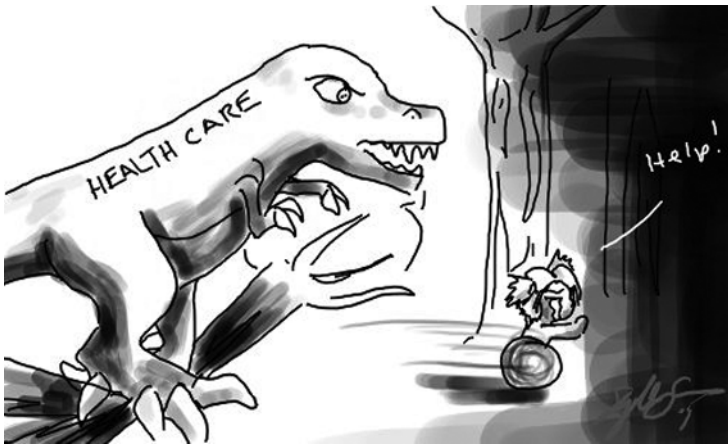


Chapter 1

Major Characteristics of U.S. Health Care Delivery



INTRODUCTION

The United States has a unique system of health care delivery compared with other developed countries around the world. Almost all other developed countries have universal health insurance programs in which the government plays a dominant role. Almost all of the citizens in these countries are entitled to receive health care services that include routine and basic health care. In the United States, the Affordable Care Act¹ (ACA) has expanded health insurance, but it still falls short of achieving universal coverage. Besides insurance, adequate access to health care services and health care costs at both the individual and national levels continue to confound academics, policy makers, and politicians alike.

¹Patient Protection and Affordable Care Act of 2010 as amended by the Health Care and Education Reconciliation Act of 2010, often shortened as the Affordable Care Act and nicknamed Obamacare.

The main objective of this chapter is to provide a broad understanding of how health care is delivered in the United States. The U.S. health care delivery system is both complex and massive. Ironically, it is not a system in the true sense because the components illustrated in **Figure 1.1** are only loosely coordinated. Yet, for the sake of simplicity, it is called a system when its various features, components, and services are referenced.

Organizations and individuals involved in health care range from educational and research institutions, medical suppliers, insurers, payers, and claims processors to health care providers. There are nearly 18.4 million people employed in various health delivery settings, including professionally active doctors of medicine (MDs), doctors of osteopathy (DOs), nurses, dentists, pharmacists, and administrators. Approximately 451,500

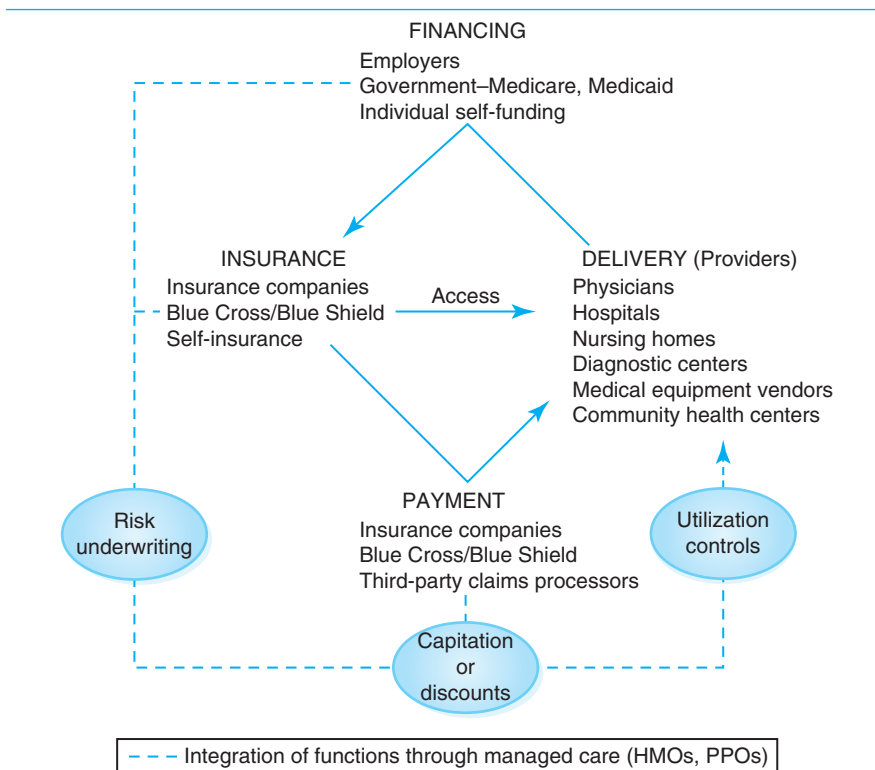


Figure 1.1 Managed Care: Integration of Functions

physical, occupational, and speech therapists provide rehabilitation services. The vast array of institutions includes 5,686 hospitals, 15,663 nursing homes, almost 2,900 inpatient mental health facilities, and 15,900 home health agencies and hospices. Nearly 1,200 programs support basic health services for migrant workers and the homeless, community health centers, black lung clinics, human immunodeficiency virus (HIV) early intervention services, and integrated primary care and substance abuse treatment programs. Various types of health care professionals are trained in 192 medical and osteopathic schools, 65 dental schools, 130 schools of pharmacy, and more than 1,937 nursing programs located throughout the country (Bureau of Labor Statistics, 2011; Bureau of Primary Health Care, 2011).

There are 201.1 million Americans with private health insurance coverage, most of whom are covered through their employers. An additional 103.1 million are covered under 2 major public health insurance programs—Medicare and Medicaid—managed by the U.S. government. Private health insurance can be purchased from approximately 1,000 health insurance companies. The private managed care sector includes approximately 452 licensed health maintenance organizations (HMOs) and 925 preferred provider organizations (PPOs). A multitude of government agencies are involved with the financing of health care, medical and health services research, and regulatory oversight of the various aspects of the health care delivery system (Aventis Pharmaceuticals, 2002; Bureau of Primary Health Care, 2011; Healthleaders, 2011; National Center for Health Statistics, 2007; Urban Institute, 2011; U.S. Bureau of the Census, 1998; U.S. Census Bureau, 2007).

SUBSYSTEMS OF U.S. HEALTH CARE DELIVERY

In the United States, multiple subsystems of health care delivery have developed, either through market forces or through government action to address the special needs of certain population segments.

Managed Care

Managed care seeks to achieve efficiency by integrating the basic functions of health care delivery, and it employs mechanisms to control (manage) utilization and cost of medical services. Managed care is the

dominant health care delivery system in the United States today. It covers most Americans in both private and public health insurance programs through contracts with a managed care organization (MCO), such as an HMO or a PPO. The MCO, in turn, contracts with selected health care providers—physicians, hospitals, and others—to deliver health care services to its enrollees. The term *enrollee* (member) refers to the individual covered under a managed care plan. The contractual arrangement between the MCO and the enrollee—including descriptions of the various health services to which enrollees are entitled—is referred to as the *health plan* (or *plan* for short).

The MCO pays providers either through a capitation (per head) arrangement, in which providers receive a fixed payment for each enrollee under their care, or via a discounted fee arrangement. Providers are willing to discount their services for MCO patients in exchange for being included in the MCO network and being guaranteed a patient population. As part of their planning process, health plans rely on the expected cost of health care utilization, which always runs the risk of costing more than the insurance premiums collected. By underwriting this risk, the plan assumes the role of insurer.

Figure 1.1 illustrates the basic functions and mechanisms that are necessary for the delivery of health services within a managed care environment. The four key functions of financing, insurance, delivery, and payment make up the quad-function model. Managed care integrates the four functions to varying degrees.

Military

The military medical care system is available mostly free of charge to active-duty military personnel of the U.S. Army, Navy, Air Force, and Coast Guard, as well as to members of certain uniformed nonmilitary services such as the Public Health Service and the National Oceanographic and Atmospheric Association. It is a well-organized system that provides comprehensive services, both preventive and treatment oriented. Services are provided by salaried health care personnel. Various types of basic services are provided at dispensaries, sick bays aboard ships, first aid stations, medical stations, and base hospitals. Advanced medical care is provided in regional military hospitals.

Families and dependents of active-duty or retired career military personnel are either treated at the hospitals or dispensaries or are covered by

TriCare, a program that is financed by the U.S. Department of Defense. This insurance plan permits the beneficiaries to receive care from both private and military medical care facilities.

The Veterans Administration (VA) health care system is available to retired veterans who have previously served in the military, with priority given to those who are disabled. The VA system focuses on hospital care, mental health services, and long-term care. It is one of the largest and oldest (dating back to 1930s) formally organized health care systems in the world. Its mission is to provide medical care, education and training, research, contingency support, and emergency management for the U.S. Department of Defense medical care system. It provides health care to more than 9.6 million individuals at over 1,100 sites that include 153 hospitals, 807 ambulatory and community-based clinics, 135 nursing homes, 209 counseling centers, 47 domiciliaries (residential care facilities), 73 home health care programs, and various contract care programs. The VA budget exceeds \$55 billion, and it employed a staff of about 280,000 in 2010 (Department of Veterans Affairs, 2011; National Center for Veterans Analysis and Statistics, 2007).

The entire VA system is organized into 21 geographically distributed *Veterans Integrated Service Networks (VISNs)*. Each VISN is responsible for coordinating the activities of the hospitals and other facilities located within its jurisdiction. Each VISN receives an allocation of federal funds and is responsible for equitable distribution of those funds among its hospitals and other providers. VISNs are also responsible for improved efficiency and cost containment.

Subsystem for Special Populations

Special populations, also called vulnerable populations, refer to those with health needs but inadequate resources to address those needs. For example, they include individuals who are poor and uninsured, those belonging to certain minority groups or of certain immigration status, or those living in geographically or economically disadvantaged communities. They typically receive care through the nation's safety net, which includes public health insurance programs such as Medicare and Medicaid, and providers such as community health centers, migrant health centers, free clinics, and hospital emergency departments. Many safety net providers offer comprehensive medical and enabling services—such as language

assistance, transportation, nutrition and health education, social support services, and child care—according to individual needs.

As an example, federally qualified health centers have provided primary and preventive health services to rural and urban underserved populations for more than 50 years. The Bureau of Primary Health Care (BPHC), located within the Health Resources and Services Administration in the Department of Health and Human Services (DHHS), provides federal support for community-based health centers that include programs for migrant and seasonal farm workers and their families, homeless persons, public housing residents, and school-aged children. These services facilitate regular access to care for patients who are predominantly minority, low income, uninsured, or enrolled in Medicaid, the public insurance program for the poor. In 2012, the nationwide network of 1,198 community health organizations served 22 million people across 8,100 service sites and handled a total of 83.8 million patient visits. Approximately 93% of this population was living on incomes that were less than 200% of the federal poverty level, and 36% were uninsured (National Association of Community Health Centers, 2014). Health centers have contributed to significant improvements in health outcomes for the uninsured and Medicaid populations and have reduced disparities in health care and health status across socioeconomic and racial/ethnic groups (Politzer et al., 2003; Shi et al., 2001).

Medicare is one of the largest sources of public health insurance in the United States, serving the elderly, the disabled, and those with end-stage renal disease. Managed by the Centers for Medicare and Medicaid Services (CMS), another division within the DHHS, Medicare offers coverage for hospital care, post-discharge nursing care, hospice care, outpatient services, and prescription drugs.

Medicaid, the third largest source of health insurance in the country, covering approximately 17.3% of the U.S. population, provides coverage for low-income adults, children, the elderly, and individuals with disabilities (Smith and Medalia, 2014). This program is also the largest provider of long-term care to older Americans and individuals with disabilities. The program has seen significant expansion under the ACA.

In 1997, the U.S. government created the Children's Health Insurance Program (CHIP) to provide insurance to children in uninsured families. The program expanded coverage to children in families that have modest incomes but do not qualify for Medicaid. In 2014, the CHIP program spent \$13 billion to cover approximately 8.1 million children (MACPAC, 2015).

Despite the availability of government-funded health insurance, the United States' safety net is by no means secure. The availability of safety net services varies from community to community. Vulnerable populations residing in communities without safety net providers must often forgo care or seek services from hospital emergency departments if available nearby. Safety net providers, in turn, face enormous pressure from the increasing number of poor and Medicaid-insured in their communities.

Integrated Systems

Organizational integration to form *integrated delivery systems (IDSs)*, or health networks, started in the early 2000s. An IDS has been defined as a network of health care providers and organizations that provides or arranges to provide a coordinated continuum of services to a defined population and is willing to be held clinically and fiscally accountable for the clinical outcomes and health status of the population served (Shortell et al., 1996). By gaining ownership of or forming strategic partnerships with hospitals, physicians, and insurers, IDSs aim to deliver a range of services. The ACA includes payment reform initiatives that encourage physician–hospital integration and coordination of services. It is hoped that integrated and coordinated care will increase cost-effectiveness and quality. A newer model of integrated organization—called an accountable care organization—is expected to respond to new payment incentives and be held accountable for better quality outcomes at reduced costs under a new Medicare Shared Savings Program. The ACA is also aimed to address issues related to fragmented care for individuals who suffer from co-occurring serious mental illness and substance use disorders. The most important principles in delivering integrated care that is specific to vulnerable populations include: (1) an emphasis on primary care; (2) coordination of all care, including behavioral, social, and public health services; and (3) accountability for population health outcomes (Witgert & Hess, 2012).

Long-Term Care Delivery

Long-term care (LTC) consists of medical and nonmedical care that are provided to individuals who have chronic health issues and disabilities that prevent them from doing regular daily tasks. Hence, LTC includes both health care and support services for daily living. It is delivered across a wide variety of venues, including patients' homes, assisted living facilities,

and nursing homes. In addition, family members and friends provide the majority of LTC services without getting paid for them. Medicare does not cover LTC; thus, costs associated with this form of care can impose a major burden on families. Medicaid covers several different levels of LTC services, but a person must be an indigent to qualify for Medicaid. LTC insurance is offered separately by insurance companies, but most people do not purchase these plans because premiums can be unaffordable. By 2020, more than 12 million Americans are projected to require LTC, which will impose a severe strain on the nation's financial resources (CMS, 2011a).

Public Health System

The mission of the *public health system* is to improve and protect community health. The Institute of Medicine's *Future of Public Health in the 21st Century* has outlined the need for a more robust public health infrastructure and a population-based health approach for a healthier America (Centers for Disease Control and Prevention [CDC], 2013). The National Public Health Performance Standards Program identifies 10 essential public health services that a system needs to deliver:

1. Monitoring health status to identify and solve community health problems
2. Diagnosing and investigating health problems and hazards
3. Informing, educating, and empowering people about health problems and hazards
4. Mobilizing the community to identify and solve health problems
5. Developing policies and plans to support individual and community health efforts
6. Enforcing laws and regulations to protect health and safety
7. Providing people with access to necessary care
8. Assuring a competent and professional health workforce
9. Evaluating the effectiveness, accessibility, and quality of personal and population-based health services
10. Performing research to discover innovative solutions to health problems

In 2009, public health accounted for 3.1% of the nation's overall healthcare expenditures of \$2.5 trillion (CMS, 2012). The amount of federal funding spent to prevent disease and improve health in communities varied

significantly from state to state in 2013, with a per capita low of \$13.67 in Indiana to a high of \$46.48 in Alaska (TFAH & RWJF, 2014). To bolster the nation's public health efforts, the ACA established the Prevention and Public Health Fund to provide expanded and sustained national investments in prevention and public health, to improve health outcomes, and to enhance health care quality.

Expanded efforts are needed to combat antibiotic resistance, fight obesity and heart disease, curb prescription drug overdose, and deal with emerging issues such as chikungunya and e-cigarettes. Advanced information systems and data sharing have become increasingly more important in assuring a strong public health system.

CHARACTERISTICS OF THE U.S. HEALTH CARE SYSTEM

The health care system of a nation is influenced by external factors, including the political climate, level of economic development, technological progress, social and cultural values, the physical environment, and population characteristics such as demographic and health trends. It follows, then, that the combined interaction of these forces has influenced the course of health care delivery in the United States. This section summarizes the basic characteristics that differentiate the U.S. health care delivery system from that of other countries. There are 10 main areas of distinction (see [Exhibit 1.1](#)).

Exhibit 1.1 Main Characteristics of the U.S. Health Care System

- No central governing agency and little integration and coordination
- Technology-driven delivery system focusing on acute care
- High in cost, unequal in access, and average in outcome
- Delivery of health care under imperfect market conditions
- Government as subsidiary to the private sector
- Fusion of market justice and social justice
- Multiple players and balance of power
- Quest for integration and accountability
- Access to health care services selectively based on insurance coverage
- Legal risks influence practice behaviors

No Central Governing Agency; Little Integration and Coordination

The U.S. health care system stands in stark contrast to the health care systems of other developed countries. Most developed countries have centrally controlled universal health care systems that authorize the financing, payment, and delivery of health care to all residents. The U.S. system is not centrally controlled; it is financed both publicly and privately and, therefore, features a variety of payment, insurance, and delivery mechanisms. Private financing, predominantly through employers, accounts for approximately 57% of total health care expenditures; the government finances the remaining 43% (CMS, 2015).

Centrally controlled health care systems are less complex and less costly than the U.S. health care system. Centrally controlled systems manage their total expenditures through global budgets and can govern the availability and utilization of services. The United States has a large private infrastructure in which hospitals and physician clinics are private businesses that are independent of the government. Nevertheless, the federal and state governments in the United States play an important role in health care delivery. They determine public-sector expenditures and reimbursement rates for services provided to Medicaid and Medicare patients. The government also formulates standards of participation through health policy and regulation, which means that providers must comply with the standards established by the government to deliver care to Medicaid and Medicare patients. Certification standards are also regarded as minimum standards of quality in most sectors of the health care industry.

Technology Driven and Focusing on Acute Care

The United States is a hotbed of research and innovation in new medical technology. Growth in science and technology often creates a demand for new services despite shrinking resources to finance sophisticated care. Other factors contribute to increased demand for expensive technological care. For example, patients often assume that the latest innovations represent the best care, and many physicians want to try the latest gadgets. Even hospitals compete on the basis of having the most modern equipment and are often under pressure to recoup capital investments made in technology.

Legal risks for providers and health plans alike may also play a role in the reluctance to deny new technology.

Although technology has ushered in a new generation of successful interventions, the negative outcomes resulting from its overuse are many. For example, the use of high technology adds to the rising costs of health care. These costs are eventually borne by society. Technological innovation certainly has a place in medicine. However, given the fact that resources are limited, enough emphasis is not placed on primary care and public health, both of which produce better population-level outcomes and are more cost-effective than high-tech care.

High in Cost, Unequal in Access, and Average in Outcome

The United States spends more than any other developed country on medical services. Despite spending such a high percentage of the national economic output (almost 17% of the gross domestic product [GDP] in 2012—see [Figure 1.2](#)) on health care, many U.S. residents have limited access to even the most basic care.

Access refers to the ability of an individual to obtain health care services when needed. In the United States, access is restricted to those who (1) have health insurance through their employers, (2) are covered under a government-sponsored health care program (which includes health coverage under the ACA), (3) can afford to buy insurance out of their own private funds, (4) are able to pay for services privately, or (5) can obtain services through safety net providers. Health insurance is the primary—but not necessarily a sufficient—means for obtaining access. After the implementation of the ACA, the proportion of the U.S. population that was uninsured dropped from approximately 16% to roughly 12% in 2014 (Kutscher, Herman, & Meyer, 2015). However, despite expansion of health insurance, some people still face access barriers. For example, one-third of U.S. physicians do not accept new Medicaid-insured patients (Decker, 2012). For consistent basic and routine care, commonly referred to as primary care, the uninsured are unable to see a physician unless they can pay on an out-of-pocket basis. Those who cannot afford to pay generally wait until health problems develop, at which point they may be able to receive services in a hospital emergency department. Experts generally believe that inadequacy and disparity in access to basic and routine primary care services are the main reasons

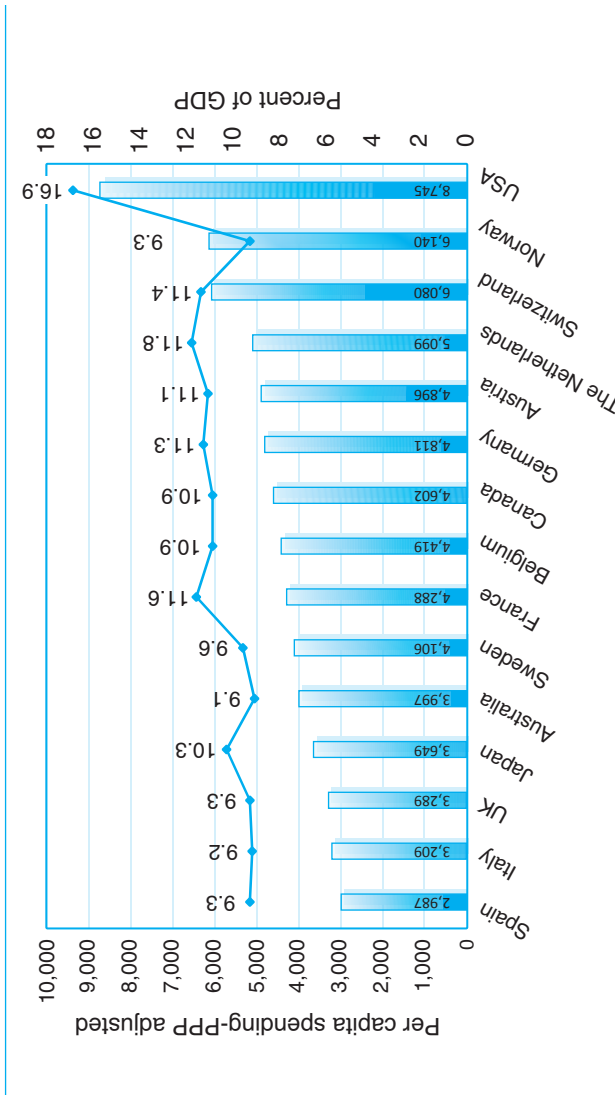


Figure 1.2 Total Health Expenditure per Capita and Share of GDP, United States and Selected Countries, 2012
Data from Organization for Economic Cooperation and Development. OECD health data. OECD Health Statistics [database], 2014. Accessed June 7, 2015.

that the United States lags behind other developed nations in measures of population health, (see **Figure 1.3** for U.S. racial disparity in life expectancy and **Figure 1.4** for death rates among children in ECD).

Imperfect Market Conditions

Under national health care programs, patients may have varying degrees of choice in selecting their providers; however, true economic market forces are virtually nonexistent. In the United States, even though the delivery of services is largely in private hands, health care is only partially governed by free market forces. Hence, the system is best described as a quasi-market or an imperfect market. The following key characteristics of free markets help explain why U.S. health care is not a true free market.

In a free market, multiple patients (buyers) and providers (sellers) act independently. In a free market, patients should be able to choose their providers based on price and quality of services. If matters were this simple, patient choice would determine prices by the unencumbered interaction of supply and demand. In reality, however, the payer is an MCO, Medicare, or Medicaid, rather than the patient. Prices are set by agencies external to the market; thus they are not freely governed by the forces of supply and demand.

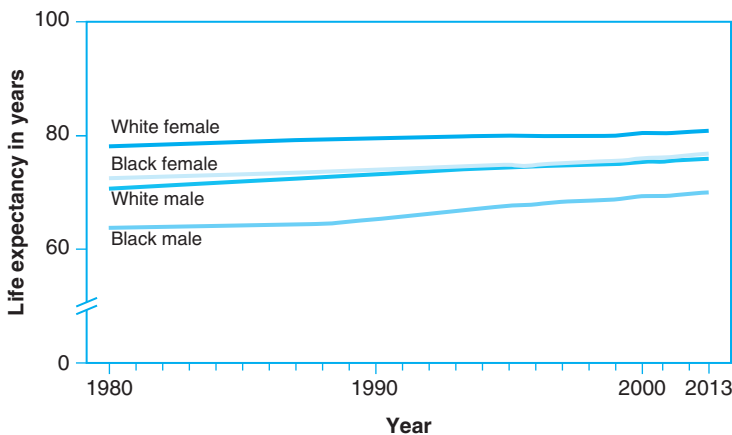


Figure 1.3 Life Expectancy at Birth

National Center for Health Statistics. Health, United States, 2014: In Brief. Hyattsville, MD. 2015, p 8. http://www.cdc.gov/nchs/data/has/has14_InBrief.pdf

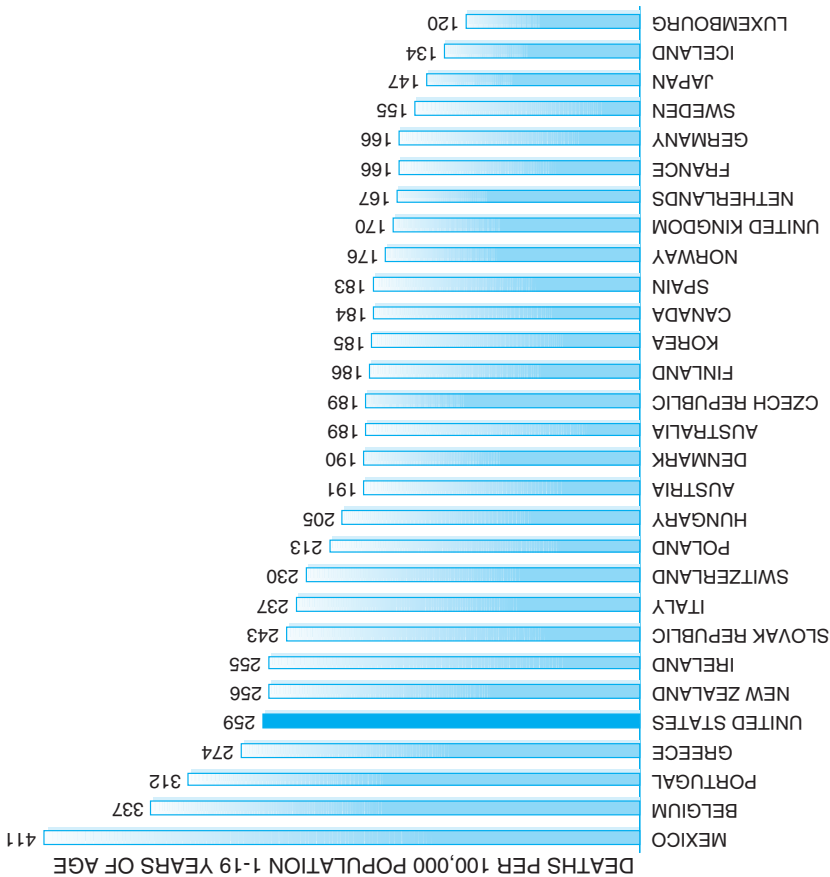


Figure 1.4 Death Rates Among Children 1–19 Years of Age, by OECD Country
Organization for Economic Cooperation and Development. Data from the year 2006 or most recent year. Source: Doing Better for Children. Chapter 2: Comparative Child Well-being across the OECD, p. 51.

For the health care market to be free, unrestrained competition must occur among providers on the basis of price and quality. Generally speaking, free competition exists among health care providers in the United States. The consolidation of buying power into the hands of MCOs, however, is forcing providers to form alliances and IDSs on the supply side. In certain geographic locations of the country, a single giant medical system has taken over as the sole provider of major health care services, restricting competition. As the health care system continues to move in this direction, it appears that only in large metropolitan areas will there be more than one large integrated system competing for the business of the health plans.

Free markets operate best when consumers are educated about the products they are using, but patients are not always well informed about health care choices. The barrage of direct-to-consumer advertising about pharmaceuticals and other products is often confusing when it comes to making a decision as to what may be best. Choices involving sophisticated technology, diagnostic methods, interventions, and pharmaceuticals can be difficult and often require physician input. Acting as an advocate, physicians can reduce this information gap for patients. Increasingly, health care consumers have begun to take the initiative to educate themselves through the use of Internet resources for gathering medical information. However, one cannot always be sure about the reliability of such information.

In a free market, patients have information on price and quality for each provider. In the United States, however, the current pricing methods for health care services further confound free market mechanisms. Hidden costs make it difficult for patients to gauge the full expense of services ahead of time. *Item-based pricing*, for example, refers to the costs of ancillary services that often accompany major procedures such as surgery. Patients are usually informed of the surgery's cost ahead of time but cannot anticipate the cost of anesthesiologists and pathologists or hospital supplies and facilities, thus making it extremely difficult for them to ascertain the total price before services have actually been received. Package pricing and capitated fees can help overcome these drawbacks by providing a bundled fee for a package of related services. *Package pricing* covers services that are bundled together for one episode of care, which is less encompassing than capitation. *Capitation* covers all services an enrollee may need during an entire year.

In a free market, patients must directly bear the cost of services received. The fundamental purpose of insurance is to cover major expenses when unlikely events occur; but health insurance covers even basic and routine services, which undermines this fundamental principle. Health insurance coverage for minor services such as colds, coughs, and earaches amounts to prepayment for such services. A moral hazard exists, in that after enrollees have purchased health insurance, they typically use health care services to a greater extent than they would without health insurance.

In a free market, demand is determined by market forces—many individuals independently determine what to buy and when to buy a product or service. That is not the case in health care. First, decisions about the utilization of health care are often determined by need rather than by price-based demand. *Need* can be self-assessed or determined by a medical expert, such as a physician. But, many of the factors discussed previously affect whether or not the person actually obtains medical care. Second, the delivery of health care can actually result in creation of demand. For example, practitioners who have a financial interest in additional treatments may create artificial demand, commonly referred to as *provider-induced demand*.

Government as Subsidiary to the Private Sector

In most other developed countries, the government plays a central role in delivering health care. In the United States, the private sector plays the dominant role. This arrangement can partially be explained by the American tradition of reliance on individual responsibility and a commitment to limiting the power of government. As a result, government spending for health care has been largely confined to filling in the gaps left open by the private sector. These gaps include public health functions, such as clean water and sanitation; support for research and training; and care of vulnerable populations.

Fusion of Market Justice and Social Justice

Market justice and social justice are two contrasting theories that govern the production and distribution of health care services. The principle of *market justice* places the responsibility for fair distribution of health care on market forces in a free economy. In such a system, medical care and its

benefits are distributed on the basis of people's willingness and ability to pay (Santerre & Neun, 1996, p. 7). In contrast, *social justice* emphasizes the well-being of the community over that of the individual; thus the inability to obtain medical services because of a lack of financial resources is considered unjust. In a system that blends public and private resources, the two theories often work well together, contributing ideals from both theories. As an example, employed individuals with middle-class incomes obtain employer-sponsored health insurance, whereas the most needy members of society depend on government-sponsored programs. On the other hand, the two principles of justice also create conflicts. For example, many of the small employers in the United States do not offer health insurance, or, if it is offered, many employees cannot afford the cost. Yet, these individuals do not qualify for government assistance in obtaining health care on account of their incomes exceeding certain threshold levels. The ACA is supposed to address this but it may take years to achieve the intended effect.

Multiple Players and Balance of Power

The U.S. health care system involves multiple players such as physicians, administrators of health service institutions, insurance companies, large employers, and the government. Big business, labor, insurance companies, physicians, and hospitals make up a set of powerful and politically active special-interest groups represented before lawmakers by high-priced lobbyists. Each player has a different economic interest to protect; however, problems frequently arise because the self-interests of the various players are often at odds. For example, providers seek to maximize government reimbursement for services delivered to Medicare and Medicaid patients, but the government wants to contain cost increases. The fragmented self-interests of the various players produce counteracting forces within the system. One positive effect of these opposing forces is that they prevent any single entity from dominating the system. In an environment that is rife with motivations to protect conflicting self-interests, achieving comprehensive, system-wide health care reforms is next to impossible, and cost containment remains a major challenge. Consequently, the approach to health care reform in the United States is best characterized as incremental or piecemeal and can sometimes be regressive when presidential administrations change. (Note: the ACA is really an example of incremental, not comprehensive, reform that primarily addresses insurance coverage.)

Quest for Integration and Accountability

Currently in the United States, there is a drive to use primary care as the organizing hub for continuous and coordinated health services. Although this model gained popularity with the expansion of managed care, its development stalled before reaching its full potential. The ideal role for primary care would include integrated health care in the form of comprehensive, coordinated, and continuous services offered with a seamless delivery (also termed medical home or health home for patients). Furthermore, this model emphasizes the importance of the patient–provider relationship and considers how it can best function to improve the health of each individual, thereby strengthening the population as a whole. Integral to this relationship is the concept of accountability. Accountability on the provider’s part means providing quality health care in an efficient manner; on the patient’s behalf, it means taking responsibility for one’s own health and using available resources sensibly.

Access to Health Care Services Selectively Based on Insurance Coverage

Although the United States offers some of the best medical care in the world, this care is generally available only to individuals who have health insurance plans that provide adequate coverage or who have sufficient resources to pay for the procedures themselves. The uninsured have limited options when seeking medical care. They can either (1) pay physicians out of pocket at rates that are typically higher than those paid by insurance plans, (2) seek care from safety net providers, or (3) obtain treatment for acute illnesses at a hospital emergency department for which hospitals do not receive direct payments unless patients have the ability to pay. The Emergency Medical Treatment and Labor Act of 1986 requires screening and evaluation of every patient, provision of necessary stabilizing treatment, and hospital admission when necessary, regardless of ability to pay. Unfortunately, the inappropriate use of emergency departments results in cost shifting, whereby patients able to pay for services, privately insured individuals, employers, and the government ultimately cover the costs of medical care provided to the uninsured in emergency rooms.

Legal Risks Influence Practice Behaviors

Americans, as a society, are quick to engage in lawsuits. Motivated by the prospects of enormous jury awards, many people are easily persuaded to drag alleged offenders into the courtroom at the slightest perception of incurred harm. Private health care providers are increasingly becoming

more susceptible to litigation, and the risk of malpractice lawsuits is a serious consideration in the practice of medicine. As a form of protection, most providers engage in what is known as *defensive medicine* by prescribing additional diagnostic tests, scheduling checkup appointments, and maintaining abundant documentation on cases. Many of these efforts are unnecessary and simply drive up costs and promote inefficiency.

HEALTH CARE SYSTEMS OF OTHER DEVELOPED COUNTRIES

Three basic models for structuring national health care systems prevail in Western European countries and Canada. In Canada, the government finances health care through general taxes, but the actual care is delivered by private providers. In the context of the quad-function model (see [Figure 1.1](#)), the Canadian system requires a tighter consolidation of financing, insurance, and payment functions, which are coordinated by the government; delivery is characterized by detached private arrangements.

In Germany, health care is financed through government-mandated contributions by employers and employees. Health care is delivered by private providers. Private not-for-profit insurance companies, called sickness funds, are responsible for collecting the contributions and paying physicians and hospitals (Santerre & Neun, 1996, p. 134). In this kind of socialized health insurance system, insurance and payment functions are closely integrated, and the financing function is better coordinated with the insurance and payment functions than it is in the United States. Delivery is characterized by independent private arrangements. The government exercises overall control.

In the United Kingdom, the government manages the infrastructure for the delivery of medical care, in addition to financing a tax-supported national health insurance program. Under such a system, most of the medical institutions are operated by the government. Most health care providers, such as physicians, are either government employees or are tightly organized in a publicly managed infrastructure. In the context of the quad-function model, the British system requires a tighter consolidation of all four functions, typically by the government.

Canada

In Canada, provinces and territories have introduced several initiatives to improve integration and coordination of care for chronically ill patients with complex needs. In 2004, as part of the 10-Year Plan to Strengthen Health

Care, all provincial and territorial governments agreed to provide at least half of their respective populations with access to multidisciplinary primary care teams. By 2007, about three-quarters of family physicians were working in physician-led, multiprofessional practices (Marchildon, 2013). Across the provinces, almost 60% of primary care physicians are using computerized medical records (Health Council of Canada, 2013; Mossialos et al., 2015).

As of April 2014, federal funding through the Canada Health Transfer has been distributed to provinces on a purely per-capita basis, ending previous compensations for variations in tax bases that benefited the less wealthy provinces (Mossialos et al., 2015). The objective of the new funding policy is to improve equity, but it has been criticized on the grounds that it reduces funding to less populated provinces with older populations and higher costs (Marchildon & Mou, 2013). There have been efforts across provinces to reduce the prices of generic drugs. Several provinces have significantly reduced prices in recent years; in Ontario, in 2010, the price ceiling was lowered to 25% of the price of the equivalent brand-name drug, and British Columbia lowered its price ceiling to 20% in 2014 (Mossialos et al., 2015).

Primary care reform has been under way across provinces since 2000, when the federal government invested CA\$800 million (US\$647 million) over 6 years through the Primary Care Transition Fund. Each province continues to reform its primary care systems, including provider payment methods, and to incentivize movement from solo to team-based practice, chronic disease management, and coordination of care with other health care providers (Hutchison et al., 2011; Sweetman & Buckley, 2014).

Germany

Germany implemented the General Law on Patients' Rights in 2013. It includes several measures designed to strengthen patients' rights. The most important one is the incorporation into the Civil Code of rights, duties, and forms of etiquette pertaining to relationships between providers and patients.

In July 2014, the federal cabinet passed the Bill of the First Act to Strengthen Long-Term Care. It aims to support families that provide care at home and to improve adult day care and short-term care by increasing the number of caregivers. Such benefits and services are to increase by 20%. The Second Act to Strengthen Long-Term Care is intended to redefine the need for care in view of the growing number of dementia patients.

The coalition agreement plan from 2013 includes proposals for various measures with a focus on the promotion of quality. In June 2014, the

Federal Joint Committee was commissioned to establish the Institute for Quality Assurance and Transparency in Health Care.

A new bill changes the way Social Health Insurance contribution rates are determined and shared between employer and employee to contain indirect labor costs. Beginning in 2015, the general contribution rate (14.6%) will be kept but both the special contribution rate for employees only (0.9%) and the supplementary premiums (and necessary specific social protection mechanisms) will be abolished (Mossialos et al., 2015). The latter two will be replaced by a supplementary income-dependent contribution rate, which will be determined by each sickness fund individually. For 2015, it is expected to be, on average, lower than 0.9%—that is, the insured will pay less than they did in 2014 (Mossialos et al., 2015).

United Kingdom

The purchasing and regulatory structures of the National Health Insurance in England have been significantly reformed under the Health and Social Care Act of 2012. The act abolished 150 primary care trusts and replaced them with clinical commissioning groups (of which there are currently 211 across England). These clinically oriented bodies are expected to make better use of resources in decisions about planning and purchasing a wide range of services for their local populations. Clinical commissioning groups differ from primary care trusts in their governance. All general practices are required to belong to a clinical commissioning group, and the groups' governing body must be chaired by a general practitioner and include other clinicians alongside managers. In 2013–2014, clinical commissioning groups controlled about half of the total NHS budget.

NHS-England was created to oversee the clinical commissioning groups. Reforms have also envisaged that all hospitals would become semi-autonomous foundation trusts, and that clinical commissioning groups would have more freedom to commission different kinds of providers and to enhance public scrutiny. However, evaluating the impact of the reform on cost, health outcomes, and quality of care will be complex, not least in the disentangling of the effects of the reform from the impact of financial pressures on health and social care services (National Audit Office, 2013).

Table 1.1 presents selected features of the national health care programs and health outcomes in Canada, Germany, and the United Kingdom and compares them with those in the United States.

Table 1.1 Health Care Systems of Selected Industrialized Countries

	United States	Canada	United Kingdom	Germany
Type	Pluralistic	National health insurance	National health system	Socialized health insurance
Ownership	Private	Public/private	Public	Private
Financing	Voluntary, multipayer system (premiums or general taxes)	Single-payer (general taxes)	Single-payer (general taxes)	Employer—employee (mandated payroll contributions and general taxes)
Reimbursement (hospital)	Varies (DRGs, negotiated fee-for-service, per diem, capitation)	Global budgets	Global budgets	Per diem payments
Reimbursement (physicians)	RBRVS, fee-for-service	Negotiated fee-for-service	Salaries and capitation payments	Negotiated fee-for-service
Consumer copayment	Small to significant	Negligible	Negligible	Negligible
Life expectancy for women	78.7	81.5	81.0	81.0
Infant mortality per 1,000 live births	6.1	4.8	4.1	3.3
Expenditures as a percentage of GDP	16.9	10.9	9.3	11.3

Note: DRGs, diagnosis-related groups; RBRVS, resource-based relative value scale. Data from Organization for Economic Cooperation and Development. OECD health data. OECD Health Statistics [database], 2014, doi:10.1787/health_glance-2013-en. Accessed June 7, 2015.

SYSTEMS FRAMEWORK

A system consists of a set of interrelated and interdependent components designed to achieve some common goals. The components are logically coordinated. Even though the various functional components of the health services delivery structure in the United States are at best only loosely coordinated, the main components can be identified with a systems model. The systems framework used here helps understand that the structure of health care services in the United States is based on some basic principles, provides a logical arrangement of the various components, and demonstrates a progression from inputs to outputs. The main elements of this arrangement are system inputs (resources), system structure, system processes, and system outputs (outcomes). In addition, system outlook (future directions) is a necessary element of a dynamic system. This framework has been used as the conceptual base for organizing later chapters in this book (see [Figure 1.5](#)).

System Foundations

The structure of the current health care system is not an accident—historical, cultural, social, and economic factors explain its current structure. As discussed later in this text, these factors also affect forces that shape new trends and developments and those that impede change.

System Resources

Both human and nonhuman resources are essential for the delivery of health care services. Human resources consist of the various types and categories of workers directly engaged in the delivery of health care to patients. Such personnel—including physicians, nurses, dentists, pharmacists, other professionals trained at the doctoral level, and numerous categories of allied health professionals—usually have direct contact with patients. Numerous ancillary workers, such as those involved in billing and collection, marketing and public relations, and building maintenance, often play important but indirect supportive roles in the delivery of health care. Health care managers are needed to manage and coordinate various types of health care services.

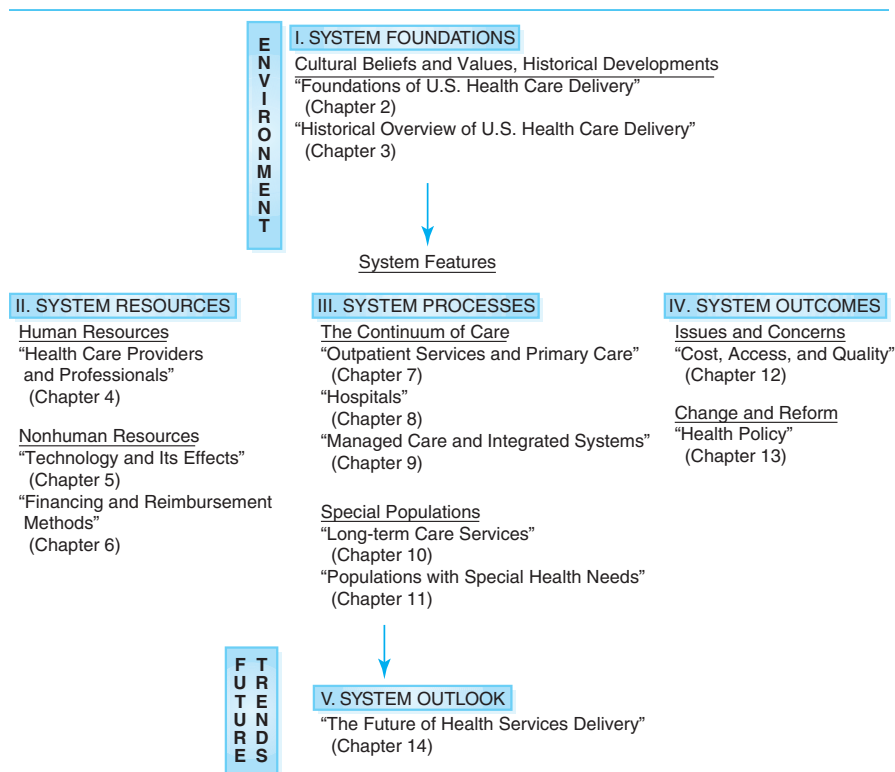


Figure 1.5 Systems Framework

System Processes

The system processes are carried out mainly through the health care delivery infrastructure consisting of hospitals, clinics, long-term care providers, etc. Most health care services are delivered in non-institutional settings, which are mainly associated with processes referred to as outpatient care. Institutional health services (inpatient care) are predominantly associated with acute care hospitals. Managed care organizations take responsibility for the actual delivery of health care, apart from their role in financing, insurance, and payment functions. Integrated systems are

equipped to deliver a range of health care services. Special institutional and community-based settings have been developed for long-term care and mental health. The health care infrastructure must also support populations that have special needs.

System Outcomes

System outcomes refer to the critical issues and concerns surrounding what the health services system is able to accomplish—or not accomplish—in terms of its primary objective. The primary objective of any health care delivery system is to provide cost-effective health services that meet certain established standards of quality to an entire nation. The previous three elements of the systems model (foundations, resources, and processes) play a critical role in fulfilling this objective. Access, cost, and quality are the main outcome criteria for evaluating the success of a health care delivery system. Issues and concerns regarding these criteria trigger broad initiatives for reforming the system through health policy.

System Outlook

A dynamic health care system must look forward. In essence, it must project into the future the accomplishment of desired system outcomes in view of social, cultural, economic, and other main forces of change.

CONCLUSION

The United States has a unique system of health care delivery, but this system lacks universal access; therefore, continuous and comprehensive health care is not enjoyed by all Americans. Health care delivery in the United States is characterized by a patchwork of subsystems developed either through market forces or the need to take care of certain population segments. These components include managed care, the military and VA systems, the system for vulnerable populations, and the emerging IDSs. No country in the world has a perfect system. Most nations with a national health care program have a private sector that varies in size. The systems framework provides an organized approach to an understanding of the various components of the United States health care delivery system.

REFERENCES

- Aventis Pharmaceuticals. *HMO-PPO Digest: Managed Care Digest Series*. Bridgewater, NJ: Aventis Pharmaceuticals; 2002; pp. 1–88.
- Bureau of Labor Statistics. Occupational employment and wages: healthcare practitioners and technical occupations. <http://www.bls.gov>. Published 2011. Accessed December 1, 2011.
- Bureau of Primary Health Care. *BPHC-UDS Annual Report*. Rockville, MD: Bureau of Primary Health Care, Health Resources and Services Administration; 2011.
- Centers for Disease Control and Prevention (CDC). National Public Health Performance Standards Program. www.cdc.gov/nphsp. Published 2013. Accessed June 7, 2015.
- Centers for Medicare and Medicaid Services (CMS). Long term care. <https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/LTC.html>. Published 2011a. Accessed August 2015.
- Centers for Medicare and Medicaid Services (CMS). National Health Expenditure Data. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/nationalHealthAccountsHistorical.html>. Accessed August 2015.
- Decker, SL. In 2011 nearly one-third of physicians said they would not accept new Medicaid patients, but rising fees may help. *Health Aff.* 2012;31(8):1673–1679.
- Health Council of Canada. *How Do Canadian Primary Care Physicians Rate the Health System? Survey Results from the 2012 Commonwealth Fund International Survey of Primary Care Doctors*. Toronto, Canada: Health Council of Canada; 2013.
- Healthleaders. Special data request via Kaiser. www.statehealthfacts.org. Published 2011. Accessed August 2011.
- Hutchison B, Levesque J-F, Strumpf E, Coyle N. Primary health care in Canada: systems in motion. *Milbank Q.* 2011;89(2):256–288.
- Kaiser Family Foundation (KFF). Medicaid managed care market tracker. <http://kff.org/data-collection/medicaid-managed-care-market-tracker/>. Published 2014. Accessed August 2014.
- Kaiser Family Foundation and Health Research & Educational Trust. Employer health benefits 2009 annual survey. Exhibit 5.1. www.kff.org. Published 2009. Accessed August 2009.
- Kutscher B, Herman B, Meyer H. Uninsured drop as ACA faces threats. *Mod Healthc.* 2015;45(22):1–11.

- Marchildon G. Canada: health system review. *Health Syst Transit*. 2013;15(1): 1–179. http://www.euro.who.int/_data/assets/pdf_file/0011/181955/e96759.pdf. Accessed August 2013.
- Marchildon GP, Mou H. The funding formula for health care is broken. Alberta's windfall proves it. *Globe and Mail*. <http://www.theglobeandmail.com/globe-debate/the-funding-formula-for-health-care-is-broken-albertaswindfall-proves-it/article14764089/>. Published October 9, 2013. Accessed October 10, 2014.
- Medicaid and CHIP Payment and Access Commission (MACPAC). State Children's Health Insurance Program (CHIP) fact sheet. <https://www.macpac.gov/wp-content/uploads/2015/03/CHIP-Fact-Sheet-April-2015.pdf>. Published April 21, 2015. Accessed June 21, 2015.
- Mossialos E, Wenzl M, Osborn R, Anderson C. 2014 international profiles of health care systems. The Commonwealth Fund. Pub. no. 1802. http://www.commonwealthfund.org/~media/files/publications/fund-report/2015/jan/1802_mossialos_intl_profiles_2014_v7.pdf. Published January 2015. Accessed May 2015.
- National Association of Community Health Centers. *A sketch of community health centers chart book 2014*. http://www.nachc.com/client/Chartbook_2014.pdf. Published 2014. Accessed June 7, 2015.
- National Audit Office. Managing the transition to the reformed health system. Department of Health, United Kingdom, pp. 1–46, July 2013.
- National Center for Health Statistics. *Health, United States*, 2007. Hyattsville, MD: Department of Health and Human Services; 2007.
- National Center for Veterans Analysis and Statistics. *FY07 VA information pamphlet*. Washington, DC: Department of Veterans Affairs; 2007.
- Politzer RM, et al. The future role of health centers in improving national health. *J Public Health Policy*. 2003;24(3):296–306.
- Santerre RE, Neun SP. *Health Economics: Theories, Insights, and Industry Studies*. Chicago: Irwin; 1996. Published December 2013. Accessed.
- Shi L, et al. The impact of managed care on vulnerable populations served by community health centers. *J Ambul Care Manage*. 2001;24(1):51–66.
- Shortell SM, Gillies RR, Anderson D, Erickson K. *Remaking Health Care in America: Building Organized Delivery Systems*. Hoboken, NJ: Jossey-Bass; 1996.
- Smith JC, Medalia C. Health insurance coverage in the United States. Current population reports. US Census Bureau. <https://www.census.gov/content/dam/Census/library/publications/2014/demo/p60-250.pdf>. Issued September 2014. Accessed June 7, 2015.
- Sweetman A, Buckley G. Ontario's experiment with primary care reform. *University of Calgary School Public Policy Research Papers*. 2014;7(11):1–37.

<http://www.policyschool.ucalgary.ca/sites/default/files/research/ontario-health-care-reform.pdf>. Accessed August 2014.

Trust for America's Health (TFAH) and Robert Wood Johnson Foundation (RWJF). Investing in America's health: a state-by-state look at public health funding and key health facts. <http://healthyamericans.org/assets/files/TFAH2014-InvestInAmericaRpt08.pdf>. Published May 2014. Accessed August 2014.

Urban Institute. The Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on data from Medicaid statistical information system (MSIS) reports from the Centers for Medicare and Medicaid Services (CMS). November 2011.

U.S. Bureau of the Census. *Statistical Abstract of the United States: 1998*. 118th ed. Washington, DC: Bureau of the Census; 1998.

U.S. Census Bureau. Current populations report. In: *Income, Poverty, and Health Insurance coverage in the United States: 2006*. Washington, DC: Government Printing Office; 2007:60–233.

U.S. Centers for Medicare and Medicaid Services (CMS). National health expenditure data. April 2012. Baltimore, MD; 2012. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/tables.pdf>. Accessed August 2012.

Welsh Government Programme for government. Cardiff, Welsh Government. <http://gov.wales/about/programmeforgov/?lang=en>. Published 2011a. Accessed August 2011.

Witgert K, Hess C. Including safety-net providers in integrated delivery systems: issues and options for policymakers. The Commonwealth Fund. http://www.nashp.org/sites/default/files/Including.SN_Providers.in_IDS_.pdf. Published August 2012. Accessed December 2012.