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THE HEALTH BENEFITS OF GOOD HEALTHCARE IN THE COMMUNITY

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ABSTRACT

INTRODUCTION

There are a lot of health benefits in the health care starting from treating patients with infections diseases and providing adequate care, the health care also helps to provide the basic and advanced health services to the communities, even in times of outbreaks the health care had proved in controlling the diseases and infections by providing and giving awareness and treatment to the infected community members, improving the health care will proved to help in reducing some serious illness in the community, and providing a better environment can help the staffs to offer their assistance to the community without any difficulty, this can also boost the performances of the health care and community members will have more confidence in coming to the hospitals to seek medical advices and treatment, the health organizations and government can help in providing enough medical equipment to the health care for the benefit of the community.

Key words: *Health services, logistics, health awareness, community health, out breaks, patients, diseases, infections, improvement.*

INTRODUCTION

The health care system is an engine for innovation that develops and broadly disseminates advanced, life-enhancing treatments and offers a wide set of choices for consumers of health care. The current health care system provides enormous benefits, but there are substantial opportunities for reforms that would reduce costs, increase access, enhance quality, and improve the health of the community,

An individual's health can be maintained or improved in many ways, including through changes in personal behavior and through the appropriate consumption of health care services, the importance of health does provide a strong rationale for this level of spending. But because health care financing and delivery are often inefficient, there are opportunities to advance health and access to health care services without further growth in spending. To improve

the efficiency of health care financing and delivery, the Administration has pursued policies that would increase incentives for individuals to purchase consumer-directed health insurance plans. The Administration has also worked to link provider payments to performance, thus rewarding efficient delivery of health care. In the President's State of the Union Address, he proposed changing the tax treatment of health insurance, offering all

Americans a standard deduction for buying health insurance. Such a change could play an important role in increasing the efficiency of the health care system and expanding health insurance coverage.

The key points in this chapter are:

A. Health can be improved not only through the consumption of health care services, but also through individual behavior and lifestyle choices such as quitting smoking, eating more nutritious foods, and getting more exercise.

B. Health care has enhanced the health of our population; greater efficiency in the health care system, however, could yield even greater health for Americans without increasing health care spending.

C. Rapid growth in health care costs and limited access to health insurance continue to present challenges to the health care system.

D. Administration policies focus on reducing cost growth, improving quality, and expanding access to health insurance through an emphasis on private sector and market-based solutions.

Health and the Demand for Health Care

The demand for health care is unlike the demand for most consumer products and services because while the desire for consumer products and services comes from direct consumption, the desire for health care is not derived directly from the consumption of the medical procedures themselves; rather, it comes from the direct value of improved health that is produced by health care. For example, demand for an MP3 player is based on the enjoyment that an MP3 player brings to a consumer, but few would choose to get a laparoscopic cholecystectomy for the same reason. Rather, a consumer's desire to have her gallbladder removed is directly related to the positive impact the operation is likely to have on her health. Understanding how health is produced, demanded, and valued is a useful starting point for evaluating the health care system and health care policy.

Demand for Health

People demand health because of its role in facilitating and providing happiness. Health can be defined along two dimensions: the length of life (longevity) and the quality of life. A person derives value from the quality of life directly and indirectly: directly because one's level of health affects the enjoyment of goods and leisure and indirectly because one's level of health enhances productivity. Enhanced productivity can be rewarded in the labor market through higher wages. The indirect effect of health on productivity suggests that health is an important component of human capital investment. Consistent with the basic principle of our economic system, consumers exercise choice in purchasing health care and other goods and services.

The Production of Health

Health care is only one of the factors that determine health. Other factors include individual behaviors, environmental factors, social factors, education, income, and genetics. If we think of an individual as a producer of health, the key production inputs are the time and money spent on health-improving activities and health care. Health-improving activities can include individual choices regarding exercise, nutrition, and lifestyle. Health care can include hospital care, outpatient visits to medical providers, nursing home care, and medication. Because health can deteriorate from accidents, sudden disease, and the effects of aging, health care inputs are needed not only to maintain current levels of health but also possibly to restore health following an illness or injury.

Trends in Health Spending

Americans are investing more in their health as measured by health care expenditure. In 2006, Americans spent over $7,000 per capita on health care, up from $2,400 in 1980 and $800 in 1960 (all in 2006 dollars). National health care spending has grown more rapidly than the economy as a whole, so health care accounts for an increasing share of the overall economy. National health care spending now accounts for about 16 percent of gross domestic product (GDP), up from 9.1 percent in 1980 and only 5.2 percent in 1960.

The primary factor that tends to drive health care expenditure growth isthe development and diffusion of new technologies. Knowledge about health and health care conditions continues to expand over time, generating an expanding inventory of new or improved products, techniques, and services, medical technology may account for about one-half or more of real long-term health care spending growth. Rising incomes are a second important factor because as income increases, a greater proportion of income is typically spent on health care. The aging of the population and increasing disease prevalence is a third important factor contributing to expenditure growth in the United States. Other cited factors include more rapid wage growth in the health sector, greater insurance coverage supported by large government subsidies through both government-sponsored programs and tax subsidies, and the low share of health expenses paid out-of-pocket by health consumers.

Trends in Life Expectancy

Life expectancy is only one of many outcome measures for health, but because it has been reliably and consistently measured over time, it offers a unique historical view of trends in health. United States life expectancy trends since 1900 both from birth and from age 65, In the two panels of this chart, we see life expectancy gains throughout the century.

Progress in life expectancy at birth was rapid in the first half of the century, growing from 48 to 68 years. Between 1950 and 1970, life expectancy at birth grew gradually, reaching only 71 by 1970. Progress picked up in the 1970s, with life expectancy reaching age 78 by 2004. There is a contrasting pattern for the life expectancy among those who live to age 65. Life expectancy at age 65 showed little progress until the 1930s; in the subsequent 4 decades, life expectancy at 65 rose 3 years to 15 (meaning that in 1930 a person who was 65 could expect to live to age 77, while in 1970 a 65-year-old person could expect to live to age 80). Starting in the 1970s, the pace of improvement accelerated. By 2004, life expectancy at age 65 was 18.5 additional years; a gain of 3.5 years of life over the past 3.5 decades.

Innovations in health and health care can explain the patterns in longevity, changes in the first half of the 20th century came largely through progress in reducing malnutrition, improving sanitation, and containing infection through improved public health measures and the use of antibiotic agents such as penicillin. After about 20 years of gradual improvement in life expectancy, the rising longevity from 1970 reflects progress in treating life-threatening ailments prevalent among those over 50, the largestsingle contributor to increased longevity has been reduced mortality from heart disease (3.6 years); reduced mortality from strokes added another 1.3 years to life expectancy. Reduced mortality from those two conditions has thus added nearly 5 years to the life expectancy of the community.

Reforming Health Care to Address Spending, Outcomes and Disparities

A second driver of change has been emanating from the health care system itself. Motivated by underlying social and economic conditions, as well as significant shifts in policy, the American health care system has begun to seriously confront a triple-threat situation: the highest per-capita health care spending in the world, relatively poor health outcomes, and significant racial, ethnic, and socioeconomic disparities in health and health care that leave burdened populations and communities vulnerable to preventable mortality and morbidity because of factors unrelated to either the need for services or the ability to benefit from high quality health interventions.

This concern about excessive health care spending, poor health outcomes, and measurable disparities has led public and private the business imperative begin to converge.

Expanding and Refining the Community Obligations of Tax-Exempt Hospitals

A third development, which touches the twothirds of all U.S. hospitals that operate as tax-exempt charitable organizations, 10 is a series of significant shifts in recent years in the underlying legal framework that defines the relationship between hospitals and their communities. It is important to understand these shifts and their interaction because of their implications for hospital efforts to assume a broader presence on issues of upstream health matters, the role of hospitals within

their communities, and the issues and challenges that remaininsurers to place a growing emphasis on payment reforms designed to incentivize better and more efficient performance, such as incentives to reduce unnecessary and avoidable hospital inpatient readmissions. For hospitals serving communities with sizable populations facing health and social risks, achieving reduction in readmissions inevitably requires a focus on the underlying conditions of health, not only at discharge but generally.Similarly, payment reforms designed to foster overall efficiency, such as case payments, global payments, and capitation with opportunity for shared savings, aim to encourage integration of care and greater alignment between medical care and community social services that may alleviate poor health.

The Basic Community Benefit Obligation of Tax-Exempt Hospitals: Origins and Evolutions

Reflecting federal policy dating back to the original enactment of the federal income tax, § 501(c)(3) of the Internal Revenue Code confers tax-exempt status on organizations organized and operated for charitable purposes. The promotion of health is not an explicit charitable purpose under the Code; since 1956 however, the Internal Revenue Service (IRS) has recognized the promotion of health as the type of activity that would qualify as charitable when conducted by institutions that otherwise meet applicable federal requirements.11 Under IRS standards,

the mere fact of a hospital's presence in a community does not confer a community benefit.12 Instead, hospitals must demonstrate that they are involved in activities recognized by the IRS as benefitting their communities.

Back and forth on "community benefit" requirements.

Originally, in the 1950s, the IRS focused on activities that made the hospital's services accessible to community residents, with provision of charitable care to community residents as the defining hallmark of charitable

status.13 In 1969, however, the IRS eliminated provision of charity care as a necessary precondition to tax-exempt status,14 adopting instead a more nebulous "community benefit" standard.

This standard served to give hospitals broad discretion over what charitable activities they would pursue, such as research, health professions training, or general efforts

to promote community health, while also qualifying for federal tax-exempt status. The IRS not only broadened the standard of community benefit to move away from the direct provision of free or discounted care but also provided little in the way of follow-on policy guidance and even less in the way of enforcement actions aimed at individual hospitals.

The early 2000s saw a renewed bipartisan focus, driven by the news coverage of the failure of many taxexempt hospitals, on the conduct of these hospitals that, despite their poor performance in providing care to the underserved and poor, pursued aggressive and

unreasonable billing and collection practices. In the Affordable Care Act (ACA), Congress amended the Internal Revenue Code to ban unreasonable billing and collection practices and added financial assistance for free or reduced cost care as a core requirement of all tax-exempt hospitals.15 Implementing federal regulations provide substantial guidance that addresses the basic elements of hospitals' financial assistance programs and practices, including the nature and structure of such programs, how programs must be adopted, publicized, and made accessible to patients, and the timing of when such assistance must be offered (i.e., at the point at which care is furnished, not after debt collection efforts).

Addressing Challenges in the Health Care System

The trends in the U.S. health care system suggest that the rapid growth in health care costswill persist. Health care costs will pose an increasing challenge for consumers of health care and health insurance as expenditures in this sector make up a greater share of household consumption. Taxpayers will also face an increasing challenge as the budgetary burden of Federal and State health care programs continues to expand, for an overview of government health care programs.) Reducing health care cost growth and increasing access while improving health care quality are the goals of Federal health care policy.

The Administration's objective has been to develop market-oriented policies to meet these goals by fostering the innovation, flexibility, and choice that are the best aspects of the American health care system. Market-oriented policies must address potential market failures that are at the root of the challenges in the health care system. These problems include insufficient information available to patients, health providers, and insurers; access barriers for lower-income or disadvantaged Americans; and two specific market failures that arise in insurance markets: moral hazard and adverse selection. Moral hazard is the

tendency for individuals to overuse certain types of health care when insurance covers a sizable fraction of the costs; adverse selection is the tendency for insurance to be purchased by those persons who are most likely to need it (and who thus have higher costs). Policies aimed at mitigating these problems can enhance the ability of our market-oriented health care system to achieve the goals of controlled cost growth, improved access to health insurance coverage, and high-quality health care.

CONCLUSION

The health care system has helped improve the health and well-being of the community,as health care costs continue to rise, enormous opportunities exist to increase the value of health care and improve health insurance coverage. Addressing these fundamental problems and fulfilling the potential of our health care system will require innovative polices to help community get the care that best meets their needs, and to create an environment that rewards high-quality, efficient care. While federally sponsored health

insurance for the most vulnerable communities through Medicare, Medicaid, and SCHIP remains a priority, private markets offer the best opportunities for controlling costs and providing innovative policies to enhance efficiency, quality, and access. Efficiency of health spending woul

d be improved if tax code reforms were enacted. Reforms could level the playing field between employer-provided and individual health insurance, thus boosting insurance coverage. At the same time, reforms could reward consumers for purchases of higher deductible plans with reasonable copayments that provide insurance for costly medical necessities, but do not encourage unwarranted procedures. By addressing concerns of adverse selection, insurance markets can become more competitive, thereby promoting innovation, choice, access, and efficiency. Finally, health care quality can be addressed by improving the transparency of health care information and by tying reimbursement to the performance of providers.

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