

THE ETHICS OF QUALITY

- Quality in healthcare is not just about meeting standards or achieving goals. It is an **ethical responsibility that every nurse must uphold in daily practice.**
- Ethics is closely connected to nursing care. Every action a nurse takes can affect patient **safety, dignity, and outcomes.**

Nurses Must:

1. Act in ways that **promote health and well-being**, ensuring patients receive the best possible care
2. Do what is best for the patient, **supporting recovery and improving health**
3. **Avoid causing harm**, including preventing errors such as wrong medication or unsafe procedures
4. Give fair and equal treatment to patients, regardless of their background or condition
5. Be responsible for their actions, which helps improve patient safety and build trust

STEWARDSHIP

- Means responsible management of healthcare resources
- Nurses ensure proper use of time and supplies
- Ethical practice promotes efficient and high-quality patient care
- Avoiding waste supports sustainability of healthcare systems
- Proper medication use prevents errors and patient harm
- Stewardship aligns with ethical quality care standards

Example: Using supplies wisely during procedures

QUALITY CARE: BENEFITS FOR EVERYONE

- Quality care promotes the greatest good
- Reduces patient harm and suffering
- Lowers healthcare costs and waste
- Prevents medical errors and complications
- Protects hospital reputation and trust
- Improves patient satisfaction and outcomes

Example: Following protocols reduces infections

FAIRNESS AND EQUALITY IN HEALTHCARE (RAWLS' THEORY)

- Healthcare must prioritize protection of vulnerable patients
- Equal access to care regardless of social status
- Anyone can become a patient anytime
- Fair systems ensure quality care for all patients
- Nurses must treat patients without bias or discrimination
- Ethical decisions should support the least advantaged

Example: Prioritizing critical care based on patient needs

ETHICAL PRINCIPLES IN QUALITY NURSING CARE

- Nonmaleficence
- Beneficence
- Justice
- Autonomy
- Ethical care improves patient safety and healthcare outcomes
- Nurses apply ethics in daily clinical decision-making

Example: Explaining procedures clearly before obtaining consent

REAL-WORLD CHALLENGES IN ETHICAL QUALITY CARE

- Limited budgets can restrict access to quality care
- Staff shortages increase workload and risk of errors
- System changes can disrupt continuity of patient care
- Regulations may limit nurses' professional decision-making
- Ethical dilemmas arise in balancing care and resources

Example: Prioritizing patients when staffing is insufficient

BUILDING A CULTURE OF QUALITY IN NURSING CARE

- Quality should be part of everyday nursing practice
- Not limited to rules or compliance requirements
- Nurses must be proactive in preventing patient harm
- Teamwork is essential for safe and effective care
- Commitment to patient safety improves care outcomes
- Ethical culture supports consistent high-quality healthcare delivery

Example: Reporting errors early to prevent patient harm

KEY TAKEAWAYS

- Quality care is an ethical duty in nursing

- Not just compliance but commitment to excellence
 - Accountability ensures safe and responsible patient care
 - Fairness promotes equal treatment for all patients
 - Compassion improves patient trust and care experience
 - Continuous improvement enhances quality and patient outcomes
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BEYOND COMPLIANCE: ETHICS AND EXCELLENCE IN PATIENT CARE

- Compliance meets laws but not full care quality
 - Ethical practice requires going beyond basic standards
 - Patient experience reflects true quality of care
 - Poor communication can reduce patient trust and safety
 - Nurses must balance rules with compassionate care
 - Ethical decisions improve outcomes and patient satisfaction
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QUALITY CARE IS WHAT PATIENTS FEEL AND EXPERIENCE

- Patients judge quality through personal care experiences
- Kindness and respect strongly influence patient satisfaction
- Clear explanations improve understanding and reduce anxiety
- Poor communication lowers perceived quality of healthcare
- High technology cannot replace compassionate nursing care
- Ethical care values patient dignity and emotional needs

COMMUNICATION DEFINES QUALITY IN PATIENT CARE

- Communication shapes patient experience and perceived care quality
- Verbal clarity helps patients understand procedures and treatments
- Nonverbal cues show empathy and build patient trust
- Smiling and eye contact create positive care experiences
- Ignoring questions leads to dissatisfaction and poor care perception
- Ethical care requires respectful and responsive communication

FIRST IMPRESSIONS SHAPE QUALITY OF PATIENT CARE

- Quality begins at the first point of contact
- Front desk interaction influences patient initial perception
- Early experiences affect trust and cooperation with care
- Every staff member contributes to overall care quality
- Ethical care requires respect from admission to discharge

TRAINING BUILDS ETHICAL AND HIGH-QUALITY PATIENT CARE

- Organizations must invest in continuous staff development
- Training improves communication skills and patient interactions
- Compassion training enhances empathy and patient-centered care
- Patient-centered care focuses on individual needs and preferences

- Ethical quality care requires skilled, caring professionals
- Ongoing education supports safe and effective nursing practice

INNOVATION DRIVES BETTER QUALITY IN PATIENT CARE

- Innovation improves efficiency and overall healthcare service delivery
- Nurses play key roles in identifying care improvement opportunities
- New ideas can solve common clinical workflow problems
- Ethical care supports safe and effective innovative practices
- Organizations should encourage creativity and continuous improvement
- Small changes can lead to significant patient care outcomes

BALANCING EFFICIENCY AND PERSONAL CARE IN NURSING

- Healthcare must balance speed with personalized patient care
- Efficient care ensures timely and organized service delivery
- Personalization respects individual patient needs and preferences
- Rushed care can reduce connection and patient satisfaction
- Ethical care supports both efficiency and human connection

CHANGING HEALTHCARE, UNCHANGING NURSING VALUES

- Healthcare constantly evolves with new technologies and systems

- Nurses must adapt to changes in clinical practices
- Compassion remains essential in all patient interactions
- Passion for care drives quality and patient satisfaction
- Commitment to learning ensures safe and updated practice
- Ethical care maintains values despite system changes

5. Emotional support (relieving fear and anxiety)
6. Involvement of family and friends

KEY TAKEAWAY

Providing quality care is not just good ethics but is good business. However, quality care does not happen without commitment from all members of the organization. Quality starts with compliance with both the intent and spirit.

PATIENT-CENTERED CARE (PCC)

- Patient-centered care (PCC) is an approach in healthcare that focuses on treating the patient as a whole person, respecting their values, preferences, and needs, rather than just addressing their illness

FOUNDATIONS AND CORE DIMENSIONS

- Patient-centered care is a key aim in healthcare improvement

Six Core Dimensions:

1. Respect for patients' values, preferences, and expressed needs
2. Coordination and integration of care
3. Information, communication, and education
4. Physical comfort

CLINICAL AND OPERATIONAL RELEVANCE

- PCC links to shared decision-making, individualized and comprehensive care plans, and teamwork involving patients, families, and healthcare providers
- Ensures care is provided at the right time and place
- Includes consideration of emotional well-being, cultural, social, and economic factors
- Encourages informed consent, patient education, empathy, health literacy, and family involvement
- Can include personalized medicine using technology and genetics when appropriate

CHALLENGES IN IMPLEMENTATION

- Early skepticism: some healthcare providers viewed PCC as impractical or a threat to traditional provider-centered care
- Many organizations are unclear about PCC's meaning or measurement
- Misinterpretation: some hospitals adopt hotel-like amenities, technologies, or structural changes, but these do not cover the full ethical and clinical scope

HCAHPS (HOSPITAL CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS)

- National survey in the US that measures patients' experience in hospitals

CMS (CENTERS FOR MEDICARE AND MEDICAID SERVICES)

- Set of standardized indicators to assess the quality of care in hospitals

MODELS OF PATIENT-CENTERED CARE

1. PLANETREE MODEL

- Founded by Angelica Thieriot after a negative hospital experience
- Focuses on holistic care and human dignity

Nine Key Areas:

1. Human interaction
 2. Information access and transparency
 3. Healing partnerships with family
 4. Food and nutrition
 5. Spiritual care
 6. Integrative medicine
 7. Healing arts
 8. Healing environment
 9. Community health
- Ethical foundation: beneficence, nonmaleficence, autonomy, justice, compassion
 - Improves patient satisfaction, engagement, and staff fulfillment
 - Certification emphasizes “people-centered care”

2. MAYO CLINIC MODEL

- Founded in 1889
- Focus: high-quality, patient-centered care with research and education

Key Features:

- Patient is central to all care decisions
- Coordination among specialists and staff
- Staff hired and evaluated based on patient-centered values
- Integrates research and education
- Ethical foundation: autonomy, beneficence, nonmaleficence, integrity, compassion
- Outcome: sustained excellence in care and high patient satisfaction

3. CLEVELAND CLINIC MODEL

- Founded in 1921; emphasizes “Patients First”
- Focus: PCC integrated with organizational culture

Key Features:

- Organized care by patient needs and disease areas
 - Leadership promotes patient-centered culture
 - Uses data to monitor outcomes and improve care
 - Includes education and staff development
 - Ethical foundation: autonomy, beneficence, nonmaleficence, justice
 - Outcome: improved patient experience, safety, and staff engagement
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PATIENT-CENTERED CARE IN PRACTICE

- Requires active support from healthcare administrators (HCAs)
- HCAs shape organizational culture, staff behavior, and patient engagement

Key Goals:

- Safe
- Effective
- Patient-centered
- Timely
- Efficient
- Equitable care
- Administrators should model mission, vision, and values
- Inspire employees and empower staff

PCC is ethically sound because it:

- Respects autonomy
- Provides beneficent care
- Reduces harm
- Ensures justice for patients and staff

tab 2

THE ETHICS OF HEALTHCARE REFORM

- The US healthcare system changed significantly after the implementation of the Affordable Care Act (ACA) 2010
 - Since then, public opinion about the law has remained divided, with many Americans holding different views on whether it should be kept or replaced
 - Highlights deeper issues related to fairness and social justice in healthcare
 - As a result, understanding healthcare reform requires not only examining policies and laws but also considering the ethical perspectives that shape decisions about access, equality, and the overall healthcare system
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HEALTHCARE SYSTEM REFORM IN THE 20TH CENTURY

Otto von Bismarck

- Introduced health insurance in 1883
 - Early European systems focused on wage protection, not medical costs
 - Coverage was limited, mainly for workers
 - Rising healthcare costs led to universal healthcare in the U.S.
 - His proposal was not passed into law
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EARLY US EFFORTS IN HEALTH INSURANCE REFORM (1912–1920)

- American Association of Labor Legislation (AALL) promoted health insurance reform (1912)
- American Medical Association initially supported the proposal (1917)
- Several states introduced bills but failed

- Strong opposition from American Federation of Labor, businesses, and insurers
 - Critics labeled it as “socialism” or “government control”
 - AMA later withdrew support in 1920, opposing reform for decades
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SLOW PROGRESS OF UNIVERSAL HEALTHCARE (1920s–1930s)

- Efforts for universal healthcare slowed down in the 1920s–1930s
 - Not included in the Social Security Act (1935)
 - Franklin D. Roosevelt avoided adding it to protect the pension plan
 - A Senate bill for government health insurance was introduced but failed to pass
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FAILED ATTEMPTS AT NATIONAL HEALTH INSURANCE (1939–1940s)

- Robert Wagner proposed the National Health Act (1939)
 - Planned coverage: doctor visits, hospital care, drugs, lab services
 - Funded by employer and employee contributions
 - Bill failed due to lack of support and political opposition
 - Wagner-Murray-Dingell Bill (1943) proposed broader coverage
 - Included workers, retirees, and low-income individuals
 - Reintroduced multiple times but never passed
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TRUMAN’S PROPOSAL FOR UNIVERSAL HEALTHCARE (1945–1946)

- Harry S. Truman proposed universal national health insurance (1945)
- Aimed for a comprehensive healthcare system for all Americans
- Robert Wagner introduced a supporting bill (1946)
- Proposal failed due to political opposition
- Republican-controlled Congress blocked the bill
- Harry S. Truman strongly supported universal health insurance
- 71% of Americans favored the idea (public support)
- Proposed compulsory national health insurance funded by taxes

Faced strong opposition from:

- Insurance companies
- Medical groups
- Political conservatives
- Critics labeled it as socialism or communism
- Bill was introduced but never passed

RISE OF EMPLOYMENT-BASED HEALTH INSURANCE (1940–1980)

- Healthcare reform efforts slowed due to growth of employer-based insurance
- After World War II, unions negotiated health insurance benefits in jobs
- Coverage increased from <10% (early 1940s) to ~50% (1952)
- In 1954, health insurance premiums became tax-deductible
- By 1980, about 80% of Americans had employer-based coverage
- Reduced demand for universal government health insurance reform

EXPANSION OF COVERAGE: MEDICARE AND MEDICAID (1960–1965)

- Kerr-Mills Act (1960) provided aid for low-income elderly
- New political influence: older adults (elderly voters)

MEDICARE AND MEDICAID: EXPANDING HEALTHCARE ACCESS (1965)

- Lyndon B. Johnson helped pass Medicare (1965)
- Medicare covered all Americans aged 65 and above

Strong opposition from:

- American Medical Association
- Insurance industry
- Conservative groups

Strong support from:

- Elderly citizens
- Labor groups
- Some business groups
- Medicaid (1965) provided care for low-income families and children

IMPACT OF MEDICARE

- Initially opposed by the American Medical Association and insurance industry
- Medicare later benefited doctors, hospitals, and insurers

- Doctors were paid their usual and customary fees
- Hospitals received cost-plus reimbursement
- Insurance companies helped process Medicare claims
- Despite expansion, many Americans remained uninsured

STALLED REFORM AND SHIFT TO COST CONTROL (1971–1990s)

- Richard Nixon proposed employment-based health insurance (1971)

Plan was opposed by:

- Business and conservative groups (against mandates)
- Liberal groups (said it was not comprehensive enough)
- Proposal quickly failed
- Focus shifted to healthcare cost control instead of expanding access
- 1991–1992 proposals for single-payer and all-payer systems
- None of the bills passed the committee

CLINTON HEALTH REFORM PLAN (1993–1994)

- Bill Clinton proposed the National Health Security Plan (1993)
- Required employer-based coverage through insurance alliances

Included:

- Standard benefits package
- Private insurance competition to control costs
- Subsidies for low-income groups
- Public support started high (~71%) but dropped to ~43%
- Strong opposition from the insurance industry and business groups
- Mixed support from medical and professional organizations
- Plan failed in Congress (1994)

RISING UNINSURED POPULATION AND DECLINE OF EMPLOYER COVERAGE

- By 2010, over 16% of Americans were uninsured
- Uninsured rates steadily increased since 1980
- Employment-based insurance dropped from 80% (1980) to 55% (2010)

Main reasons:

- Rising healthcare costs
- Less affordability for employers and workers
- Increasing reliance

CHALLENGES IN THE US HEALTHCARE SYSTEM AND GOALS

- Shortages of healthcare professionals in rural areas and inner cities
- High healthcare costs growing faster than incomes and the economy

- US has the most expensive healthcare system among OECD countries
- High spending does not guarantee high-quality care
- Studies show quality gaps in healthcare services
- Rising uninsured rates, cost, and quality issues led to reform efforts

Reform goals:

- Greater access to care
- Improved quality of care
- Cost control

PASSAGE OF THE AFFORDABLE CARE ACT (2010)

- In 2009, the US Congress began debating healthcare reform bills
- After extensive debates and compromises, two key laws were passed:
 - H.R. 359: Patient Protection and Affordable Care Act (PPACA)
 - H.R. 4872: Health Care and Education Reconciliation Act (Public Law 111-152)
- The ACA 2010 became the main healthcare reform law
- Passed on March 30, 2010, after years of political debate g Nunn no g GBM

Here is your content cleaned, properly arranged, and formatted into a **reviewer format**, with corrected spelling and structure only (no rewording or rephrasing):

KEY PROVISIONS OF THE HEALTHCARE REFORM LEGISLATION OF 2010 (ACA)

- There is a requirement for all Americans and legal immigrants to have health insurance coverage or pay a penalty (with some exemptions for financial hardship and religious belief)
- Businesses are also required to provide health insurance coverage or pay a penalty (businesses with 50 or fewer employees are exempted)
- Households with incomes of up to 400% of the poverty level are provided subsidies for premium support and out-of-pocket expenses
- Small businesses will receive tax credits to offset the costs of employee coverage
- There is a state option for an extension of Medicaid eligibility to all persons, including childless adults, with incomes at or below 133% of the federal poverty level
- It improves Medicare benefits by providing preventive care with no copayments and lower drug prices for Medicare Drug Plan (Part D) participants, and there will be a gradual elimination of the Part D coverage gap
- There is substantial insurance reform:
 - Insurers are required to offer a federally defined benefit plan
 - Guarantee issue and renewal with limited risk rating
 - Coverage cannot be denied to anyone
 - No annual or lifetime limits on benefits
 - Preventive care with no copayment
- Insurers must have minimum loss ratios:

- 80% for individual and small group coverage
- 85% for large group coverage
- States can receive financial assistance to set up state-based insurance exchanges where individuals and small businesses may shop for insurance offered by private insurers
- If any states decline to set up exchanges, the federal government will provide one
- There is substantial support for efforts to improve quality:
 - Support of comparative effectiveness research
 - Support for integration and coordination of healthcare services
 - Incentive payments to providers based on quality measures
- To provide a balanced health professions workforce:
 - Ensure adequate numbers of primary care providers
 - Encourage practice in underserved areas
 - Incentives include scholarships, loan forgiveness, bonus payments, and higher Medicare and Medicaid payments
- Funding sources include:
 - New taxes, savings, and penalties for noncompliance
 - Tax on high-cost “Cadillac” health plans
 - Increased Medicare taxes for individuals earning more than \$200,000 and families earning more than \$250,000
 - Taxes on insurers, pharmaceutical companies, and medical device companies
- Savings achieved through:
 - Enforcement of laws against fraud and abuse (Medicare and Medicaid)
 - Reduction of hospital readmissions
 - Administrative efficiencies in claims processing
 - Reduction of payments to Medicare Advantage Plans
 - Reduction of disproportionate share payments due to fewer uninsured
- The Congressional Budget Office estimated that the ACA 2010 would reduce the deficit by \$143 billion over the first 10 years after enactment

PHASED IMPLEMENTATION (2010–2020)

2010

- Insurers may not deny children coverage because of preexisting conditions
- Young adults up to age 26 can be covered by their parents’ health plans
- By late 2011, 2.5 million young adults were newly covered
- Insurers may not rescind coverage except in cases of intentional fraud
- No annual or lifetime limits on coverage
- No copayments for preventive care
- Tax credits for small employers providing coverage
- \$250 rebates for Medicare Part D participants in the coverage gap
- Incentives to improve healthcare workforce:
 - Scholarships and loan forgiveness for primary care
 - Training grants for underserved populations
- Grants for comparative effectiveness and prevention research

2011

- Copayments for Medicare preventive services are phased out

- Includes annual comprehensive risk assessment and prevention plan
- 50% discount on brand-name drugs in the Part D coverage gap
- 10% Medicare and Medicaid bonus for primary care physicians and general surgeons in shortage areas
- Increased funding for community health centers
- Minimum loss ratios enforced (80%–85%)
- Increased primary care training opportunities
- Grants for nurse practitioner training
- Wellness program grants for small employers

2012

- Performance- and efficiency-based Medicare payments begin
- Bonus payments for high-quality Medicare Advantage Plans

2013

- Simplified and uniform insurance claims processing and payment
- Federal subsidies phased in to close the Part D coverage gap
- Increased Medicaid payment for primary care

2014

- All citizens and legal residents must have health coverage or pay a penalty
- Coverage sources: employer plans, individual plans, Medicaid, Medicare
- State-based health benefit exchanges established
- Insurers must offer essential benefits package
- Guaranteed issue and renewal required

- Premium limits:
 - Age rating limited to 3:1
 - Tobacco users may be charged 50% higher
- Deductible limits:
 - \$2,000 per individual
 - \$4,000 per family
- Subsidies:
 - Premium subsidies (133%–400% of poverty level)
 - Out-of-pocket subsidies (up to 400%)
- Employers with more than 200 employees must automatically enroll employees (opt-out allowed)
- Medicaid expanded to individuals under 65 with incomes up to 133% of poverty level
- Medicare Part D coverage gap reduced

2016

- States may form interstate compacts for cross-state insurance sales
- Employers with more than 50 employees must provide coverage or contribute to a subsidy pool

2018

- Taxes imposed on “Cadillac” health plans:
 - \$10,200 (individual)
 - \$27,500 (family)

2020

- Full phase-out of the Medicare Part D coverage gap (“donut hole”)
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ETHICAL FOUNDATIONS OF HEALTHCARE REFORM

- Healthcare is considered a basic human right
 - Many countries believe everyone should have access to medical care
 - Supported by international agreements such as:
 - Universal Declaration of Human Rights
 - Everyone has the right to a standard of living that includes healthcare and medical services
 - World Health Organization
 - Health is a fundamental human right for all people
 - American Declaration of the Rights and Duties of Man
 - Emphasizes the right to health and well-being, including medical care
 - International Covenant on Economic, Social and Cultural Rights
 - The right of everyone to enjoy the highest attainable standard of physical and mental health
 - UNESCO
 - Declaration on Bioethics and Human Rights
 - Convention on the Rights of the Child
 - Ensures that children have the right to healthcare and access to medical services
 - Convention on the Rights of Persons with Disabilities
 - Protecting the rights of persons with disabilities to access healthcare without discrimination
 - These agreements promote fairness and equal access to healthcare
 - Ethical belief: healthcare should not depend on income or social status
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- ### ETHICAL BASIS OF HEALTHCARE AS A RIGHT (US PERSPECTIVE)
- Preamble of the United States Declaration of Independence:
 - “All men are created equal”
 - Have rights to life, liberty, and the pursuit of happiness
 - Healthcare is seen as a right because:
 - It is necessary to protect life
 - It supports freedom and well-being
 - It helps individuals achieve happiness
 - Public opinion in the U.S.:
 - 70%–89% of Americans have supported universal healthcare since 1948
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- ### ETHICAL BASIS OF HEALTHCARE AS A RIGHT (US PERSPECTIVE)
- Not everyone agrees:
 - Some people believe healthcare is not a guaranteed right

- Many religious groups support healthcare as a right:
 - Roman Catholics
 - Protestants (e.g., Baptists, Methodists, Anglicans)
 - Jews
 - Muslims

HEALTHCARE AS A SOCIAL GOOD

- Health and healthcare are considered social goods
- Healthy individuals benefit society as a whole
- Based on ethical ideas:
 - Contractarianism – having a social contract
 - Communitarianism – focus on the well-being of the community as a whole (herd immunity)
- Society has a shared responsibility to promote health
- Healthy populations contribute to:
 - Strong economy
 - Productive communities
- A social contract means:
 - We work together for the common good
 - We support systems that benefit everyone
- Therefore:
 - Healthcare should be accessible, affordable, and high-quality for all
- U.S. healthcare reform has been:
 - Gradual and developed over many decades

SOCIAL JUSTICE PERSPECTIVES IN THE ACA 2010

- ACA reforms reflect an egalitarian perspective on social justice
- Based on ideas from:

JOHN RAWLS

- Egalitarianism means promoting fairness and reducing inequality, especially for disadvantaged groups
- In healthcare, this means people should have a fair opportunity to access care regardless of income or social status

NORMAN DANIELS - Key Principle: Difference Principle

- Policies are fair if they help the least advantaged

Examples in ACA:

- Subsidized insurance for low- and middle-income groups
- Expansion of Medicaid for poor populations

social justice perspectives in the aca 2010

- limitations of aca
 - around 20 million people remain uninsured
 - some states did not expend Medicaid
 - weak penalties for not having insurance
- reflects another view
 - libertarian perspective (small government, individual freedom)
 - people have the freedom to choose whether to participate
- overall:

- aca balances equality (fairness) and freedom (choice)

TENSION IN SOCIAL JUSTICE: ACA DEBATE

- Different views on social justice create conflict in healthcare policy
 - Political environment in the U.S. is highly divided (hyperpartisan)
 - ACA reflects an “uneasy balance” between two ideas:
 - Egalitarian / Rawlsian view:
 - More government role
 - Focus on equality
 - Libertarian view:
 - Market-based system
 - Focus on individual choice
-

TENSION IN SOCIAL JUSTICE: ACA DEBATE (CONT.)

- Government role in ACA:
 - Expands access (Medicaid, subsidies)
 - Market role in ACA:
 - Uses private insurance companies
 - Encourages competition to control costs
 - Result:
 - Ongoing tension and debate about healthcare policy
 - No full agreement on what is “fair” healthcare
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RISING UNINSURED POPULATION AND DECLINE OF EMPLOYER COVERAGE (1980–2010)

- By 2010, over 16% of Americans were uninsured
- Uninsured rates have steadily increased since 1980
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Main reasons:

- Rising healthcare costs
- Less affordability for employers and workers
- Increasing reliance on Medicare eligibility

Tab 3

I . Ethics of Disasters: Planning and Response

Disaster Definition: Disasters are sudden events that cause serious disruption and overwhelm the ability of communities and systems to respond.

General Disaster Concepts

- **Occurrence:** Disasters occur worldwide and require **prevention, preparedness, response, rehab, and reconstruct** (WHO).
- **Causes:** They can be caused by natural events (*earthquakes, floods, storms*) or human-made events (*fire, war, terrorism, industrial accidents*).
- **Vulnerability:** WHO explains disasters using vulnerability, which includes *poverty, lack of education, limited resources, and health conditions*.
- **IFRC Definition:** The International Federation of Red Cross defines disaster as a situation where community capacity is overwhelmed by losses (*human, economic, environmental*).
- **The Disaster Formula:**
- $$\frac{\text{Vulnerability} + \text{Hazard}}{\text{Capacity}} = \text{Disaster}$$
- **Modern Trends:** Modern disasters include increasing human-made or anthropogenic hazards, such as chemical releases, explosions, and mass casualties.
- **Coordination:** Effective disaster response requires coordination among national, state, and local agencies, including healthcare systems.
- **Ethical Priorities:** Include reducing harm, ensuring fairness, and respecting individual autonomy during emergencies.

II . Disaster Planning and Response by the Federal Government

A. Department of Homeland Security (DHS)

- **Origin:** Created after the 9/11 attacks to strengthen US security and disaster preparedness.
- **Primary Duty:** Responsible for preventing terrorism and protecting the country from domestic and international threats.
- **Expanded Roles:** Cybersecurity, border security, disaster response, and immigration enforcement.
- **Oversight:** Oversees major agencies such as **FEMA** (*Federal Emergency Management Agency*), U.S. Coast Guard, and Customs and Border Protection.
- **Budget Allocation:** A large part of its budget is used for national security, emergency management, and disaster resilience programs.
- **Public Awareness:** Promotes public safety awareness, including cybersecurity campaigns like “*Stop, Think, Connect.*”

B. Federal Emergency Management Agency (FEMA)

- **History:** Has responded to both local and national disasters for nearly 40 years.
- **Mission:** To prepare for, respond to, and recover from disasters of all types.
- **System Collaboration:** Disaster response requires strong coordination among federal, state, and local governments, NGOs, healthcare systems, first responders, and citizens.
- **US Landscape:** The US is generally effective in crisis response and shows strong humanitarian concern and compassion. However, because it is rooted in individual autonomy and rights, disaster planning must balance individual needs and community welfare. Multiple federal agencies are involved in disaster preparedness and response coordination.

C. The Centers for Disease Control and Prevention (CDC)

- **Scope:** Involved in planning and responding to natural and human-caused disasters, especially health-related emergencies.
- **Office of Public Health:** Works closely with local and state public health departments for coordination and preparedness.
- **Workforce:** Promotes the need for well-trained health professionals who can quickly mobilize during emergencies.
- **Resources:** Maintains a stockpile of medicine and medical supplies for emergency use.
- **Infrastructure:** Operates a system of about 150 laboratories that help identify threats and guide prevention and treatment.

D. American Red Cross (ARC)

- **Nature:** A non-government humanitarian organization that supports disaster response.
- **Origin:** Founded in 1881 and inspired by the International Red Cross movement.
- **Personnel:** Uses a network of trained volunteers (*medical and non-medical*) to respond to disasters like floods, earthquakes, fires, and storms.
- **Immediate Relief:** Provides food, shelter, and emergency healthcare.
- **Emotional Care:** Offers mental health and emotional support to disaster victims and responders.
- **Recovery:** Helps in post-disaster recovery including cleanups support and basic survival kits.
- **Education:** Promotes preparedness through education, emergency planning, and disaster readiness training. Provides training programs like first aid, voluntary training, and healthcare-related certifications.

III. Ethical Issues in National Disaster Response

- **The Reality Gap:** Government agencies provide plans, funding, and support for disaster preparedness and response. However, these efforts are not always fully effective due to limited resources and implementation challenges.
- **Social Justice:** Disaster response raises ethical concerns, especially related to social justice and fairness.
- **Chaos Factor:** Even with strong planning, actual disaster situations are often chaotic and difficult to manage.
- **Principle Violations:** During emergencies, there is a risk that ethical principles may be violated, such as fairness, equality, and proper allocation of resources.
- **The Planning Stage (Michael J. Roberts & Evan G. DeRenzo):** Ethical responsibility in disaster response should **stay at the planning stage**, not during the disaster itself.
 - Disaster preparedness must include both logistical planning and ethical decision-making.
 - Planners should integrate ethical principles as guiding foundations in disaster plans.
 - Disasters often create conflicts of interest that require clear ethical standards.
 - Planning must balance the needs of the community, healthcare providers, and responders.

IV. Ethical Approaches & Triage in Disaster Response

Disaster ethics involves balancing **utilitarian** and **deontological** approaches.

A. The Utilitarian Approach

- **Core Focus:** Focuses on the "*greatest good for the greatest number*," often measured by lives saved.
- **Application:** In disasters, healthcare providers use **triage** to prioritize patients and maximize survival.
- **Resource Management:** Triage helps manage limited resources for both critically ill patients and those with special needs or chronic conditions.

- **Goals:** Minimize risk, maximize resources, and improve efficiency in emergency care. Priority is often given to the most vulnerable patients to ensure fair and effective aid distribution.
- **Utility of Triage:** Helps disaster responders bring order to chaotic emergency situations. It is used to guide decisions on treatment and intervention when resources are limited. There are different triage systems, including special systems for children and CareFlight.

B. Triage Color Categories

Category	Priority & Description
Immediate (Red)	Patients with life-threatening conditions who need urgent treatment. Given top priority to save lives.
Delayed (Yellow)	Patients who need care but are not in immediate danger of death.
Minimal/Minor (Green)	Patients with minor injuries that can safely wait for treatment.
Expectant/Dead (Black)	Patients with very low or no chance of survival, even with treatment. / Dead: Patients who are not breathing and show no signs of life.

C. Limitations of Utilitarianism in Triage

- While triage is utilitarian, this approach has limitations when considering individual and community values.
- **The Deceased Example:** After disasters like Hurricane Katrina, significant resources were used to recover bodies of the deceased.
- **The Conflict:** Strict utilitarianism may view this as less useful because it does not save lives. However, families and communities see body recovery as morally important and respectful. This shows that ethical disaster response must balance efficiency with dignity and human values.

V. Duty-Based Ethics, Autonomy, and Decision-Making

A. Duty-Based (Kantian) Ethics

- **Core Focus:** Emphasizes that all humans have equal worth and dignity.
- **Rejection of Sacrifice:** It rejects the idea of sacrificing some individuals even for the "greater good."
- **Vulnerable Populations:** Supports giving care to elderly, ill, and vulnerable individuals, even if they require more resources.
- **Abandonment:** Ethical duty requires that no one is abandoned simply because they are harder to assist.
- **Case Highlight:** This issue was highlighted in disaster cases such as the **Memorial Hospital** response.

B. Autonomy in Disaster Ethics

- **Definition:** Respect for autonomy means respecting individual freedom.
- **Personal Risk Choices:** People may make personal choices that increase their risk, such as building in flood-prone areas or refusing insurance. Individuals may also ignore disaster warnings or be unable to act during emergencies.
- **Government Role:** This raises the question of the government's responsibility in protecting or assisting them.
- **The Collective Exception:** In public health emergencies, such as infectious diseases, quarantine may be used even without consent. A major ethical question is balancing individual rights (autonomy) and community safety.

C. Decision-Making and Preparedness (The Ostrich Paradox)

- **Brain Behavior:** Meyer and Kunreuther explain that people's brain behavior affects disaster preparedness decisions.
- **The Ostrich Paradox:** Describes how individuals often avoid or ignore disaster warnings.
- **Cognitive Biases:** People may also be influenced by cognitive biases, affecting how they perceive risk. These behaviors explain why some individuals do not prepare or act during warnings.
- **The Dilemma:** This creates a challenge in balancing individual autonomy and the common good. Improving disaster outcomes requires better communication and strategies to influence behavior.

VI. Social Justice and Historical Case Studies

A. Social Justice in Disaster Response

- **Core Principle:** Social justice is a key ethical issue in disaster response.
- **Public Expectation:** People expect the government to act quickly to reduce suffering during disasters.
- **Community Behavior:** Historically, communities show compassion and generosity toward disaster victims. Citizens expect coordinated action that protects both lives and property.
- **System Vulnerability:** Poor communication and coordination among agencies can lead to serious problems.
- **Public Backlash:** When response fails, communities often express anger and demand accountability or investigation.

B. Hurricane Katrina and Disaster Response Failure

- **The Lesson:** Hurricane Katrina highlighted the importance of coordination in disaster response.
- **System Exposure:** The disaster exposed weaknesses in government preparedness and response systems.

- **Official Investigation:** This led to an official investigation and report titled ***A Failure of Initiative***.
- **Report Scope:** The report analyzed both the human impact and ethical issues during the disaster. It identified gaps in planning, communication, and coordination among agencies.
- **Moving Forward:** The report also provided recommendations to improve future disaster response at both government and community levels.

VII. Disaster Preparation and Hospital Response

- **Community Reliance:** During disasters, communities rely on healthcare professionals and institutions for emergency response.
- **Key Responders:** Includes doctors, nurses, paramedics, EMTs, firefighters, police, and the military.
- **Ethical Duty:** These professionals and institutions have an ethical duty to be prepared for disasters.
- **Flexibility:** Hospitals must have flexible disaster plans that can adapt to different emergency situations.
- **Continuous Readiness:** Since hospitals are the main centers of care during disasters, they must continuously prepare and practice emergency response plans. Readiness and training are essential to ensure effective and timely response to save lives.

A. Hospital Emergency Management

- **All-Hazards Approach:** Hospitals should develop an all-hazards emergency plan for different types of disasters.
- **Inclusivity:** Planning should include community involvement to improve effectiveness and coordination.
- **Quality & Safety:** Hospitals are encouraged to follow **The Joint Commission (TJC)** standards for quality and safety.
- **Operational Core:** Effective emergency management requires strong communication systems. It also involves ensuring adequate capacity, equipment, and medical supplies.
- **Resource Management:** Proper coordination of volunteers is important during disasters. Continuous education and training of healthcare staff is essential for preparedness.

B. Hospital Accreditation and Emergency Preparedness

- **Dual Responsibility:** Hospitals have an ethical duty to serve communities during disasters. They must also maintain accreditation to ensure credibility and funding.
- **TJC Role:** The Joint Commission (TJC) includes emergency management standards for hospitals and provides an all-hazards planning approach for different types of disasters.
- **TJC Offerings:**
 - Provides step-by-step guidance for emergency plan design, budgeting, and command systems.
 - Offers disaster-specific resources available for events like storms, floods, and security threats.
 - Addresses mental health needs of healthcare workers and patients after disasters.
 - Includes guidance on modern risks such as cybersecurity threats like ransomware attacks.

C. Ethics & Beneficence in Hospital Disaster Preparation

- **The Ethical Burden:** Hospitals have an ethical duty to be prepared for disasters and protect patients and communities. However, disaster preparedness involves important ethical challenges and responsibilities.
- **The Preparedness Disparity:** The burden of preparedness is not equal across all hospitals.
 1. *Small rural hospitals:* May have limited staff, equipment, and capacity during disasters.
 2. *Large hospital systems:* Usually have more resources and can respond more effectively.
 3. *Universal Obligation:* Despite differences in capacity, all hospitals still have the obligation to prepare for emergencies.

- **Applying Beneficence:** Hospitals can apply the ethical principle of beneficence by helping communities prepare for disasters. This includes providing education and support for emergency planning.
- **Individual Safety (Redlener):** Suggests that individual preparedness improves safety during disasters. Key preparedness criteria include:
 1. Knowing how to respond in emergencies
 2. Maintaining CPR certification
 3. Having a personal communication and emergency network plan
 4. Building family resilience and readiness
- **Outreach:** Hospitals can use these strategies for community outreach and disaster education programs.

VIII. Altered Standards of Care in Disaster Ethics

- **Capacity Overwhelm:** Hospitals may face situations where demand for care exceeds their capacity, as seen during Hurricane Katrina at Memorial Hospital.
- **Crisis Decisions:** These extreme conditions require difficult and emotionally challenging ethical decisions.
- **The Concept:** A concept called "**altered standards of care**" was developed to guide hospitals during such crises. These standards are used when normal healthcare procedures cannot be fully applied due to limited resources.
- **Institutional Policy:** Guidance from the Department of Homeland Security (DHS) helps hospitals create policies for these situations.
- **Example:** A rural hospital during a mass casualty event (*e.g., a mass shooting*) may need to apply altered standards of care.

Key Components of Altered Standards of Care

- **Scope:** Altered standards of care guide hospitals when normal care is not possible during disasters. They address critical areas such as staffing, patient ratios, scope of practice, and medical supplies.
- **Flow Logistics:** They include guidelines for patient admission, transport, and hospital flow management.
- **The Workforce Dilemma:** During outbreaks, healthcare workers may hesitate to report due to fear for personal and family safety.
- **Staff Adjustments:** Plans include adjusting staffing schedules and increasing patient-to-staff ratios temporarily. Some trained staff may be reassigned to support roles, even if they are not usually in clinical practice.
- **Proactive Practice:** Regular disaster simulations and planning help improve readiness and response in real emergencies.

IX. Professional Responsibility & Ethics in Disaster Planning

A. Professional Responsibility in Disasters

- **Social Trust:** Society entrusts key professionals with disaster response.
- **Core Duties:**
 - Responsibility to support society's recovery.
 - Need for logistical preparedness.
 - Importance of ethical readiness.
 - Practice for rare but critical events.

- Ensure strong support systems for coping.

B. Ethics in Disaster Planning and Response

- **Integration:** Ethical principles must be integrated in disaster planning.
- **Key Principles:** Nonmaleficence, justice, autonomy, beneficence.
- **Execution:** Emergency situations require rapid ethical decision-making.
- **Phases of Care:** Ethical issues occur across all phases of care:
 1. Before intervention
 2. During treatment
 3. End-of-life care
- **System Stress:** Challenges in applying ethics during scarcity and risk.

C. Ethical Issues in Treatment and End-of-Life Care

- **The Principle Balance:** Balance between beneficence and nonmaleficence.
- **Triage Target:** Triage aims for "maximum beneficence."
- **Clinical Realities:** Common treatment challenges in emergencies, alongside issues with informed consent and patient competence.
- **Dilemmas & Guidelines:** Ethical dilemmas in end-of-life decisions. Role of protocols in guiding decisions.

X. Individual Response & Disaster Preparedness

A. Disaster Preparedness and Public Readiness

- **The "Red Cross Ready" Concept:** Prepare emergency kits and supplies, stored in accessible containers for quick use, which includes:
 - First aid supplies
 - Flashlight
 - Battery-operated radio
 - Extra money or cash
 - At least 3 days of survival essentials
- **Storage Timeframe:** Preparedness includes storing enough supplies for at least 3 days:
 - **Water:** At least 1 gallon per person per day.
 - **Food:** Around 1600 calories per day, non-cook items.

B. Developing a Personal Disaster Plan

- **Timing:** Preparedness is being ready before a disaster happens.
- **Action Steps:** Create a clear disaster plan. Identify evacuation areas and contacts. Communicate the plan with family. Practice the plan regularly.
- **Awareness:** Know local disaster risks (*e.g., typhoons, earthquakes, floods*) and know where to get accurate, real-time information. Learn basic first aid and CPR.

C. Shelter-in-Place Preparedness

- **Purpose:** Shelter-in-place may be required during disasters to prevent exposure to chemical or radiological hazards.
- **Home Preparation:** Prepare a designated room at home and stock supplies (*food, water, emergency kit*). The shelter room should have essential supplies such as:
 - Drinking water

- Ready-to-eat food
- First aid kit and emergency items
- **External Factors:** Workplaces must have shelter plans. Authorities issue shelter-in-place warnings.

D. Irwin Redlener on Disaster Preparedness

- **Cooperation:** Disaster preparedness is a shared responsibility; community readiness is essential for survival.
- **Individual Capability:** Individuals should receive CPR and first-aid training. Awareness of surroundings improves safety. Know local risks and evacuation routes.
- **System Failure:** Prepare for communication failure during disasters. Use alternative communication devices (*e.g., mobile phones*).

XI. Ethical Implications in Individual Response

- **Survival Mode:** Disasters trigger fear and survival behavior. Survival mode may reduce respect for others' rights and dignity.
- **Self-Reliance:** Individuals cannot rely solely on government response. There is an ethical duty to be personally prepared.
- **The Autonomy Conflict:** Tension between safety and personal autonomy.
- **Modern Concerns:** Growth of surveillance technology raises privacy concerns, prompting a debate between security benefits vs. loss of freedom.
- **Beneficence in Individual Disaster Response:**
 - Beneficence is essential for survival during disasters. People often become more altruistic in crises.
 - Acts of kindness and help increase community survival.
 - Uncertainty in the scope of individual responsibility.
 - *Ethical dilemma:* Family vs. community obligations.
 - *System Gap:* Gap between personal duty and government responsibility raises deeper questions about moral responsibility (*deontology*).

XII. Systems, Behavior, and Psychology of Planning

A. Evolution of Disaster Planning and Ethics

- **Modern History:** Disaster management evolved after major events (*e.g., 9/11*). Disaster response involves complex logistics and ethics.
- **Shared Responsibility:** Responsibility for preparedness is shared (*citizens, government, responders*). There is an ethical duty for citizens to be prepared and self-sufficient.
- **Operational Success:** Effective response requires leadership, communication, and teamwork. Disaster plans must be tailored to specific communities. Preparedness is needed at all levels: national to individual.

B. Disaster Planning and Individuals

- **Vulnerability & Autonomy:** Vulnerability is a key concern in disaster planning. The goal is to reduce harm and respect individual autonomy. Disaster response is human-centered.
- **Social Cognitive Theory:** Explains behavior in disasters via a triadic interaction: **person, environment, and task**. According to Bandura, disaster situations involve:
 - **Person:** The individual (*rescuer or victim*).
 - **Environment:** The location (*home, airport, restaurant, etc.*).

- **Task:** The action needed (*survival, evacuation, response*).
- **Adaptation:** Individuals adapt knowledge across different situations. Survival makes the individual the central focus.

C. How Individuals Plan for Disasters

- **Dynamics:** Disaster planning involves person-behavior-environment interaction. Individuals can adapt to changing situations, which requires self-referent and self-regulatory skills.
- **Cognition:** Knowledge is transformed into action through thinking and reflection. Planning is based on past experience and learning.
- **The Dual-System Brain:** Decision-making may become automatic or controlled during disasters. In emergencies, the brain may respond in two ways:
 - *Automatic system:* Fast, instinctive reactions.
 - *Controlled system:* Slower, logical thinking.
- **Mitigation:** Experience improves response and reduces panic.

X III. Behavioral Models & Training Frameworks

A. Self-Efficacy and Behavioral Change

- **Self-Efficacy:** Behavior is influenced by belief in one's ability (*self-efficacy*). Self-efficacy affects planning and disaster preparedness actions.
- **Internal Skills:** Skills include self-reflection and self-regulation. Includes creating and practicing disaster plans. Change occurs through deciding, planning, and action.
- **The Transtheoretical Model:** Explains the behavior change process and consists of three basic components: **(1) stages of change, (2) processes people use to change, and (3) levels of change.** It helps identify readiness and guide individualized interventions.

B. The Six Stages of Change

Behavior change occurs in 6 stages. Each stage has specific tasks and timeframes. Progress depends on readiness and mastery; change is not always linear.

1. **Precontemplation:** No awareness or intention to prepare.
2. **Contemplation:** Aware but undecided.
3. **Preparation:** Planning and starting small steps.
4. **Action:** Actively implementing disaster plan.
5. **Maintenance:** Sustaining preparedness long-term.
6. **Relapse:** Returning to unprepared behavior.

C. Behavioral Processes and Self-Efficacy Adjustments

- **Mechanisms:** Behavior change involves overt and covert processes. 10 change processes guide behavior modification, which includes awareness, emotional, and behavioral strategies.
- **Model Expansion:** Two other additional constructs are integrated into the transtheoretical model of behavioral change:
 - **Decisional balance**
 - **Self-efficacy affects**
- **Confidence:** Behavior outcome depends on confidence level. Helps explain the adoption of disaster preparedness.

D. Personal Ethics Challenges in Emergency Care

- **Duty Conflict:** Personal ethics may be challenged in practice. Conflicts can arise between personal beliefs and professional duty.
- **Neutrality:** There is a need to provide unbiased care to all patients.
- **Reflective Growth:** Importance of ethical reflection and discussion. Support systems enhance ethical decision-making.

XIV. Preparation and Deliberate Practice for Responders

A. Preparation of Responders

- **Demands:** Mass casualty events require rapid critical thinking. Triage is essential for safe and ethical care.
- **Educational Gaps:** Disaster training is time-consuming and costly. There is limited disaster exposure in health education; training is mostly classroom-based, not real-world.

B. Deliberate Practice in Disaster Response

- **Skill Mastery:** Requires mastery of motor and procedural skills. Performance improves through quality and quantity of practice.
- **Structure:** Highly structured, goal-directed training. Feedback identifies gaps and improves skills.
- **Methodology:** Simulation improves safety and reduces errors. Virtual and technology-based training enhance realism. Builds competence, confidence, and decision-making ability.

XV. Summary

Human behavior becomes more complex during disasters, so understanding responses is important for improving preparedness. Education helps people recognize risks and prepare, though it may challenge personal autonomy and resistance to change. Disaster preparedness remains essential because it improves survival and safety. Training using realistic methods, deliberate practice, and simulation builds responders' skills, confidence, and decision-making. Although resource-intensive, these efforts save lives, speed recovery, strengthen communities, and support ethical principles like beneficence, nonmaleficence, and social justice.