Public and Private Health

Traditionally, public health focuses on the health of populations of people, or communities. The focus is on prevention of infectious and chronic diseases and extending life years and quality of life. Public health services are paid for by federal and state taxes.

Private health focuses on clinical services to the individual patient, such as diagnosing, treatment, and prevention of diseases.

It is important to note that the line between public and private health services is getting thinner with the many initiatives that have been implemented, including Healthy People 2000, 2010, and 2020, and the Affordable Care Act of 2010.

Levels of Public Health Prevention

*Primary prevention* is pre-disease. It is when health promotion and prevention occurs before a disease is present. Some examples are: community health education on nutrition, exercise, good health habits, health screenings, monitoring risk factors with annual exams, bike helmet education, immunization against infectious diseases, and controlling potential hazards at home and in the workplace.

*Secondary prevention* is latent. It is when a disease is present and has been diagnosed, but it is pre-symptomatic; therefore, treatments are used to control and prevent the progression of the disease. Some examples would be a physician prescribing low-dose aspirin to prevent a stroke or an acute myocardial infarction; screening exams for those that have had or have a disease in remission, or work-hardening programs to provide appropriate modified work for workers’ compensation patients.

*Tertiary prevention* is when the disease is present and symptomatic. Treatments are focused on limiting disability from early symptoms and rehabilitation for late symptoms of disease. Some examples are stroke and heart attack rehabilitation programs, chronic pain treatments, or psychological support groups for patients who have serious or debilitating diseases.
10 Essential Public Health Services

Slide Content:

According to health.gov, which is part of the Department of Health and Human Services (DHHS), there are 10 essential public health services. They are to:

1. Monitor health status to identify community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate and empower people about health issues.
4. Mobilize community partnerships to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure a competent public health and personal health care workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems.


Joint Public-Private Responsibility in an Era of New Threats

Public health is aimed at decreasing the burden of disease and injury in populations. However, in more recent years, public health has teamed up with the nation in a new way. In the aftermath of the 2001 terrorist attacks, the U.S. public health infrastructure is much more involved in domestic public health activities. Prior to the 2001 attacks, Congress passed the Public Health Threats and Emergencies Act (P.L. 106-505) to address the decaying public health infrastructure, and to prepare for bioterrorism and other public health emergencies. Following the 2001 attacks, Congress passed the Public Health Security and Bioterrorism Preparedness and Response Act (P.L. 107-188), expanding grants to state health departments and adding a new national hospital preparedness program, as well as adding new food safety and security authorities, protections for water infrastructure, and other provisions. Congress also passed the Homeland Security Act (P.L. 107-296), creating the new Department of Homeland Security (DHS) to serve as a coordination point for homeland security activities as well as house certain public health preparedness programs.

The new challenge for public health officials is ensuring public health preparedness. This has been achieved by partnering with the private health sectors through reporting mechanisms and planning. Specifically, the challenge for private health is to be accountable to report real-time surveillance through programs such as the CDC’s Biosense program for early detection of disease and hazards.
Specific challenges for public health include: ensuring the coordinated planning for and response to emergencies by a variety of public health and other governmental actors, given that public health authority rests principally with states rather than the federal government; setting goals and standards for preparedness at the federal, state, and local levels; ensuring programmatic and fiscal accountability and steady progress toward goals; and training and sustaining a skilled public health workforce at all levels of government. The overarching challenge for policymakers is in making sound trade-offs with finite resources, ensuring all-hazards preparedness for a variety of emergencies, while appropriately balancing resources between emergency preparedness and the prevention of injuries and chronic diseases that kill millions annually.

**Hospital Classifications**

Hospitals may be classified by the type of services they provide, the number of beds and services they provide, and the average length of stay.

Hospitals may be boutique facilities that do highly specialized care, such as cosmetic surgery, or cardiac care. This may provide a higher quality, more efficient level of care, which allows the patient a shorter inpatient stay. Hospitals may also be very large urban facilities, such as general hospitals, that provide almost every type of medical service. They may be affiliated with a medical school to train physicians, nurses, and other medical technologists. They may be a "critical access" hospital in a rural area. Rural hospitals differ from urban hospitals in that they often are challenged by the large geographic areas that they serve with few health care providers, e.g., medical shortage areas.

Hospital sizes vary from a few beds in rural or boutique facilities, to 800 or more beds in large metropolitan facilities. According to the literature, statistics show that the optimal size of a hospital is between 150 and 250 beds, and the ideal occupancy should be around 85%. This profile would yield a hospital big enough to promote efficient operations, but small enough to manage without a lot of bureaucracy. Whatever the type of hospital today, the core primary issues for all hospitals are maintaining a healthy financial picture, smooth operations, being a provider of quality health care services, and staying compliant with health care regulations.

**Hospital by Ownership**

The hospital system in the U.S. has always been a complex mixture of public and private facilities. Hospitals are either "for-profit" (example, C-corps), subject to IRS corporate income tax requirements, or "not-for-profit" [501(c)(3)-corps], exempt from corporate tax requirements. In the United States, fifty-eight (58%) percent of all U.S. hospitals are not-for-profit, meaning they are granted tax exemption to care for the poor. The U.S. Budget Office reports that 51% of nonprofit "community" hospitals are in large urban areas, 34% are in suburban areas, and 14% are in rural areas. According to the IRS, the definition of a C-corporation is an organization that conducts business, realizes net income or loss; thus, is required to pay taxes on earned income, as well as, pay profits in the form of dividends to
corporate shareholders. 501(c)(3) corporations are exempt because their charters and purposes are required to have a charitable, community focus. They must have a board of directors that represent the communities that they serve, and they must provide charitable services in the mix of their paid services. There are no shareholders, or paid dividends in a not-for-profit hospital or corporation. Not-for-profits may also do fundraising and accept philanthropic donations. All of these funds are required to be reinvested in the hospital or 501(c)(3) organization, or activities that provide community benefit. The C-corps must pay taxes on any capital or funds given to the organization in donations.


Forces Affecting the Development of Hospitals

Current forces are transforming hospitals even further, changing the mix of services from inpatient to ambulatory services. Six forces that are affecting the development and the transformation of hospitals are: 1) advances in medical science, 2) the proliferation of technology and the specialization of medical practice, 3) the development of professional nursing, 4) advances in medical education, 5) the growth of health insurance, and 6) the influence of government in its various roles.

Hospital Classification Summary

In summary, hospitals may be classified in several ways, by length of stay such as short-term versus long-term, type of service provided (general versus specialty), ownership, or IRS status (public vs. private, for profit, vs. not-for-profit, federal government vs. local community).

Types of hospitals also may be classified by type of service: general vs. specialty, or trauma center, vs. academic medical center or teaching hospital. Types of hospitals may also be classified by place of services, such as large urban hospital, small rural hospitals, and critical access hospitals.

Uncompensated Care

Hospitals have transformed from community hospitals to comprehensive centers of care, providing all services or one-stop-shopping. They work closely with public health officials for purposes of surveillance, reporting, and prevention. Unfortunately, not all services provided are paid for. This is known as uncompensated care. Almost all hospitals will provide some uncompensated care, but the amount will depend on where the hospital is located and its general service area. The county and district hospitals that provide large amounts of uncompensated care are most often supported with tax assistance from the local governments.

Well, it comes from patients who need services but do not have insurance and cannot pay for the services themselves. The hospital then provides the services to them at a loss to the
hospital. So, you can quickly see that if a hospital is located in an economically depressed neighborhood and serves a large number of uninsured patients, their uncompensated care rate will be much higher than a hospital that cares for individuals who have mostly private insurance. This is one of the reasons hospitals have been so hard hit as the reimbursement amounts for Medicare/Medicaid have dropped and the numbers of the uninsured continue to climb. Obviously, if hospitals do a large amount of uncompensated care, they will need to make up that difference in other ways to remain afloat.