Health Care: Then and Now

**Question 1:** What are some of the changes to the early health system that improved health care?

**Answer 1:** In the 19th century, scientists discovered that microorganisms were responsible for many diseases like cholera and tuberculosis. Public health initiatives were followed to improve sewage disposal and clean up water supplies. Florence Nightingale was a nurse who helped treat soldiers during the Crimean War, and it was Nightingale and her nursing colleagues who improved sanitation conditions. After she returned to England, she applied her experiences to the Nightingale School for Nursing. During this time, many health issues could have improved with the onset of better sanitation (Dowling, 2002).

With the discovery of penicillin by Alexander Fleming and its application in treating patients in the mid-1900s, many patients were cured from illnesses that might have otherwise killed them. Antibiotic use for infections is common today, but many infections killed people before the advent of penicillin (Torrens, 2002).

According to Malugani (1999), "vaccinations have also virtually eliminated deadly diseases that were common in the United States earlier in the century, including diphtheria, tetanus, poliomyelitis, measles, mumps, rubella and Haemophilus influenzae type b meningitis." World War II helped usher in technological inventions that translated to improvements to diagnosis and treated health conditions (Torrens, 2002).

**Question 2:** How has the role of hospitals changed since the 19th century?

**Answer 2:** Early hospitals were places where people went if they could not afford to be cared for at home. Infection was rampant; care was palliative. The money to run hospitals was donated by charitable organizations (Pointer, 2004).

In the early- to mid-1900s, improvements were made in understanding the biological bases of medicine and sanitation. Penicillin was also discovered. Physicians gained more power in hospitals because the care and cure of patients depended on their expertise due to the biological-based and science-based nature of physician training (Pointer, 2004).

From the mid-1960s to the 1980s, medical knowledge and technology grew. Patients went to hospitals to avail themselves of the concentrated expertise found there. Patient care became more sophisticated and costly (Pointer,
From the mid-1980s to the present, hospitals have grown in complexity and expense. Employers, as purchasers of health care benefits for employees (and the government as payers), did not wish to see large costs affect their budgets. Managed care started as a way to control costs. Hospitals and physicians have become more competitive for available reimbursement dollars (Pointer, 2004).

**Question 3:** What are some changes that have occurred in managed care since its inception?

**Answer 3:** Before the 1990s, managed care offered few options to patients in regards to choices of physicians and hospitals and was not well received by consumers. Rovner (2003) wrote that "it took a combination of factors, including federal financial incentives in the 1970s and the desire of employers in the 1980s to control their health care costs, to push managed care from the health system’s back benches to the front row."

As a result of managed care plans that gave patients and providers more choices, "between 1986 and 1995, the number of Americans in health maintenance organizations (HMOs) more than doubled" (Rovner, 2003, p. 117).

"HMOs may be independent organizations. They may be owned and operated by an insurance company, or they may be owned and operated by groups of physicians and hospitals" (Rovner, 2003, p. 118). They are viewed as somewhat restrictive in offering patients a choice of physician or hospital. HMOs usually offer purchasers of health insurance, like employers, a variety of services for a monthly fee.

While an HMO may limit the types of services for which it pays, it generally offers many preventive care services to help keep patients healthy; subsequently, patients use fewer health care services (Rovner, 2003).

Preferred provider organizations are also known as PPOs. "PPOs are networks of independent physicians (and hospitals and other providers) that contract with insurers to provide care. A physician who participates in a PPO will accept a fee lower than normal, in exchange for a higher volume of patients" (Rovner, 2003, p. 120). Patients will have higher fees if they go to a provider outside of the PPO. Physicians will try to negotiate the best possible rates of reimbursement and will select the type of managed care option that suits their
business needs.

**Question 4:** How did managed care actually start?

**Answer 4:** In the late 1930s, workers were being sought to build a dam in a very remote part of the United States. Workers wanted to make sure that they would have medical care if needed because of the dangerous work, but it was difficult to recruit a physician to set up a practice. There was no guarantee there would be enough patients to enable the physician to make a living.

The head of the company that was contracted to build the dam decided to have the workers contribute a small amount of money on a weekly basis that would be collected by the company to ensure that medical care would be available. The physician was paid from those contributions. The person who implemented this plan was Henry Kaiser. Similar prepaid health plans arose following this template (Budrys, 2001).

During the Nixon presidency, advisors to President Nixon recommended using a prepaid care template for Medicare and Medicaid because costs for the two plans were overbudgeted. They recommended that a prepaid plan be developed that allowed people to use health care services to help maintain their health in the hope of minimizing illness. Thus, the first HMO was born (Budrys, 2001).

The HMO concept struggled because of objections from the American Medical Association (AMA) about the lack of fee-for-service structure that had defined physicians’ billing arrangements with their patients. Also, patients who complained about restrictive rules did not always have access to their doctors without incurring additional costs if their doctors were not part of the HMO network. However, the idea of controlling costs remained in the minds of payers and employers who purchased health coverage for their employees.

As the health care industry grew, more sophisticated financial plans were needed to keep track of revenues and expenses. Just like many businesses, hospitals found ways to improve their buying power by affiliating with other hospitals by sometimes merging; ultimately, the industry got very complex from a business perspective. Payers also became very sophisticated and continued to explore ways to limit their costs. From this environment, a system was devised that controlled physician office visit costs and hospital costs. This system became known as managed care (Budrys, 2001).
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References


