Key Terms

- Fringe benefits
- Medical technology
- Magnetic resonance imaging (MRI)
- Fiber optics
- Lasers
- Distributive health care
- National health insurance
- Healthcare financing
- American Medical Association (AMA)
- Third-party payers
- Long-term care (LTC)
- Reimbursement
- Fee-for-service payment
- Capitation
- Managed care
- Health maintenance organization (HMO)
- Blue Cross/Blue Shield
- Preferred provider organization (PPO)
- Managed care organization (MCO)
- Deregulation
- Devolution
- Centers for Medicare & Medicaid Services (CMS)
- Telemedicine
Objectives

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

1. Identify the major factors that have influenced healthcare financing.
2. Describe the factors that have affected national health insurance.
3. Explain the different methods of payment: (a) private insurance, (b) third-party payment, (c) Medicare, (d) Medicaid, (e) group insurance, (f) individual insurance, (g) managed care, and (h) fee-for-service payment.
4. Discuss ways insurance systems can be abused.

During the 1980s a radical change occurred in the way health care was financed. The term managed care came into common usage and remains a significant aspect of the present evolution. Four major factors changed health care: fear, a shift in the balance of power, an excess of doctors, and a shift in the healthcare setting.

Fears that Medicare would go bankrupt prompted the government into invoking policies intended to bring healthcare costs under control. Tax reductions in 1981 induced huge budget deficits, increasing the possibility that the Medicare trust fund would run out of money by 1990. Medicare's costs have always exceeded budgeted monies. In 1983, Congress passed a prospective payment bill, under which hospitals are paid a set amount for each patient in any of the established disease categories and diagnosis related groups (DRGs). This means that the government will not pay beyond the fees set for the identified type of illness, no matter how long the patient stays or what services he or she receives. As a result, Medicare hospital admissions dropped and the length of stays shortened, but Medicare payments continued to rise. In 1984, Congress began to regulate direct Medicare payments to physicians by a resource-based relative value scale for payment and established the Physician Payment Review Commission. In 1988, the Commission replaced the CPR (customary, prevailing, and reasonable) system with a fee schedule that was implemented in 1992 in an effort to control healthcare costs. The current Medicare Physician Fee Schedule requires a 10 percent reduction in physician's fees in 2008 and an additional 5 percent reduction each year for the next 10 years.

A shift in the balance of power between unions and management is another dramatic change that has radically altered health care. The 1980s saw a weakening of union bargaining power and a high unemployment rate. These two factors enabled management to decrease employee benefits. Prior to this time, fringe benefits, especially those related to health care, had been escalating with the same intensity as healthcare costs. Employees had come to expect increasing health benefits with each ensuing contract. Now employers were able to restrain costs by requiring employees to pay higher deductibles and copayments. Many companies sought out managed care health plans, which direct patients to the most cost-effective source of care.

The oversupply of physicians has led to competition, reorganization of medical practice, advertising for clients, and increased medical costs. It has been widely assumed that there is a shortage of doctors in the United States. The fact is that there is a growing surplus of doctors. The government directly intervened in medical education more than 30 years ago to ensure that there would be enough physicians to keep up with the demands of Medicare. This
was accomplished with grants, scholarships, low-interest or no-interest loans, and other incentives, making access to a medical education easy for qualified individuals. The supply of doctors subsequently increased 57 percent from 1970 to 1990, while the population increased only 30 percent. Medical care has shifted from the hospital into the community because revolutionary advances in medical technology created a new dimension in healthcare delivery. Examples of recent advances are portable, mobile units for diagnosing almost every known disease without hospital admission. Magnetic resonance imaging (MRI), mammography, ultrasound, telemedicine and other technological advances are now available in doctors’ offices and outpatient clinics and can even be taken into homes. Freestanding surgical centers and outpatient surgery are thriving, facilitated especially by advances made in fiber optics and lasers. These factors together have led to what is called distributive health care, which is changing the healthcare system as well as creating different ways of paying for health care. This chapter discusses the changing objectives of national health insurance, the content of some health insurance proposals, and who pays for health services.

Access to affordable health care has slowly eroded over recent years, despite government attempts to close the gaps through new programs such as Medicare Advantage Programs, the Health Insurance Portability and Accountability Act (HIPAA), expansion of state Medicaid programs through the 10-year, and the $40 billion state children’s health insurance program (SCHIP) implemented in 1997. Despite these efforts, the number of Americans without insurance has increased. The economic downturn in 2001, coupled with rapidly rising insurance premiums, has decreased employer-sponsored health insurance. Since 2001, health insurance premiums have increased 78 percent while wages have increased only 19 percent (Kaiser Commission on Medicaid and the Uninsured). The most important trends that account for deterioration of health coverage are the following:

- Employers eliminating coverage because of escalating costs of premiums or shifting more costs to employees by choosing those plans with the highest out-of-pocket payments.
- Rising premium costs, both for those who buy insurance individually and for those insured through an employer plan. In 2007, the annual premium for a family of four was $12,106 (Kaiser Commission on Medicaid and the Uninsured).
- The trend toward temporary and part-time work, which seldom includes health coverage. In 2006, 11 percent of working Americans had part-time jobs and another 10 percent worked as independent contractors. Most of these positions offered no health coverage.
- Limitations of care covered by HMOs.
- Rising costs of “Medigap” coverage for elderly, leading to substantial underinsurance for those with low incomes.
- A crackdown on illegal immigrants and a reduction in services to legal immigrants. Since July 2006, application and renewal of Medicaid benefits requires proof of citizenship status.

As a result of these trends, lack of insurance and underinsurance are becoming widespread problems.
Changing Objectives of National Health Insurance

The costs of sickness include two principal components: the cost of lost earnings and the cost of medical care. The beginnings of national health insurance early in this century aimed at relieving the economic problems of illness. Income loss remains a concern, but concern has shifted during the twentieth century. Reformers shifted their attention, at the individual level, from lost earnings to medical costs as health insurance became more concerned with healthcare financing than with income maintenance.

Health insurance has become increasingly divorced from public health. Health insurance is now viewed as an instrument of institutional reorganization and cost containment. The enormous increases in the costs of medical care and the general changes in U.S. society have shifted the objectives of insurance away from those originally envisioned.

The health insurance business expanded steadily as it shifted from an economic to a medical emphasis. The desirability of expanding medical services became a reality after World War II, when the federal government began subsidizing hospital construction and medical research. The principal goal of public policy then was to expand medical resources rather than to correct distributional inequities. The government aided the expansion of private insurance companies by excluding employers' contributions to health insurance from taxable income. This effectively encouraged employees to accept wage increases as fringe benefits for health insurance instead of as cash. Private insurance companies, forbidden by antitrust laws to limit fees and rates, found it easier to raise their rates than to pursue cost control.

Government policy and the expansion of the private insurance business eventually resulted in a system of health insurance that channeled a greater proportion of national income into health care without infringing on physicians' autonomy or the prerogative of setting their own fees. Medicare and Medicaid did not change this pattern. The government filled the gaps in the private insurance system and continued to accommodate physicians by not challenging their fee structures. Since physicians were paid based on usual and customary fees, those typically charged in their communities, doctors could raise rates to increase reimbursement. Medicare also paid hospitals based on their costs, which did not encourage cost containment, since higher fees meant more reimbursement.

The United States spends more on health per capita than any other country. Costs have gradually increased since the implementation of Medicare in 1965. In 2004, healthcare expenditures totaled $1.9 trillion. The portion of the gross national product (GNP) attributable to health care increased from 5.9 percent to 14 percent between 1965 and 1997 because of the huge surge in medical, hospital, and nursing home costs during this period. Costs continue to rise because of the complexity of health care and the number of elderly requiring care.

Not all increases in medical costs after World War II could be attributed to the insurance system. Overall growth in technological development, public expectations, and public investment in research all contributed to this trend. Inflationary patterns in medical costs were evident in all industrialized nations. An exception was Great Britain, where the medical budget is set at the national level and must compete with defense, education, and other government programs. This system was rejected, however, in the United States, partly due to the fear of “socialized medicine” but also due in large part to the bitter opposition of the American
Medical Association (AMA) and physicians in private practice who believed a national system would take away their autonomy. As a consequence, calls for a national health plan as a means to counteract the escalating cost of health resources repeatedly died out due to lack of both political and popular support.

In the mid-1970s, the United States entered a new stage in the history of health insurance. Prior to this time, the government had accepted the philosophy of increased investment in health care. The dispute that arose over the extent and control of insurance obscured the fact that fee-for-service payment was no longer appropriate or sufficient for managing medical expenses. As one of the four most inflationary sectors of the economy (energy, food, and housing being the top three), medical care logically became a target of anti-inflation measures.

Attempts to slow the increasing costs of health care included industry-wide wage and price controls initiated in 1971, followed by Medicare policies to slow price increases by doctors and hospitals and decrease the unnecessary use of hospital services. This led to the establishment of Peer Review Organizations that also monitor the quality of services.

Medical costs cause concern because of their magnitude and raise questions about their legitimacy. Studies reveal unnecessary surgery, duplication of technology, excess charges, and other discrepancies as major reasons for loss of confidence in the value of medical services.

The rising costs of medical care are of concern to many institutions, among them unions, corporations, and the federal government. All acknowledge the need for change. Today, health insurance programs seem to be more about cost containment and economic management than about efficiency and social equality.

Healthcare Financing

The largest category of expenditures for health is for hospital care (33 percent). Physicians’ services rank second in monies spent for health care, at about 23 percent of the total health service budget; the remaining 45 percent of the health dollar is divided among nursing homes, drugs, and miscellaneous health services.

Most of the financing for health care is through government programs and private health insurance (generally referred to as third-party payers). Citizens with private insurance have access to sophisticated medical resources and private physicians who are in charge of their care. However, private insurance premiums have escalated to the point that only those people who are economically secure can afford the cost. Most employers now offer managed care options to their employees, and 15 percent of Medicare recipients are in HMOs. Patient care decisions about an illness are now determined by the organization to which patients subscribe, and are primarily based on cost.

Consumers increasingly complain that their doctors are not in control of their care, and that companies are putting their own bottom line first. Not all managed care is equal. There is a strong movement under way to regulate managed care organizations (MCOs).

Healthcare expenditures fall unevenly on the population. If age 65 is the lower limit for the elderly segment of the population, then this group’s expenditures are three times higher than the per capita expenditures for younger people, and the expenditures for those 85 years or older are two times higher than for those 65 to 74 years of age. There is a mismatch between acute and chronic care needs, and between the effects and effectiveness of various
long-term care (LTC) policies, as the following examples illustrate. The 15 percent of Medicare beneficiaries who have heart failure account for 45 percent of Medicare spending and the 18 percent with diabetes account for 32 percent of Medicare spending.

Women live an average of eight years longer than men, but are in poorer health. A majority of those older than 65 are women, and women become a greater majority in the 85-years-plus age group. While acute fatal diseases are prevalent among men, women experience a high incidence of chronic conditions and higher rates of institutionalization. Older women have lower incomes from every source. Three-fourths of the elderly who live in poverty are women. This gender difference affects access to health care because Medicare covers only one-third of their expenses. Their socioeconomic status, poverty, widowhood, and care giving are affected to a greater extent by government changes, especially program cutbacks, than are the equivalent factors for men.

The predominant method of physician reimbursement is fee-for-service payment. The biggest problem with fee-for-service is the definition of a service and what it includes. More services result in a higher income and can lead to abuse. Capitation, defined as paying the physician a fixed amount per person per unit of time without regard to the volume of services provided, is another mechanism for reimbursement. In capitation, insurance pays the physician a set fee to cover all the services; in fee-for-service insurance pays only for the particular itemized service(s) rendered at a given time. A third method of reimbursement is salary. Salary is used only in organizations where various other incentives are provided to the physician to enhance productivity.

Like physicians, hospitals can be reimbursed through several methods. First is reimbursement for specific services (same as fee-for-service). Second is the capitation method. The hospital may also be reimbursed by the number of days of care. Many hospitals average payments among patients instead of individualizing costs.

**Health Insurance Coverage in the United States**

An estimated 47 million people in the United States were without insurance coverage in 2006. Of those between 18 and 64 years of age, 19.8 percent did not have health insurance and men were more likely than women to lack health insurance. Lack of coverage is a result of the economic downturn in 2001 in combination with rapid increases in health insurance premiums. Great disparities were seen between ethnic groups and within the general population. For example, only 8.5 percent of Minnesota residents lack coverage compared to 25 percent of Texas residents.

- The Medicaid program insured 38.3 million people, but 13.9 million still had no health insurance.
- The foreign-born population was more likely to be without health insurance than natives—34 percent compared with 13 percent in 2006. In addition, 60 percent of poor immigrants had no health insurance.
- Among the general population, 37 percent of poor full-time workers were uninsured in 2006 and of these, 71 percent were in families with at least one full-time worker and 11 percent in families with a part-time worker. Workers most likely to be unins-
Health Insurance Coverage in the United States

sured are low-wage workers and those employed in small businesses, service industries, and blue-collar jobs.

- The key factors influencing lack of insurance coverage were age, race, educational attainment, and work experience.
- People aged 18 to 24 years were more likely than other groups to lack coverage in 2006. The elderly, because of Medicare, are at the other extreme (1.5 percent without coverage).
- Hispanics had the highest rate of noncoverage; 40 percent lacked coverage in 2004.
- Among all adults, the likelihood of being uninsured declines as education level rises.
- Part-time workers have a higher noncoverage rate than do full-time workers.

Findings concerning children
- Children ages 12 to 17 are less likely to be insured.
- Some 22 percent of Hispanic children were uninsured in 2006 (42 percent were insured by Medicaid).
- Approximately 44 percent of African American children were insured by Medicaid.
- Roughly 21 percent of Asian/Pacific Islander children were covered by Medicaid.

MEDICARE AND MEDICAID

Medicare and Medicaid are government insurance programs designed to pay for the treatment of disease and medically diagnosed conditions. Historically, they have not included payment for preventive services. Only since January 2005 has Medicare Part B covered the cost of preventive services, including screening for diabetes and cardiovascular disease; breast, colon and prostate cancer screenings; bone density measurements to detect osteoporosis; and certain immunizations.

The Medicare program is a federal insurance program for people aged 65 and older, certain disabled people younger than age 65 and any adult with permanent kidney failure (End-Stage Renal Disease). Patients on Medicare are entitled to the same benefits and care as patients in middle-income families with private insurance. The main difference is that the government pays the hospital bills, instead of the individual or private insurance. The Medicare program is administered by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (USDHHS).

There are four parts to the Medicare program. Part A is hospital insurance, Part B is medical insurance, Part C is supplemental hospital and medical insurance, and Part D is medication insurance. All have deductibles and coinsurance. For Part A in 2008 the patient must pay the first $1,204 of the hospital bill. Medicare then pays only for the first 60 days of hospitalization, or 20 days of skilled nursing care. Beyond these lengths of stay, the patient is required to pay the total cost. Part B of Medicare requires a monthly premium, which was $96.40 in 2008. It carries a $135 deductible and the patient must pay 20 percent of the approved amount and limited charges above that amount. Part C is supplemental or “Medigap” insurance, known as Medicare Advantage, that must be purchased. Part D, the newest
part of Medicare benefits, began in 2006; it requires a monthly premium of $27.93, a deductible of $250, and a 25 percent co-pay.

"Approved amount" does not mean that Medicare will pay what the doctor or facility charges. This refers to the DRGs upon which Medicare bases its payments. Third-party and out-of-pocket payments, which include payments for premiums, deductibles, uncovered services, and coinsurance (supplemental insurance), lower the elderly's standard of living. Low-income elderly spend an average of 32 percent of their annual income for medical care. Medicare Advantage programs offer a wide range of options if the employer joins the federal programs. The beneficiaries can establish a medical savings account, make private arrangements with their own physicians, or receive coverage from a PPO. For the elderly poor, who are unable to afford the premiums, Medicaid is available.

Medicaid is the federal–state cooperative health insurance plan for the indigent. People with incomes below the poverty level established by their state can use this government-sponsored health insurance program. Individual states administer Medicaid programs; states receive matching funds from the federal government to help pay for Medicaid coverage. The matching rate ranges from 50 to 76 percent depending on a state's per capita income; wealthier states receive lower federal matches and poorer states receive higher matches. SCHIP is an expansion of Medicaid coverage for uninsured children from families with incomes above that of Medicaid recipients. Medicaid finances over one third (37 percent) of all births in the United States, nearly half (47 percent) of all nursing home spending, and 61 percent of all publicly funded family planning services.1 Women and children account for 75 percent of all Medicaid beneficiaries. The majority of Medicaid spending, however, funds long-term care services for the elderly, chronically ill, or disabled. In 2004, 60 percent of Medicaid recipients received Medicaid benefits through managed care. Many private facilities and physicians do not accept these patients because of low reimbursement, a conflicting system of payment, or denial of payment for services already rendered.

**MANAGED CARE: HMOs AND PPOS**

The term *managed care* refers to a system in which employers and health insurers channel patients to the most cost-effective site of care. An umbrella label, health maintenance organization (HMO), was coined in the 1970s to describe independent plans that offer benefits to an enrolled group of subscribers. The benefits cover hospital, physician, and related auxiliary services. These plans offer benefits with the requirement that both hospital care and physician services are contracted through the HMO. An exact number of such organizations in the United States is difficult to ascertain because of many business changes such as bankruptcy, buyouts, mergers, and so on. However, a rough estimate by various private and government agencies includes 500–600 such organizations.

The major characteristic of an HMO is that it combines medical insurance with a broad range of health services. It must compete with commercial insurers and Blue Cross/Blue Shield. Therefore, it has a strong incentive to operate in a cost-effective, efficient manner. The HMO has been seen as a model for encouraging the regulation of healthcare costs through competition. On average, prepaid group practice is less expensive, for the same benefit package, than is traditional underwriting.
The greatest drawback of the HMO lies in the fact that the enrollee must find a physician within the HMO group for services. This often entails geographic challenges, because HMO group physicians tend to practice in large, metropolitan medical centers. If enrollees go outside the HMO for health care, no benefits are available to them.

The most rapid growth among managed care organizations has been among individual practice associations and preferred provider organizations (PPOs). PPOs may be a group of providers who have voluntarily joined together to render health care on a contractual basis, or a group of providers who have been organized by a payer through contractual arrangement for a particular delivery system. These providers can be hospitals, physicians, other healthcare services, or any combination of these. PPOs are fee-for-service systems, as opposed to HMOs, which are capitated (Insurance pays providers a set fee in advance to cover all required services.) Patients subscribing to a PPO have the freedom to go wherever they want for care, including outside the PPO system. From an economic standpoint, however, the incentive to use PPO contract providers is that they are less expensive. Under a PPO contract, standard fee-for-service charges are generally discounted. These discounts range from 10 to 20 percent for hospital services performed by a physician in a hospital environment. The essential elements of a PPO are these: fee-for-service, contractual arrangement, organization of providers, discounts, free choice, and economic incentives. PPOs are an emerging trend. There are currently about 120 to 130 such healthcare providers in the United States. The majority of these are provider-based, and about 48 percent of them are located in California. It is estimated that, as the healthcare field continues to change, at least 20 percent of the fee-for-service market will be in PPO products.

Medicare is gradually expanding its managed care plan, Medicare Advantage. Enrollment has increased 50 percent since 2003 with 8 million, or 20 percent of those who are eligible participating.

The biggest impact on healthcare delivery caused by the managed care explosion is a substantial reduction in hospital use. As more and more people are covered by managed care plans, incentives to cut hospital use will continue to bring the number of hospital stays down. As this trend continues, it is probable that marginal providers will leave the market and that the remainder will compete based on convenience, price, and quality. Health care has not been deregulated in the strict sense that airlines and financial services have been, but there is little doubt that free-market pricing for health care is achieving the same results.

**Implications of Devolution**

More information is needed regarding the role and effects of managed care organizations (MCOs) on health and human services. Significant questions exist concerning MCOs and their effects on quality of care and nonprofit community-based support. The growing limitation on consumer choice of health plans and practitioners is producing a rising tide of consumer complaints. Many states are considering limiting the growth of HMOs. Physicians and nurses who find their job opportunities limited by managed care have initiated this move. The rapid shift to managed care also raises concerns about access to care for people with chronic mental illness, substance abusers, and the homeless.
Political issues regarding healthcare funding include the following:

- Partisan struggles in Congress and the White House regarding the fate of Medicare and Medicaid.
- Governors and state legislatures intent on budget and tax cuts.
- The enhanced ability of proprietary interests to shape public policy creates changes and uncertainty. Nonprofit community care providers are pitted against powerful for-profit nursing homes and managed care.

Economic factors include a rapid rise in for-profit ownership throughout all sectors of medical care. This means increased profitability for owners and shareholders. In addition, the means of achieving cost containment have become ends in themselves. Political and economic attacks on entitlements make the fate of Medicare and Medicaid and the future of long-term care (LTC) uncertain.

Deregulation is one instrument being used selectively to further goals of the federal government: The Unfunded Mandate Reform Act of 1995 limits federal power to adopt mandates for states, localities, and tribal governments without paying for them. Welfare reform and other domestic policy changes are designed to diminish the federal role in health and welfare programs. The responsibility will instead fall on the states.

Business and provider interests are mediating public policy, so problems of access are likely to increase. Accountability issues arise as federal oversight gives way to oversight that depends on variable state and local data. There is little assurance of consistency or uniformity of policy with deregulation, or devolution, as it is sometimes called. Devolution is a term that simply means transfer of power or authority from a central government to local governments, delegation to another entity, or in some cases simplification or elimination. The latter definition does not really apply to healthcare issues.

Devolution raises critical questions about policy regarding health care and long-term care of the aging population. The answers to these questions depend on the fiscal condition of individual states, the rapid growth of managed care, and the way in which LTC services will be integrated into managed care programs. Comparing health outcomes, cost, and quality of LTC under both MCOs and fee-for-service programs raises myriad questions.

**Continuing Debate**

There is a crisis atmosphere surrounding health care. Some reform must be undertaken because the nation cannot afford to continue on its present path. No doubt there will be adverse consequences and many policy makers fear the outcome for themselves and their constituents. Polls in 2007 indicated continuing discontent with the U.S. healthcare system but no agreement about how to reform it. Many people reported going without medical care—not seeing a doctor when ill, not receiving recommended care, or not taking prescribed medications—because of cost. Other complaints were difficulty obtaining a same-day appointment, and fragmented and inefficient care, including medical record and test delays, and time wasted on paperwork.
The United States is committed to changing its healthcare system. It is the only industrialized nation aside from South Africa that does not provide universal health care, or subsidize the education of medical students. Hospitals are a key element in the debate. Not only do they provide essential services to the poor, such as emergency room, inpatient, and outpatient services, but they are also the major centers for graduate medical education. The major problems include loss of faculty practice revenue, threats to clinical research, and trends related to primary care. Many medical centers are making significant organizational changes, such as merging and downsizing.

In the absence of leadership for healthcare reform at the federal level, states and cities are developing healthcare financing at the local level. Massachusetts was the first state to implement near universal coverage; Maine, Vermont, and California also have plans for providing health coverage for nearly all residents. Healthy San Francisco is a health plan for uninsured residents; the plan pays for prescription medications, clinic visits, and hospital stays within San Francisco. In 2007, the Health Coverage Coalition for the Uninsured (HCCU), a diverse group of 16 major national organizations proposed policy approaches to expand healthcare coverage for the uninsured. Coalition members include the American Medical Association, the American Public Health Association, the American Hospital Association, U.S. Chamber of Commerce and America's Health Insurance Plans. Proposed policy approaches are: (1) increase enrollment of children in SCHIP, (2) create a new family tax credit to cover the cost of insurance premiums, and (3) offer competitive grants to states to cover costs of expanding coverage.

The obstacles to successful and desirable healthcare reform include market failure, high-cost technology, unnecessary care, defensive medical practices, patient complexity, low productivity, and the general disfavor toward sweeping healthcare reform.

**Effect on Healthcare Providers**

According to the U.S. Department of Labor’s most recent statistics, more than 10 million people, or 1 in 10 working Americans, are employed in health care with 45 percent working in hospitals, 17 percent in nursing or personal care facilities, and 27 percent in offices and clinics. Age demographics are predicted to change in 2020 with a 54 percent increase in those 65 years and older and a 57 percent increase in those 85 years and older with almost no corresponding increase in those in the age range of typical healthcare workers, 18 to 64 years old. Predicted growth of available employment in the healthcare professions is twice that of other professions because of the expected aging population. The vast structural shift in healthcare employment in the 1990s affected all health personnel. Redistribution and retooling affect many of the nontechnical and nonprofessional jobs. Hospitals, the industry’s largest employers, are predicted to be up to 50 percent fewer by 2010. Those remaining will likely merge into large associations.

There are some winners in the job redistribution. Demands for primary care physicians (family practitioners), physician assistants and nurses with advanced degrees, such as nurse practitioners or nurse midwives, are increasing. More procedures performed outside of hospitals means jobs for skilled laboratory personnel. President Bush’s mandate to require all med-
ical records to be in an electronic format by 2014 is expanding opportunities in computer software and records management. There is an increased need for many rehabilitation specialties, such as therapists of many kinds, home health workers, and geriatric personnel. Large insurance companies will benefit and expand.

The health field of the future remains full of challenges for health personnel. Other issues are discussed in later chapters. Health care as it is known will not disappear, but may take a very changed form.

References