

This is a sample of the instructor materials for *Essentials of Healthcare Management*, second edition, by Leigh W. Cellucci, Michael R. Meacham, and Tracy J. Farnsworth.

The complete instructor materials include the following:

- Instructor resources for each chapter, including answer guides for the end-of-chapter discussion questions
- PowerPoint slides for each chapter
- A test bank

This sample includes the instructor resources and PowerPoint slides for chapter 1, “A Brief History of the Development of Healthcare in America.”

If you adopt this text, you will be given access to the complete materials. To obtain access, e-mail your request to [hapbooks@ache.org](mailto:hapbooks@ache.org) and include the following information in your message:

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**INSTRUCTOR RESOURCES – CHAPTER ONE – END-OF-CHAPTER MATERIAL**

This case was selected to demonstrate the contrast in the enactment process between the Affordable Care Act (ACA) and Medicare/Medicaid. Specifically, Medicare/Medicaid enjoyed bipartisan support because Ways and Means Committee Chairperson Wilbur Mills incorporated Republican concepts into the final version of the Medicare/Medicaid legislation. As a consequence, to a greater or lesser degree from time to time, Medicare and Medicaid have enjoyed relatively broad support with few partisan attacks in over 50 years of existence. The ACA, on the other hand, was enacted solely with support from the Democrat side of the aisle. As a consequence, the Republican members of Congress felt no ownership in it and were relentless in seeking its repeal. In political science terminology, one could say that Medicare and Medicaid have a greater degree of “legitimacy” than the ACA because of the way they were enacted into law.

## **Mini Case Study Questions**

**1. How did the bipartisan support for Medicare facilitate it becoming a critical part of the US healthcare system?**

The way Wilber Mills (D-AR), Chairman of the House Ways and Means Committee, structured the overall plan made it possible, for some even obligatory, for Republican members of the House to vote for Medicare as well as Medicaid. Remember that Part B of Medicare is premium-driven like commercial insurance. The fact that it was both voluntary and funded by premiums was consistent with Republican ideas on health insurance at the time. Likewise, allowing the states to manage Medicaid was also consistent with Republican themes of empowering the states to manage their affairs, rather than the federal government.

**2. Provide a prognosis for the future of the ACA. What did you describe and why?**

The prognosis for the ACA appears challenging. A federal court ruling on December 15, 2018, declared the entire act unconstitutional. An “individual mandate,” requiring every individual to have insurance or pay what the Supreme Court declared was a “tax,” was subsequently found to be moot because, subsequent to the passage of the ACA, Congress and the Trump administration implemented tax reduction legislation that “zeroed out” the penalty—in essence, repealing the tax. The ruling was the result of one of many court challenges launched by multiple states. Prior to this, between 2014 and 2016, the House of Representatives had already voted approximately 50 times to repeal the ACA. No doubt much of this was political theater at the time. It does reflect, however, the highly controversial and partisan nature of the backlash to the one-sided enactment of the ACA.

## INSTRUCTOR RESOURCES – CHAPTER ONE – END-OF-CHAPTER MATERIAL

On the flip side, however, the ACA will be difficult to replace politically, as it extends coverage and mandates benefits that were not available prior to its passage.

**3. What might have happened had Wilbur Mills led the outright rejection of the Republican proposal?**

Of course, what might have happened is entirely speculative. It would be fair to say, however, that had Mills killed the Republican proposal, the only remaining parts of the legislation would garner supports only from Democrats. The question then becomes, would Mills and President Johnson have been able to corral enough congressional Democrats to vote for a Medicare/Medicaid proposal that would not have included Part B. Who knows? One thing for certain is that the legislative path would have been considerably rockier (and it was already *very* difficult terrain), and the ultimate plan, if enacted, likely would have been the target of partisan attack similar to what the ACA faces today.

## INSTRUCTOR RESOURCES – CHAPTER ONE – END-OF-CHAPTER MATERIAL

## Challenge Yourself

**1. Should the federal government's role in the healthcare system be greater than it is, or should it be less than it is? Explain why in either case.**

Here, of course, the student's point of view is mostly impertinent. What matters is the explanation they provide. Those who favor a greater role should point out the inequity in the current system and how government could improve access; how government can lead quality improvement through provider compensation mechanisms that commercial insurance companies can be expected to follow; and how only the federal government could bear the costs associated with the other two initiatives. Those who oppose a greater role for the federal government can be expected to discuss the responsibility of individuals to care for themselves and the idea that market mechanisms will weed out costly processes and things in favor of better, lower-cost care. They might also argue that federal government involvement will lead to higher costs, reduced choice, poorer access, and mediocre care, because of the absence of competition in the marketplace.

**2. Why is the "germ theory" of medicine still important today?**

Virtually all of the hygiene procedures in healthcare today are extensions of the response to germ theory. Instruments and environments are sterilized before a medical procedure. Likewise, all of the class of antibiotic medicines that kill bacteria within the body are also founded on the germ theory.

**3. Other than generating a need for more long-term care facilities and organizations, what impact will the continuing aging of the population have on the healthcare system?**

Students should note the proportional differences in population growth in the US, noting that the entire population is aging. As it does, both utilization of the healthcare system and the costs associated with it can be expected to increase. Simply put, there will be more "elderly" people, who will have multiple comorbidities that will, over time, lead to diminished functioning. As that happens, the healthcare system will respond (and already has) by developing subspecialties in gerontology, by increasing the variety of pharmaceuticals available, and by developing new assistive and prosthetic devices to help people maintain their ability to ambulate. In addition, the aging population will be a major factor in shortages of primary care providers and, with regional exceptions, shortages also in a myriad of subspecialties.

## INSTRUCTOR RESOURCES – CHAPTER ONE – END-OF-CHAPTER MATERIAL

## For Your Consideration

**1. Research the trends regarding employer-sponsored insurance (ESI) from 1950 through 2000. What did you find? Explain how that trend might affect public policy as it relates to healthcare.**

The students should find that ESI increased from 1950, reaching a peak in 1973 (see <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.25.6.1538>). More recent history has seen the percentage of employees covered by ESI decrease to approximately 56% in 2014 (see <https://www.kff.org/private-insurance/issue-brief/trends-in-employer-sponsored-insurance-offer-and-coverage-rates-1999-2014/>). We have seen the effect this has had on public policy through the enactment of Medicaid (1965) and the state-optional expansion of Medicaid in the Affordable Care Act. Thus, when confronted with a decline in insurance coverage, the public policy response has been to try to fill some of the gap.

**2. Research population trends. Look ahead 30 years, to when you will be in the prime of your career. What will the population graph look like then? Compare the number of people over 65 to those between 18 and 64. What will this new population distribution mean for your career as a health services administrator?**

The first answer is easy to find. Indeed, one website has a dynamic population curve that calculates a dependency ratio (see <https://www.theblaze.com/news/2014/11/12/population-pyramids-are-terrifying-reminders-of-the-problems-countries-face-as-people-live-longer-but-dont-have-babies>). Generally, the population will continue to age through 2050; the median age in the US will increase; and the proportion of those in need of greater levels of care will increase relative to the decreasing number of people to support those needs. What this means to future healthcare administrators is that they will confront more people who need more care in the face of diminishing resources to do the job. Medicare taxes will need to increase OR the scope of services will need to decrease OR the age at which one becomes eligible will need to increase OR the compensation for providers will decrease OR some combination of those alternatives. For a healthcare administrator, this means, potentially, a higher volume of patients in hospitals, physician offices, surgi-centers and the like. It will also mean flat to diminished revenue.

# **A Brief History of the Development of Healthcare in America**

## **Chapter 1**

# **Key Periods in US Healthcare**

- **Germ theory to the “Great War”**
- **Industrialized care: WWI to WWII**
- **World War II**
- **Post-WWII – 1970s**
- **1970s – Affordable Care Act**
- **Affordable Care Act – present day**

# **GERM THEORY TO THE “GREAT WAR”**



# Germ Theory to the “Great War”

- < 1850 — *Miasma* theory of disease
- 1854 — John Snow and the Broad Street Pump  
— Beginning of epidemiology

# **Germ Theory to the “Great War”**

- **1864 — Louis Pasteur: germ science**
- **1867 — Joseph Lister: sterilization of surgical instruments and wounds**

# **Germ Theory to the “Great War”**

- **Moving from “snake oil” salesmen to science-based medicine**
- **1904 — AMA calls for minimum educational standards**
- **1910 — Flexner Report re: medical curriculum**
  - **2 years of science + 2 years of clinical training**

# **INDUSTRIALIZED CARE: WWI TO WWII**

# Industrialized Care: WWI to WWII

- **1929 — the birth of Blue Cross**
  - Baylor University Hospital
  - Dallas teachers paid 50 cents per month
    - Pre-pay for healthcare
    - May or may not use
- **Community rating**
- **Adverse selection**

# **Industrialized Care: WWI to WWII**

- **1935 — Social Security Act**
  - Social insurance
  - First direct payment from federal government to citizens
  - Became legal framework for Medicare and Medicaid

# **WORLD WAR II**

# World War II

- **Expanded role for federal government**
  - GI health coverage
  - Health coverage for GI dependents
- **Employer-sponsored insurance (ESI)**
  - Wages frozen
  - Health insurance used to recruit labor



# **POST-WWII TO THE 1970S**

# Post-WWII to the 1970s

- **Hill-Burton Act of 1945**
  - Political tool to blunt national health insurance proposals
- **Expired in 1976**
  - 10,000 projects
  - \$6 billion in uncompensated care
  - 410,000 hospital beds

# Post-WWII to the 1970s

- **Investment in science: National Institutes of Health (NIH)**
  - 1950: \$52.7 million
  - 1969: \$1.1 billion
- **Results**
  - New procedures and drugs to treat patients

# Post-WWII to the 1970s

- **Growth of medical education**
  - **1963 — Congress authorizes 54 new medical schools**
  - **Medical school class size: from 90 to 149**
  - **1956 — 8,250 medical students**
  - **1980 — 18,200 medical students**

# **Post-WWII to the 1970s**

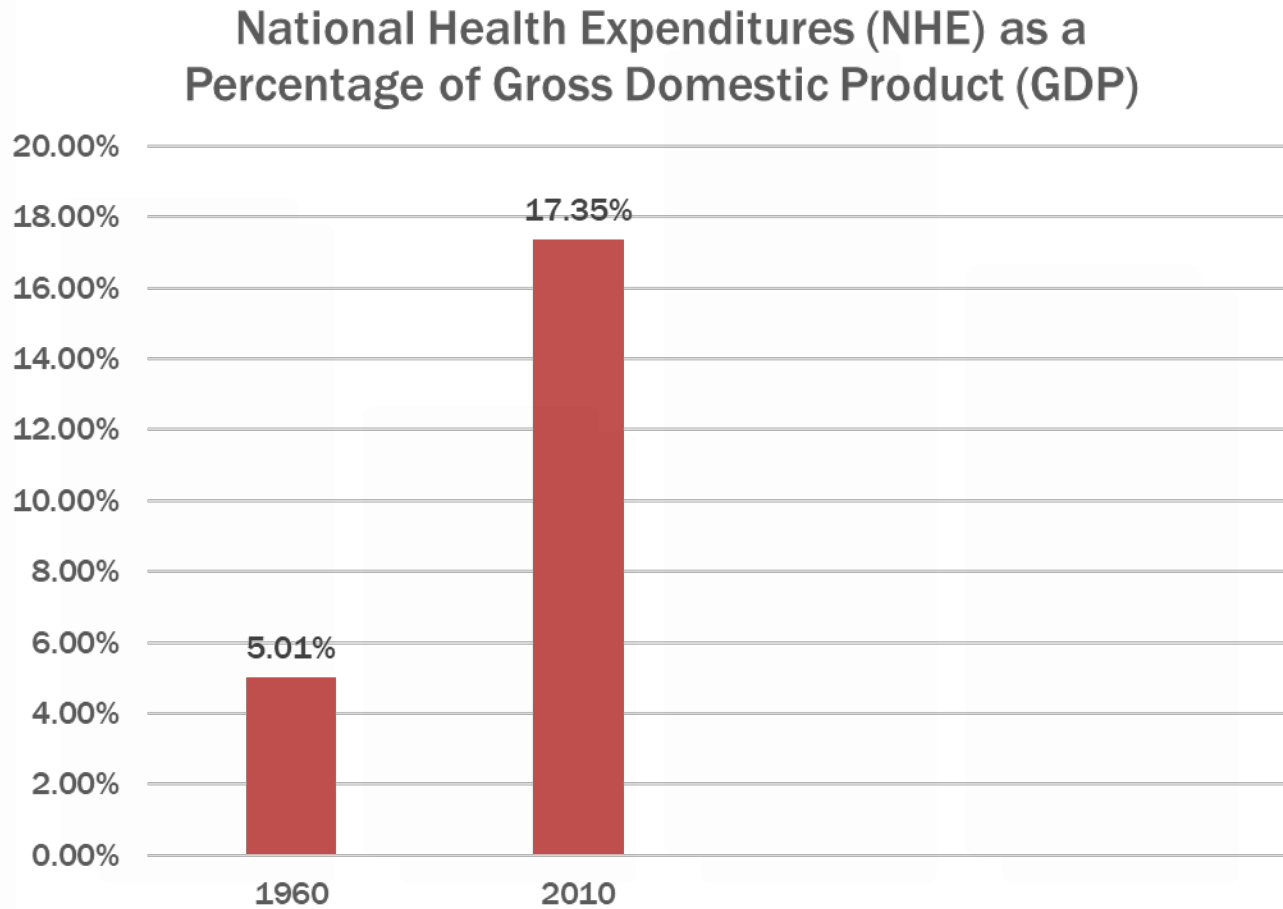
- **Expansion of employer-sponsored health insurance (ESI)**
- **Employer tax deduction for ESI codified in Internal Revenue Act of 1954**
- **Negotiated benefit for employees**

# Post-WWII to the 1970s

- **1965 — Medicare: for citizens 65+**
  - **Part A: Mandatory hospitalization coverage**
    - Funded by payroll tax
  - **Part B: Voluntary outpatient coverage**
    - Funded by premium and federal appropriations
- **1965 — Medicaid: for indigent persons**
  - **Federal / state partnership**

# **1970S TO THE AFFORDABLE CARE ACT**

# 1970s to the Affordable Care Act



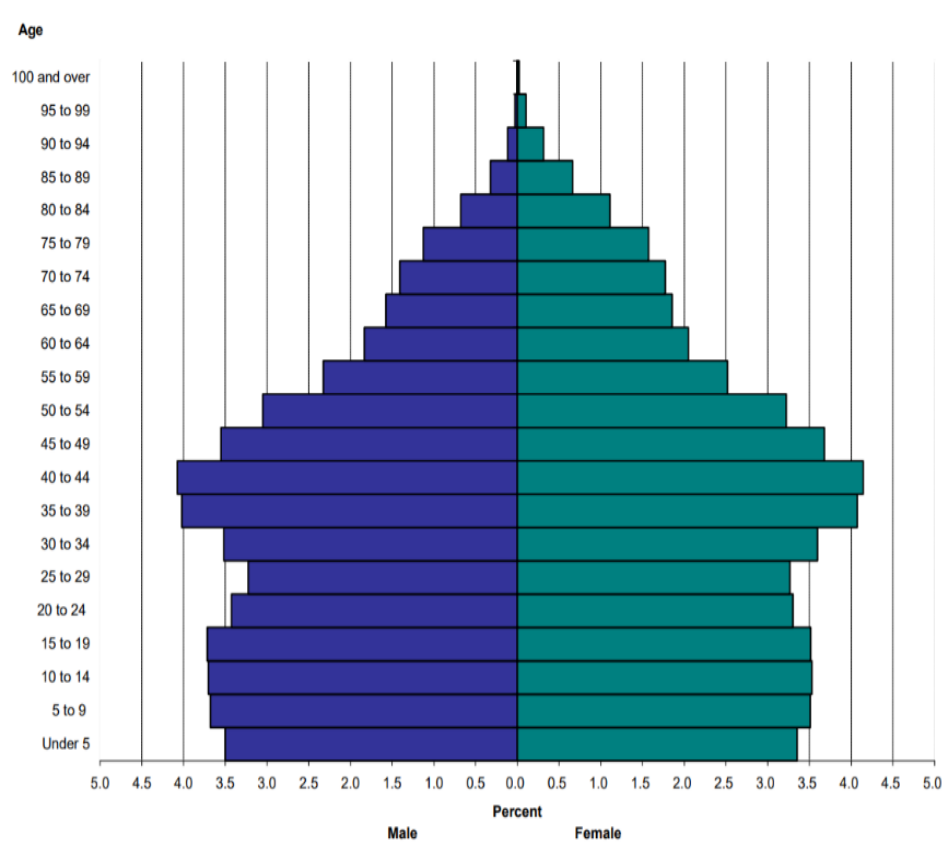


# **1970s to the Affordable Care Act**

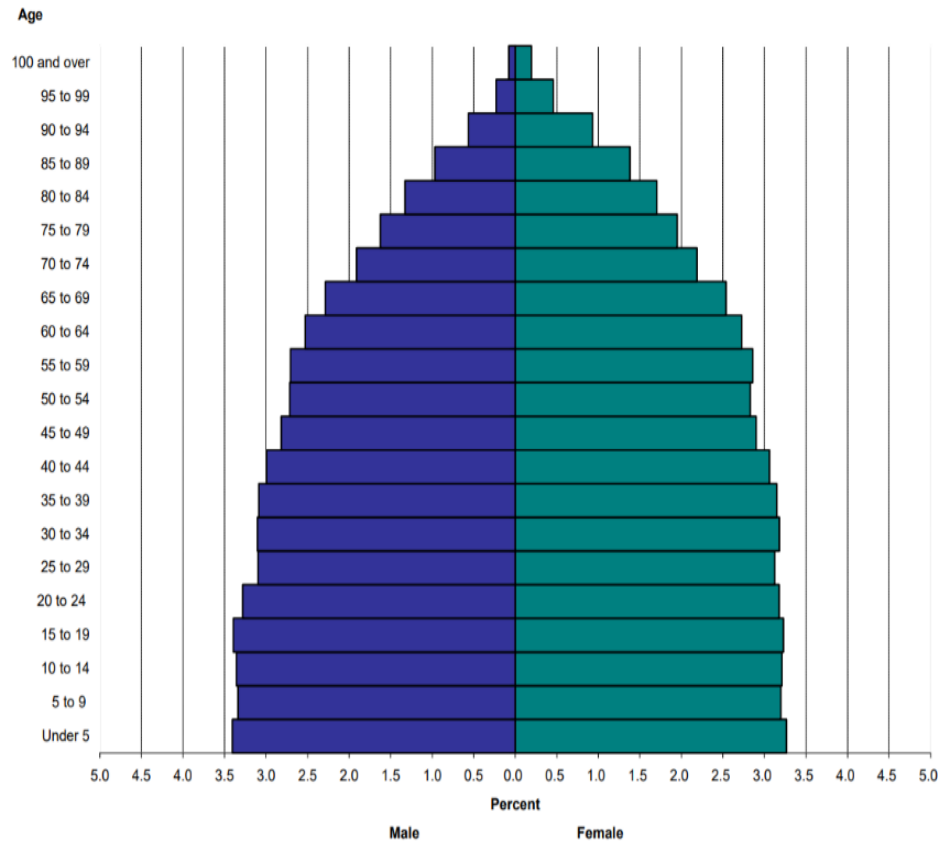
- **1973 — Health maintenance organizations (HMOs) authorized in federal law**
  - **Several types evolved**
  - **Broad term: managed care organizations (MCOs)**
  - **Capitation: risk shifts to provider**
  - **Gate-keeper: limited choice for consumers**

# 1970s to the Affordable Care Act

Estimated US Population by Age and Gender, 1990



Estimated US Population by Age and Gender, 2050



# **AFFORDABLE CARE ACT TO PRESENT DAY**

# **Affordable Care Act to Present Day**

- **Affordable Care Act (ACA) enacted 2010**
- **Partisan divide**
- **Step closer to universal healthcare coverage**

# **Affordable Care Act to Present Day**

- **Electronic health records**
  - Digital record of care the patient has received
    - Link between hospitals, doctors, and other providers
- **Clinical integration**
  - Reduce medical errors by providing patient care through interdisciplinary teams

# Affordable Care Act to Present Day

- **Payment and structural changes**
  - Pay for performance (P4P)
  - Bundled payment
- **Mergers and acquisitions**
  - Occurring many times over in recent years
  - Hospital acquiring / merging with / aligning with another hospital
  - Hospital acquiring / aligning with physician practice

# Conclusion

- **US Health System: from “snake oil” to science**
- **Investment in science, medical education**
- **Proliferation of health insurance**
  - Employer-sponsored insurance
  - Medicare and Medicaid
- **Chronic inflation**
- **Cost controls**