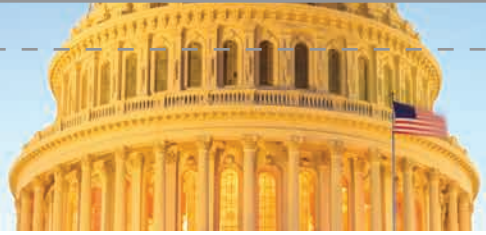
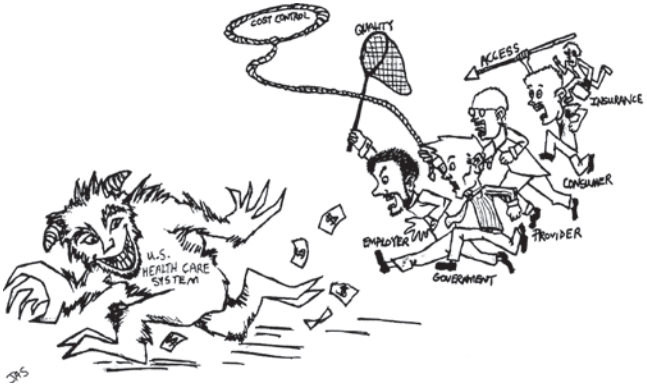


CHAPTER 1

An Overview of U.S. Health Care Delivery

LEARNING OBJECTIVES

- Understand the basic nature of the U.S. health care system.
- Outline the key functional components of a health care delivery system.
- Get a basic overview of the Affordable Care Act.
- Discuss the primary characteristics of the U.S. health care system.
- Emphasize why it is important for health care practitioners and managers to understand the intricacies of the health care delivery system.
- Get an overview of health care systems in selected countries.
- Point out global health challenges and reform efforts.
- Introduce the systems model as a framework for studying the health care system in the United States.



The U.S. health care delivery system is a behemoth that is almost impossible for any single entity to manage and control.

Introduction

The United States has a unique system of health care delivery that is unlike any other health care system in the world. Almost all other developed countries have national health insurance programs run by the government and financed through general taxes. Nearly all citizens in such countries are entitled to receive health care services. Such is not yet the case in the United States, where Americans are not automatically covered by health insurance.

Though U.S. health care is often called a system because is has various features, components, and services, it may be misleading to talk about the American health care delivery "system," because a true, cohesive system does not exist (Wolinsky, 1988). Indeed, a major feature of the U.S. health care system is its fragmented nature, as different people obtain health care through different means. The system has continued to undergo periodic changes, mainly in response to concerns regarding costs, access, and quality.

Describing health care delivery in the United States can be a daunting task. To facilitate an understanding of the structural and conceptual basis for the delivery of health care services, this text is organized according to the systems framework presented at the end of this chapter. Also, for the sake of simplicity, the mechanisms of health care delivery in the United States are collectively referred to as a system throughout this text.

The main objective of this chapter is to provide a broad understanding of how health care is delivered in the United States. Examples of how health care is delivered in other countries are also presented for the sake of comparison. The overview presented here introduces the reader to several concepts discussed more extensively in later chapters.

An Overview of the Scope and Size of the System

TABLE 1-1 demonstrates the complexity of health care delivery in the United States. Many organizations and individuals are involved in health care. To name just a few: educational and research institutions, medical suppliers, insurers, payers, and claims processors to health care providers. A multitude of providers are involved in the delivery of preventive, primary, subacute, acute, auxiliary, rehabilitative, and continuing care. A large number of managed care organizations (MCOs) and integrated networks now provide a continuum of care, covering many of the service components.

The U.S. health care delivery system is massive, with total employment that exceeded 16.4 million people in 2010 in various health delivery settings. This number included more than 838,000 professionally active doctors of medicine (MDs), 70,480 osteopathic physicians (DOs), and 2.6 million active nurses (U.S. Census Bureau, 2012). The majority of health care and health services professionals (5.98 million) work in ambulatory health service settings, such as the offices of physicians, dentists, and other health practitioners, medical and diagnostic laboratories, and home health care service locations. Smaller proportions of these professionals are employed by hospitals (4.7 million) and nursing and residential

TABLE 1-1 The Complexity of Health Care Delivery

Education/Research	Suppliers	Insurers	Providers	Payers	Government
Medical schools Dental schools Nursing programs Physician assistant programs Nurse practitioner programs Physical therapy, occupational therapy, speech therapy programs Research organizations Private foundations U.S. Public Health Service (Agency for Healthcare Research and Quality, Agency for Toxic Substances and Disease Registry, Centers for Disease Control and Prevention, Food and Drug Administration, Health Resources and Services Administration, Indian Health Service, National Institutes of Health, Substance Abuse and Mental Health Services Administration) Professional associations Trade associations	Pharmaceutical companies Multipurpose suppliers Biotechnology companies	Managed care plans Blue Cross/ Blue Shield plans Commercial insurers Self-insured employers Medicare Medicaid Veterans Affairs Tricare	***Preventive Care*** Health departments ***Primary Care*** Physician offices Community health centers Dentists Nonphysician providers ***Subacute Care*** Subacute care facilities Ambulatory surgery centers ***Acute Care*** Hospitals ***Auxiliary Services*** Pharmacists Diagnostic clinics X-ray units Suppliers of medical equipment ***Rehabilitative Services*** Home health agencies Rehabilitation centers Skilled nursing facilities ***Continuing Care*** Nursing homes ***End-of-Life Care*** Hospices ***Integrated*** Managed care organizations Integrated networks	Blue Cross/ Blue Shield plans Commercial insurers Employers Third-party administrators State agencies	Public insurance financing Health regulations Health policy Research funding Public health

care facilities (3.13 million). The vast array of health care institutions in the United States includes approximately 5,795 hospitals, 15,700 nursing homes, and 13,337 substance abuse treatment facilities (U.S. Census Bureau, 2012).

In 2015, 1,375 federally qualified health center grantees, with 188,851 full-time employees, provided preventive and primary care services to approximately 24.3 million people living in medically underserved rural and urban areas (Health Resources and Services Administration [HRSA], 2015). Various types of health care professionals are trained in 180 medical and osteopathic schools (Association of American Medical Colleges, 2017), 66 dental schools (American Dental Association, 2017), 136 schools of pharmacy (American Association of Colleges of Pharmacy, 2017), and more than 1,500 nursing programs located throughout the country. Multitudes of government agencies are involved with the financing of health care, medical research, and regulatory oversight of the various aspects of the health care delivery system.

A Broad Description of the System

U.S. health care delivery does not function as a rational and integrated network of components designed to work together coherently. To the contrary, it is a kaleidoscope of financing, insurance, delivery, and payment mechanisms that remain loosely coordinated. Each of these basic functional components represents an amalgam of public (government) and private sources. Government-run programs finance and insure health care for select groups of people who meet each program's prescribed criteria for eligibility. To a lesser degree, government programs also deliver certain health care services directly to certain recipients, such as veterans, military personnel, American Indians/Alaska Natives, and some uninsured people. Nevertheless, the financing, insurance, payment, and delivery functions largely remain in private hands.

The market-oriented economy in the United States attracts a variety of private entrepreneurs that pursue profits by facilitating the key functions of health care delivery. Employers purchase health insurance for their employees through private sources, and employees receive health care services delivered by the private sector. The government finances public insurance through Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) for a significant portion of the country's low-income, elderly, disabled, and pediatric populations. However, insurance arrangements for many publicly insured people are made through private entities, such as health maintenance organizations (HMOs), and health care services are rendered by private physicians and hospitals. This blend of public and private involvement in the delivery of health care has resulted in the following characteristics of the U.S. system:

- A multiplicity of financial arrangements for health care services
- Numerous insurance agencies or MCOs that employ various mechanisms for insuring against risk
- Multiple payers that make their own determinations regarding how much to pay for each type of service
- A diverse array of settings where medical services are delivered

- Numerous consulting firms offering expertise in planning, cost containment, electronic systems, quality, and restructuring of resources

There is little standardization in a system that is functionally fragmented, and in which the various system components fit together only loosely. Because a central agency such as the government does not oversee the overall coordination of such a system, problems of duplication, overlap, inadequacy, inconsistency, and waste occur. Lack of system-wide planning, direction, and coordination leads to a complex and inefficient system. Moreover, the system as a whole does not lend itself to standard budgetary methods of cost control. Individual and corporate entities within a predominantly private entrepreneurial system seek to manipulate financial incentives to their own advantage, without regard to their impact on the system as a whole. Hence, cost containment remains an elusive goal.

In short, the U.S. health care delivery system is like a behemoth that is almost impossible for any single entity to manage or control. The United States consumes more health care services as a proportion of its total economic output than any other country in the world. The U.S. economy is the largest in the world and, compared to other nations, consumption of health care services in the United States represents a greater proportion of the country's total economic output. Although the system can be credited for delivering some of the best clinical care in the world, it falls short of delivering equitable services to every American. It certainly fails in terms of providing cost-efficient services.

An acceptable health care delivery system should have two primary objectives: (1) enable all citizens to obtain needed health care services; and (2) ensure that services are cost-effective and meet certain established standards of quality. While the U.S. health care delivery system falls short of both these basic ideals, the United States leads the world in providing the latest and the best in medical technology, training, and research. It offers some of the most sophisticated institutions, products, and processes of health care delivery.

Basic Components of a Health Care Delivery System

FIGURE 1-1 illustrates that a health care delivery system incorporates four functional components—financing, insurance, delivery, and payment; hence, it is termed a **quad-function model**. Health care delivery systems differ depending on the arrangement of these components. The four functions generally overlap, but the degree of overlap varies between private and government-run systems, and between traditional health insurance and managed care–based systems. In a government-run system, the functions are more closely integrated and may be indistinguishable. Managed care arrangements also integrate the four functions to varying degrees.

Financing

Financing is necessary to obtain health insurance or to pay for health care services. For most privately insured Americans, health insurance is employment based; that is, the employers finance health care as a fringe benefit for their employees. A

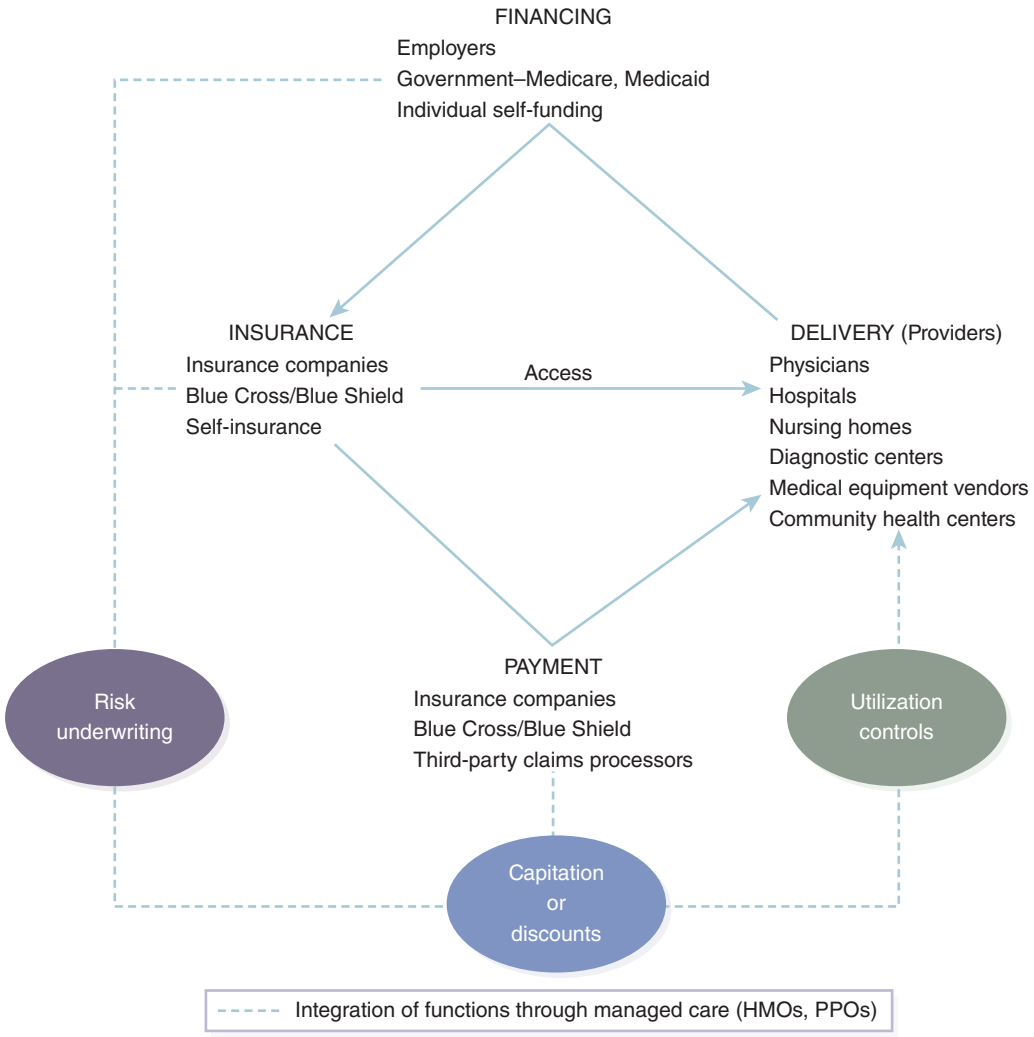


FIGURE 1-1 Basic health care delivery functions.

dependent spouse or children may also be covered by the working spouse's or working parent's employer. Most employers purchase health insurance for their employees through an MCO or an insurance company selected by the employer. Small employers may or may not be in a position to afford health insurance coverage for their employees. In public programs, the government functions as the financier; the insurance function may be carved out to an HMO.

Insurance

Insurance protects the insured against financial catastrophe by providing expensive health care services when needed. The insurance function determines the package of health services that the insured

individual is entitled to receive. It specifies how and where health care services may be received. The MCO or insurance company also functions as a claims processor and manages the disbursement of funds to the health care providers.

Delivery

The term "delivery" refers to the provision of health care services by various providers. The term **provider** refers to any entity that delivers health care services and either independently bills for those services or is supported through tax revenues. Common examples of providers include physicians, dentists, optometrists, and therapists in private practices, hospitals, and diagnostic and imaging clinics, and suppliers of medical equipment (e.g., wheelchairs, walkers, ostomy supplies, oxygen). With few exceptions, most providers render services to people who have health insurance and even those covered under public insurance programs receive health care services from private providers.

Payment

The payment function deals with **reimbursement** to providers for services delivered. The insurer determines how much is paid for a certain service. Funds for actual disbursement come from the premiums paid to the MCO or insurance company. At the time of service, the patient is usually required to pay an out-of-pocket amount, such as $25 or $30, to see a physician. The remainder is covered by the MCO or insurance company. In government insurance plans, such as Medicare and Medicaid, tax revenues are used to pay providers.

Insurance and Health Care Reform

The U.S. government finances health benefits for certain special populations, including government employees, the elderly (people ages 65 years and older), people with disabilities, some people with very low incomes, and children from low-income families. The program for the elderly and certain disabled individuals, which is administered by the federal government, is called **Medicare**. The program for the indigent, which is jointly administered by the federal government and state governments, is named **Medicaid**. The program for children from low-income families, another federal/state partnership, is called the Children's Health Insurance Program (CHIP).

However, the predominant employment-based financing system in the United States has left some employed individuals uninsured for two main reasons. First, some small businesses simply cannot get group insurance at affordable rates and, therefore, are not able to offer health insurance as a benefit to their employees. Second, in some work settings, participation in health insurance programs is voluntary, so employees are not required to join. Some employees choose not to sign up, mainly because they cannot afford the cost of health insurance premiums. Employers rarely pay 100% of the insurance premium; instead, most require their employees to pay a portion of the cost. This is called **premium cost sharing**. Self-employed people and other individuals who are not covered by employer-based plans have to obtain health insurance on their own. Individual rates are typically higher than

group rates available to employers. In the United States, working people earning low wages have been the most likely to be uninsured because most cannot afford premium cost sharing and are not eligible for public benefits.

In the U.S. context, **health care reform** refers to the expansion of health insurance to cover the **uninsured**—those without private or public health insurance coverage. The Patient Protection and Affordable Care Act of 2010, more commonly known as the Affordable Care Act (ACA), was the most sweeping health care reform in recent U.S. history. One of the main objectives of the ACA was to reduce the number of uninsured.

The ACA was rolled out gradually starting in 2010, when insurance companies were mandated to start covering children and young adults younger than age 26 under their parents' health insurance plans. Most other insurance provisions went into effect on January 1, 2014, except for a mandate for employers to provide health insurance, which was postponed until 2015. The ACA required that all U.S. citizens and legal residents must be covered by either public or private insurance. The law also relaxed standards to qualify additional numbers of people for Medicaid, although many states chose not to implement the Medicaid expansion based on a 2012 ruling by the U.S. Supreme Court. Individuals without private or public insurance had to obtain health insurance from participating insurance companies through Web-based, government-run exchanges; if they failed to do so, they had to pay a tax. The exchanges—also referred to as health insurance marketplaces—would determine whether an applicant qualified for Medicaid or CHIP programs. If an applicant did not qualify for a public program, the exchange would enable the individual to purchase a government-approved health plan offered by private insurers through the exchange. Federal subsidies enabled low-income people to partially offset the cost of health insurance.

A predictive model developed by Parente and Feldman (2013) estimated that, at best, full implementation of the ACA would reduce the number of uninsured by more than 20 million. Nevertheless, by its own design, the ACA failed to achieve **universal coverage** that would enable all citizens and legal residents to have health insurance. Possible future scenarios for health care reform are discussed later in this text.

By March 2015, approximately 16.5 million uninsured Americans had gained health insurance coverage due to the Affordable Care Act ("Impact of Obamacare on Coverage," 2016). By 2016, an estimated 20 million had gained coverage (Uberoi et al., 2016), and by 2017, 31 states and the District of Columbia had expanded Medicaid through the ACA's provisions (Kaiser Family Foundation, 2017). By March 2016, states that had expanded Medicaid experienced an 8.1% decline in their uninsured rate (from 18.2% to 10.1%). States that had not expanded Medicaid experienced a comparably smaller decline of 7.3%—from 23.4% to 16.1% ("Impact of Obamacare on Coverage," 2016). The uninsured rate declined among all race/ethnicity categories, with the greatest decreases seen among African Americans and Hispanics, compared to whites (Uberoi et al., 2016). The uninsured rate declined from 22.4% to 10.6% among African Americans, from 41.8% to 30.5% among Hispanics, and

from 14.3% to 7.0% among whites (Uberoi et al., 2016). Additionally, females experienced a greater decline in their uninsured rate (49.7% decline) compared to males (37.6% decline). Specifically, the uninsured rate among females decreased from 18.9% to 9.5%, whereas the uninsured rate among males decreased from 21.8% to 13.6% (Uberoi et al., 2016). Despite these gains, however, the ACA left more than 27.3 million Americans uninsured in 2016 (Cohen et al., 2016).

During his first week in office in January 2017, President Donald Trump signed an Executive Order to repeal and replace the ACA (commonly referred to as Obamacare) in an effort to minimize the ACA's economic and regulatory burdens and to waive any requirement imposing a fiscal burden on states or families, individuals, health care providers, insurers, or other parties.

Role of Managed Care

Under traditional insurance, the four basic health delivery functions have been fragmented; with few exceptions, the financiers, insurers, providers, and payers have been different entities. However, during the 1990s, health care delivery in the United States underwent a fundamental change involving a tighter integration of the basic functions through managed care.

Previously, fragmentation of the four functions meant a lack of control over utilization and payments. The quantity of health care consumed refers to **utilization** of health services. Traditionally, determination of the utilization of health services and the price charged for each service had been left up to the insured individuals and the providers of health care. However, due to rising health care costs, current delivery mechanisms have instituted some controls over both utilization and price.

Managed care is a system of health care delivery that (1) seeks to achieve efficiency by integrating the four functions of health care delivery discussed earlier; (2) employs mechanisms to control (manage) utilization of medical services; and (3) determines the price of services and, consequently, how much the providers are paid. The primary financier is still the employer or the government. Instead of purchasing health insurance through a traditional insurance company, the employer contracts with an MCO, such as an HMO or a preferred provider organization (PPO), to offer a selected health plan to its employees. In this case, the MCO functions like an insurance company and promises to provide health care services contracted under the health plan to the enrollees of the plan. The term **enrollee** (member) refers to the individual covered under the plan. The contractual arrangement between the MCO and the enrollee—including the collective array of covered health services that the enrollee is entitled to—is referred to as the **health plan** (or "plan," for short). The health plan uses selected providers from whom the enrollees can choose to receive services.

Compared with health services delivery under fee-for-service plans, managed care was successful in accomplishing cost control and greater integration of health care delivery. By ensuring access to needed health services, emphasizing preventive care, and maintaining a broad provider

network, managed care can implement effective cost-saving measures without compromising access and quality, thereby achieving a health care budget predictability unattainable by other kinds of health care delivery.

Major Characteristics of the U.S. Health Care System

In any country, certain external influences shape the basic character of the health services delivery system. These forces consist of a national political climate, economic development, technological progress, social and cultural values, physical environment, population characteristics (i.e., demographic and health trends), and global influences (**FIGURE 1-2**). The combined interaction of these environmental forces influence the course of health care delivery.

Ten basic characteristics differentiate the U.S. health care delivery system from most other countries:

1. No central agency governs the system.
2. Access to health care services is selectively based on insurance coverage.
3. Health care is delivered under imperfect market conditions.

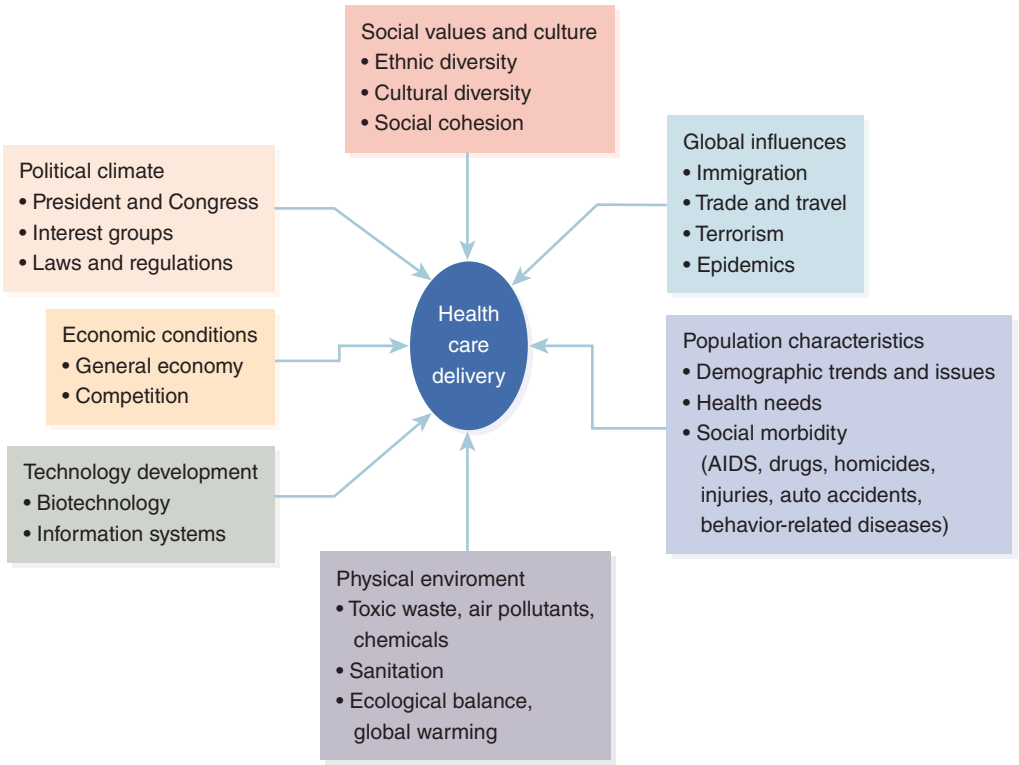


FIGURE 1-2 External forces affecting health care delivery.

4. **Third-party** insurers act as intermediaries between the financing and delivery functions.
5. The existence of multiple payers makes the system cumbersome.
6. The balance of power among various players prevents any single entity from dominating the system.
7. Legal risks influence the practice behavior of physicians.
8. Development of new technology creates an automatic demand for its use.
9. New service settings have evolved along a continuum.
10. Quality is no longer accepted as an unachievable goal.

No Central Agency

Unlike health care systems in most developed nations, the U.S. health care system is not administratively controlled by a department or agency. Most other developed nations have a national health care program in which citizens are entitled to receive a defined set of health care services. To control costs, these systems use **global budgets** that determine total health care expenditures on a national scale and allocate resources within budgetary limits. As a consequence, both availability of services and payments to providers are subject to such budgetary constraints. The governments of these nations also control the proliferation of health care services, especially costly medical technology. System-wide controls over the allocation of resources determine the extent to which government-sponsored health care services are available to citizens. For instance, the availability of specialized services is restricted.

By contrast, the United States has a mainly private system of financing and delivery. Private financing, predominantly through employers, accounts for approximately 52% of total health care expenditures; the government finances the remaining 48% (Centers for Medicare and Medicaid, 2015). Private delivery of health care means that the majority of hospitals and physician clinics are private businesses, which are independent of the government. No central agency monitors total expenditures through global budgets or controls the availability and utilization of services. Nevertheless, federal and state governments play important roles in health care delivery. They determine public-sector expenditures and reimbursement rates for services provided to Medicare, Medicaid, and CHIP beneficiaries. The federal government also formulates **standards of participation** through health policy and regulation, meaning providers must comply with the standards established by the government to be certified to provide services to Medicare, Medicaid, and CHIP beneficiaries. Certification standards are regarded as minimum standards of quality in most sectors of the health care industry.

Partial Access

Access means the ability of an individual to obtain health care services when needed, which is not the same as having health insurance. Americans can access health care services if they (1) have health insurance through their employers; (2) are covered under a government health care program; (3) can afford to buy insurance with their own private funds; (4) are able to pay for services privately; or (5) can obtain

charity or subsidized care. Health insurance is the primary means for ensuring access. Although the uninsured can access certain types of services, they often encounter barriers to obtaining needed health care. For example, while federally supported health centers provide physician services to anyone regardless of ability to pay, such centers and free clinics are located only in certain geographic areas and provide limited specialized services. However, under U.S. law, hospital emergency departments are required to evaluate a patient's condition and render medically needed services for which the hospital does not receive any direct payments unless the patient is able to pay. Therefore, even uninsured are able to obtain medical care for acute illness. While one can say that the United States does have a form of universal catastrophic health insurance, it does not guarantee the uninsured access to continual basic and routine care, commonly referred to as **primary care** (Altman and Reinhardt, 1996).

Countries with national health care programs provide universal coverage. However, even in these countries, access to services may be restricted because no health care system has the capacity to deliver every type of service on demand. Hence, **universal access**—the ability of all citizens to obtain health care when needed—remains mostly a theoretical concept.

As previously mentioned, having coverage does not necessarily equate to having access. The cost of insurance and care and availability of services have continued to present barriers to receiving health care services in a timely manner.

Imperfect Market

Though the U.S. health care delivery system is largely in private hands, this system is only partially governed by free-market forces. The delivery and consumption of health care in the United States does not quite pass the basic test of a **free market**, so the system is best described as a quasi-market or an imperfect market.

In a free market, patients (buyers) and providers (sellers) act independently, with patients able to choose services from any provider. Providers do not collude to fix prices, and prices are not fixed by an external agency. Rather, prices are governed by the free and unencumbered interaction of the forces of supply and demand (**FIGURE 1-3**). **Demand**—the quantity of health care purchased—is driven by the prices prevailing in the free market. Under free-market conditions, the quantity demanded will increase as the price is lowered for a given product or

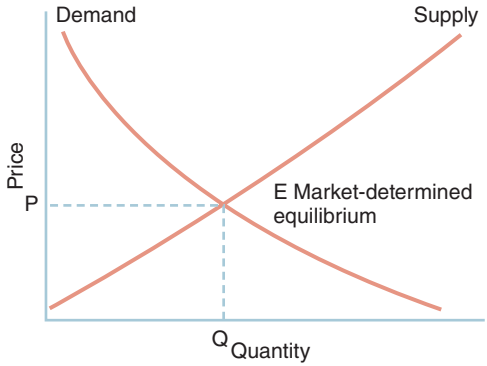


FIGURE 1-3 Relationship between price, supply, and demand under free-market conditions.

Note: Under free-market conditions, there is an inverse relationship between the quantity of medical services demanded and the price of medical services. That is, quantity demanded goes up when the prices go down, and vice versa. In contrast, there is a direct relationship between price and the quantity supplied by the providers of care. In other words, providers are willing to supply higher quantities at higher prices, and vice versa. In a free market, the quantity of medical care that patients are willing to purchase, the quantity of medical care that providers are willing to supply, and the price reach a state of equilibrium. This equilibrium is achieved without the interference of any nonmarket forces. It is important to keep in mind that these conditions exist only under free-market conditions, which are not characteristic of the U.S. health care market.

service. Conversely, the quantity demanded will decrease as the price increases.

At first glance, it might appear that multiple patients and providers do exist. Most patients, however, are now enrolled in either a private health plan or one or more government-sponsored programs. These plans act as intermediaries for the patients, and the enrollment of patients into health plans has the effect of shifting the power from the patients to the administrators of the plans. The result is that the health plans—not the patients—are the real buyers in the health care services market. Private health plans, in many instances, offer their enrollees a limited choice of providers rather than an open choice.

Theoretically, prices are negotiated between the payers and providers. In practice, prices are determined by payers, such as MCOs, Medicare, and Medicaid. Because prices are set by agencies external to the market, they are not governed by the unencumbered forces of supply and demand.

For the health care market to be free, unrestrained competition must occur among providers based on price and quality. However, the consolidation of buying power in the hands of private health plans has been forcing providers to form alliances and integrated delivery systems on the supply side. In certain geographic sectors of the country, a single giant medical system has taken over as the sole provider of major health care services, restricting competition. As the overall 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 to get the business of the health plans.

A free market requires that patients have information about the appropriateness of various services to their needs. Such information is difficult to obtain because technology-driven medical care has become highly sophisticated. Knowledge about new diagnostic methods, intervention techniques, and more effective drugs fall in the domain of the professional physician, not the patient. Moreover, because medical interventions are commonly required in a state of urgency, patients have neither the skills nor the time and resources to obtain accurate information when needed. Channeling all health care needs through a primary care provider can reduce this information gap when the primary care provider acts as the patient's advocate or agent. In recent years, consumers have been seizing some measure of control over the flow of information: The Internet is becoming a prominent source of medical information for patients, and medical advertising is influencing consumer expectations.

In a free market, patients must directly bear the cost of services received. The purpose of insurance is to protect against the risk of unforeseen catastrophic events. Since the fundamental purpose of insurance is to reimburse major expenses when unlikely events occur, having insurance for basic and routine health care undermines the principle of insurance. When you buy home insurance to protect your property against the unlikely event of a fire, you do not anticipate the occurrence of a loss. The probability that you will suffer a loss by fire is very small. If a fire does occur and cause major damage, insurance will cover the loss, but insurance does not cover routine wear and tear on the house, such as chipped paint or a leaky faucet. However, unlike other types of insurance, health

insurance generally covers basic and routine services that are predictable. Coverage for minor services, such as colds and coughs, earaches, and so forth, amounts to prepayment for such services. In this sense, health insurance has the effect of insulating patients from the full cost of health care. This situation may also create a **moral hazard** in that, once enrollees have purchased health insurance, they may use more health care services than if they were to pay for these services on an out-of-pocket basis.

At least two additional factors limit the ability of patients to make decisions in the health care system. First, decisions about the utilization of health care are often determined by need rather than by price-based demand. **Need** has been defined as the amount of medical care that medical experts believe a person should have to remain or become healthy (Feldstein, 1993). Second, the delivery of health care can result in demand creation. This follows from self-assessed need, which, coupled with moral hazard, leads to greater utilization, creating an artificial demand because prices are not taken into consideration. Practitioners who have a financial interest in additional treatments also create artificial demand (Hemenway and Fallon, 1985). This is referred to as **provider-induced demand**, or supplier-induced demand. Functioning as patients' agents, physicians exert enormous influence on the demand for health care services (Altman and Wallack, 1996). Demand creation occurs when physicians prescribe medical care beyond what is clinically necessary. This can include practices such as making more frequent follow-up appointments than necessary, prescribing excessive medical tests, or performing unnecessary surgery (Santerre and Neun, 1996).

In a free market, patients have information on the price and quality of each provider. The current system, however, has drawbacks that obstruct information-seeking efforts. Item-based pricing is one such hurdle. Surgery is a good example to illustrate item-based (also known as fee-for-service) pricing. Patients can generally obtain the fees the surgeon would charge for a particular operation. But the final bill, after the surgery has been performed, is likely to include charges for supplies, use of the hospital's facilities, and services performed by other providers, such as anesthesiologists, nurse anesthetists, and pathologists. These providers, sometimes referred to as **phantom providers**, function in an adjunct capacity and bill for their services separately. Item billing for such additional services, which sometimes cannot be anticipated, makes it extremely difficult to ascertain the total price before services have actually been received. Package pricing can help overcome these drawbacks, but it has made relatively little headway for pricing medical procedures. **Package pricing** refers to a bundled fee for a package of related services. In the surgery example, this would mean one all-inclusive price for the surgeon's fees, hospital facilities, supplies, diagnostics, pathology, anesthesia, and postsurgical follow-up.

Third-Party Insurers and Payers

Insurance often functions as the intermediary among those who finance, deliver, and receive health care. The insurance intermediary does not have an incentive

to be the patient's advocate on either price or quality. At best, employees can air their dissatisfactions with the plan to their employer, who has the power to discontinue the current plan and choose another company. In reality, however, employers may be reluctant to change plans if the current plan offers lower premiums than a different plan.

Multiple Payers

A national health care system is sometimes also referred to as a **single-payer system** because there is one primary payer, the government. When delivering services, providers send the bill to a government agency that subsequently sends payments to each provider. By contrast, the United States has a multiplicity of health plans. Multiple payers often represent a billing and collection nightmare for the providers of services. Multiple payers make the system more cumbersome in several ways:

- It is extremely difficult for providers to keep tabs on numerous health plans. It is challenging for providers to keep up with which services are covered under each plan and how much each plan will pay for those services.
- Providers must hire claims processors to bill for services and monitor receipt of payments. Billing practices are not standardized, and each payer establishes its own format.
- Payments can be denied for not precisely following the requirements set by each payer.
- Denied claims necessitate rebilling.
- When only partial payment is received, some health plans may allow the provider to **balance bill** the patient for the amount the health plan did not pay, the difference between provider charges and insurance payment. Other plans prohibit balance billing. Even when the balance billing option is available to the provider, it triggers a new cycle of billings and collection efforts.
- Providers must sometimes engage in lengthy collection efforts, including writing collection letters, turning delinquent accounts over to collection agencies, and finally writing off as bad debt amounts that cannot be collected.
- Government programs have complex regulations for determining whether payment is made for services actually delivered. Medicare, for example, requires that each provider maintain lengthy documentation on services provided. Medicaid is known for lengthy delays in paying providers.

It is generally believed that the United States spends far more on **administrative costs**—costs associated with billing, collections, bad debts, and maintaining medical records—than do the national health care systems in other countries.

Power Balancing

The U.S. health care system involves multiple players, not just multiple payers. The key players in the system have traditionally been physicians, administrators of health service institutions, insurance companies, large employers, and the government. Big business, labor, insurance companies, physicians, and hospitals make up the powerful and politically active special-interest groups represented before lawmakers by high-priced lobbyists. Each set of players has its own economic interests to protect. Physicians, for instance, want to maintain

their incomes and have minimum interference with the way they practice medicine; institutional administrators seek to maximize reimbursement from private and public insurers; insurance companies and MCOs are interested in maintaining their share of the health insurance market; large employers want to contain the costs they incur providing health insurance to their employees; the government tries to maintain or enhance existing benefits for those covered under public insurance programs and simultaneously contain the cost of providing these benefits. The problem is that the self-interests of different players are often at odds. For example, providers seek to increase government reimbursement for services delivered to Medicare, Medicaid, and CHIP beneficiaries, but the government wants to contain cost increases. Employers dislike rising health insurance premiums. Health plans, under pressure from the employers, may limit fees for the providers, who then resent these cuts.

The fragmented self-interests of the various players produce competing forces within the system. In an environment that is rife with motivations to protect conflicting self-interests, achieving comprehensive system-wide reform has been next to impossible, and cost containment has remained a major challenge. Consequently, the approach to health care reform in the United States has been characterized as incremental or piecemeal, and the focus of reform initiatives has been confined to health insurance coverage and payment cuts to providers rather than focusing on the better provision of health care.

Litigation Risks

The United States is a litigious society. Motivated by the prospects of enormous jury awards, many Americans are quick to drag an alleged offender into a courtroom at the slightest perception of incurred harm. Private health care providers, too, have become increasingly susceptible to litigation and the risk of malpractice lawsuits is a real consideration in the practice of medicine. To protect themselves against the possibility of litigation, practitioners may engage in what is referred to as **defensive medicine** by prescribing additional diagnostic tests, scheduling return checkup visits, and maintaining copious documentation. Many of these additional efforts may be unnecessary, costly, and inefficient.

High Technology

The United States has been the hotbed of research and innovation in new medical technology. Growth in science and technology often creates demand for new services despite shrinking resources to finance sophisticated care. People generally equate high-tech care with high-quality care. They want "the latest and the best," especially when health insurance will pay for new treatments. Physicians and technicians want to try the latest gadgets. Hospitals compete on the basis of having the most modern equipment and facilities. Once capital investments in these new services are made, those costs must be recouped through utilization. Legal risks for providers and health plans may also play a role in discouraging denial of new technology. Thus, several factors promote the use of costly new technology once it is developed.

Continuum of Services

Medical care services are classified into three broad categories: curative (i.e., drugs,

treatments, and surgeries), restorative (e.g., physical, occupational, and speech therapies), and preventive (i.e., prenatal care, mammograms, and immunizations). Health care settings are no longer confined to the hospital and the physician's office. Additional settings, such as home health, subacute care units, and outpatient surgery centers, have emerged in response to the changing configuration of economic incentives. **TABLE 1-2** describes the continuum of health care services. The

TABLE 1-2 The Continuum of Health Care Services

Types of Health Services	Delivery Settings
Preventive care	Public health programs Community programs Personal lifestyles Primary care settings
Primary care	Physician's office or clinic Community health centers Self-care Alternative medicine
Specialized care	Specialist provider clinics
Chronic care	Primary care settings Specialist provider clinics Home health Long-term care facilities Self-care Alternative medicine
Long-term care	Long-term care facilities Home health
Subacute care	Special subacute units (hospitals, long-term care facilities) Home health Outpatient surgical centers
Acute care	Hospitals
Rehabilitative care	Rehabilitation departments (hospitals, long-term care facilities) Home health Outpatient rehabilitation centers
End-of-life care	Hospice services provided in a variety of settings

health care continuum in the United States remains lopsided, with a heavier emphasis on specialized services than on preventive services, primary care, and management of chronic conditions.

Quest for Quality

Even though the definition and measurement of quality in health care are not as clear-cut as they are in other industries, the delivery sector of health care has come under increased pressure to develop quality standards and demonstrate compliance with those standards. There are higher expectations for improved health outcomes at the individual and community levels. The concept of continual quality improvement has also received much emphasis in managing health care institutions.

Trends and Directions

Since the 1980s, the U.S. health care delivery system has continued to undergo fundamental shifts in emphasis, summarized in **FIGURE 1-4**. Later chapters discuss these transformations in greater detail and focus on the factors driving them.

FIGURE 1-4 Trends and directions in health care delivery.

These trends have been primarily driven by the desire to promote health while reducing costs. An example of a fundamental shift is the concept of health itself. Health is now increasingly seen as the presence of wellness rather than solely the absence of illness. Such a change requires new methods for wellness promotion, although the treatment of illness remains the primary goal of the health care delivery system. The ACA had partially shifted the focus from disease treatment to disease prevention, better health outcomes for individuals and communities, and lower health care costs.

At present, the greatest challenge to the U.S. health care system is the quest to control costs while still meeting the increasing health care demands of an aging population, a population with more chronic diseases and comorbidities. This is challenging because patients are more informed about high-tech discoveries while economic conditions are also more uncertain. In response, players in the health care system have been moving toward providing more effective and efficient quality care. Recent trends have focused more on delivery of services by mid-level health professionals and health coaches as well as use of health information technology. However, the health care system continues to face challenges related to managing costs, focusing on care delivery, adopting new technologies, delivering new operating models, and meeting various federal and state regulations (Deloitte, 2017).

Patients with multiple chronic conditions use the most health services and each chronic condition increases costs by a factor of three (DeVore, 2014). Managing chronic

diseases has been a major focus of efforts to control health care costs. Chronic care models, patient-centered care, and continuous care are being implemented as means to improve health care delivery performance, quality, and patient health outcomes. In particular, patient-centered medical homes (PCMHs) and ambulatory intensive care units (A-ICUs) are being incorporated into accountable care organizations (ACOs). The main objective in establishing these programs is to better manage chronic conditions exclusively within a "clinically integrated, financially accountable primary care practice" (DeVore, 2014). Ultimately, providers hope these measures can address behavioral health needs, lower hospital utilization rates, decrease inpatient bed-days, shorten lengths of stay, limit admissions and readmissions, and minimize emergency department visits.

Mid-level health care professionals and health coaches are important for managing chronic conditions and reducing costs. Health coaches, for examples, complement medical professionals by getting to know patients through one-on-one contact and can keep the clinical staff apprised of financial struggles, issues with housing, family concerns, or other obstacles that may stand in the way of the patient following a prescribed care plan (DeVore, 2014). Health coaches do not need a medical degree, can be recruited from various professional backgrounds, and help improve the effectiveness and efficiency of care.

Similarly, health information technology has helped improve access to information and, consequently, health. The market for telemedicine and remote monitoring applications was estimated to double from $11.6 billion in 2011 to $27.3 billion in 2016 (DeVore, 2014). This growth is in part driven by the increased demands for care owing to expansion of insurance coverage through the ACA; the health system may not have the capacity to treat each individual in person. For example, the Johns Hopkins Hospital at Home program delivers acute care services at the homes of patients with chronic illnesses who might otherwise need inpatient care. In this way, health information technology also increases access to care, particularly for patients living in rural areas where distance to the closest hospital is a major barrier.

Electronic health records have helped provide clinical measures and decision support tools, enabled providers to automate processes to reduce redundancy, and captured more clinical data (DeVore, 2014). Trends toward greater interoperability of health information systems, along with open source interfaces, will allow for greater transparency, increased availability of data, and more creative use of data.

Significance for Health Care Practitioners

An understanding of the intricacies within the health services system would be beneficial to all those who come in contact with the system. In their respective training programs, health professionals, such as physicians, nurses, technicians, therapists, dietitians, and pharmacists may understand their own individual clinical roles but remain ignorant of the forces outside their profession that could significantly impact both current and future clinical practices. An understanding of the health care delivery system can attune

health professionals to their relationship with the rest of the health care environment. It can help them understand changes and the impact of those changes on their own practice. Adaptation and relearning are strategies that can prepare health professionals to cope with an environment that will see ongoing change long into the future, particularly as the U.S. health care system is expected to further evolve under subsequent efforts to reform the system.

Significance for Health Care Managers

An understanding of the health care system has specific implications for both private and public health services managers, who must understand the macro environment in which they make critical planning and management decisions. Such decisions will ultimately affect the efficiency and quality of services delivered. The interactions between the system's key components and the implications of these interactions must be well understood because the operations of health care institutions are strongly influenced, either directly or indirectly, by the financing of health services, reimbursement rates, insurance mechanisms, delivery modes, new statutes and legal opinions, and government regulations.

For the foreseeable future, the environment of health care delivery will remain fluid and dynamic. The viability of delivery and the success of health care managers often depends on how the managers react to the system dynamics. Timeliness of action is often a critical factor that can make the difference between failure and success. Following are some more specific reasons why understanding the health care delivery system is indispensable for health care managers.

Positioning the Organization

Managers need to understand their own organizational position within the macro environment of the health care system. Senior managers, such as chief executive officers, must constantly gauge the nature and impact of the fundamental shifts illustrated in Figure 1-4. Managers need to consider which changes in the current configuration of financing, insurance, payment, and delivery might affect their organization's long-term stability. Middle and first-line managers also need to understand their roles in the current configuration and how these roles might change in the future.

How should resources be realigned to effectively respond to those changes? As an example, managers need to evaluate whether certain functions in their departments must be eliminated, modified, or added. Would the changes involve further training? Which processes are likely to change, and how? Which steps do the managers need to take to maintain the integrity of their institution's mission, the goodwill of the patients they serve, and the quality of care? Well-thought-out and appropriately planned changes are likely to cause less turbulence for both the providers and the recipients of care.

Handling Threats and Opportunities

Changes in any of the functions of financing, insurance, payment, and delivery can

present new threats or opportunities in the health care market. Health care managers will be more effective if they proactively deal with any threats to their institution's profitability and viability. Managers need to find ways to transform certain threats into new opportunities.

Evaluating Implications

Managers are better able to evaluate the implications of health policy and new reform proposals when they understand the relevant issues and appreciate how such issues link to the delivery of health services in the establishments they manage. Health care reform has brought more individuals into the U.S. health care system, creating greater demand for health services. Planning and staffing to ensure the right mix of health care workers are available to meet this anticipated surge in demand are critical.

Planning

Senior managers are often responsible for strategic planning regarding which services should be added or discontinued, which resources should be committed to facility expansion, and what should be done with excess capacity. Any long-range planning must take into consideration the current makeup of health services delivery, the evolving trends, and the potential impact of these trends.

Capturing New Markets

Health care managers will be in a better position to capture new health services markets if they understand emerging trends in the financing, insurance, payment, and delivery functions. New opportunities must be explored before any newly evolving segments of the market become crowded with competition. An understanding of the dynamics within the system is essential to forging new marketing strategies that will let the institution stay ahead of the competition and, in some cases, find a service niche.

Complying with Regulations

Delivery of health care services is heavily regulated. Health care managers must comply with government regulations, such as standards of participation in government programs, licensing rules, and security and privacy laws regarding patient information, and they must operate within the constraints of reimbursement rates. On a periodic basis, the Medicare and Medicaid programs have made drastic changes to their reimbursement methodologies that have triggered the need for operational changes in the way services are organized and delivered. Private agencies, such as the Joint Commission, also play an indirect regulatory role, mainly in the monitoring of quality of services. Health care managers have no choice but to play by the rules set by the various public and private agencies that regulate the health care marketplace. Hence, it is paramount that health care managers acquaint themselves with the rules and regulations governing their areas of operation.

Following the Organizational Mission

Knowledge of the health care system and its development is essential for effective management of health care organizations. By keeping up-to-date on community

needs, technological progress, consumer demand, and economic prospects, managers can be in a better position to fulfill their organizational missions to enhance access, improve service quality, and achieve efficiency in the delivery of services.

Health Care Systems of Other Countries

Except for the United States, the 25 wealthiest nations in the world all have some form of universal health care coverage (Rodin and de Ferranti, 2012). Canada and Western European nations have used three basic models for structuring their national health care systems:

- In a system based on **national health insurance (NHI)**, such as that found 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, NHI requires a tighter consolidation of the financing, insurance, and payment functions coordinated by the government. Delivery is characterized by detached private arrangements.
- In a **national health system (NHS)**, such as that found in the United Kingdom, in addition to financing a tax-supported NHI program, the government manages the infrastructure for the delivery of medical care. Thus, the government operates most of the country's medical institutions. Most health care providers, such as physicians, either are government employees or are tightly organized in a publicly managed infrastructure. In the context of the quad-function model, NHS requires a tighter consolidation of all four functions.
- In a **socialized health insurance (SHI)** system, such as that found in Germany, government-mandated contributions from employers and employees finance health care. Private providers deliver health care services. Private, not-for-profit insurance companies, called sickness funds, are responsible for collecting the contributions and paying physicians and hospitals (Santerre and Neun, 1996). The insurance and payment functions are closely integrated in a SHI system, and the financing function is better coordinated with the insurance and payment functions than in the United States. Delivery is characterized by independent private arrangements, but the government exercises overall control of the system.

In the remainder of this text, the terms "national health care program" and "national health insurance" are used generically and interchangeably to refer to any type of government-supported universal health insurance program. Following is a brief discussion of health care delivery in selected countries from various parts of the world to illustrate the application of the three models discussed and to provide a sample of the variety of health care systems in the world.

Australia

In the past, Australia had switched from a universal national health care program to a privately financed system. In 1984, it

returned to a national program—called Medicare—financed by income taxes and an income-based Medicare levy. This system is built on the philosophy that everyone should contribute to the cost of health care according to his or her capacity to pay. In addition to carrying Medicare, approximately 49% of Australians carry private health insurance (Australian Government, Department of Health, 2016) to cover gaps in public coverage, such as dental services and care received in private hospitals (Willcox, 2001). Although private health insurance is voluntary, it is strongly encouraged by the Australian government through tax subsidies for purchasers and tax penalties for nonpurchasers (Healy, 2002). Public hospital spending is funded by the government, but private hospitals offer better choices. Costs incurred by patients receiving private medical services, whether in or out of the hospital, are reimbursed in whole or in part by Medicare. Private patients are free to choose and change their doctors. The medical profession in Australia is composed mainly of private practitioners, who provide care predominantly on a fee-for-service basis (Hall, 1999; Podger, 1999).

In 2011, the Council of Australian Governments (COAG) signed the National Health Reform Agreement, which established the architecture for national health insurance reform. In particular, the Agreement provides for more sustainable funding arrangements for Australia's health system. At the same time, the National Health Reform Act 2011 establishes a new Independent Hospital Pricing Authority and a National Health Performance Authority. The Pricing Authority determines and publishes the national price for services provided by public hospitals. The Commonwealth Government determines its contribution to funding public hospitals on the basis of these prices. The Performance Authority is charged with monitoring and reporting on the performance of local hospital networks, public and private hospitals, primary health care organizations, and other bodies or organizations that provide health care services. The 2011 act also provides a new statutory framework for the Australian Commission on Safety and Quality in Health Care (Australian Government, 2011).

Australia is focused on developing various health service delivery models to contain costs and provide quality and accessible care (Brownie et al., 2014). Notably, Australia has encouraged interprofessional practice as a means to enhance socioeconomic development and improve health outcomes (Brownie et al., 2014). COAG defined new Australian Health Care Agreements (AHCAs), under which each state and territory funds a portion of the public hospital operation costs, commits to providing equitable access to free public hospital services based on clinical need, and agrees to match the rate of growth in the Australian government's hospital funding (Australian Institute of Health and Welfare, 2017).

Additionally, Australia has developed a National Primary Health Care Strategy and established a Preventative Health Taskforce to lead its National Preventative Health Strategy (Policy Review, 2010). The National Primary Health Care Strategy aims to better incentivize prevention, promote evidence-based management of chronic disease, support the role of general practitioners in health care

teams, encourage a focus on interprofessional team-based care, and address the increased need for access to various health professionals such as practice nurses and allied health professionals, such as physiotherapists and dieticians (Policy Review, 2010). The Preventative Health Taskforce aims to stop the obesity epidemic, reduce the prevalence of daily smoking to less than 9%, reduce the prevalence of binge consumption and other harmful alcohol consumption habits by 30%, and reduce the 17-year life expectancy gap between indigenous and non-indigenous people by the year 2020 (Policy Review, 2010). Other health reforms seek to achieve continuity of care, provide high-quality education and training for existing and incoming health care workers, and embed a culture of interprofessional practice (Brownie et al., 2014).

Canada

Canada implemented its national health insurance system—referred to as Medicare—under the Medical Care Act of 1966. Medicare consists of 13 provincial and territorial health insurance plans, sharing basic standards of coverage, as defined by the Canada Health Act (Health Canada, 2013). The bulk of financing for Medicare comes from general provincial tax revenues; the federal government provides a fixed amount that is independent of actual expenditures. Public-sector health expenditures account for 70% of the total Canadian health care expenditures. The remaining 30% consists of private-sector expenditures, which include household out-of-pocket expenditures, commercial and not-for-profit insurance expenditures, and nonconsumption expenditures (Canadian Institute for Health Information, 2012). Many employers also offer private insurance that gives their employees supplemental coverage.

Provincial and territorial departments of health have the responsibility to administer medical insurance plans, determine reimbursement for providers, and deliver certain public health services. Provinces are required by law to provide reasonable access to all medically necessary services and to provide portability of benefits from province to province. Patients are free to select their providers (Akaho et al., 1998). According to Canada's Fraser Institute, specialist physicians surveyed across 12 specialties and 10 Canadian provinces reported a total waiting time of 20.0 weeks between referral from a general practitioner and delivery of treatment in 2016—an increase from 18.3 weeks in 2015. Patients had to wait the longest to undergo neurosurgery surgery (46.9 weeks) (Barua et al., 2016).

Nearly all the Canadian provinces—Ontario is one of the exceptions—have resorted to regionalization of health care services, through the creation of administrative districts within each province. The objective of regionalization is to decentralize authority and responsibility in order to more efficiently address local needs and to promote citizen participation in health care decision making (Church and Barker, 1998). The majority of Canadian hospitals are operated as private nonprofit entities run by community boards of trustees, voluntary organizations, or municipalities, and most physicians are in private practice (Health Canada, 2013). Most provinces use global budgets and allocate set reimbursement

amounts for each hospital. Physicians are paid fee-for-service rates, which are negotiated between each provincial government and medical association (MacPhee, 1996; Naylor, 1999).

In 2004, Canada created the 10-Year Plan to Strengthen Health Care, which focuses on problems with wait times, health human resources, pharmaceutical management, electronic health records, health innovation, accountability and reporting, public health, and Aboriginal health. Overall, progress has been made in these areas, but the goals have not yet been fully achieved (Health Council of Canada, 2013).

Although most Canadians are quite satisfied with their health care system, sustaining the current health care delivery and financing remains a challenge. Spending on health care has increased dramatically in recent decades, from approximately 7% of program spending at the provincial level in the 1970s to almost 41% in 2015. It is expected to surpass 50% in every province and territory within the next few years (Barua et al., 2016).

With global pressure on health reforms, Canada is also transitioning to patient-centered care (Dickson, 2016), but has not implemented major country-wide health reform since 2005 (Health Systems and Policy Monitor [HSPM], 2012). In addition to leadership challenges, two reasons that Canada has been reluctant to reform its health system are (1) resistance from long-standing professional associations; and (2) a lack of follow-through from provincial governments (Dickson, 2016).

The 2014 version of the Canada Heath Act expanded services such as nursing home intermediate care, adult residential care, home care services, and ambulatory care services (Canada Minister and Attorney General, 2016). Other initiatives include collaboration between provincial and territorial governments to purchase drugs in bulk and cut costs in order to make drugs more affordable to patients and also a program to improve access to high-quality mental health services, particularly for veterans and first-responders (Granovsky, 2016).

China

Since the economic reforms initiated in the late 1970s, health care in the People's Republic of China has undergone significant changes. In urban China, health insurance has evolved from a predominantly public insurance (either government or public enterprise) system to a multipayer system. Government employees are covered under government insurance as a part of their benefits. Employees for public enterprises are largely covered through public enterprise insurance, but the actual benefits and payments vary according to the financial well-being of the enterprises. Employees of foreign businesses or joint ventures are typically well insured through private insurance arrangements. Almost all of these plans contain costs through a variety of means, such as experience-based premiums, deductibles, copayments, and health benefit dollars (i.e., pre-allocated benefit dollars for health care that can be converted into income if not fully used). The unemployed, self-employed, and employees working for small enterprises (public or private) are largely uninsured. They can purchase individual or family plans in the private market or pay for services out of

pocket. In rural China, the New Cooperative Medical Scheme (NCMS), discussed later, has become widespread; it relies on funds pooled from national and local governments, as well as private citizens. Although the insurance coverage rate is high (more than 90%) in China, the actual benefits are still very limited.

Similarly to the United States, China has been facing the growing problems of a large uninsured population and health care cost inflation. Although health care funding was increased by 87% in 2006 and 2007, the country has yet to reform its health care system into an efficient and effective scheme. Employment-based insurance in China does not cover dependents, nor does it cover migrant workers, leading to high out-of-pocket cost sharing as part of total health spending. Rural areas in China are most vulnerable to poor access to health care because of a lack of true insurance plans and accompanying comprehensive coverage. Health care cost inflation is also growing 7% faster than the growth rate for China's gross domestic product (GDP), which is 16% per year (Yip and Hsiao, 2008).

In recent years, health care delivery in China has undergone significant changes. The former three-tier referral system (primary, second, tertiary) has been largely abolished. Patients can now go to any hospital of their choice as long as they are insured or can pay out of pocket. As a result, large (tertiary) hospitals are typically overutilized, whereas smaller (primary and secondary) hospitals are underutilized. Use of large hospitals contributes to both escalation of medical costs and greater medical specialization.

Major changes in health insurance and delivery have made access to medical care more difficult for the poor, uninsured, and underinsured. Consequently, wide and growing disparities in access, quality, and outcomes are becoming apparent between rural and urban areas, and between the rich and the poor. After the severe acute respiratory syndrome (SARS) epidemic in 2003, the Chinese government created an electronic disease-reporting system at the district level. Each district in China now has a hospital dedicated to infectious diseases. However, these are still flaws in this system, particularly in monitoring infectious diseases in the remote localities that comprise some districts (Blumenthal and Hsiao, 2005).

To fix some of its problems, the Chinese government has pushed through health reform initiatives in five major areas: health insurance, pharmaceuticals, primary care, public health, and public/community hospitals. For example, it created the New Cooperative Medical Scheme to provide rural areas with a government-run voluntary insurance program. This program is intended to prevent individuals living in these areas from becoming impoverished due to illness or catastrophic health expenses (Yip and Hsiao, 2008). In 2008, a similar program was established in urban areas, called the Urban Resident Basic Medical Insurance scheme. It targets uninsured children, elderly persons, and other nonworking urban residents and enrolls them into the program at the household level rather than at the individual level (Wagstaff et al., 2009).

To improve access to primary care, China has reestablished community health centers (CHCs) that provide preventive and primary care services so patients no longer need to seek expensive

outpatient services at hospitals. The goal is to reduce hospital utilization and increase CHCs that can provide prevention, home care, and rehabilitative services (Yip and Hsiao, 2008; Yip and Mahal, 2008). The CHCs have not been very popular among the public because of their perceived lack of quality and because of their poor reputation from perceived lack of quality. It remains uncertain whether China will restore its previously integrated health care delivery system, aimed at achieving universal access, or continue on its current course toward greater medical specialization and privatization.

Another major component of Chinese health reform has been the establishment of an essential drug system that aims to enhance access to and reduce out-of-pocket spending for essential medicines. The reform policies specified a comprehensive system including selection, procurement, pricing, prescription, and quality and safety standards (Barber et al., 2013).

In terms of public hospital reform, quality, efficiency, and development of a hospital governance structure have been emphasized. Several pilot reforms have been launched in various cities in China, but no national implementation plan has been formulated (Yip et al., 2012).

China's National Health and Family Planning Commission (previously the Ministry of Health) and State Council have detailed several health reform objectives, such as constraining drug prices, enhancing the affordability of medical services at public hospitals, and improving staff performance (Hsu, 2015). Eliminating markups on drug sales in hospitals has led to financial losses in country-level pilot programs, although government subsidies to these programs have increased.

In 2012, China lifted restrictions on foreign investments in private hospitals in an effort to increase the number of hospitals and improve access to care (Hsu, 2015). By 2015, the State Council aimed to increase use of private health services by 20%. Health insurance reform is also being developed. The Chinese government plans to give tax breaks to private health insurance policyholders in an attempt to increase insurance coverage. Some of these tax breaks include allowing those privately insured to deduct 2,400 Renminbi per year from their assessable income for health insurance premiums (Hsu, 2015).

In 2015, China announced a 5-year plan for the health system, which outlined key areas for development by 2020 (Zhu, 2015). Despite broad reforms, the Chinese health care system continues to be plagued by resource shortages and underdevelopment in rural areas. Thus, the latest reforms target three main areas: infrastructure development, reduction of costs expansion of insurance coverage, and investment in novel technologies. Importantly, these reforms will open up new opportunities for foreign investments.

Germany

Health insurance has been mandatory for all citizens and permanent residents in Germany since 2009 (Blumel and Busse, 2016). As mentioned earlier, the German health care system is based on the SHI model, and voluntary substitutive private health insurance is available. "About 86 percent of the population receive their

primary coverage through SHI and 11 percent through substitutive PHI" and there are also special programs to cover the rest of the population (Blumel and Busse, 2016). Sickness funds act as purchasing entities by negotiating contracts with hospitals. However, paying for the increasing costs of medical care has proved challenging in Germany because of an aging population, fewer people in the workforce, and stagnant wage growth during recessions.

During the 1990s, Germany adopted legislation to promote competition among sickness funds (Brown and Amelung, 1999). To further control costs, its national system employs global budgets for the hospital sector and places annual limits on spending for physician services. Inpatient care is paid per admission based on diagnosis-related groups (DRGs)—a system that was made obligatory in 2004 (Blumel and Busse, 2016).

Health reforms in Germany have focused on improving the efficiency and appropriateness of care. In 2011, the Pharmaceutical Market Reform Act introduced an assessment scheme for all new pharmaceuticals, under which only those drugs that offer additional benefits relative to existing alternatives can be reimbursed at a higher rate (World Health Organization [WHO], 2014). The Hospital Financing Reform Act of 2009 requires performance-based flat-rate grants for investments in hospitals, rather than non-performance-based flat-rate grants on a case-by-case basis as of 2012 (WHO, 2014).

One of Germany's biggest challenges is the division between SHI and private health insurance. The differences in risk pools, financing structures, access, and provisions in these alternative insurance plans contribute to inequalities in care (WHO, 2014). Additionally, more work is needed to improve quality of medical services, patient satisfaction, and accessibility of health services in rural communities (WHO, 2014).

The most recent reforms in Germany have focused on improving services for SHI-covered patients and enhancing hospital quality. In June 2015, the Act to Strengthen SHI Health Care Provision gave municipalities the right to establish medical treatment centers, gave patients the right to see a specialist within 4 weeks, and promoted innovative forms of care in an effort to strengthen services for SHI-covered patients (HSPM, 2016). This act improves prevention services and health promotion through investments in schools, the workplace, and long-term care facilities. In addition, the 2016 Hospital Care Structure Reform Act introduced quality aspects in the regulation of hospital volume and payments (Blumel and Busse, 2016). Substantial funds will be invested to improve the hospital care structure in Germany.

United Kingdom

The United Kingdom follows the national health system model. Its health delivery system is called the National Health Service (NHS). The NHS is founded on the principles of primary care and has a strong focus on community health services. The system owns its hospitals and employs its hospital-based specialists and other staff on a salaried basis. The primary care physicians, referred to as general practitioners (GPs), are mostly private practitioners. All NHS-insured patients are required to register with a local GP. In 2014, there were

on average 7,171 patients per practice and 1,530 patients per GP (Thorlby and Arora, 2016).

The NHS emphasizes free point of access and equal access to all (HSPM, 2015). In England, the Health and Social Care Act abolished the Primary Care Trust and Strategic Health Authority in 2012, replacing them with the Clinical Commissioning Group. In 2013, the Better Care Fund was enacted to improve integration of health and social care. In 2014, the Care Act was introduced to cap out-of-pocket expenditures (HSPM, 2015).

Delivery of primary care occurs through primary care trusts (PCTs) in England, local health groups in Wales, health boards in Scotland, and primary care partnerships in Northern Ireland. PCTs have geographically assigned responsibility for community health services; each person living in a given geographic area is assigned to a particular PCT. A typical PCT is responsible for approximately 50,000 to 250,000 patients (Dixon and Robinson, 2002). PCTs function independently of the local health authorities and are governed by a consumer-dominated board. A fully developed PCT has its own budget allocations, used for both primary care and hospital-based services. In this respect, PCTs function like MCOs in the United States.

Approximately 83% of U.K. health expenditures in 2013 went to the public sector (Office of National Statistics, 2015). Private expenditures involve mainly drugs and other medical products as well as private hospital care. Despite having a national health care system, 10.9% of the British population maintains private health insurance (Arora et al., 2013).

England, Scotland, Wales, and Northern Ireland are taking their own approaches to health care. England is moving toward decentralization, reinforcement of an internal market, and more localized decision making (HSPM, 2015). Scotland and Wales are dissolving the internal market and centralizing authority. While Scotland is embracing a publicly funded universal health system, England is emphasizing private partnerships and internal competition. Costs are increasing in the United Kingdom owing to infrastructure improvements, technology innovations, an aging and growing population, more patients with chronic diseases, heightened focus on quality of care, informed and empowered consumers, and innovative treatments (Deloitte, 2017).

In 2014, NHS England introduced the Five Year Forward View plan, which lays out strategies for addressing the most pressing challenges in the health care system (National Health Services England, 2015). This plan places a greater emphasis on prevention, integration of services, and patient-centered care. It sets out strategies and new care models whose goals include integrating primary and acute care systems, creating multispecialty community providers, and fostering collaborations in acute care. These models will redesign services and change the way health services are administered, financed and regulated in coming years.

Israel

Until 1995, Israel had a system of universal coverage based on the German SHI model, financed through an employer tax and income-based contributions from individuals. When the National Health

Insurance (NHI) Law went into effect in 1995, it made insurance coverage mandatory for all Israeli citizens. Adults are required to pay a health tax. General tax revenues supplement the health tax revenues, which the government distributes to the various health plans based on a capitation formula. Each year, the government determines how much from the general tax revenue should be contributed toward the NHI. In 2013, public funds accounted for 60% of NHI revenues. The remaining share came from individuals' copayments, supplemental health insurance, and sales of health products (Rosen, 2016).

Health plans (or sickness funds) offer a predefined basic package of health care services and are prohibited from discriminating against those who have preexisting medical conditions. Recent reforms have added mental health and dental care for children to the benefits package (WHO, 2015). The capitation formula has built-in incentives for the funds to accept a larger number of elderly and chronically ill members. Rather than relying on a single-payer system, the health care reform supported the development of multiple health plans (today there are four competing, nonprofit sickness funds) to foster competition among funds, under the assumption that competition would lead to better quality of care and an increased responsiveness to patient needs. The plans also sell private health insurance to supplement the basic package. The system is believed to provide a high standard of care (Rosen et al., 2016).

Israel has a highly efficient health care system due to the regulated competition between the health plans, the country's strict regulatory controls on the supply of hospital beds, its accessible and high-quality primary care, and its reliance on electronic health records (WHO, 2015). In 2014, the Ministry of Health created a national health information exchange for sharing clinical patient data across all general hospitals, health plans, and other providers in the country. Emerging challenges include an increasing reliance on private financing, which affects equity and efficiency, the need to expand public financing and improve the efficiency of the public system, reduction of health inequalities, and goals related to measuring and improving quality of hospital care, reducing surgical waiting times, and enhancing dissemination of comparative data on performance (WHO, 2015).

Japan

Since 1961, Japan has been providing universal coverage to its citizens through two main health insurance schemes: (1) an employer-based system, modeled after Germany's SHI program; and (2) a national health insurance program. Generally, large employers (with more than 300 employees) have their own health programs. Nearly 2,000 private, nonprofit health insurance societies manage insurance for large firms. Smaller companies either band together to provide private health insurance or belong to a government-run plan. Day laborers, seamen, agricultural workers, the self-employed, and retirees are all covered under the national health care program. Individual employees pay roughly 8% of their salaries as premiums and receive coverage for approximately 90% of the cost of medical services, with some limitations. Dependents receive slightly less than 90% coverage. Employers

and the national government subsidize the cost of private premiums. Coverage is comprehensive, including most dental care and approved prescription drugs, and patients are free to select their providers (Matsuda, 2016). Providers are paid on a national fee-for-service basis set by the government, and have little control over reimbursement (Ikegami and Anderson, 2012).

Several health policy issues have emerged in Japan in the past few years. First, since 2002, some business leaders and economists have urged the Japanese government to lift its ban on mixed public/private payments for medical services, arguing that private payments should be allowed for services not covered by medical insurance (i.e., services involving new technologies or drugs). The Japan Medical Association and the Ministry of Health, Labor, and Welfare have argued against these recommendations, stating such a policy would favor the wealthy and create disparities in access to care. Although the ban on mixed payments has not been lifted, Prime Minister Koizumi expanded the existing "exceptional approvals system" for new medical technologies in 2004 to allow private payments for selected technologies not covered by medical insurance (Nomura and Nakayama, 2005).

Another policy development in Japan is hospitals' increased use of a system of reimbursement for inpatient care services, called diagnosis-procedure combinations (DPCs). With the DPCs, hospitals receive daily fees for each condition and treatment, proportionate to patients' length of stay regardless of actual provision of tests and interventions. In theory, the DPC system will incentivize hospitals to become more efficient (Nomura and Nakayama, 2005).

Japan's economic stagnation in the last several years has led to an increased pressure to contain the country's health care costs (Ikegami and Campbell, 2004). In 2005, Japan implemented reform initiatives in long-term care (LTC) delivery in an effort to contain the rapidly rising costs in this growing health care sector. The policy required residents in LTC facilities to pay for room and board. It also established new preventive benefits for seniors with low needs. Charging nursing home residents a fee for room and board was a departure from past policies, which had promoted institutionalization of elderly individuals (Tsutsui and Muramatsu, 2007).

Despite their overall success, Japan's health and long-term care systems face sustainability issues similar to those found in the United States, including rising costs and increasing demands for services. The Japanese government is considering and pursuing several options: preventive services, promotion of community-based services, and increases in taxes, premiums, and fees. In 2011, reform centered on the comprehensive community care model was implemented. This model ensures access to long-term care, medical or hospital care, preventive services, residential care facilities, and "life support" (or legal services) within a community where an elder lives. The focus on prevention and service consolidation is expected to result in health populations and, therefore, decreased use of more expensive services.

More recently, health reforms in Japan have introduced the general practitioner (GP) and family physician (FP)

system. Starting in 2017, the Japan Primary Care Society will run a training program to qualify doctors as GP/FP specialists (Takamura, 2015). By permitting the Japan Primary Care Society to run this program, the Japanese government aims not only to increase the number of systematically trained GPs/FPs, but also to maintain good community care, improve health outcomes through prevention and primary care, and lower medical expenses. Challenges arising from the GP/FP reform include questions about where to place GPs and FPs (clinics or hospitals), how organ-specialists currently providing primary care will be affected, and whether the GP/FP culture will be accepted by Japanese patients and citizens at large.

Singapore

Prior to 1984, Singapore had a British-style NHS program, in which medical services were provided mainly by the public sector and financed through general taxes. Since then, the nation has designed a system based on market competition and self-reliance. Singapore has achieved universal coverage through a policy that requires mandatory private contributions but little government financing. The program, known as Medisave, mandates every working person, including the self-employed, to deposit a portion of earnings into an individual Medisave account. Employers are required to match employee contributions. These savings can be withdrawn only for two purposes: (1) to pay for hospital services and some selected, expensive physician services; or (2) to purchase a government-sponsored insurance plan, called MediShield, for catastrophic (expensive and major) illness. For basic and routine services, people are expected to pay out of pocket. Out-of-pocket expenditures can be quite high, as only 38% of health spending is publicly funded (Salkeld, 2014). Those who cannot afford to pay for health care services receive government assistance (Hsiao, 1995). In 2002, the government introduced ElderShield, which defrays out-of-pocket medical expenses for elderly persons and severely disabled individuals who require long-term care (Singapore Ministry of Health, 2007). The fee-for-service system of payment is widely used throughout Singapore (McClellan and Kessler, 1999).

In 2006, the Ministry of Health launched the Chronic Disease Management Program. By November 2011, this program covered 10 chronic diseases, including mental health illnesses. More than 700 GP clinics and GP groups are supported by the Ministry to provide comprehensive chronic disease management to patients. Patients can use their own Medisave accounts or their family members' accounts to pay for outpatient services under the program (Singapore Ministry of Health, 2012).

Future challenges in Singapore include adjusting copayments to avoid discouraging patients from seeking necessary primary care and preventive services that might lower their risk of developing chronic diseases. Overall, Singapore faces the challenge of ensuring positive health outcomes and containing costs given an aging population that is facing an increased prevalence of chronic disease (Tan et al., 2014).

Developing Countries

Developing countries, which are home to almost 85% of the world's population, are responsible for only 11% of the world's total health spending—even though they account for 93% of the worldwide burden of disease. The six developing regions of the world are East Asia and the Pacific, Europe (mainly Eastern Europe) and Central Asia, Latin America and the Caribbean, the Middle East and North Africa, South Asia, and sub-Saharan Africa. Of these regions, the latter two have the least resources and the greatest health burden. On a per-capita basis, industrialized countries have six times as many hospital beds and three times as many physicians than do developing countries. People with private financial means can find reasonably good health care in many parts of the developing world. Unfortunately, the majority of the populations have to depend on limited government services that are often of questionable quality, when evaluated by Western standards. As a general observation, government financing for health services increases in countries with higher per-capita incomes (Schieber and Maeda, 1999).

Developing countries are moving toward adopting universal health coverage to decrease the financial impoverishment due to health spending, improve health, and increase access to care (Lagomarsino et al., 2012). Trends in health reforms in developing countries include increasing enrollment in government-sponsored health insurance, expanded benefits packages, decreasing out-of-pocket expenditures, and increasing the government's share of health spending. Countries that have successfully met the Millennium Development Goals—the world's time-bound and quantified targets for addressing extreme poverty in its many dimensions (income poverty, hunger, disease, lack of adequate shelter, and exclusion) while promoting gender equality, education, and environmental sustainability—have used a comprehensive set of strategies to reduce maternal and child mortality, improve health financing, address workforce challenges, and improve quality of care (Ahmed et al., 2016).

Global Health Challenges and Reform

There is a huge gap in health care and health status between developing and developed countries. For example, in 2014, the global life expectancy at birth was 71.4 years of age, but life expectancy in the African region was only 60 years (WHO, 2016). In that same year, infant mortality rates varied between 2 deaths per 1,000 live births and 110 deaths per 1,000 live births. There were also wide variations in health care for pregnant women, availability of skilled health personnel for childbirth, and access to medicine.

The poor quality and low efficiency of health care services in many countries—especially services provided by the public sector, which is often the main source of care for poor people—have become a serious issue for decision makers in these countries (Sachs, 2012). This issue, combined with the rising out-of-pocket costs and high numbers of uninsured, has forced many governments to launch health care reform efforts. Many low and middle-income countries are moving

toward universal health coverage (Lagomarsino et al., 2012). Even so, international health assistance continues to play a significant role in health care in many developing countries. Global aid for health care increased from $10 billion in 2000 to $27 billion in 2010 (Sachs, 2012), but then began to decrease in 2011 because of a global recession (Organization for Economic Cooperation and Development [OECD], 2012).

Since 1999, the Bill and Melinda Gates Foundation (2017) has invested $7 billion in international health delivery programs. This foundation's focus is on coordination of delivery efforts, strengthening of country health systems, and building of integrated delivery systems. Funded initiatives include community health worker programs, information and communications technology, and investment into data systems. From 2010 to 2015, USAID dedicated $50 billion to strengthening international health systems. This U.S. agency set forth a plan for continuing its progress, from 2015 to 2019, by strengthening six interrelated health system functions: (1) human resources for health; (2) health finance; (3) health governance; (4) health information; (5) medical products, vaccines, and technologies; and (6) service delivery (USAID, 2015). The ultimate goal of that initiative is to strengthen these systems so they will contribute to positive health outcomes and create an environment for universal health coverage.

The Systems Framework

A **system** consists of a set of interrelated and interdependent, logically coordinated components designed to achieve common goals. 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 using a systems model. The systems framework used here helps one understand that the structure of health care services in the United States is based on some foundations, 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 feature of a dynamic system. This systems framework is used as the conceptual base for organizing later chapters in this text (**FIGURE 1-5**).

System Foundations

The current health care system is not an accident. Historical, cultural, social, and economic factors explain its current structure. These factors also affect forces that shape new trends and developments, as well as those that impede change. The chapters titled *Beliefs, Values, and Health* and *The Evolution of Health Services in the United States* provide a discussion of the system foundations.

System Resources

No mechanism for health services delivery can fulfill its primary objective without deploying the necessary human and nonhuman resources. Human resources consist of the various types and categories of workers directly engaged in the

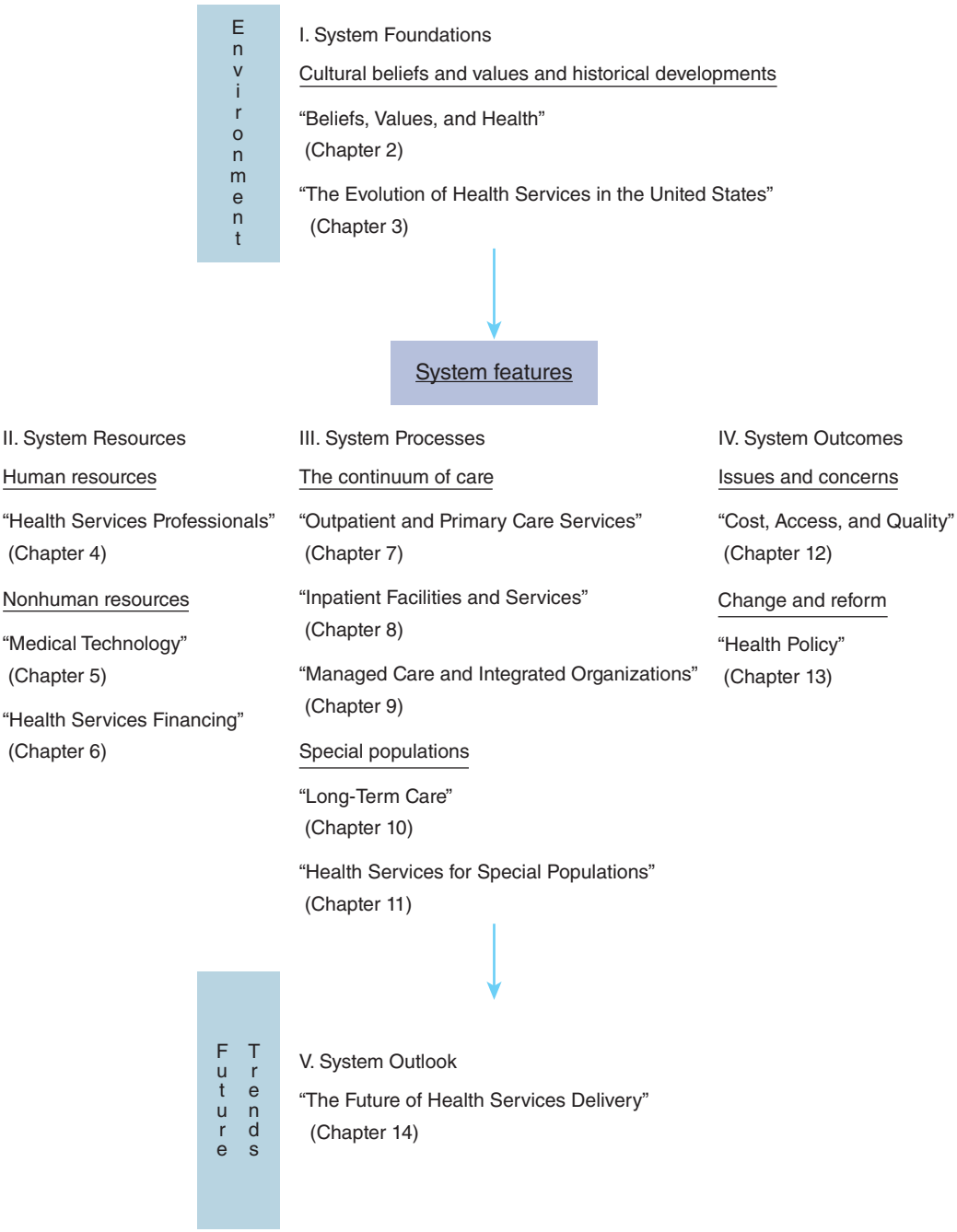


FIGURE 1-5 The systems model and related chapters.

delivery of health services to patients. Such personnel—physicians, nurses, dentists, pharmacists, other doctoral-trained professionals, and numerous categories of allied health professionals—usually have direct contact with patients. Numerous ancillary workers—billing and collection agents, marketing and public relations personnel, and building maintenance employees—often play important, but indirect, supportive roles in the delivery of health care. Health care managers are needed to manage various types of health care services. This text primarily discusses the personnel engaged in the direct delivery of health care services (*Health Services Professionals* chapter). The nonhuman resources include medical technology and health services financing (discussed in the chapters with those titles, respectively).

Resources are closely intertwined with access to health care. For instance, in certain rural areas of the United States, access is restricted due to a shortage of health professionals within certain categories. Development and diffusion of technology also determine the caliber of health care to which people may have access. Financing for health insurance and reimbursement to providers affect access indirectly.

System Processes

System resources influence the development and change in the physical infrastructure—such as hospitals, clinics, and nursing homes—essential for the different processes of health care delivery. Most health care services are delivered in noninstitutional settings, mainly associated with processes referred to as outpatient care (*Outpatient and Primary Care Services* chapter). Institutional health services provided in hospitals, nursing homes, and rehabilitation institutions, for example, are predominantly inpatient services (*Inpatient Facilities and Services* chapter). Managed care and integrated systems (discussed in the chapter with that title) represent a fundamental change in the financing (including payment and insurance) and delivery of health care. Special institutional and community-based settings have been developed for long-term care (discussed in the chapter with that title). Delivery of services should be tailored to meet the special needs of certain vulnerable population groups (*Health Services for Special Populations* chapter).

System Outcomes

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

System Outlook

A dynamic health care system must be forward looking. In essence, it must

project into the future the accomplishment of desired system outcomes in view of anticipated social, economic, political, technological, informational, ecological, anthro-cultural, and global forces of change (*The Future of Health Services Delivery* chapter).

Summary

The United States has a unique system of health care delivery. Its basic features characterize it as a patchwork of subsystems. Health care is delivered through an amalgam of private and public financing, through private health insurance and public insurance programs; the latter programs are reserved for special groups. Contrary to popular opinion, health care delivery in the United States is not governed by free-market principles; at best, it is an imperfect market. Yet, the system is not dominated or controlled by a single entity as would be the case in national health care systems.

No country in the world has a perfect health care insurance system, and most nations with a national health care program also have a private sector that varies in size. Because of resource limitations, universal access remains a theoretical concept even in countries that offer universal health insurance coverage. The developing countries of the world also face serious challenges due to the scarcity of resources and strong underlying needs for services in those nations.

Health care managers must understand how the health care delivery system works and evolves. Such an understanding can help them maintain a strategic position within the macro environment of the health care system. The systems framework provides an organized approach to an understanding of the various components of the U.S. health care delivery system.

Test Your Understanding

Terminology

access
administrative costs
balance bill
defensive medicine
demand
enrollee
free market
global budgets
health care reform
health plan
managed care
Medicaid
Medicare
moral hazard
national health insurance (NHI)
national health system (NHS)
need
package pricing
phantom providers
premium cost sharing
primary care
provider
provider-induced demand
quad-function model
reimbursement
single-payer system
socialized health insurance (SHI)
standards of participation
system
third-party
uninsured
universal access
universal coverage
utilization

Review Questions

1. Why does cost containment remain an elusive goal in U.S. health services delivery?
2. What are the two main objectives of a health care delivery system?
3. Name the four basic functional components of the U.S. health care delivery system. Which role does each play in the delivery of health care?
4. What is the primary reason for employers to purchase insurance plans to provide health benefits to their employees?
5. Why is it that, despite public and private health insurance programs, some U.S. citizens are without health care coverage?
6. What is managed care?
7. Why is the U.S. health care market referred to as "imperfect"?
8. Discuss the intermediary role of insurance in the delivery of health care.
9. Who are the major players in the U.S. health services system? What are the positive and negative effects of the often conflicting self-interests of these players?
10. Which main roles does the government play in the U.S. health services system?
11. Why is it important for health care managers and policymakers to understand the intricacies of the health care delivery system?
12. What is the difference between national health insurance (NHI) and a national health system (NHS)?
13. What is socialized health insurance (SHI)?
14. Provide a general overview of the Affordable Care Act. What is its main goal?

References

Ahmed, S. M., et al. 2016. Cross-country analysis of strategies for achieving progress towards global goals for women's and children's health. *Bulletin of the World Health Organization* 94, no. 5: 351–361.

Akaho, E., et al. 1998. A proposed optimal health care system based on a comparative study conducted between Canada and Japan. *Canadian Journal of Public Health* 89, no. 5: 301–307.

Altman, S. H., and U. E. Reinhardt. 1996. Introduction: Where does health care reform go from here? An uncharted odyssey. In: *Strategic choices for a changing health care system*. S. H. Altman and U. E. Reinhardt, eds. Chicago, IL: Health Administration Press. pp. xxi–xxxii.

Altman, S. H., and S. S. Wallack. 1996. Health care spending: Can the United States control it? In: *Strategic choices for a changing health care system*. S. H. Altman and U. E. Reinhardt, eds. Chicago, IL: Health Administration Press. pp. 1–32.

American Association of Colleges of Pharmacy. 2017. *Academic pharmacy's vital statistics*. Available at: http://www.aacp.org/about/Pages/Vitalstats.aspx. Accessed April 2017.

American Dental Association. 2017. *Education*. Available at: http://www.ada.org/en/science-research/health-policy-institute/dental-statistics/education. Accessed April 2017.

Arora, S., et al. 2013. *Public payment and private provision: The changing landscape of health care in the 2000s.* Nuffield Trust. Available at: https://www.nuffieldtrust.org.uk/research/public-payment-and-private-provision-the-changing-landscape-of-health-care-in-the-2000s. Accessed February 2017.

Association of American Medical Colleges. 2017. *2016 data book*. Available at: https://www.aamc.org/data/databook/tables/. Accessed April 14, 2017.

Australian Government. 2011. *Improving primary health care for all Australians.* Canberra, Australian: Commonwealth of Australia. Available at: http://www.g21.com.au/sites/default/files/dmdocuments/ImprovingPHCforallAustralians.pdf. Accessed April 14, 2017.

Australian Government, Department of Health. 2016. *Department of Health annual report 2015–16.* Canberra, Australia: Commonwealth of Australia. Available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/annual-report2015-16. Accessed February 2017.

Australian Institute of Health and Welfare. 2017. *Australia's health system*. Available at: http://www.aihw.gov.au/australias-health/2016/health-system/. Accessed April 14, 2017.

Barber, S. L., et al. 2013. The reform of the essential medicines system in China: A comprehensive approach to universal coverage. *Journal of Global Health* 3, no. 1: 10303.

Barua, B., et al. 2016. *The sustainability of health care spending in Canada*. Vancouver, Canada: Fraser Institute.

Bill and Melinda Gates Foundation. 2017. *Integrated delivery strategy system.* Available at: http://www.gatesfoundation.org/What-We-Do/Global-Development/Integrated-Delivery. Accessed February 2017.

Blumel, M., and R. Busse. 2016. *The German health care system*. The Commonwealth Fund. Available at: http://international.commonwealthfund.org/countries/germany/. Accessed February 2017.

Blumenthal, D., and W. Hsiao. 2005. Privatization and its discontents: The evolving Chinese health care system. *New England Journal of Medicine* 353, no. 11: 1165–1170.

Brown, L. D., and V. E. Amelung. 1999. "Manacled competition": Market reforms in German health care. *Health Affairs* 18, no. 3: 76–91.

Brownie, S., et al. 2014. Australian health reforms: Enhancing interprofessional practice and competency within the health workforce. *The Journal of Interprofessional Care* 28, no. 3: 252–253.

Canada Minister and Attorney General. 2016. *Canada Health Act.* Available at: http://laws-lois.justice.gc.ca/eng/acts/c-6/. Accessed April 14, 2017.

Canadian Institute for Health Information. 2012. *National health expenditure trends, 1975 to 2012.* Ottawa, ON: The Institute. Available at: https://secure.cihi.ca/free_products/NHEXTrendsReport2012EN.pdf. Accessed December 16, 2013.

Centers for Medicare and Medicaid. 2015. *National health expenditures 2015 highlights.* Available at: https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/downloads/highlights.pdf. Accessed February 2017.

Church, J., and P. Barker. 1998. Regionalization of health services in Canada: A critical perspective. *International Journal of Health Services* 28, no. 3: 467–486.

Cohen, R. A., et al. 2016. *Health insurance coverage: Early release of estimates from the National Health Interview Survey, January–March 2016.* National Center for Health Statistics. Available at: http://www.cdc.gov/nchs/nhis/releases.htm. Accessed February 2017.

Deloitte. 2017. *2017 global health care sector outlook: Making progress against persistent challenges.* Available at: https://www2.deloitte.com/global/en/pages/life-sciences-and-healthcare/articles/global-health-care-sector-outlook.html. Accessed February 2017.

DeVore, S. 2014. *The changing health care world: Trends to watch in 2014.* Available at: http://healthaffairs.org/blog/2014/02/10/the-changing-health-care-world-trends-to-watch-in-2014/. Accessed May 2, 2016.

Dickson, G. 2016. Health reform in Canada: Enabling perspectives for health leadership. *Healthcare Manage Forum* 29, no. 2: 53–58.

Dixon, A., and R. Robinson. 2002. The United Kingdom. In: *Health care systems in eight*

countries: Trends and challenges. A. Dixon and E. Mossialos, eds. London, UK: European Observatory on Health Care Systems, London School of Economics & Political Science. pp. 103–114.

Feldstein, P. J. 1993. *Health care economics*. 4th ed. New York, NY: Delmar.

Granovsky, D. 2016. A new government: A new open and collaborative era? *Canadian Nurse* 112, no. 1: 15–18.

Hall, J. 1999. Incremental change in the Australian health care system. *Health Affairs* 18, no. 3: 95–110.

Health Canada. 2013. Available at: http://laws-lois.justice.gc.ca/eng/acts/C-6/index.html. Accessed July 2013.

Health Council of Canada. 2013. *Progress report 2013.* Available at: http://www.healthcouncilcanada.ca/rpt_det.php?id=481. Accessed July 2013.

Health Resources and Services Administration (HRSA). 2015. *2015 health center data: Health center program grantee data.* Available at: https://bphc.hrsa.gov/uds/datacenter.aspx. Accessed February 2017.

Health Systems and Policy Monitor (HSPM). 2012. *Health systems in transition (HiT) profile of Canada.* Available at: http://www.hspm.org/countries/canada22042013/livinghit.aspx?Section=6.1%20Analysis%20of%20recent%20reforms&Type=Section. Accessed April 14, 2017.

Health Systems and Policy Monitor (HSPM). 2015. *United Kingdom.* Available at: http://www.hspm.org/countries/england11032013/countrypage.aspx. Accessed May 17, 2016.

Health Systems and Policy Monitor (HSPM). 2016. *Country page: Germany.* Available at: http://www.hspm.org/countries/germany28082014/countrypage.aspx. Accessed February 2017.

Healy, J. 2002. Australia. In: *Health care systems in eight countries: Trends and challenges*. A. Dixon and E. Mossialos, eds. London, UK: European Observatory on Health Care Systems, London School of Economics & Political Science. pp. 3–16.

Hemenway, D., and D. Fallon. 1985. Testing for physician-induced demand with hypothetical cases. *Medical Care* 23, no. 4: 344–349.

Hsiao, W. C. 1995. Medical savings accounts: Lessons from Singapore. *Health Affairs* 14, no. 2: 260–266.

Hsu, S. 2015. *China's health care reforms.* Available at: http://thediplomat.com/2015/05/chinas-health-care-reforms/. Accessed May 17, 2016.

Ikegami, N., and G. F. Anderson. 2012. In Japan, all-payer rate setting under tight government control has proved to be an effective approach to containing costs. *Health Affairs* 31, no. 5: 1049–1056.

Ikegami, N., and J. C. Campbell. 2004. Japan's health care system: Containing costs and attempting reform. *Health Affairs* 23: 26–36.

Impact of Obamacare on coverage. 2016. *Congressional Digest* 95, no. 3: 7–32.

Kaiser Family Foundation. 2017. *Current status of state Medicaid expansion decisions.* Available at: http://kff.org/health-reform/slide/current-status-of-the-medicaid-expansion-decision/. Accessed February 2017.

Lagomarsino, G., et al. 2012. Moving towards universal health coverage: Health insurance reforms in nine developing countries in Africa and Asia. *Lancet* 380, no. 9845, 933–943.

MacPhee, S. 1996. Reform the watchword as OECD countries struggle to contain health care costs. *Canadian Medical Association Journal* 154, no. 5: 699–701.

Matsuda, R. 2016. The Japanese health care system, 2015. In: *International profiles of health care systems, 2015.* E. Mossialos, M. Wenzl, R. Osborn, and D. Sarnak, eds. New York, NY: The Commonwealth Fund. pp. 107–114. Available at: http://www.commonwealthfund.org/~/media/files/publications/fund-report/2016/jan/1857_mossialos_intl_profiles_2015_v7.pdf. Accessed February 2017.

McClellan, M., and D. Kessler. 1999. A global analysis of technological change in health care: The case of heart attacks. *Health Affairs* 18, no. 3: 250–257.

National Health Services England. (2015). Five Year Forward View: Time to deliver. Available at: https://www.england.nhs.uk/wp-content/uploads/2015/06/5yfv-time-to-deliver-25-06.pdf. Accessed February 2017.

Naylor, C. D. 1999. Health care in Canada: Incrementalism under fiscal duress. *Health Affairs* 18, no. 3: 9–26.

Nomura, H., and T. Nakayama. 2005. The Japanese healthcare system. *BMJ* 331: 648–649.

Office of National Statistics. 2015. *Expenditure on healthcare in the UK, 2013*. Available at: https://

socialwelfare.bl.uk/subject-areas/services-activity/health-services/ons/176574dcp171766_399822.pdf. Accessed April 2017.

Organization for Economic Cooperation and Development (OECD). 2012. *Development: Aid to developing countries falls because of global recession*. Available at: http://www.oecd.org/newsroom/developmentaidtodevelopingcountriesfallsbecauseofglobalrecession.htm. Accessed April 2017.

Parente, S. T., and R. Feldman. 2013. Micro-simulation of private health insurance and Medicaid take-up following the U.S. Supreme Court decision upholding the Affordable Care Act. *Health Services Research* 48, no. 2 Pt 2: 826–849.

Podger, A. 1999. Reforming the Australian health care system: A government perspective. *Health Affairs* 18, no. 3: 111–113.

Rodin, J., and D. de Ferranti. 2012. Universal health coverage: The third global health transition? *Lancet* 380, no. 9845: 861–862.

Rosen, B. 2016. The Israeli health care system, 2015. In: *International profiles of health care systems, 2015*. E. Mossialos, M. Wenzl, R. Osborn, and D. Sarnak, eds. New York, NY: The Commonwealth Fund. pp. 87–95. Available at: http://www.commonwealthfund.org/~/media/files/publications/fund-report/2016/jan/1857_mossialos_intl_profiles_2015_v7.pdf. Accessed February 2017.

Rosen, B., et al. 2016. Israel: Health system review. *Health Systems in Transition* 17, no. 6: 1–243.

Sachs, J. D. 2012. Achieving universal health coverage in low-income settings. *Lancet* 380, no. 9845: 944–947.

Salkeld, G. 2014. *Creating a better health system: lessons from Singapore*. The Conversation. Available at: http://theconversation.com/creating-a-better-health-system-lessons-from-singapore-30607. Accessed May 17, 2016.

Santerre, R. E., and S. P. Neun. 1996. *Health economics: Theories, insights, and industry studies*. Chicago, IL: Irwin.

Schieber, G., and A. Maeda. 1999. Health care financing and delivery in developing countries. *Health Affairs* 18, no. 3: 193–205.

Singapore Ministry of Health. 2007. *Eldershield experience 2002-2007*. Available at: https://www.moh.gov.sg/content/dam/moh_web/Publications/Information%20Papers/2007/ESH_Experience_2002-2007.pdf. Accessed April 6, 2017.

Singapore Ministry of Health. 2012. *Medisave for Chronic Disease Management Programme (CDMP) and vaccinations*. Available at: http://www.moh.gov.sg/content/moh_web/home/policies-and-issues/elderly_healthcare.html. Accessed December 16, 2013.

Takamura, A. 2015. The present circumstance of primary care in Japan. *Quality in Primary Care* 23, no. 5: 262.

Tan, K. B., et al. 2014. Monitoring and evaluating progress towards universal health coverage in Singapore. *PLoS Medicine* 11, no. 9: e1001695.

Thorlby, R., and S. Arora. 2016. The English health care system, 2015. In: *International profiles of health care systems, 2015*. E. Mossialos, M. Wenzl, R. Osborn, and D. Sarnak, eds. New York, NY: The Commonwealth Fund. pp. 49–58. Available at: http://www.commonwealthfund.org/~/media/files/publications/fund-report/2016/jan/1857_mossialos_intl_profiles_2015_v7.pdf. Accessed February 2017.

Tsutsui, T., and N. Muramatsu. 2007. Japan's universal long-term care system reform of 2005: Containing costs and realizing a vision. *Journal of the American Geriatrics Society* 55: 1458–1463.

Uberoi, N., et al. 2016. *Health insurance coverage and the Affordable Care Act, 2010–2016. ASPE Issue Brief*. Washington, DC: Office of the Assistant Secretary for Planning and Evaluation.

USAID. 2015. *USAID's vision for health systems strengthening: 2015–2019*. Available at: https://www.usaid.gov/what-we-do/global-health/health-systems/usaids-vision-health-systems-strengthening. Accessed February 2017.

U.S. Census Bureau. 2012. *The 2012 statistical abstract*. Available at: https://www2.census.gov/library/publications/2011/compendia/statab/131ed/2012-statab.pdf. Accessed April 14, 2017.

Wagstaff, A., et al. 2009. China's health system and its reform: A review of recent studies. *Health Economics* 18: S7–S23.

Willcox, S. 2001. Promoting private health insurance in Australia. *Health Affairs* 20, no. 3: 152–161.

Wolinsky, F. D. 1988. *The sociology of health: Principles, practitioners, and issues*. 2nd ed. Belmont, CA: Wadsworth.

World Health Organization (WHO). 2014. Germany: Health system review. *Health Systems in Transition* 16, no. 2. Available at: http://www.euro.who.int/__data/assets/pdf_file/0008/255932/HiT-Germany.pdf?ua=1. Accessed May 17, 2016.

World Health Organization (WHO). 2015. Israel: Health system review. *Health Systems in Transition* 17, no. 6. Available at: http://www.euro.who.int/__data/assets/pdf_file/0009/302967/Israel-HiT.pdf. Accessed May 17, 2016.

World Health Organization (WHO). 2016. *World health statistics 2016.* Available at: http://www.who.int/gho/publications/world_health_statistics/2016/en/. Accessed February 2017.

Yip, W., and W. C. Hsiao. 2008. The Chinese health system at a crossroads. *Health Affairs* 27: 460–468.

Yip, W., and A. Mahal. 2008. The health care systems of China and India: Performance and future challenges. *Health Affairs* 27: 921–932.

Yip, W. C., et al. 2012. Early appraisal of China's huge and complex health-care reforms. *Lancet* 379, no. 9818: 833–842.

Zhu, C. 2015. *Healthy China 2020.* Singapore: People's Medical Publishing House.