I. Health Services System Overview

** Purposes/goals of organized systems of health services delivery may be many in number, but typically involves the amelioration of pain, suffering, and/or discomfort related to disease or injury, or the more general promotion of healthy life through health promotion/disease prevention activities.

** As part of the overall paradigm for health, the provision of health services proper comprises a small portion of all activities related to the achievement of the stated goals with respect to population health status. Many of the components of this model (heredity, environment, and perhaps lifestyle as well) are beyond the traditional scope of the HSO in terms of achieving health.

** History: the majority of the gains made in this century with regard to the stated goals were directly related to a number of public health advances made in the areas of food and water purity, infection control (Koch and Pasteur), etc. The latter concepts (infection control) were a critical discovery, and their understanding and widespread application were primarily responsible for the development of a number of other health services and technologies that substantially reduced morbidity and mortality from certain types of diseases.

** The overall burden of disease has shifted over the past century away from acute causes to chronic causes, primarily due to advances in public health (Food, water sanitation) and health services delivery (surgery for appendicitis, drugs for MI, etc.) Most chronic diseases are multi-factorial in nature, and typically include factors (environment, lifestyle) that are not as amenable to public health or health services interventions.

** Historically, planning for and delivering healthcare services, whether public health or health services, were primarily a local responsibility, with local philanthropy or local governments serving as the impetus for the implementation of these activities. States and federal governments have become more involved since the early 1930's in conjunction with the concept of social welfare and social security, primarily from a financing and regulatory standpoint. Most health services delivery is still the responsibility of private, local HSO’s.
II. Ambulatory Care Services

** Provision of medical care services on an outpatient basis, not requiring institutionalization. Examples include office-based physician services, Hospital-based services such as day surgery, outpatient specialty clinics, emergency room services, etc. Also would include health care provided in the home (HHC, respite services, hospice)

** The most basic unit of ambulatory health care provision is primary care, which is day-to-day care dealing with routine diagnosis and treatment of common, non-complicated illness/injury. In today’s Managed care environment, primary care providers serve as Gatekeepers for patients by coordinating all of their care, from managing referrals to specialists to providing continuous care for chronic illness. Of note, most other socialistic health systems (UK, Canada) also rely heavily on a primary care focus, and most services provided in those systems are primary care focused.

** In general, primary care providers include physicians in the following specialties: internal medicine, FP, GP, Pediatrics, OB-GYN. Physician extenders such as nurse practitioners, physician assistants, and certified nurse midwives also provide primary care services, and are, in many cases, the only primary care providers in certain rural areas of the country.

** The most common reasons for primary care visits to the office-based physician include medical exams, prenatal care, well-baby care, Conditions of the throat, and postoperative followup. Among the Majority of primary care encounters, either nothing was done (except perhaps physician counseling) or a blood pressure reading was taken.

** Types of Office-based Primary Care - solo practice and group practice.

** Solo practitioners, a dying breed as a result of increased managed care prevalence, typically include secondary care specialist such as allergists, Dermatologists, and surgeons. Solo primary care practitioners still exist, but more likely in rural settings.

** Group practices involve affiliations of three or more physicians who typically share staff, medical equipment, medical records, and income. The first successful non-industrial group practice was the Mayo Clinic in Rochester, MN in 1887. Other well known group practices include Kaiser Permanente, Group Health Cooperative of Puget Sound.
A 1932 report from the Committee on the Costs of Medical Care made the first official recommendation to emphasize the use of group practices in the provision of medical care. The report also emphasized other concepts that were dismissed as radical at the time, such as regionalization of health care, prepayment for all services provided, etc.

Increasing specialization of medical care, the increasing threat of managed care, and the desire to be affiliated with a group of physicians for the purpose of sharing risks and resources have all fueled the increases seen in the formation of group practices. (Incentive to form groups to increase ability to collectively bargain).

Among medical specialties, those forming groups most often include family practice/general practice, internal medicine, OB/GYN, pediatrics, anesthesiology, and radiology. The majority of group practices currently employ a business manager or group practice administrator (GPA).

Advantages of group practice arrangements would include (from the MD’s perspective) less administrative burden, increased collaboration with other physicians, better coverage and more time for leisure, stable income. Some disadvantages (MD’s viewpoint) might include reduced autonomy. From the patient’s viewpoint, group practice advantages might include one-stop shopping for a wide variety of care, simplification of referrals, possible reduction of administrative burden, etc. Potential disadvantages from the patient’s perspective may include loss of patient-physician relationship, increased waiting times, and increased administrative burden.

The more specialized forms of care are secondary and tertiary care. Secondary care involves such services as routine hospitalizations, specialized outpatient care (cataract surgery), and other types of outpatient diagnostic services (cardiac cath, stress testing, etc.). Secondary care services are typically short-term in duration, and the primary goal is to cure or prevent the progression of morbidity or disability through early treatment. Tertiary care services include highly specialized services – such as open heart surgery, transplantation, burn treatment, etc. - for very complex illnesses/injuries. Such services typically are long-term or require long-term followup, with the primary goal of rehabilitation.

Historically, secondary and tertiary services were delivered almost exclusively within an institutional setting. As technology has increased and reimbursement pressures have dictated, many procedures that used to require hospitalization are now done routinely on an outpatient basis.

By the year 1993, the majority of surgical procedures done in the U.S. were performed on an outpatient basis, a historical first.
III. Hospital Services

** History: The first public hospitals did not appear until the late 1800's. Prior to this, institutions such as almshouses/pesthouses were places where the sick, poor, and/or mentally ill were housed/quarantined and fed, clothed, and, to a lesser extent, given medical care. Persons who were of means were typically cared for at home. The first voluntary or community hospitals appeared in the early 1800's, deriving most of their resources from philanthropy.

** Factors that influenced the rapid development of hospitals in this Century include advances in medical science, the development of technological sophistication and specialization, the development of professional nursing as a discipline, advances in medical education, The growth and widespread dissemination of health insurance, and the increased role of government.

** Hospital Classification System: based on LOS (short-term stay or Long-term); type of services provided (general, specialty), and/or ownership (public, private-for-profit, private-not-for-profit).

** Public Hospitals include those for veterans, American Indians, and merchant seamen (federal level). State-run public hospitals include mental hospitals and TB hospitals. Public hospitals in major urban locations often serve as the place of last resort for many indigent persons to receive medical care. Approximately 90% of all charity care is provided by public hospitals.

** Privately owned hospitals include non-profits and for-profits. These may be further classified into either community hospitals or multi-hospital systems. For-profit hospitals, while smallest in number, have been the fastest growing category on the private side during the 1990’s, especially multi-hospital systems. Almost 60% of all non-federal short term hospitals are non-profit, and they account for two-thirds of all hospital admissions and outpatient visits. As with the group practice phenomena with MD’s, the trend towards multi-hospital systems is increasing due to competitive pressures from managed care, changes in reimbursement methods, etc. Such multi-hospital systems would include Humana, HCA, Tenet Health, etc. and such should be differentiated from ‘affiliated hospitals’, which do not have the degree of corporate control found in multi-hospital systems.
** Current Trends in Hospital Industry: increased managed care emphasis on primary and preventive care, the increased utilization of discounted reimbursement or capitated reimbursement for services provided, increasing rates of consolidation among competing hospitals and increasing rates of regionalization with larger, urban hospitals affiliating with smaller, rural feeder hospitals, and increased competition for business/managed care contracts.

** Hospital responses to such trends include staff reductions, trends towards the adoption of cross-training and patient-focused care, product-line management to develop needed services for customers/patients (sports medicine centers, Women’s hospitals, etc.), increased emphasis on early and effective discharge planning, increasing rates of integration and diversification so as to capture market share, etc.

** Hospital Regulation: external regulation of hospitals has grown significantly since the 1960’s. Currently, regulations exist for institutional quality standards (Licensure through state boards, certification for serving Medicare and Medicaid patients, accreditation through JCAHO), facility and service provision (CON), Costs (TEFRA-PPS), and utilization rates (PRO’s).

IV. Long Term Care Services

** Who uses LTC? Primarily persons with chronic health problems, functional disabilities, mental health, and/or social problems who are typically unable to care for themselves. This would include the chronically ill elderly, persons with mental retardation, persons with paralytic disease or congenital Abnormalities, etc.

** Approximately 66% of all persons requiring some form of long term care are aged 65 or over. Projections into and beyond the year 2000 are that the number of persons requiring some form of LTC will increase anywhere from 30% to 75%, Mainly due to the aging of the population and increased chronic morbidity due to increased life expectancy.

** LTC is defined as the provision of health, mental health, social, and residential services to chronically disabled persons over an extended period of time with the goal of enabling these persons to maintain as high as possible a level of Independent functioning.

** Contrary to prior beliefs, approximately 90% of all LTC is provided informally by networks of friends and family. The ideal LTC system within a community setting would provide for a continuum of care on an ongoing basis at various levels of intensity.
** The basic services that comprise a typical continuum of care for LTC services include extended care facilities (SNF, ICF, Psychiatric, swing beds, respite care), acute care facilities (hospitals, both medical and psych.), ambulatory care facilities (physician care, outpatient services, day care services), home health care services (Skilled care, custodial care, hospice), outreach services (transportation, EMS, support groups), wellness/health promotion services, social services, and housing facilities.

** In order for a LTC system to be efficient and effective at achieving its stated goals, the system must be integrated across facilities. Integrating management principles include system structure, information systems, case management/care coordination, and financing.

** Continuum of Care LTC Services

** Hospitals: approximately 8-10% of all hospitals in the U.S. are classified as long term care hospitals (with avg. LOS greater than 30 days). A large proportion of these hospitals are for psychiatric services. A significant portion of acute care hospitals either contract with or directly own long term care beds. Many acute care hospitals also have developed rehabilitation services within their physical facilities for the purpose of obtaining market share in the rehab/long term care market.

** Nursing Homes: approximately 2 million people require care within approximately 25,000 skilled nursing facilities to date. Each state is charged with licensing these facilities within its borders, and each state has its own rules and regulations regarding licensing requirements, reimbursement policies, governing regulations, and classification systems. Federal regulations classify nursing homes into four types of facilities:

1. **Skilled Nursing Facilities** are those in which at least 50% of the residents require skilled nursing (non-custodial) care during a given week. Typically, these facilities specialize in providing 24-hour skilled nursing care.

2. **Intermediate Care Facilities** are those in which less than 50% of the residents require skilled nursing care during a given week. These types of facilities specialize in the provision of part-time skilled nursing care supplemented by extensive social and rehabilitative services.

3. **Intermediate Care Facilities for the Mentally Retarded** are similar to ICF’s but with the emphasis on the mentally retarded.

4. **Personal Care Homes** provide room, board, and other support services for those who do not require nursing care or other therapies.
The majority of nursing facilities are small, fewer than 100 beds. Average nursing facility occupancy rates hover around 90-100%. These facilities tend to be for-profit and increasingly corporatized across state lines. These facilities are typically heavily staffed with LPN’s and nursing aides, with a handful of RN’s, mainly in administrative positions. The typical resident of nursing facilities is white, female, unmarried, and 65 years of age or greater. Major causes of admission to nursing facilities include mental dysfunction, incontinence, inability to self-care, and lack of social support systems. Approximately 50% of all nursing facility charges are paid for out of pocket, another approx. 50% are paid by Medicaid (medically needy), with Medicare paying less than 5% of total charges for most long term residents (> 3 months continuous).

**Home Health Care:** fastest growing segment of health care expenditures during the 1980’s/1990’s. Two major types of home health care agencies are (1) Medicare-certified and (2) Private. Agencies who meet stringent federal criteria may be classified as ‘Medicare-Certified’ and provide care to Medicare recipients under Part A and Part B. The number of home health agencies almost doubled between 1980 and 1985, with total visits and charges per visit increasing as well. Private home health care facilities have a more broad clientele, including the elderly as well as Mothers/newborn infants, accident victims, etc. Private home health Agencies take referrals from hospitals, social service agencies, and friends/families of patients, etc., unlike the Medicare-certified agencies, which typically get referrals from hospitals. Most home health agencies are currently a hybrid of both Medicare-certified and private home health agencies.

**Hospice:** the provision of care for the terminally ill, typically in some type of institutional facility. The concept for hospice care was imported from great Britain in the 1970’s. Hospices may be free-standing, or may be part of a hospital, home health or skilled nursing facility. Typical services include psychosocial and spiritual support, bereavement counseling, and palliative drug therapy. Hospice services may be privately-based or Medicare-certified, or both. Approximately 100,000 persons are cared for by hospice every year, the majority of these having less than 6 months to live and suffering from terminal cancer.