

Healthcare has undergone several changes within the past twenty years for different reasons. Some efforts have been made to improve the quality of healthcare, others to increase its accessibility to the general public. This discussion focused on the idea that the variety of changes in today's many healthcare delivery sectors including private insurance, government health plans, healthcare systems, mental health, and hospital systems is primarily due to the factor of cost. Although, each of the three factors, (e.g., quality, accessibility, and quality,) affects the other two, cost seems to have the greatest impact. The American public is always pushing for a better quality of life and quick, easy access to most everything. But, *someone must pay* for access to quality healthcare, even if the individual cannot. Therefore, it is in everyone's interest, whether individual, statewide, or national to keep healthcare costs as affordable as possible.

One change brought about in an effort to reduce healthcare costs is the development of managed care, which encompasses the areas of both private and commercial insurance, Medicare, HMOs, and other primary sources of payment for patient office visits. Some would argue that it cannot be cost efficient due to a seemingly endless paper shuffle and may actually hinder patient access to quality healthcare. But, managed healthcare is intended to give the patient more bang for their buck, the paper shuffle only growing pains.

In the readings, Williams & Torrens note that horizontal integration is one of two major ways the United States has responded to the rising costs of healthcare not just to curb spending, but also to afford providing it at all. There has been a move from working in private practice or small corporations to group practice, loosely defined as three or more providers. Physicians seem to be recognizing the many financial benefits that can be gained through integrating

resources.

Since 1969 group practices began opening up in response to the changes in state and federal laws regarding taxation. In group practice providers are not responsible for the large amount of investment capital that is necessary in starting a private practice and often buy into the group practice over time. Also, they do not have to bear the burden of personal financial pressures facing practitioners today.

It is thought that personnel like receptionists, medical records specialists, and nurses are used more efficiently in group versus private practice. They can afford more specialized personnel, which may not even be possible for physicians in private practice. For example, group practice physicians may have the ability to contract with many different specialist to provide the “one stop shopping” the American public has come to expect. providers not only share the burden of paying for their equipment but have the plus of being able to afford and utilize otherwise too-expensive, high technology equipment. Lastly, the physicians gain the advantage of sharing the expense of the facilities and the basic equipment.

These group practices are better at controlling who is seen and why, as opposed to emergency rooms and are, therefore, able to keep their costs down. Also, managed-care environments and large medical HMOs are often able to procure cheaper, large-scale contracts and negotiation tactics. This monetary relief can easily trickle down to the individual patient. Unfortunately, none of us can say for certain whether or not this financial relief is actually translated directly to the patient.

As shown here, the trend toward group practices is often more financially efficient. However, in joining forces, as it were, there is less direct competition from other healthcare

providers in the surrounding area. This decrease in healthy rivalry may, over time, make it difficult for insurers, employers, and other plan sponsors to negotiate the terms of the contracted care.

Hospitals are responsible for almost 40% of the nation's health expenditures. Thus, it stands to reason, that to deal with rising costs of healthcare the U.S. had to address the entity of hospitals. This consolidation of hospitals, physicians, and other providers into systems is called vertical integration. This single source of healthcare also brings together home care agencies and long-term care facilities. It is a method used to better organize the progression of patient care, dealing with each step more efficiently. Vertical integration is more of a "cradle to grave" ideology where the healthcare providers are better positioned to more effectively serve the patient.

To accomplish this lofty goal, vertical integration must do many things. A network of primary care physicians is strategically located to best serve the public and have access to all the facilities and services, including specialists, available. Vertical integration monitors patient care, making every attempt to avoid fragmentation, duplication, and redundancy. Also, there is constant reporting on how the system is working, if the efforts are proving to be cost-effective, and what can be done to improve the system.

Preventive medicine plays a major role in curtailing costs. Realizing that prevention of disease is often the key to less spending later in the patient's life, a great deal of research has been done to delineate cheaper, alternative treatments, quicker medical diagnoses, and shorter hospital stays. In fact, it has been said that preventive medicine has impacted health more, dollar for dollar, than efforts to treat illness once it occurs.

Unfortunately, hospitals are still forced to restrict costs. This has led to replacement of trained nurses with less-skilled personnel. Though at the same time, these cost-reduction measures have created a need for specially trained nurses who can respond to the outpatient, long-term care, and homecare population. Where hospitals once relied on certificate of need programs to control costs, they are now moving toward insurance plans based on prospective rates for services. This shift in approach, simultaneously encourages *non-hospital*, and serves to control whom is admitted and how long they are permitted to stay.

Long-term care is an area of considerable contention when discussing the cost of U.S. healthcare. The demand for long-term care, for both acute and chronic cases, outweighs the resources. This leaves the current state of such healthcare financially uneven and its services piecemeal. The demand is created as a result of the increased aging population, as well as other populations including; veterans, the young disabled, patients with AIDS/AIDS -related conditions, the mentally ill, the blind and visually impaired, and caregivers and employers.

In response to this costly issue Medicare serves as the primary source of coverage for those 65 and older with acute and long-term care problems. In contrast, Medicaid is a federal program designed to help low-income individuals. However, both of these programs give only a *very small* percentage of available monies to nursing homes and home health care programs. Additionally, long-term care is not covered under standard, commercial health insurance and managed care plans.

Not every disease or condition is easily preventable. On a daily basis, people will suffer from both chronic and short-term illness, develop disabilities, and contract diseases that are unpreventable. Managed care helps control these costs, while providing the patient with

personalized handling of their case, which may prevent other potentially expensive problems. In order to provide more efficient and effective long-term care, continued efforts must be made to further develop internal organization and information systems that can integrate patient data with resource data. Also, it is necessary to better coordinate individual cases from beginning to end, as well as, more flexible, best-appropriated funds. The U.S. recognizes long-term care as an important area of opportunity and will continue to address this financially problematic area until a more comprehensive, publicly responsible method takes shape.

In the discussion, it was noted that in the desperate struggle to lower healthcare costs, the American public needs to maintain a *healthy* perspective. The country has not definitively translated its need for a prudent use of money into a prudent standard of care. Lower costs are expected, but it is not always feasible for services rendered. Healthcare is made up of expensive technological advances, (proclaimed by the thankful public as good.) Some argue that perhaps these higher standards of medicine fall into the quality factor and are above and beyond a patient's basic standard of care. Either way, with these pricey advances, it remains difficult to lower costs to a consumer-accepted level.

The combination of technological advances paired with lack of established standard of care raises many ethical questions as to who "deserves" the benefits of these expensive services. As was mentioned, health should not equal wealth. Each citizen should do all he or she can to contribute to the costs of healthcare. Although the baby boomers led to a larger aging population, they also have provided a great deal of support to the economy by paying taxes and generate a lot of revenue. It was suggested that instead of deciding who has "earned" access to healthcare services that measures be taken to penalize government inefficiencies,

waste, and abuse to generate money for the costly U.S. healthcare system.

This puzzle-like depiction of the U.S. healthcare system seems to indicate that the government is dragging its feet in coming up with a national healthcare policy. In truth, however, the country is simply hesitant to commit to a policy that may inadvertently sacrifice the American way of life; a politically defined, basic, and necessary standard of life that even COST is not strong enough to alter. In the future, the country will continue to logically and creatively come up with ways to deal with the financial problems faced by its healthcare system.

In conclusion, the U.S. healthcare system is, striving to lower the cost factor of healthcare for the public. Accelerated managed-care is providing patients with more personalized attention. Horizontal integration is combining hospitals into systems, individual physician practices into group practices, and home care facilities together to streamline its operations and eliminate redundancy. Vertical integration allows a single organization to effectively follow the patient from “cradle to grave.” Although long-term care requires the most work, it is simply in a younger stage of development. It is exhibiting the same growing pains that the other areas of change do from time to time. If the country continues to work on this financially driven issue, recognizing the need to provide healthcare for everyone, though lowering costs will never make healthcare *free*, the U.S. will persist in achieving efficient, quality care one American at a time.