1. This week shifts the discussion from the public health system to the U.S. health care delivery system. While the public health system provides some personal health services, the majority of such services are provided in the private sector, and the majority of U.S. health expenditures is spent on health services. As noted in this week’s reading, workers who provide personal health services have been the target of privatization efforts, shifting such care from health departments to the private sector. This week’s review of the development of the U.S. health care delivery system will hopefully provides some insights on contemporary problems and the need for health reform.

2. The session objective is to identify the main issues in the development and organization of health services in the U.S. Health services include prevention, treatment, and illness management, as well as the preservation of mental and physical well-being through services. Health services are provided by diverse health professionals, and in diverse settings, such as hospitals, clinics, and nursing homes.

3. Ideally, health services are provided in a continuum of care that is integrated and tracks patients over time through the comprehensive array of services. Other developed nations tend to use this approach, in particular emphasizing basic primary care services, with primary care being the source for coordinating all care. However, in the U.S., health care is characterized by individual providers of care, which have not been organized to provide a coordinated approach to health care. As an analogy, the U.S. health system is more like a forest, where the strongest species thrive, rather than a garden that is planned based on what is needed or wanted.

4. At present, concerns about U.S. health services include high costs, misuse and overuse of certain services, and patient safety where patients are harmed from mistakes made. Further, some people who need health services cannot access them due to the high cost, meaning they underuse health services because they cannot afford what is needed. Finally, there is a shortage of primary care professionals, which results in patients seeking care from specialists. This adds to adds expense and potentially a missed diagnosis if the correct type of specialist was not selected. This week’s lecture reviews the evolution of the U.S. health system and how it evolved with competing providers, who are not expected to function as a system.

5. The major stages that shaped medicine and hospitals in the US can be characterized as first advancing professionalism, then technologic advancement, and finally containing costs and assuring value. The early stages of development focused on defining professionalism for the purpose of assuring quality. This was followed by a tremendous advancements in technology, which can result in quality improvement, but also adds expense. Since the 1970s, the focus has shifted to finding means to control costs and assure value. Value is defined from the patient's perspective and is measured by the outcomes achieved relative to the cost.

6. The first stage of US health system development focused on professionalism. The need for professionalism became evident in the early to mid 1800s. At the time predominant health problems were infectious diseases. The predominant health system problems were lack of medical education standards and the lack of sanitation and infection control systems, reflecting needs in both medicine and public health.

7. In the 1800s, medicine was a relatively weak profession. Physicians did not earn high incomes.
They were not highly regarded in their communities, and barriers did not exist as to who could practice medicine, so most anyone could do so.

8. At the time, physicians were grouped based on their training or lack thereof. Regulars or allopathic physicians were traditionally trained based on conventional medical science. However, in the 1800s, medical school standards varied, even among these physicians. Homeopaths viewed disease as a matter of spirit and used a somewhat experimental approach. They emphasized the individual physician-patient relationship. The eclectics used herbal medicine based on medical science. They opposed excessive drugging and bloodletting and their schools admitted women. Heroic therapy emphasized bleeding, heavy doses of mercury, and other modes that could be ineffective and sometimes lethal. Some physicians were simply untrained, such as the local snake oil salesman.

9. In the 1800s, physicians had long-standing relationships with their patients and families. A physician would be responsible for an entire family, meaning a family physician. In addition, they collected for their services. At this time, health insurance or third-party payment did not exist, so physicians would bill and collect from the patient. They could also agree to take payment in the form of goods or services.

10. The American Medical Association or AMA was founded in 1847 with the specific goal to raise and standardize medical education requirements. They developed a code of ethics that intended to exclude the “irregulars” from practicing medicine. Irregulars were those physicians who were not traditionally educated in medicine. Despite the effort, the irregulars thrived throughout the 1800s, and AMA's initial attempt at voluntary medical education reform was ineffective.

11. During the 1800s, many states made attempts to control who could practice medicine through licensure of physicians. The first attempts at licensure tended to be based on favoritism rather than education and training. Many states enacted medical licensing laws during the 1800s and then repealed them. The attempts were weak and ineffective in controlling the practice of medicine.

12. The major change in U.S. medical education followed the Flexner report, which was published in 1910. The study was conducted by the Carnegie Foundation and included an inspection of all medical schools in the U.S. The AMA had asked the Carnegie Foundation to conduct this study. Medical schools readily participated. They did so because it appeared the Carnegie Foundation was looking to give funds to medical schools. The report is titled the Flexner report because it was conducted by Abraham Flexner. Flexner was not a physician. Instead, he was an unemployed schoolteacher.

13. The inspection of medical schools focused on these five areas: 1) the school's entrance requirements and whether they were enforced, 2) the size and training of the faculty, 3) the endowment and funds available to support the institution and the allocation of these funds, 4) the quality and adequacy of laboratories and qualifications of lab instructors, and 5) the relationship between schools and hospitals.

14. Please notice the inspection of medical schools considered the relationship between the medical school and hospitals. Unlike most other developed nations, the U.S. health system has not emphasized primary care. Many people attribute this to the Flexner Report, when the advancement of medical education was linked to hospitals, the setting of high tech, high cost care, and not to physician clinics.

15. The Flexner report identified many medical schools that were doing a very effective job in medical education, such as Johns Hopkins. However, it also concluded that in some medical schools, a significant discrepancy existed between medical science and medical education. Flexner found this to be particularly apparent at the proprietary or for-profit schools. Flexner
reported many problems, such as a lack of laboratories in training medical students or a lack of medical texts in the library. In addition, some faculty were reported to be busy with their private practice, rather than training medical students, and some schools waived admission requirements if an applicant could afford the tuition.

16. The Flexner report motivated a decrease in the number of medical schools, some closed while others consolidated. It also advanced licensure of physicians and licensure requirements, such as specific college coursework. In addition, the AMA Council became the accrediting association for medical schools, which states use in granting licensure.

17. The Flexner report is considered one of the most significant reforms in medical education. It brought scientific method and professionalism to medical education in the U.S. and Canada. However, there is controversy about Flexner and the report.

18. At the time, Flexner was an unemployed former schoolmaster who needed a job. He gained the Carnegie position from a family connection despite being unfamiliar with medical institutions. He prepared for his assessment with a one-month literature review. His visits are regarded as cursory because he inspected 167 medical schools in 180 days, traveling the nation by train. He did not use a standard questionnaire or fixed procedure and many of his assessments were not conducted with school officials. In fact, one inspection was reported to be conducted with the janitor. Even medical journals expressed concern about the methods used and the validity of his findings.

19. The final Flexner report supported Carnegie Foundation and AMA interests, in particular their opposition to for-profit medical schools. For-profit medical schools were often owned by physicians and the schools were self-sufficient and not dependent on foundations or grants. The report supported reduction in physician numbers by restricting the number of medical schools, which ultimately resulted in increasing physician salaries. The report recommended what became the traditional four-year medical school curriculum with the first two years focusing on lab science. The report supported faculty being actively involved in research, and supported specialists over generalists. Finally, the report advanced physician homogeneity since many of the schools serving minorities and women were closed.

20. Once again, the Flexner Report helps us understand why the U.S. health system is so different from other developed countries. The report emphasized medical school faculty who conduct research. It emphasized specialty care over primary care. As a consequence, it is not surprising that our health system emphasizes scientific advancements and specialty and hospital care.

21. To further advance professionalism in medicine, medical specialty boards began to emerge following the Flexner Report. The medical boards emphasize specialist expertise and can serve to prohibit generalists, or those without specialty certification, from certain types of medical practice. The first was the Ophthalmology board, which was established in 1916. The second was Otolaryngology in 1924. The final boards to be developed were Family Practice and Emergency Medicine, which were both developed in the 1970s.

22. What was the motivation for creating medical specialty boards? Board certification can advance quality since it requires specific education and training in a specialty area. In addition, it can provide a barrier to competition. For example, at the time the Ophthalmology board was established, ophthalmologists had competition from otolaryngologists who were also treating patients with eye problems.

23. Ultimately, the AMA was successful in 1) reducing the number of medical schools, 2) requiring licensure of physicians, and 3) requiring accreditation of medical schools. Medical schools must be accredited in order for graduates to be eligible for licensure.

24. In the U.S. today, 133 medical schools offer that M.D. or Doctor of Medicine degree. These schools are accredited by the Liaison Committee on Medical Education. Six of the 17 Liaison
Committee members are appointed by the AMA and six are appointed by the American Association of Medical Colleges, which represents the medical schools. In addition, 29 colleges offer the D.O. or Doctor of Osteopathic Medicine degree. These colleges are accredited by the American Association of Colleges of Osteopathic Medicine. Graduates of both M.D. and D.O. schools take the same licensure exam and are eligible to complete the same graduate medical education programs.

25. This map from the Florida Physician Workforce Initiative identifies counties that have a shortage of primary care doctors. One byproduct of the emphasis on specialization is that many rural counties, in particular, have shortages of primary care doctors, as illustrated here. One reason physicians choose to become specialists is that the incomes earned are much higher since reimbursement rates are higher for procedures than for office visits. For example, family practice doctors earn an average of $200,000 annually whereas cardiac surgeons average more than $500,000.

26. The AMA is still very active in working to influence public policy regarding who can provide care. For example, nurse practitioners are trained to provide primary care and many perceive them as an effective substitute to physicians in primary care shortage areas. However, the AMA supports restricting the practice of nurse practitioners by requiring them to be supervised by a physician. The reason given for reservations about expanding the scope of nurse practitioners is the difference between physician and nurse practitioner training. Also, in California, physicians have sued to assure nurse anesthetists must be supervised by physicians. Thus, the AMA continues to support certain public policies that ultimately restrict competition for physician care.

27. At the conclusion of Part 1, you should be able to answer the following questions.