mental illness (SMI) has had serious consequences for those with SMI: unemployment, homelessness, and incarceration.
9. In response to deaths from the opioid crisis and homelessness and incarceration of those with serious mental illness, federal legislators funded Certified Community Behavioral Health Clinics (CCBHC) beginning in 2017.
10. Hospitals provide patient care, train health professionals, conduct research, and provide public education for consumers and members of the community.
11. Four major forces responsible for the development of hospitals in the United States are (1) aseptic techniques, (2) advances in medical education, (3) professional development of nurses, and (4) specialized technology.
12. Hospitals are categorized by function, length of stay, and financial support or ownership. Public hospitals are financed by the government, while private hospitals are financed by businesses, churches, physicians, and others. There are more community, nonprofit hospitals than all other categories of hospitals.
13. Most health care is delivered in ambulatory care settings by a variety of health professionals.
14. The American Hospital Association developed the Patient Care Partnership as a guide for hospital personnel in providing care to patients and to inform hospital patients of their rights and responsibilities.
15. The coronavirus, COVID-19, caught the world unprepared for an infectious disease pandemic resulting in the infection and death of thousands around the world.
16. The most important federal agency responsible for the health of the United States is the U.S. Department of Health and Human Services, which administers 11 operating divisions responsible for Medicare, Medicaid, public health, biomedical research, food and drug safety, disease control and prevention, mental health services, and Indian Health Services.

Issues for Discussion

1. View the 5½-minute video "American's Health Centers: An Enduring Legacy, Value for Today & Tomorrow," March 21, 2015. National Association of Community Health Centers. Discuss the history of federally funded national health centers. Discuss the medical services provided at these centers and the medical and economic benefits for local communities. https://www.youtube.com/watch?v=aV9jJpX0PZI
2. View the 2-minute cartoon video "My Hospital—Advancing Health in America" from the American Hospital Association. Discuss community outreach programs of the hospital and how health care is coordinated with other health service facilities in the wider community that make up health care in the entire community. https://www.youtube.com/watch?v=NFiLJksGOxA
3. Go to the Centers for Disease Control and Prevention (CDC) webpage, link to *Emergency Preparedness and Response,* and select one disaster to review what to do before, during, and after the event, especially regarding food and water safety.

   Which weather-related disasters are common in your area? What can you do to be prepared to prevent injury or illness? Which agencies in your community provide support during emergencies? https://www.cdc.gov/disasters/alldisasters.html

LEARNING PORTFOLIO

4. Review the infographic titled "Multicultural Mental Health Infographic" from the National Alliance for Mental Illness.

   At what age does chronic mental illness appear? Which ethnic group has the highest incidence of mental illness? Which other minority groups have a high incidence of mental illness? https://www.nami.org/NAMI/media/NAMI-Media/Infographics/MulticulturalMHFacts10-23-15.pdf

Enrichment Activities

1. Access the website for the National Association of Free and Charitable Clinics; enter the zip code where you live to find out if there are any free clinics where you live. https://www.nafcclinics.org/find-clinic
2. Go to the Indian Health Services' website to find out what healthcare services are provided and how the quality of the health services are monitored. http://www.ihs.gov/forpatients/healthcare/
3. Go to the Centers for Disease Control and Prevention website and review information about the 1918 Pandemic Flu (H1N1 virus). What are the similarities with the COVID-19 pandemic in 2020? What are the differences? https://www.cdc.gov/flu/pandemic-resources/1918-pandemic-h1n1.html

CASE STUDY: CATEGORIES OF HEALTH CARE

Jenny was enlisted in the United States Navy and was on active duty as a hospital corpsman serving as an operating room technician during surgery. Jenny was able to begin taking basic college courses while in the Navy with a goal of becoming a registered nurse. She has been admitted to a community college in a suburb of Chicago to begin an associate's degree that will enable her to complete the requirements to take the national licensing exam required to become a registered nurse. Jenny plans to work part time as a waitress; however, she will have no health benefits through her job. Jenny is a single mother of a 5-year-old daughter and is concerned about obtaining health care for herself and her daughter while she attends college.

Based on the information about healthcare systems, answer the following questions.

1. Jenny has found it challenging to follow a routine of regular physical activity since leaving the military. Which of the following category of health services would assist Jenny in meeting her goal of becoming physically fit?
   A. Diagnosis
   B. Health promotion
   C. Disease prevention
   D. Treatment
2. Which category of health services are immunizations?
   A. Diagnosis
   B. Health promotion
   C. Disease prevention
   D. Treatment
3. Jenny's boyfriend Joe is also a veteran. He is a construction worker and injured his back several months ago. Joe's doctor prescribed a pain medication, and Joe was able to continue to work because the medication stopped the pain. Joe has tried to stop taking the pain medication but experienced withdrawal symptoms. Where would you recommend that Joe not go for treatment of his addiction?
   A. VA clinic
   B. Primary doctor
   C. Certified Community Behavioral Health Clinic
   D. Emergency room

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