DOWNLOAD PDF TWO DECADES OF HEALTH SERVICES

Chapter 1 : United States Public Health Service - Wikipedia

Moral hazard has to do with insured patients' demand for health care services. True Since the final two decades of the 20th century, the U.S. health care delivery system has begun to shift its emphasis from wellness to illness.

For example, in and , two of the largest health care systems in southeastern Michigan i. These closures result in additional strains on remaining hospitals, creating even greater stresses for an already fragile system. While hospital closings and mergers create many issues and concerns, both the declining number of beds and the declining number of admissions is related to a significant decline in the number of in-patient surgeries. By , the respective percentages of in-patient and out-patient surgeries were 42 percent and 58 percent. While the cost savings to insurers is real, although difficult to calculate, the impact on formal and informal after-care services and in home health care is equally difficult to estimate. Now many more patients return home on the same day of their surgeries. For individuals with familial and social supports this reality may not be as challenging as for patients who live alone and have little if any family or social network on which to depend. It is calculated by the Institute for the Future that 40 percent of sickness is related to life style and health behavior choices. Clearly education and early case finding are paramount. Prevention has proven effective for individuals or families who have made life style and health behavior changes. However, for many patients, changing to a managed care program, or switching between managed care programs, changes and limits the choices of providers to those on preferred panels. In many plans, if a patient wants to see a provider with whom he or she is familiar, but who is not included as a provider in their "new" plan, an option may exist for obtaining "out of network" services, but it almost always comes with a significantly higher out-of pocket co-pay. Some employers are covering fewer persons. Some are passing the increases on to employees and requiring higher levels of employee contribution. And some employers are just doing away with health care benefits all together. While reductions in the "value" of an existing plan adversely impact employees, the ability to contain insurance costs helps for more people to at least remain covered in some fashionâ€"even if their coverage is only for very serious illnesses. The number of people in the population without health care has increased. Currently it is estimated that 42 million people, or 16 percent of the population, is without any form of health care insurance. The Institute for the Future projected that the number of uninsured will reach 48 billion by While this statistic usually rises during times of recession and decreases in times of expansion, the number of uninsured has increased even during the expansion of the late s and early s. The Institute for the Future also reported that the number of non-elderly persons covered by employment related health insurance dropped from In Michigan, for example, the Access to Health Care Coalition reported that between and the percent of residents without health insurance decreased from However, given the relationship between the economy and the availability of health insurance, this decrease appears temporary. An increase is expected in the number of uninsured, especially in light of the economic downturn of While not all eligible children have been enrolled in these programs, a considerable number are not eligible based on family income exceeding a percentage of the Federal Poverty Level FPL. Mirroring national trends, Michigan is struggling with rising unemployment, a budget deficit, and growing demands for health services and insurance coverage. Often the underinsured and uninsured use the emergency room, the most expensive form of health care service, for any illness. Weiss and Lonnquist reported that uninsured emergency room care visits totaled 93 million in In approximately half of the cases, urgent care was not needed, nor did the individuals seeking care have a regular physician or other option for gaining access to health care services. Their observations are summarized below: The first group represents 38 percent of the population. It consists of empowered consumers with considerable discretionary income, who are well educated and use technology, including the Internet,, to get information about their health. Usually they are able to make choices in their plans and coverages. They are able to educate themselves about health behaviors as well as health care issues and concerns. They are likely to engage in shared decision making with physicians and other allied health professionals. Their primary concern is benefit security and the issue of value as plans become more restrictive. People included in this group include those with unstable job security, both employers and employees, and also early retirees who are

waiting for Medicare to begin. Though they have limited access to information, they are likely to focus on learning more about plans and coverages. They are also likely to become more empowered due to some of the voluntary associations to which they belong who focus on problems in the health care system. The third group represents 28 percent of the population whose main concern is access to health care. It includes people under 65 who are uninsured as well as children who have no coverage or are covered by Medicaid. Access to care for this tier is severely limited because the safety net has frayed. People in this tier depend on the limited resources and strained generosity of safety net funding streams and providers. While some are covered by Medicaid, this plan offers only limited choices and benefits depend on funding which often competes with prisons and schools. Generally poor and lacking education, most people in this tier have serious trouble overcoming the information gap between patients and providers. They may be largely ineffective in changing legislation or the structure of health care. If the problem of access is to be solved, it will need to be driven from the top two tiers. Trust however is another issue. Survey results indicated that only 30 percent of patients in managed care plans trusted that their plan would do the right thing for their care, while 55 percent in traditional plans trusted their plans. Also, fewer than 30 percent of patients trusted their HMOs to control costs without adversely affecting quality of care Dranove, Managed care has a long way to go in persuading the public that managed care is actually care management, although they frequently advertise high quality at a reasonable cost. What Can Be Done? All of this information may be overwhelming, although it represents only a brief overview of the issues and concerns related to our evolving health care system. Nevertheless, there are several practical steps that we can take both individually and collectively: What Does the Future Hold? While trends can be traced and often predicted, there are a significant number of "wild cards" in the future that make the evolution of the American health care system uncertain and volatile. Some of these, according to the Institute for the Future , include Demographic trends and increasing numbers of elderly people in the population; Reimbursement rates for home health care services; new cost containment and cost-shifting strategies; Increasing technology; Economic recessions or expansions; legal and mandatory restrictions on managed care plans; Malpractice insurance, settlements, and jury awards; universal health insurance legislation; and Switching from a private and public insurance model to a national health insurance system. One solution is to learn from other health care delivery models. Perhaps we could benefit both by learning more about other systems especially from countries with high levels of access , and also by beginning to advocate for needed changes in the American health care system. Indeed, the greatest changes may come about as consumers make their concerns known to providers and to state and federal policy makers. It would also make strategic and tactical sense for providers to partner with consumers and policy makers to bring about needed changes. Given our current reality, the focus of change will need to address both access and affordability. References Access to Health Care Coalition Improving access to health care in Michigan. Blue Cross Blue Shield of Michigan. Retrieved March 1, from http: A comprehensive summary of U. A clinical approach 2nd ed. The evolution of American health care. Employer-Sponsored Health Benefits Institute for the Future Health and health care The forecast, the challenge. National Survey of Health Insurance. National health spending trends in Health Affairs, 17, The sociology of health, healing, and illness 3rd ed. Upper Saddle River, NJ: For more information please contact mpub-help umich.

Chapter 2 : Two decades of Neo-Marxist class analysis and health inequalities: A critical reconstruction

Uganda's maternal health journey over the last two decades has important implications for global policymakers. While impressive numbers of women in low- and middle-income countries have been reached by predominantly publicly-provided ANC and delivery services [68, 69], the road ahead is long, and the destination not clearly in focus.

Back to Top Emerging Issues in Access to Health Services Over the first half of this decade, as a result of the Patient Protection and Affordable Care Act of , 20 million adults have gained health insurance coverage. In addition, data from the Healthy People Midcourse Review demonstrate that there are significant disparities in access to care by sex, age, race, ethnicity, education, and family income. These disparities exist with all levels of access to care, including health and dental insurance, having an ongoing source of care, and access to primary care. Disparities also exist by geography, as millions of Americans living in rural areas lack access to primary care services due to workforce shortages. Future efforts will need to focus on the deployment of a primary care workforce that is better geographically distributed and trained to provide culturally competent care to diverse populations. Specific issues that should be monitored over the next decade include: Increasing and measuring insurance coverage and access to the entire care continuum from clinical preventive services to oral health care to long-term and palliative care Addressing disparities that affect access to health care e. Access to Health Care in America. National Academies Press; Agency for Healthcare Research and Quality; May Insurance coverage, medical care use, and short-term health changes following an unintentional injury or the onset of a chronic condition. Self-assessed health status and selected behavioral risk factors among persons with and without healthcare coverageâ€"United States, The medical home, access to care, and insurance. Provider continuity in family medicine: Does it make a difference for total health care costs? The importance of having health insurance and a usual source of care. The timing of preventive services for women and children; the effect of having a usual source of care. Am J Pub Health. Evidence from primary care in the United States and the United Kingdom. Balancing health needs, services and technology. Oxford University Press; Contribution of primary care to health systems and health. A national profile on use, disparities, and health benefits. Partnership for Prevention; Aug. Data needed to assess use of high-value preventive care: A brief report from the National Commission on Prevention Priorities. Future of emergency care series: Agency for Healthcare Research and Quality; April The increasing weight of increasing waits. Trends Affecting Hospitals and Health Systems. American Heart Association; Department of Health and Human Services; Mar 3.

Chapter 3 : Two Decades of Health Services: Social Survey Trends in Use and Expenditure

Introduction. Telemedicine, as defined by the World Health Organization, is the use of communication technologies in healthcare for the exchange of medical information for diagnosis, treatment, prevention, research, evaluation, and education over a distance ().

A gleaming brick and glass buildingâ€"half hospital, half community centerâ€"the three-story, 70,square-foot WellStar Acworth Health Park will offer services such as urgent care, diagnostic imaging, preadmission testing and cardiac and sleep labs. The facility also will have a cafe and retail pharmacy onsite. And as ambulatory surgery centers enabled doctors to perform procedures in just about every corner of suburbia, hospitals began to realize that they need to offer the same access and convenience to remain competitive. But with the financial incentives lining up for health systems to focus on total population management rather than just acute care, the shift has been accelerating. As a result, WellStar has seen outpatient services account for a growing percentage of its revenue. In , outpatient services represented LifePoint Hospitals, Brentwood, Tenn. Health Management Associates, Naples, Fla. Analysts attributed the performance to a strong showing in outpatient care, which helped counteract weak inpatient volume. Not only is outpatient care more cost-effective to deliver, but it also attracts more patients with commercial health plans at a time when Medicare and Medicaid reimbursement is being squeezed. Moreover, the trend now is to bring more services out of urban centers, where most tertiary-care hospitals are located, and into the suburbs, he notes. Patients are driving this to some degree. Cohen adds that providers are also increasingly turning to virtual care as part of that same idea. And it expects that side of its business to keep growing. The system now attributes And hospitals are still spending significant amounts of capital to maintain their acute-care facilities. But not all partnerships have been financially motivated; others are about acquiring new skills. Texas Health Resources earlier this year forged a year agreement with Franklin, Tenn. Scholl notes that the need to account for cost and quality requires systems to have greater control over the entire spectrum of care, from promoting wellness and prevention to offering post-acute and home health services. With reimbursement models changing, forward-thinking hospitals and health systems are maximizing advantages of expanded outpatient services.

Chapter 4 : Access to Health Services | Healthy People

Equity in Health Services: Empirical Analyses in Social Policy ï»¿ Andersen, Ronald; Kravitz, Joanna; and Anderson, Odin W. () Three Comments Received on Multinational Hospital Growth Trends in Privatization of Health Services 1.

Open in a separate window Yet Neo-Marxist class indicators are consistently associated with predictable health outcomes, with large and medium size employers and managers showing the healthiest profiles Schwalbe and Staples, ; Muntaner and Parsons, ; Wohlfarth, ; Wohlfarth and van den Brink, ; Muntaner et al, , , , ; Borrell et al, , ; Rocha et al, , ; Hadewijch et al, In particular, studies that conceptualize and test CCL hypotheses demonstrate the added value of Neo-Marxist thinking and analysis. The key advantage is that CCL hypotheses suggest social mechanisms that do not follow the gradient Muntaner et al, ; Prins et al, in press. That is, gradient hypotheses postulate that supervisors would present worse mental health than managers but better than frontline workers. Here, the idea is that increases in income correspond with improvements in health. In contrast, CCL hypotheses are based on the domination from managers and the opposition of workers to their domination by supervisors. Instead of graded health outcomes, one would anticipate worse mental health among supervisors than among frontline, non-managerial workers Muntaner et al, Compared with an occupational gradient hypothesis, Neo-Marxist class analysis reveals relational class mechanisms that make a logical link between psychosocial and proximal processes for example, lack of control, high demands and different, non-linear predictions for example, increases in income do not automatically translate into enhanced health Muntaner et al, Moreover, the theorized organizational control mechanisms among manager, supervisor, and non-managerial worker relations ground Neo-Marxist class analysis in realist epistemology Scambler, ; Scambler et al, Overall, these Neo-Marxist studies reveal a genuine lack of correspondence between theoretical definitions and social class measures. Exploitation is defined by Wright in Neo-Marxist terms, coupling it with power and domination during production. Three principles are invoked to define this key class mechanism Wright, The inverse interdependent welfare principle: This means that the interests of actors within such relations are not merely different, they are antagonistic: Exclusion generates material advantage to exploiters because it enables them to appropriate the labor effort of the exploited. Instead, most studies are measuring employment relations for example, employer, self-employed owner, worker , which makes them practically analogous to Neo-Weberian indicators of social class Marshall et al, A heuristic solution to this impasse might be to measure the process of exploitation, and its associated domination, with its own set of indicators. For example, in a recent study among nursing assistants and their mental health within the context of US nursing homes, exploitation was measured at the organizational level with for-profit status and domination was measured with rating scales answered by key informants in each workplace Muntaner et al, Results showed strong multilevel effects of indicators of exploitation and domination on worker mental health. A specific focus on the social mechanisms of exploitation and domination Wright, that underlie inequalities in welfare between persons in different class positions could hold promise for future Neo-Marxist class analyses. A Neo-Marxist class approach has implications for the way that researchers think about and engage with efforts to reduce health inequalities, implications that invert the mainstream relationship between research and action. We argue here that, although this mainstream orientation to social class and health inequalities may appear innocuous or politically neutral, it in fact functions in the service of incremental, apolitical, technical changes that are ultimately system-justifying and status-quo-reproducing Chomsky, As we described at the outset, the individual attribute approach to social class tracked broader trends in social science theory and research towards reductionism and methodological individualism. This absolves researchers from engaging with social processes and relations, which demand analyses of exploitation, domination, and even employment relations. These intellectual trends, in turn, reflect structural changes in the political economy of academic institutions that produce such knowledge Muntaner et al, a. While a complete discussion of the impact of neo-liberalism on health inequalities research is beyond the scope of this analysis, we contend that such trends conform to political options that often perpetuate inequalities, because they produce knowledge that explicitly avoids the mechanisms that generate social and

health inequalities. What can a Neo-Marxist approach to social and health inequalities add? This is not to say that all researchers of social inequalities in health must become public social scientists Burawoy, but it is to say that we cannot consign ourselves, under a thin veil of neutrality, to de facto approaching policy from a privileged position of access to elites, that is, from the orientation of serving policymakers. At the very least, we should have a more class-conscious perspective Burawoy, Returning to and advancing relational approaches to class may be the only way this will be possible. Future Directions Previous research on the relational effects of social class on health inequalities confirms the explanatory and analytical value of conceptualizing mechanisms of exploitation and domination as health determinants. Our critical reconstruction of two decades of Neo-Marxist scholarship provides an overview of the state-of-evidence and offers several promising directions for future research. First, there is a clear need to advance the conceptualization and measurement of social class in health inequalities scholarship. However, new contributions are needed. Public health scholars run the real risk falling into an intellectual trap if we fail to consider, integrate, and synthesize other concepts into our explanatory frameworks and research methods. For example, most studies make predictions about the health of individuals based on the assumption that capitalists and workers occupy a single class position at one time. Yet, prior work finds that individuals are often simultaneously engaged in multiple class positions that have the effect of generating different amounts of economic resources and creating different kinds of exploitation relations for example, an individual can be self-employed and a recipient of welfare assistance while occupying a working poor or underclass position Muntaner and Stormes, Other important needs in terms of advancing the conceptualization and measurement of social class include: Second, future work will benefit from incorporating mechanism-based explanations on how and why social class relations generate avoidable and unfair health inequalities, and under what circumstances. On one hand, existing social class studies have successfully identified plausible mechanisms that may contribute to health inequalities. Exploitation, for example, generates and reproduces health inequalities by i ensuring that the material welfare of capitalists comes at the expense of the working class; ii excluding the working class from owning productive resources, and iii appropriating the labour of the working class in the form of profits for the capitalist class. On the other hand, more theory-driven work is needed that considers how social class mechanisms interact with specific contexts to generate intended and unintended outcomes for example, income and wealth as well as health outcomes. By identifying and testing CMO patterns, researchers will be well-positioned to describe and understand the various contingencies that shape and influence the likelihood that social class relations may generate social, economic, and health outcomes. In turn, such findings can potentially inform how social class relations may be restructured in egalitarian policies for example, increasing workplace democracy that most likely trigger causal mechanisms for example, increasing social solidarity that narrow health inequalities for example, among capitalist, managers, and workers Ng and Muntaner, Third, health sociologists and social epidemiologists can significantly advance the ultimate goal of reducing health inequalities by investigating the egalitarian effects of social change. Over the next two decades, it is essential that we overcome barriers to knowledge production and translation in order to make real progress toward changing and transforming the nature of social class inequalities in health Muntaner et al, a. He has conducted research on social inequalities in health in the United States, European Union, Latin America, and Western Africa, integrating the public health fields of occupational health and social epidemiology. His research interests include the political determinants of population health and the Neo-Marxian concept of social class. Her research deals with the political economy of health, especially the impact of welfare states on health care systems and population health. His research interests include the political-economic determinants of mental illness, the criminalization of mental illness, and the medicalization of crime. What does it contribute to social class differences in health. Social class and self-reported health status among men and women: What is the role of work organisation, household material standards and household labour. Immigration and self-reported health status by social class and gender: The importance of material deprivation, work organisation and household labour. Journal of Epidemiology and Community Health. What makes a social class? On the theoretical and practical existence of groups. Berkeley Journal of Sociology. Sociology as a vocation: Moral commitment and scientific imagination. Extending the reach of public health genomics: Indiana University

Linguistics Club; Work and health in a contemporary society: Demands, control, and insecurity. Class and Class Conflict in Industrial Society. Stanford University Press; Neo-Marxist social class inequalities in the mental well-being of employed men and women: The role of European welfare regimes. Race and reification in science. Inequalities in health by social class dimensions in European countries of different political traditions. International Journal of Epidemiology. Structural and intermediary determinants of social inequalities in the mental well-being of European workers: Hypothetical interventions to define causal effects â€” Afterthought or prerequisite. American Journal of Epidemiology. The jichi medical school cohort study. Social stratification and psychiatric disorders. American Culture in the Age of Academe. Class, occupation, and orientation. Measuring social class in US public health research: Concepts, methodologies, and guidelines. Annual Review of Public Health. Is subjective social status a more important determinant of health than objective social status? Evidence from a prospective observational study of Scottish men. A public health institution. American Journal of Public Health. Social Class in Modern Britain. The class structure of job rewards: Realist synthesis of the impact of unemployment insurance policies on poverty and health. Evaluation and Program Planning. Income, social stratification, class, and private health insurance: A study of the Baltimore metropolitan area. International Journal of Health Services. Social class and behavior: Simultaneous class positions yield different amounts of income. Social class, assets, organizational control and the prevalence of common groups of psychiatric disorders. The social class determinants of income inequality and social cohesion. Social inequalities in mental health: A review of concepts and underlying assumptions.

Chapter 5 : Health Care in the United States: An Evolving System

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This article has been cited by other articles in PMC. Abstract Teledermatology, originating in , has been one of the first telemedicine services to see the light of day. Two decades of teledermatology research is summarized in this review. A literature search was conducted in PubMed. One hundred fourteen publications and 14 systematic reviews were included for full text reading. Focus of this review is on the following outcomes: To conclude, teledermatology is an efficient and effective healthcare service compared to in-person care. Teledermatology, Implementation requirements, Integration national healthcare system, Delivery modalities, Merits Introduction Telemedicine, as defined by the World Health Organization, is the use of communication technologies in healthcare for the exchange of medical information for diagnosis, treatment, prevention, research, evaluation, and education over a distance 1. Teledermatology is a mature and frequently used form of telemedicine. The first publications about teledermatology listed in PubMed were published in 2 â€" 5 and the number has grown exponentially. The visual character of dermatology makes it well-suited for telemedicine. However, some barriers in teledermatology remain, e. Teledermatology is currently applied throughout all kinds of medical settings, e. Furthermore, it is applied in countries e. Teledermatology has been used during wars, in military and maritime settings and reduced the number of medical evacuations 10 , The aim of this narrative review is to give an overview of the current status of teledermatology concerning 1 the actors of teledermatology, 2 the purposes and subspecialties of teledermatology research, 3 the delivery modalities and technologies used, 4 business models used, 5 the integration of teledermatology in national health infrastructures, 6 preconditions and requirements for implementation of teledermatology, and 7 surplus merits of teledermatology. Method A literature search was conducted in PubMed. First, all titles were scanned and all duplicates were removed. Secondly, titles and abstracts were scanned and included if they met the review questions. All papers without an abstract were scanned quickly and were included if they focused on teledermatology. Unavailable publications and publications focusing solely on teledermatopathology were excluded. Finally, one reviewer read all remaining publications and completed a data abstraction form with publication characteristics and relevance for every publication. Results discussed in this review were based on this final selection of the publications and any additional publications that were cited in one of the publications and met the inclusion criteria, but were not in the original search result. Search Results The literature search, as conducted in November , resulted in references and after removal of the duplicates unique publications remained. After title selection, publications were included for abstract selection and publications were included for full text reading. Furthermore, 60 systematic reviews, published before were found and 14 of those reviews remained for full reading after title and abstract selection. Actors There are different instances of teledermatology in which actors are involved. An overview of different actors in teledermatology is presented in Fig. Primary teledermatology includes direct communication between the patient and the primary healthcare provider i. Most common is secondary teledermatology. Patients visit the GP and the GP communicates or exchanges medical information of the patient with the dermatologists. Other secondary actors who are not explicitly mentioned in the literature are health insurance companies and healthcare institutions, e. Tertiary teledermatology concerns the collaboration and communication among dermatologists Finally, patient-assisted teledermatology is a form of teledermatology in which the patient interacts directly with a healthcare professional, for example in follow-up care in which the patients interacts with a public health nurse or wound-care nurse.

Chapter 6 : Outpatient care takes the inside track - Modern Healthcare

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He said that over the past two decades there has been a "slow erosion of care" in the state, to the point where now Victoria spends less per capita on both community-based care and inpatient beds than any other state. Alan Porritt Public hospitals at the frontline In the past decade, the number of people presenting at Victorian emergency departments with mental health crises has jumped by more than 60 per cent â€" from 33, in to 54, in â€" according to the Australian Institute of Health and Welfare. Mental health emergency presentations have grown by 19 per cent in the past four years alone. The Australasian College for Emergency Medicine says those who do present are waiting longer to be assessed and treated, and are twice as likely to leave emergency departments before finishing treatment. We need to recognise that," said Dr Judkins. Ms Lashay lost a friend to suicide after her friend was discharged from hospital. Chloe Lashay has been in hospital multiple times with mental health issues. Zalika Rizmal Ms Lashay said a single phone call from the hospital was the most she had ever received after being discharged. For someone who is mentally ill, that is basically an impossible task. She moved in with her daughter to support her. Although the number of beds has increased by 7 per cent over the past eight years, population growth has meant there has actually been a 9 per cent reduction in per capita terms. The Royal Australian and New Zealand College of Psychiatrists said an extra beds â€" at minimum â€" are needed to bring Victoria into line with the rest of the nation. Dr Judkins said the current state of affairs is unacceptable. And if the system is full, it means patients are going to be waiting, somewhere along the line. We know that happens. There are measures we could implement tomorrow. Simon Judkins says emergency departments are struggling to deal with a rapid increase in patients. Australasian College for Emergency Medicine Once a leader, now a laggard Stephen Duckett, health program director at the independent think tank the Grattan Institute, says Victoria used to lead the nation in mental health. Now, fewer people are accessing community mental health care services in Victoria than anywhere else in Australia. Now, only one in three Victorians in need of mental health care is able to access such care. Dr Duckett says the reduction in mental health funding is most apparent in the decline of community mental health services, where funds have been diverted to the National Disability Insurance Scheme NDIS. This is not what we should be doing," he said. Lifting the lid on that, and setting some priorities, is a good thing. Dr Judkins says improving community services was crucial â€" so that patients could be directed there from the hospital, instead of being discharged into the unknown. We really need to look at how we link all those parts of the system together. Running a successful floristry business has been her constant, even when she has been unwell. My family, we love each other so much. I have a business that I love.

Chapter 7 : Two Decades of Teledermatology: Current Status and Integration in National Healthcare Syste

Since the final two decades of the 20th century, the US health care delivery system has begun to shift its emphasis from wellness to illness. false The US health care system is administratively controlled by an agency of the government.