The Office of the National Coordinator for Health Information Technology

Audio Transcript

Introduction to Health Care and Public Health in the U.S.

Introduction to and History of Modern Health Care in the U.S.

Lecture c

Health IT Workforce Curriculum
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Welcome to Introduction to Health Care and Public Health in the U.S.: Introduction to and History of Modern Health Care in the U.S. This is lecture c.

The component, Introduction to Health Care and Public Health in the U.S., is a survey of how health care and public health are organized and how services are delivered in the U.S. It covers public policy, relevant organizations and their interrelationships, professional roles, legal and regulatory issues, and payment systems. It also addresses health reform initiatives in the U.S.

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The learning objectives for Introduction to and History of Modern Health Care in the U.S. are to:

- Define key terms in health care and public health
- Describe components of health care delivery and health care systems
- Discuss examples of improvements in public health

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- Define core values and paradigm shifts in U.S. health care
- And describe the technology used in the delivery and administration of health care

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This lecture will introduce the core values of U.S. Health Care, and then discuss several major paradigm shifts in medicine, with an emphasis on patient-centric care, personal health records, team-based care, and the effect of technology on health care delivery.

Let us consider some of the core values of health care in the United States today.

A central tenet of the practice of health care and health care delivery in the U.S. at this time is the concept of patient centricity. Patients are at the center of the universe of health care delivery, and often exercise individual choice when it comes to management of their illnesses.

The concept of interdisciplinary care has also gained attention, especially as diseases become more complex and management options correspondingly increase in complexity. Technology and innovation drive health care, but technology can also drive health care spending.

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When we look at the cost of health care, there are five general options for financing health care. The first is taxation or general revenue. The second is to have a system or some form of social health insurance that will finance health care. The third is to have

voluntary or private health insurance. The fourth option is out-of-pocket payments that patients will make in order to take care of their illnesses. And the fifth is internal donations which may come from communities, organizations, or professional societies.

But the fact of the matter is that health care expenditure has increased dramatically in the last few decades. In the United States, health care expenditure was 253 billion dollars in 1980 and increased to 714 billion dollars in 1990. By 2015, it increased to 3.2 trillion dollars, which was nearly 18 percent of gross domestic product, or GDP, and $10,125 per capita. We're spending sixteen percent of our GDP on health care. There is definitely a need for cost containment, and this has been one of the driving forces, one of the core values, in U.S. health care today.

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Let us spend some time discussing some of the key paradigm shifts in medicine. The first of which is the shift from a physician-centric model of care to a patient-centric model of care. Just a few decades ago, patient care options were determined by the provider and patients were offered limited or no opportunity to make decisions. In the past few years there has been a cultural shift towards giving patients greater responsibility for their care. There has been a shift from paternalism, or the opinions of the physician, to patient autonomy, or the opinion of the patient.

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The Patient Self Determination Act was passed by Congress in 1990. This act requires that at the time of in-patient admission or enrollment, health care organizations give patients certain information about their rights, including the right to participate in and direct their own health care decisions, the right to accept or refuse medical or surgical treatment, the right to prepare an advance directive, and information on the provider's policy that governs the utilization of these rights. Providers, organizations, and health care systems have become more responsive in the past few years to patient needs, and now actively foster a partnership with patients. This shift from physician-centricity to patient-centricity is a key paradigm shift that influences medicine as it is practiced in the U.S. today.

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The second paradigm shift in medicine that we will examine is the shift from individual care to team-based care. Historically, care for a patient was provided by an individual health care provider. With increasing complexity of health care and patients, there has been an evolution towards collaboration between health care providers to optimize patient care and solve complex bio-psycho-social problems. This had led to the formation of interdisciplinary teams. An interdisciplinary team may be defined as "a group of individuals with diverse training and backgrounds who work together as an identified unit or system". Many such teams operate in the health care environment. For example, in intensive care units, in hospice care, and even in the outpatient setting, you will often see teams of physicians, social workers, care management specialists, and pharmacists working together in the care of the patient's medical problems.

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As the paradigm shifts from individual care to team-based care, the concept of the patient-centered medical home has gained traction. This is a term introduced by the American Academy of Pediatrics in 1967 that is now endorsed by multiple organizations, including the American Academy of Family Physicians, or the AAFP, the American College of Physicians, or the ACP and the American Osteopathic Association, or the AOA.

Features of the patient-centered medical home include a personal physician. This implies that each patient has an ongoing medical relationship with a personal physician who is trained to provide continuous and comprehensive care.

The patient-centered medical home is characterized by physician-directed medical care. The personal physician leads a team of individuals who collectively take responsibility for the care of the patient. In this model, care is coordinated and may be integrated across all elements of the complex health care system. There is an emphasis on quality and safety, and enhanced access to care is available through systems such as open scheduling, expanded hours, and new options for communication between patients, physicians, and members of the interdisciplinary team.

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With the passage of the Affordable Care Act came the concept of Accountable Care Organizations, or ACOs.

These are groups of physicians, hospitals, and other health care providers who come together to provide coordinated high-quality care. The goal of ACOs is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and aiming to prevent medical errors. Under some models, when an ACO succeeds both in delivering high-quality care and spending health care dollars more wisely, it shares in the savings it achieves.

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The next paradigm shift that we will examine is the shift from physician-kept patient records to personal health records. The first medical records were notes that were maintained by physicians. In 1907, Dr. Henry Stanley Plummer at the Mayo Clinic in Rochester, Minnesota, developed a system of medical records where each individual patient was assigned his or her own record. These records were stored in a centralized fashion in the Mayo Clinic, and any clinician who was taking care of a patient could access the patient record. Now current advances in technology have led to the electronic medical record, but these are still usually created, maintained, and updated by the provider or the system. The current trend is towards the personal health record, which is created and maintained by the patient. The patient has significant control over the content within the personal health record and can even assign different privileges to different providers.

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The final paradigm shift that we will examine in this unit is the shift toward a dominance of technology in health care delivery. We have seen this over the past few years, but technology has taken an ever more important role in health care delivery. Health Information Technology, or HIT allows comprehensive management of medical information and its secure exchange between health care consumers and providers. But the dominance of technology has also been driven by other factors. The broad use of Health Information Technology has the potential to improve health care quality, prevent medical errors, increase the efficiency of care, and reduce unnecessary health care costs. Technology can increase administrative efficiencies, decrease paperwork, and expand access to affordable care. In the arena of public health, technology can improve population health.

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This concludes lecture c of Introduction to and History of Modern Health Care in the U.S.

In summary, the core values of U.S. health care emphasize patient choice and an interdisciplinary approach to care. The emergence of multi-level care, accompanied by significant technological advances, reflects the increasing complexity of diseases and their management. This progress has, in part, driven a dramatic increase in health care costs – something that U.S. patients would like to see better contained.

These core values are demonstrated in several significant paradigm shifts in medicine – from physician-centric to patient-centric care; from individual to team-based care; from team-based care to accountable care; and from paper-based management of medical information, to the use of technology in the management of medical information and the delivery of health care.

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