2 Categories of Health Services

Key Terms

- Department of Health and Human Services (DHHS)
- Public Health Service (PHS)
- Health promotion and illness prevention services
- Diagnosis and treatment
- Rehabilitation
- Healthcare facilities
- Managed care organization (MCO)
- Health maintenance organization (HMO)
- Preferred provider organization (PPO)
- Medicare and Medicaid
- Diagnosis related groups (DRGs)
- Informed consent
- Health teams
- Public hospital
- Proprietary hospital
- Ambulatory care
- Mental health services

Objectives

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

1. Describe the healthcare functions of private and public facilities, inpatient and outpatient services, military facilities, and volunteer facilities.
2. Explain how healthcare systems are financed.

3. Identify the four major types of health services and their functions.
4. Compare the functions of the two major providers of managed care.
5. Explain the concept of diagnosis related groups.
6. Name the major points of the Patient's Bill of Rights.
7. Describe public health, hospital, ambulatory, and mental health services.

Overview of the U.S. Healthcare System

The U.S. healthcare system is extremely varied. Individual healthcare units, which at times overlap, serve a variety of people based on their economic and social status. Individuals and families receive and buy healthcare services based on what they perceive to be their immediate needs. At the present time, physicians in private practice direct delivery of health care. Health care is primarily financed by personal, nongovernment funds or is paid directly by consumers through private health insurance plans. Local and state governments provide public health services.

The federal government provides very few health services directly, preferring to develop new, improved services by furnishing money to buy the developments it wants to see expanded. With minor exceptions—Veterans Administration and the Indian Health Service—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 and individual health care for the elderly and indigent (via Medicare and Medicaid).

Congress plays a key role in this federal activity by making laws, allocating funds, and doing investigative work through committees. The most important federal agency concerned with health affairs is the *U.S. Department of Health and Human Services (USDHHS)*. The principal unit within this department is the Public Health Service (PHS), which has eight agencies within its domain: National Institutes of Health (NIH); Substance Abuse and Mental Health Services Administration (SAMHSA); Food and Drug Administration (FDA); Centers for Disease Control and Prevention (CDC); Health Resources and Services Administration (HRSA); Agency for Healthcare Research and Quality (AHRQ); Agency for Toxic Substances and Disease Registry (ATSDR); and the Indian Health Service (IHS). The PHS is described more completely later in this chapter.

A wide variety of healthcare facilities are available. These facilities, the places where persons involved in the healthcare industry work, are broadly summarized in this chapter and are individually detailed in succeeding chapters. This discussion of the numerous healthcare fields should assist students in selecting a career and becoming knowledgeable about their chosen fields.

The healthcare industry is a complex system of remedial, therapeutic, and preventive services. Hospitals, clinics, government and volunteer agencies, healthcare professionals, pharmaceutical and medical equipment manufacturers, and private insurance companies provide these services. The healthcare system offers four broad types of services: health promotion, disease prevention, diagnosis and treatment, and rehabilitation.

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 consumers prenatal nutrition classes and local health departments that offer selected recipients prenatal nutrition classes plus the foods that satisfy their nutrient requirements (the Women, Infants, and Children [WIC] program). Other classes at both hospitals and health departments 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.

Illness 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. Preventive measures such as these can reduce the overall costs of health care.

Traditionally the *diagnosis and treatment* of illnesses have been the most heavily used of the healthcare services. Normally people waited until they were ill to seek medical attention. However, 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.

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 institutions, hospitals, outpatient settings, and extended care facilities. Rehabilitation is a long process, and both the client and family require extra assistance in adjusting to a chronic disability.

Healthcare Facilities

Expansion of the healthcare system and professional specialization has resulted in an increase in the range and types of healthcare settings. A wide variety of *healthcare facilities* are now available. The range includes inpatient, outpatient, community-based, voluntary, institutional, governmental, hospice, and comprehensive health maintenance agencies.

Clients not requiring hospitalization can find health care in physicians' offices, ambulatory care centers, and outpatient clinics. Immediate care clinics exist as freestanding clinics or inside a pharmacy and are staffed by physicians, nurse practitioners or physician assistants who treat minor acute illnesses such as colds, cuts, or sprains. Although physicians with office practices focus mainly on diagnosis and treatment of specific diseases, many clinics and ambulatory centers offer health education and rehabilitation as well.

Community-based agencies provide health care to people within their defined neighborhoods. Such diverse facilities as 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.

Institutions that provide *inpatient* (persons admitted to a facility for diagnosis, treatment, or rehabilitation) services include hospitals, nursing homes, extended care facilities, and

rehabilitation centers. Hospitals are the major agency in the healthcare system. They vary greatly in size, depending on location. A rural hospital may have two dozen beds; a hospital in a large city may have more than a thousand.

Hospitals are either private or public. A private hospital is owned and operated by groups such as churches, businesses, corporations, and physicians. Private hospitals are operated in such a way as to make a profit for their owners. A public hospital is financed and operated by a government agency, either at the local or national level. Such facilities are termed *nonprofit* facilities, and they admit many clients who cannot afford to pay for medical care. Clients 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.

Each branch of the military operates and owns hospitals that provide care and treatment for military personnel and their families. The federal government operates Veterans Administration (VA) and Indian Health Service (IHS) hospitals and clinics. The VA provides health care for veterans of the armed services. The IHS is responsible for providing health services to American Indians and Alaska Natives. The IHS currently provides health services to approximately 1.5 million American Indians and Alaska Natives who belong to more than 557 federally recognized tribes in 35 states.

Every state operates hospitals that offer long-term care, if necessary, for treatment of the mentally ill or retarded. 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 hospitals are run by counties and provide services for the poor and private patients. City hospitals are usually controlled by municipal and county governments. Many city hospitals provide care primarily for the poor.

Healthcare professionals working in such widely different facilities encounter diverse challenges 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 Veterans Administration Hospitals and the Public Health Service. If you choose to practice in Canada, the Canada Health Care System covers medical care for all residents of Canada.

Managed Care

Managed care organizations (MCOs) were the health insurers of choice in 2000. They were divided primarily into *health maintenance organizations (HMOs)* and *preferred provider organizations (PPOs)*.

Some of the most prominent HMOs included Kaiser Permanente in California, Group Health Association in Washington, DC, and the Medical Care Group of Washington University in St. Louis. An HMO provides basic and supplemental health maintenance and treatment services to enrollees who pay a fixed fee. The range of health services delivered depends

on the voluntary contractual agreement between the enrollee and the plan. The focus of HMOs is health maintenance, and these agencies employ a large number of healthcare professionals. People belonging to an HMO must use the agency's designated facilities instead of choosing their own, but the services rendered are all prepaid. The consumer's cost is generally less than in other facilities.

Preferred provider organizations offer another option to the consumer for the delivery of health care. PPOs comprise groups of physicians or a hospital that provides companies with comprehensive health services at a discount. They employ paraprofessionals as needed.

Managed care organizations, such as these, showed robust growth in the early and middle 1990s, but experienced a sudden decline in profits in the late 1990s. By the early 2000's MCOs were again showing a profit. The reasons for the losses vary, but the most prevalent ones included the following:

1. The 1990s saw many privately insured employees changing from fee-for-service plans to HMOs, a one-time shift that could save them 10 to 15 percent on their premiums. By late 1990 the majority of employees had made their transition to HMOs and the large gains in enrollment were over.
2. Physicians started to organize to improve their bargaining power with the MCOs. Consumer groups began lobbying their political representatives in Congress and state legislatures to pass consumer protection laws that would provide more choices. These movements also reduced managed care profits.
3. The Balanced Budget Act of 1997 reduced payments to providers, hospitals, and doctors.

The Consumer and Health Care

As discussed in Chapter 1, U.S. society has come to believe that all people have a right to health care regardless of ethnic, social, or economic background. This belief in the 1940s led to the enactment of the *Medicare* and *Medicaid* programs. These programs, with revisions, continue to provide health care for those who cannot afford it, generally the poor and the elderly. However, with escalating medical costs, payments for services have become *prospective*, which means that the rates for reimbursement to healthcare providers are standardized under federal guidelines. The rates are determined on the basis of 492 *diagnosis related groups (DRGs)*. This policy has advantages and disadvantages. On one hand, if Medicare costs are kept from unreasonable increases, the client may be protected in the right to health care. On the other hand, since an agency is reimbursed only a set amount, regardless of its actual costs, the client's right to health care may be threatened because the facility will be reluctant to provide more expensive tests and procedures and in some cases may not accept the client at all.

The Consumer's Rights

In 1973 the American Hospital Association developed a Patient's Bill of Rights, which lists 12 specific rights of hospitalized patients. This bill, while not a legally binding document,

states the responsibilities of the hospital and staff toward the client and his or her family. The major tenets are that the client has the right to:

- Receive information pertaining to diagnosis and treatment
- Receive information on fees for services rendered
- Receive continuity of care
- Refuse diagnosis and treatment procedures
- Enjoy privacy and confidentiality from staff and physicians
- Seek a second opinion
- Change physicians and/or facilities if unsatisfied

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

In early 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. Its five care provisions were:

- The right to treatment information
- The right to privacy and dignity
- The right to refuse treatment
- The right to emergency care
- The right to an advocate

Each of these rights contains additional provisions to help the consumer understand their meaning and obtain the best care.

Health Teams

The concept of health teams throughout all types of health services has brought about changes in healthcare delivery. The health team consists of a variety of health personnel, each with a specialized function. The membership of the health team varies in accordance with the needs of the client and his or her family.

There are two general types of health teams, functional and patient-centered. Each varies according to the kind of problem to be solved and may dissolve at any given point and regroup to address other special problems. Team members are usually doctors, nurses, dietitians, therapists, and other direct care providers. *Functional teams*, such as the mental health team or the coronary care team, are formed to take care of specific problems. *Patient-centered teams* include patients and family members who are involved in making healthcare decisions together with their doctor and other healthcare professionals.

Medical technologists, radiologic technologists, and pathologists may form a back-up medical care team for the patient. They are not in close contact with the patient, but deal with specific parts of the patient's care, such as his or her X-rays, blood samples, and cultures.

At the outside edge of the interrelated teams are the people who concentrate on the delivery, the costs, the quality, and the availability of services. This healthcare team is composed of public health agents, hospital administrators, health educators, sanitarians, and others.

People working in the health professions must accept the changing nature of health teams and recognize that the combined skills of many professionals contribute to modern health care.

Healthcare Costs

Some major problems plague the healthcare system in the United States. First, the cost of health care is exorbitant and continues to rise. Health insurance premiums are increasing and may approach double-digit increases in the near future. Hospitals are finding it more difficult to maintain profit margins. In 2005, for example, 25 percent of all community hospitals in the United States received inadequate government reimbursement and hospital costs exceeded the amount reimbursed by Medicare and Medicaid by $25 billion. More hospitals, more doctors (80 percent of whom are specialists), more growth in medical science and healthcare technology, greatly expanded research, and expanded insurance coverage have contributed to this phenomenal rise in costs. Second, health care is fragmented. Patients no longer see a family physician with whom they are familiar, but rather a battery of specialists. This fragmentation is confusing and worrisome for the average consumer. Third, the many technological changes taking place can quickly outdate the knowledge and skills of the health practitioner. Fourth, the elderly population is expanding rapidly, increasing the need for special care and technology for this group. Services provided to the poor and the elderly are inadequate. Last, there is an uneven distribution of health services. Although rural areas and towns usually build small clinics or hospitals, the number of rural health workers is low when compared to the number in cities.

There were 47 million uninsured persons in 2006 including 9 million children, and more than 30 million additional underinsured individuals in the United States. Because healthcare costs must be controlled, the government may have to provide essential coverage to the entire population. People who want more and better care will have to pay for it out of their own pockets through private insurance or employer benefits. It is speculated that many employers and employees may separate employment from health care. The employer will just increase wages or provide a supplementary health benefit. This trend will make the future of managed care even more uncertain. The financing of health care is discussed in Chapter 3.

Public Health Services

The threats to health change over time. As one set of diseases, epidemics, and conditions is brought under control or eliminated, new diseases appear. Public health services previously focused on preventing or mitigating the effects of acute infectious diseases such as smallpox, bubonic plague, typhoid fever, childhood diseases, and other highly lethal maladies. As living conditions changed in the twentieth century, degenerative, debilitative diseases, such as chronic obstructive pulmonary disease (COPD), mental and emotional dysfunction, cancer, arthritis, strokes, and coronary heart disease (CHD) replaced infectious diseases. Practitioners in public health, including researchers, study the nature of new threats and organize public measures to combat them. Since 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.

Public health services deal primarily with four aspects of care: identifying diseases that cause health or debility; assessing the causes and methods of transmission; finding ways to control or cure diseases and prevent their spread; and educating the public to apply the findings effectively.

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 whose purpose 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.

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:

- Vital statistics (the recording, reporting, and publication of births, deaths, and diseases)
- Communicable disease control (any disease, such as sexually transmitted disease, that is transmissible between humans)
- Sanitation of the food, milk, and water supply, as well as public eating establishments
- Laboratory services
- Maternal and child health
- Health education

Services added since the basic functions were established have broadened the scope of the American Public Health Association (APHA) and have vested more power in it. The domain 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. Current major goals are:

- Expansion of services and treatment for poor children
- Health promotion, disease prevention, and health maintenance
- Mental health services, especially at the community level

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. New and changing 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 solutions from both a preventive and curative standpoint. These persons will also need 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 that is changing in dynamics while still fulfilling fundamental, long-accepted functions.

Hospitals: Development and Services

The hospital is the key resource and center of the U.S. healthcare system. Hospitals not only deliver primary patient care but 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 third-largest business in the United States. They employ approximately 75 percent of healthcare personnel, with a collective payroll that accounts for at least 40 percent of the nation's health expenditures. Approximately 60 percent of federal health monies and 40 percent of all state and local health monies go to hospitals.

Hospitals also account for the most pressing of today's healthcare system problems—namely, cost inflation. Challenges faced by hospitals include widespread duplication of services, overemphasis on specialized services and diagnostic tests, and a detached manner of caring for the ill.

The major forces affecting the development of hospitals include the following: (1) advances in medical science, most notably 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, though simple, procedures were a great boon to hospital growth, 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, all of which came into being early in the twentieth century.

Hospitals have not responded quickly to the healthcare needs of an aging population. In the late 1980s they finally began to offer nontraditional services such as outpatient care, home health care, extended care units, and rehabilitation. Hospital resources, however, continue to be concentrated on acute care, short-term, curable, and special cases instead of the chronic, long-term illnesses that most often affect the elderly.

The growth of health insurance (discussed in Chapter 3) and of government's increasing role 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. Since 54 percent

of all hospital bills are paid by government programs, federal and state agencies are in a position to exert a great deal of control.

The complex hospital industry is usually categorized three ways: (1) function or type of service provided (e.g., hospitals treating a single disease, such as cancer, or those with multiple specialties, usually teaching hospitals); (2) length of stay (from many short-term, where five days is the average length of stay, to fewer long-term, such as psychiatric or chronic disease hospitals, where stays average four to six months); and (3) ownership or source of financial support—government (or public), proprietary (private for profit), or voluntary and religious (private nonprofit) ownership.

Public hospitals are owned by local, state, or federal agencies. Federally owned hospitals are generally reserved for the military, veterans, Native Americans, or other special groups. State government usually operates chronic long-term hospitals, such as mental institutions. Local government has 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.

Proprietary hospitals are operated for the financial benefit of the persons, partnerships, or corporations that own them. The present 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 operation change drastically under management systems—sometimes for the better, at other times with dubious benefit. However, the proliferation of multisystem hospitals (corporation owned, leased, or managed) will probably persist. More than 50 percent of community hospitals are part of a corporate system and the mergers will continue in the twenty-first century.

Ambulatory Healthcare Services

Care that is provided outside of 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 an office of either a solo or group practice, or in a noninstitutional clinic. The type of service is primary or secondary care, and the principal health practitioners are physicians, dentists, nurses, technicians, therapists, and aides. In ambulatory surgical centers there are anesthesiologists as well. 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 hot lines and poison control centers. Primary and secondary care is given at neighborhood health centers and migrant health centers. Community mental health centers are manned by psychologists and

social workers. Home health services and school health services are staffed by nurses who give both primary and preventive care. Public health services, as discussed previously, include targeted programs such as family planning, immunizations, inspections, screening, maternal and child nutrition, and health care 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 sanitarians. 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 give specialized services in medical laboratories. The federal health system, previously detailed, furnishes all types of ambulatory care, as does the prison system.

Many of the ambulatory care services evolve into large, highly complex organizations. For example, an executive committee may be elected to administer the operation. 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 scope and quality of care, as well as personnel practices.

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 ophthalmology, neurology, and endocrine care. Teaching hospitals operate many specialty ambulatory clinics that expose medical students and house staff to a greater variety of 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 springing up in many communities. Forces are at work within communities throughout the nation to enhance primary and specialized health care for all citizens.

Mental Health Services

Mental health facilities in the United States were developed in the nineteenth century (as was the American Psychiatric Association), but were little more than warehouses for large numbers of poor, homeless, and social misfits. They were state hospitals whose primary purpose, rather than treating the patient, was to protect the public. Creation of the National Institute of Mental Health (NIMH) in 1946, and the development of psychopharmaceuticals in the 1950s, were the major breakthroughs leading to real treatment of mental illnesses. Psychotropic drugs enabled thousands of people to return to their communities and to be treated on an outpatient basis. The community mental health center network, conceived in the late 1960s, discharged residents from institutions back into the community with the development of community mental health centers for providing out patient mental health services. Unfortunately, however, this network failed to care for the deinstitutionalized and there are now fewer hospitals specializing in acute psychiatric illness. As a result, visits to community hospital emergency rooms for acute mental health problems have increased. Many people with severe mental illness have returned to institutions for the chronically mentally ill or live in group homes, halfway houses or nursing homes.

Mental health personnel involved in the delivery of mental health services include psychiatrists, medical doctors (MDs) who make a mental diagnosis, prescribe medications, and may provide psychotherapy; and psychologists, clinical social workers, and psychiatric nurses who have advanced degrees and provide case management and/or psychotherapy. 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 and special education teachers, and others such as art, music, and recreational therapists.

Many problems exist within the mental health system, including a surrounding society that clings to the concept of mental illness as a stigma. Over 44 million Americans suffer from a mental disorder and one out of four suffers from mental illness and substance abuse disorders every year. Mental illness and substance abuse disorders are leading causes of disability and death. Adequate and appropriate treatment for mental illness is difficult at best; funding is low and payment is not easy to get from insurance, especially for long-term treatment. Compared to physical illness, most insurance policies limit the number of days in the hospital and the number of outpatient visits for treating mental illness.

Health Care in the Twenty-First Century

From its humble, unscientific, and often haphazard beginnings to the present multibillion-dollar industry, the 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. Since healthcare costs are escalating out of control, the most pressing problem of this century will be to bring health care within the reach of everyone without sacrificing quality—a very large order indeed, and one not likely to go away. American ingenuity will face a difficult challenge in formulating a workable, affordable system for all the people.

Summary

The health status of the U.S. population has improved dramatically in the last 30 years. Improvements have been made in public health measures, socioeconomic status, and medical care, especially in preventive clinical services.

The Balanced Budget Act of 1997 set the directions for the twenty-first century. Some of the most pressing issues in health reform remain to be addressed, however. These include:

- Containing mushrooming healthcare costs—the average cost per person now is $6,700 annually
- Providing health security for the middle class
- Providing coverage for the uninsured
- Mitigating the effects of health spending on the federal budget

Objectives for health care, as set forth in *Healthy People 2010*, are to:

1. Increase the quality and years of healthy life. Babies born in 2003 are expected to live an average of 77.5 years. Healthy life is defined as full range of functional capacity at each stage of the life cycle from infancy to old age. The goals are to (1) increase life expectancy; (2) increase the percentage of persons reporting good, very good, or excellent health; and (3) decrease the total death rate.

2. Through new or improved health policy, eliminate health disparities among segments of the population, including differences that occur by gender, race or ethnicity, education or income, disability, geographic location, or sexual orientation.