Chapter 2

The American Health Care System

Chapter Objectives

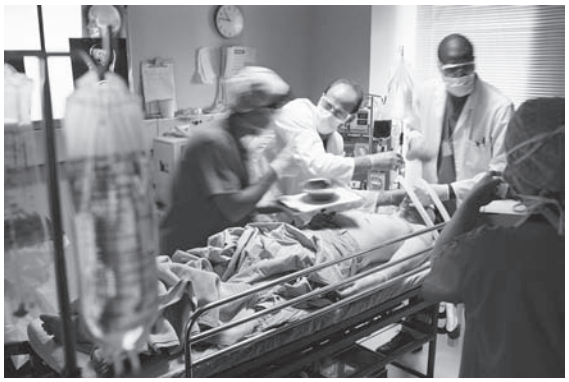
The student will:

- Discuss the structure of the medical care system in the United States.
- Describe the quality of the U.S. health care system.
- Describe health disparities in the U.S. health care system.
- Describe how lack of access to health insurance affects overall health and health care.
- Compare the U.S. health care system to those of other industrialized countries.
- List some measures of quality in a health care system.
- Describe ways to improve the system.
- Describe quality assurance methods in today's health care system.
- Compare arguments for and against a universal health care system.
- List some measures contained in the health care reform legislation of 2010 that may improve the health care system.
- Discuss the processes of selecting a hospital and senior living facility.

Medical Care in the United States

The health care delivery system in the United States is composed of many types of provider groups and institutions. There are 213 federal hospitals and 5,010 **community hospitals** in the United States (American Hospital Association, 2010b). The majority of America's community hospitals, about 59 percent, are nongovernmental and not-for-profit. About 18 percent are private, for-profit institutions. The rest are operated by state or local governments (American Hospital Association, 2007). In addition, there are specialty hospitals that concentrate on special populations like children or specific diseases like cancer.

Most hospitals have emergency departments that will quickly provide urgent medical care to persons who are very ill or injured people. Emergency medical care is quite expensive and should be reserved for true emergencies. Paramedics, emergency medical technicians (EMTs), and some nurses are highly trained in emergency medical care. They often accompany the patient to the emergency room in the ambulance and begin to administer crisis care during the transport. Some hospitals provide care that is so sophisticated that they are referred to as trauma centers.



The emergency room serves as a bridge, stabilizing a patient before full hospital admission. They also provide outpatient care when primary care is not available.

Most hospitals offer services beyond traditional inpatient treatment. According to the American Hospital Association (2010b), 61 percent of hospitals offer home health service, 62 percent offer **hospice care**, and 22 percent offer Meals on Wheels.

Some of the larger teaching hospitals and county hospitals have clinics that provide health care at a reduced rate. These clinics provide some forms of medical care such as immunizations and contraceptives for families who cannot afford private care and who do not have insurance. Some clinics are general care and some are specialty clinics, such as prenatal care or cardiology clinics. Clinics often afford experience for interns or residents as they serve a rotation there. Departments of public health also run community health clinics. These clinics are usually open to all, but they are used primarily by people who have no health insurance and people whose income is low. They are often located in rural or low-income areas where there are few medical services available.

Acute care clinics, or minor emergency care clinics, are usually located in the community and often close to a hospital. In general, they provide care for people who are ill or injured but not serious enough to need an emergency room. They are sometimes called walk-in clinics because patients can be seen without an appointment. Many people who do not have primary care physicians receive acute care at these facilities.

Aspiring physicians complete four years of college and then pass tests to demonstrate their qualifications before being admitted into medical school. Medical school is usually four more years of study. Medical students do clinical studies in a hospital, including a year of internship, then several years as a resident, learning under the supervision of experienced physicians. They may choose to specialize in a branch of medicine, or they may choose to become a primary care or internal medicine doctor. The box defines several medical specialties. Physicians may go into private practice or they may practice at hospitals or clinics.

DEFINITIONS OF MEDICAL SPECIALTIES

Allergy and immunology: evaluation, physical and laboratory diagnosis, and management of disorders involving the immune system, including asthma, eczema, adverse reactions to food, drugs, and insect stings and bites

Anesthesia: application of pharmacology and physiology to dull sensation or awareness and manage the airway of patients receiving treatment

Cardiology: diagnosis and treatment of conditions related to the heart and blood vessels

Dermatology: care and treatment of the skin, hair, and nails

Emergency medicine: urgent medical care for acute medical or surgical conditions or injuries

Endocrinology: diagnosis and treatment of conditions relating to the endocrine system (i.e., hormones and glands), including diabetes and thyroid conditions

Family medicine: continuing, comprehensive health care for the individual and family; often serves as the primary care physician

Gastroenterology: diagnosis and care of diseases of the digestive system, including the stomach, intestines, liver, and pancreas
Geriatrics: care and treatment of the elderly
Gynecology: care for women, particularly the health of women's reproductive organs
Hematology: diagnosis and treatment of disorders of the blood and blood-forming organs
Hepatology: a branch of gastroenterology involving the liver and biliary tract
Infectious diseases: diagnosis and treatment of conditions caused by biological agents
Intensive care: continuous monitoring and treatment of seriously ill patients using special medical equipment and services
Internal medicine: general medical care of adults, usually 18 years of age and older
Neonatology: care and development of newborn babies and the treatment of their diseases
Nephrology: care and treatment of diseases of the kidneys
Neurology: diagnosis and treatment of diseases, disorders, and injuries to the brain, spinal cord, nervous system, and related structures
Obstetrics: medical care during pregnancy and delivery and for a short period thereafter
Oncology: diagnosis and treatment of cancer and other malignant diseases
Ophthalmology: diagnosis and treatment of eye diseases and conditions
Orthopedics: diagnosis and treatment of diseases and conditions affecting the bones, joints, muscles, and tendons
Otorhinolaryngology: care and treatment of diseases of the ears, sinuses, nose, throat, and upper airway
Palliative care: deals with pain and symptom relief and emotional support in patients with terminal illnesses
Pathology: interpretation of laboratory tests on blood, urine, and other body fluids
Pediatrics: medical care of infants, children, and adolescents
Physical medicine and rehabilitation: care designed to provide functional improvement and restoration after injury, illness, or congenital disorders
Plastic surgery: elective cosmetic surgery and reconstructive surgery after traumatic mutilation or disfigurement
Podiatry: treatment of diseases of the foot and ankle
Preventive medicine: health care to delay or avert disease or illness
Proctology: care of the rectum, anus, and colon
Psychiatry: diagnosis, treatment, and prevention of cognitive, perceptual, emotional, and behavioral disorders; may include treatment of substance abuse and addictive disorders
Pulmonology: treatment of diseases and disorders of the lung
Radiology: use of x-ray, ultrasound, computerized tomography, and magnetic resonance imaging for diagnostic purposes
Radiology, nuclear: use of radioactive isotopes in diagnosis and/or treatment
Rheumatology: diagnosis and treatment of diseases of the joints, including arthritis and autoimmune diseases
Sports medicine: care and prevention of injuries and diseases acquired in sports
Surgery, general: surgery involving the skin, endocrine glands, abdomen, and breasts; usually, a precursor to more specialized surgery
Urology: deals with urinary tracts of males and females and the male reproductive system

Most private practice physicians have privileges to practice at one or more hospitals. A large majority of physicians work in physician-owned private practices. Less than one-fourth of all physicians work in practices of ten or more physicians, and nearly 60 percent work in groups of fewer than five (Kane, 2004).

Nurses and medical assistants help physicians provide health care in hospitals, clinics, and private offices. Often, nurses are the first person to see a patient, recording the medical history and checking vital signs. They may also draw blood for laboratory tests and conduct minor procedures. If the patient is admitted to a hospital, nurses and medical assistants administer many treatments that have been ordered by a physician. They must be licensed by graduating from a nursing training program, usually at a college or university, and passing a licensing exam. Nursing school is from two to four years depending on the type of license or degree.

Quality of Care in America

Many Americans believe that they live in a nation that delivers the best, most comprehensive health care in the entire world. They would be mistaken. While it may be true that the United States has some of the best-equipped hospitals and the best-trained physicians in the world, the system falls far short of what is attainable (The Commonwealth Fund, 2008).

Infant mortality rate (IMF) and life expectancy at birth (LEB) are two measures of the health of a nation that reflect the quality of the health care delivery system. According to the U.S. Central Intelligence Agency (2010), the United States ranks forty-fifth among the nations of the world in IMF and forty-nineth in LEB.

In 2000, the World Health Organization evaluated the health care delivered in 191 nations. In the analysis, WHO developed three primary goals for what a good health system should do:

- Good health: "making the health status of the entire population as good as possible" across the whole life cycle
- Responsiveness: responding to people's expectations of respectful treatment and client orientation by health care providers
- Fairness in financing: ensuring financial protection for everyone, with costs distributed according to one's ability to pay

WHO (2000) also distinguished between the overall "goodness" of health systems, described as "the best attainable average level" and fairness, described as "the smallest feasible differences among individuals and groups." The United States ranked number 37, behind such countries as Italy, Andorra, Oman, Colombia, United Arab Emirates, and Costa Rica. On the positive side, WHO ranked the United States first among the 191 nations in the category of responsiveness, the extent to which caregivers are responsive to the client/patient expectations with regard to non-health areas such as being treated with dignity and respect.

In a study involving 1,536 children in 12 metropolitan areas, Mangione-Smith et al. (2007) produced some startling data about the medical care received by children. Children were found to receive appropriate outpatient medical care only 47 percent of the time. They received indicated care for acute medical problems 67.6 percent of the time, appropriate care for chronic conditions 53.4 percent of the time, and appropriate preventive care only 40.7 percent of the time. McGlynn et al. (2003) found that adults received appropriate care only 54.9 percent of the time. The Institute of Medicine (IOM; 1999) stated that at least 44,000 people, and perhaps as many as 98,000 people, die in hospitals each year as a result of medical errors that could have been prevented. In addition, there are about 99,000 deaths per year from hospital-acquired infections (Klevins et al., 2007), most of which could have been prevented. The IOM concluded, "Even using the lower estimate, preventable medical errors in hospitals exceed attributable deaths to such feared threats as motor-vehicle wrecks, breast cancer, and AIDS." These findings raise questions about the quality and safety of health care in the United States.

Emergency room care in America may be sliding in quality. In 2010, about half of all urban and teaching hospitals reported that their emergency departments were "at" or "over" capacity (American Hospital Association, 2010a). In a study by Johns Hopkins University (Vanlandingham, Powe, Marone, Diener-West, & Rubin, 2005), two-thirds of hospital emergency department directors who responded reported that on-call coverage is inadequate to meet the needs of their patients. On-call coverage problems were reported more often in urban (73 percent) than rural (60 percent) hospitals and were similar in geographic regions of the country. The greatest shortage of specialists was in hand surgery. Among hospitals where hand surgery coverage is perceived to be very or extremely important for overall patient outcomes, 69 percent of hospitals had less than full-time coverage. Hospitals also had less than full-time coverage for plastic surgery (52 percent), neurosurgery (49 percent), ear, nose, and throat (44 percent), and psychiatry (42 percent). On-call coverage shortages were related to the proportion of uninsured patients in the hospital emergency department, but not to the supply of specialists. The researchers concluded that the shortage of on-call coverage is an emerging trend that threatens the integrity of the health care safety net, placing patients at potential risk for injury.

In a study of the health care systems in seven industrialized nations, Schoen, Osborn, Doty, Bishop, Peugh, and Murukutla (2007) found that, among adults in seven countries, U.S. adults reported the highest overall error rates, including lab and medication errors. One-third of U.S. patients with chronic conditions reported a medical, medication, or lab test error in the past two years, compared with 28 percent of patients in Canada and 26 percent in Australia. Patient-reported errors were highest for patients seeing multiple doctors or with multiple chronic illnesses.

In response to the problem of medical errors, the state of Massachusetts announced a new policy in 2009. Under the policy, five state agencies, including Medicaid, have adopted uniform nonpayment policies for costs associated with 28 serious reportable health care events, with the goal of advancing quality care. Under the new guidelines, state agencies and their contractors will not pay for certain serious reportable health care events. These largely preventable events include surgery on the wrong body part; surgery on the wrong patient; care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed provider; and patient death or serious disability associated with a medication error. It remains to be seen if this policy will affect overall health care or if other states will adopt similar policies.

Disparities in the Health Care Delivery System

Healthy People 2020 (U.S. Department of Health and Human Services, 2009) contains the health objectives for the United States to be reached by 2020. It sets the course for federal and state efforts to improve the health status of Americans. The document continued the themes established in *Healthy People 2010* (U.S. Department of Health and Human Services, 2000). One of the four overarching goals of the recent document is to achieve health equity, eliminate disparities, and improve the health of all groups. Despite enormous resources that were committed to eliminating disparities in the past, they continue.

Access to health care, defined as the availability and timely use of health services to produce the optimum outcomes, is vital to overall health and wellness. Attaining full access to health care involves three discrete steps:

- Gaining entry into the health care system
- Gaining access to sites of care where patients can receive needed services
- Finding providers who will meet the needs of individual patients and with whom patients can develop a relationship based on mutual communication and trust (Bierman, Magari, Jette, Splaine, & Wasson, 1998)

All three of these steps are largely dependent on whether or not an individual has health

insurance. Among 30 industrialized nations, only the United States, Mexico, and Turkey have not achieved near universal health care coverage (Organisation for Economic Co-operation and Development, 2009).

In the United States, racial and ethnic minorities and low-income populations experience serious disparities in rates of insurance and access to health care (Agency for Healthcare Research and Quality, 2009). Four in ten low-income Americans do not have health insurance, and nearly half of all uninsured people in the United States are poor. About one-third of the uninsured have a chronic disease, and they are six times less likely to receive health care for a health problem than the insured (Kaiser Family Foundation, 2009). In contrast, 94 percent of upper-income Americans have health insurance (Agency for Healthcare Research and Quality, 2009). More than one in three Hispanics and American Indians and just under one in five African Americans are uninsured (Kaiser Family Foundation, 2009). In comparison, only about one in eight whites lacks health insurance (Agency for Healthcare Research and Quality, 2009). Health care reform legislation, the Health Care and Education Reconciliation Act of 2010 (HCERA) that revised the previously passed Patient Protection and Affordable Care Act (PPACA), has the potential to shrink the disparities.

Uninsured patients are about twice as likely to leave a hospital emergency department without being seen as patients with private insurance. In addition, African Americans were about 50 percent more likely to leave without being seen as whites (Agency for Healthcare Research and Quality, 2009).

A primary care provider and a facility where a person receives regular care substantially improve health outcomes. However, Hispanics are only half as likely as whites to have a usual source of care. Half of Hispanics and more than a quarter of African Americans do not have a regular doctor, as compared with only one-fifth of whites. Low-income Americans are three times less likely to have a usual source of care compared with those with higher incomes (HealthReform.gov, 2009).

A Costly System

The United States has by far the most expensive health care system in the world, based on health expenditures per capita and on total expenditures as a percentage of gross domestic product (University of Maine, 2001). We spend more on health care than any other country. Moreover, resources are allocated unequally, inefficiently, and wastefully. The money spent does not yield the value we expect.

The United States spends a disproportionate amount of its gross domestic product (GDP) on health care, and a greater percentage of GDP on health care than any other country. Table 2.1 illustrates large and consistent increases in expenditures. In 1940, after the Great Depression had ended and as the world was plunging into war, we spent about 4 percent of the U.S. GDP on health care. By 1985, we were spending over 10 percent of GDP on health care. Without major adjustments, we are projected to spend almost 20 percent of GDP on health care in the year 2019. This means that one-fifth of every dollar produced in goods and services in the United States will be spent on health care. The Organisation for Economic Co-operation and Development (2009) reported that in 2007, other industrialized countries spent 6 to 11 percent of GDP on health care, with an average of 9 percent, far lower than the percentage of GDP spent in the United States.

Table 2.1 demonstrates growth in terms of real dollars. In 1985, health care expenditures in the United States were just over $439 billion. By the year 2000, expenditures had grown to over $1.3 trillion. In 2008, we spent over $2.3 trillion on health care, a figure that is projected to expand to over $4.7 trillion in 2019. The data in Table 2.1 for the years 2010, 2014, and 2019 are based on estimates of the cost after passage of the health reform legislation of 2010. Many of the provisions of the law go into effect in 2014. We will discuss this legislation later in this chapter.

The amount of money spent on health care per person is illustrated in the right-hand column of Table 2.1. A steady and rapid increase is occurring

Table 2.1 Health Care Expenditures

Year	GDP in Billions	Health Care Expenditures in Billions	%GDP	Amt. Per Capita
1929	$ 103.4	$ 3.6	3.5	$ 29.49
1935	72.2	2.9	4.0	22.65
1940	100.0	4.0	4.0	29.62
1950	286.2	12.7	4.4	81.86
1960	526	27.5	5.2	148
1970	1,039	74.9	7.2	356
1975	1,638	133.1	8.1	605
1980	2,790	253.4	9.1	1,100
1985	4,220	439.3	10.4	1,818
1990	5,803	714.0	12.3	2,813
1993	6,657	912.6	13.7	3,469
1998	8,747	1,190.0	13.6	4,297
2000	9,817	1,353.6	13.8	4,790
2002	10,470	1,603.4	15.3	5,560
2005	12,434	1,973.3	15.9	6,649
2007	13,841	2,300.3	16.0	7,600
2008	14,441	2,338.7	16.2	7,681
2009*	14,283	2,472.2	17.3	8,047
2010**(est.)	14,789	2,632.4	17.8	
2014**(est.)	17,966	3,358.8	18.8	
2019**(est.)	22,460	4,716.5	21.0	

Sources: Centers for Medicare & Medicaid Services, Office of the Actuary: Data from the National Health Statistics Group. *NHE summary including share of GDP*. Retrieved from http://www.cms.hhs.gov/NationalHealthExpendData/02.NationalHealthAccountsHisorical.asp#TopofPage

*Centers for Medicare & Medicaid Services. (2010). *National health expenditure projections, 2009–2019*. Retrieved from http://www.cms.hhs.gov/NationalHealthExpendData/proj2009.pdf

**Centers for Medicare & Medicaid Services. (2010). *Estimated financial effects of the "Patient Protection and Affordable Care Act," as amended* (Memorandum April 22, 2010). Retrieved from http://www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf

and can be emphasized by the fact that the per-person expenditure will double between 2005 and 2019. Figure 2.1 demonstrates the rate of annual growth in health care spending in the United States, a rate that is much greater than inflation, the economy as a whole, and workers' earnings. Figure 2.2 depicts how the health care dollar is spent in America.

Utilization of health care and the accompanying costs are not spread evenly among the population. In 2002, 5 percent of the civilian noninstitutionalized population accounted for 49 percent of overall U.S. health care spending. Among this group, annual medical expenses, not including health insurance premiums, equaled or exceeded $11,487 per person. The average expenditure was

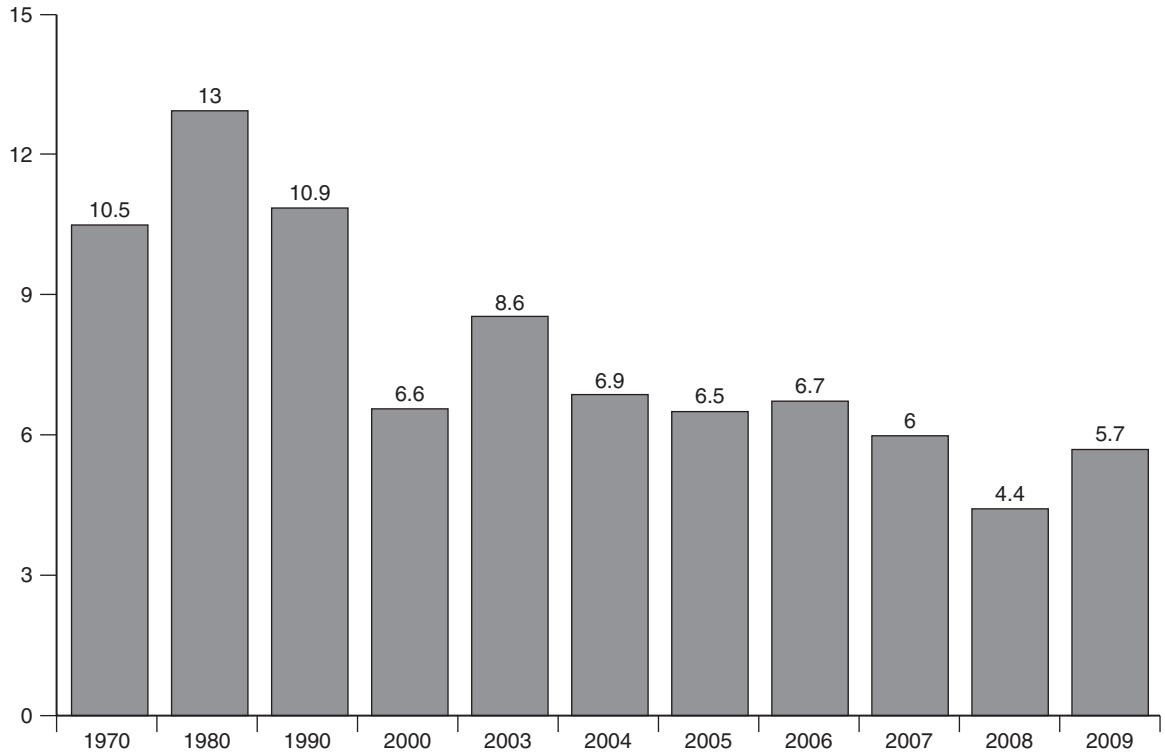


FIGURE 2.1 ANNUAL PERCENTAGE GROWTH RATES IN HEALTH SPENDING, UNITED STATES

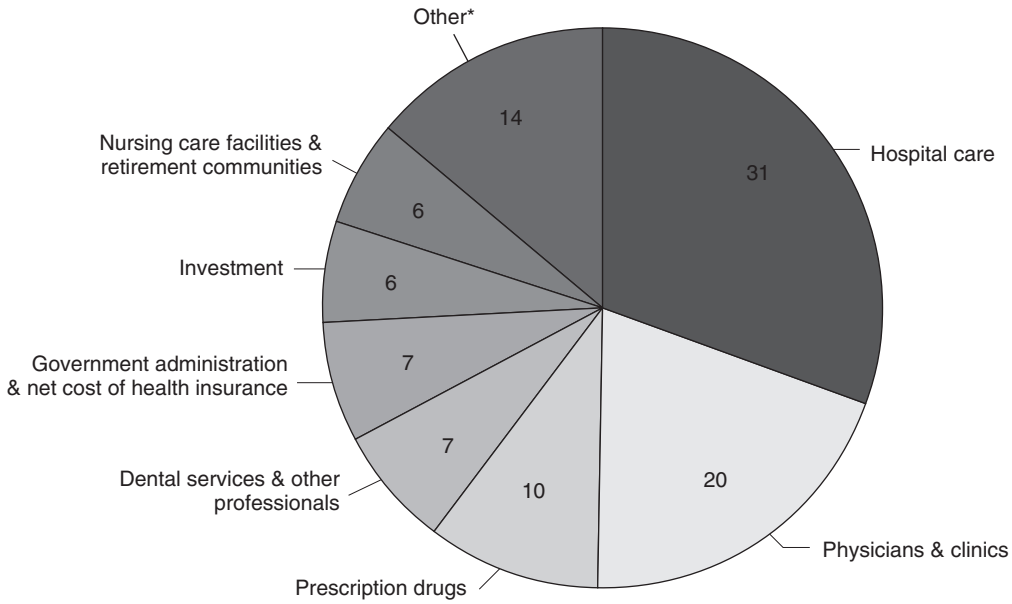
Source: Centers for Medicare and Medicaid Services, Office of the Actuary.

about $35,543 for the top 1 percent. In contrast, the 50 percent of the population with the lowest expenses accounted for only 3 percent of overall U.S. medical spending. For this group, annual medical spending was below $644 per person (Conwell & Cohen, 2005).

In 2002, persons over the age of 65 made up about 13 percent of the U.S. population, but they consumed 36 percent of the total U.S. personal health care expenses. The average health care expense in 2002 was $11,089 for those older than age 65 and $3,352 for those between the ages of 19 and 64 (Keehan, Lazenby, Zezza, & Catlin, 2004). In studying insurance company data on 3.75 million enrollees and data from the Medicare Current Beneficiary Survey, Alemayehu and Warner (2004) found that 8 percent of health care expenses occurred before age 20, 13 percent during young adulthood (20–39 years), 31 percent during middle age (40–64 years), and 49 percent after age 65. Both of these reports clearly indicate that health care expenses go up dramatically with advancing age.

Other reasons for the exceptionally high cost of health care in the United States can be attributed to a number of factors, ranging from costs of medical technology and prescription drugs to the high administrative costs of the complex multiple-payer system in the United States (Woolhandler & Himmelstein, 1997; University of Maine, 2001). There appears to be a shift from nonprofit to for-profit health care providers, including for-profit hospital chains, that has also contributed to the rise in costs.

In 2007, an estimated 45.3 million Americans, over 15 percent of the population, had no health insurance, as reported by the U.S. Bureau of the Census (2008). Another 16 million people are considered underinsured (Schoen, Doty, Collins, & Holmgren, 2005). People without health insurance are much less likely than those with insurance to receive recommended preventive services and



*Includes medical goods, government and public health activities, home health care, and other health, residential, and personal care.

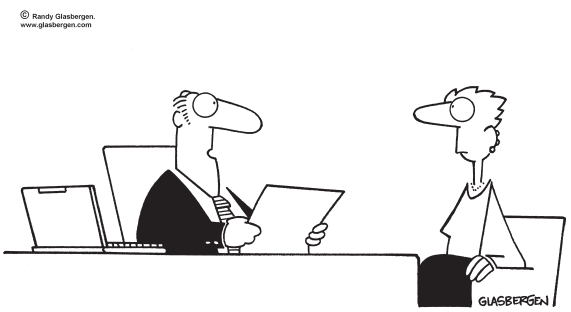
Figure 2.2 Percentages of US health care expenditures, 2009

Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Services Group. Retrieved from http://www.cms.gov/NationalHealthExpendData/downloads/PiechartSourcesExpenditures2009.pdf.

medications, are less likely to have access to regular care by a personal physician, and are less able to obtain needed health care services. Consequently, Americans receive appropriate preventive, short-term, and long-term health care as recommended by professional guidelines in only about 55 percent of the instances in which those recommendations would apply (McGlynn et al., 2003). The uninsured are more likely to suffer preventable illnesses, more likely to suffer complications of those illnesses, and more likely to die prematurely (Ayanian, Weissman, Schneider, Ginsburg, & Zaslavsky, 2000; McWilliams et al., 2007). Delayed treatment frequently results in more expenses as conditions worsen and services such as intensive care become necessary. Uninsured individuals are more likely to use emergency rooms for care, a practice that increases costs by large measure. As the American College of Physicians—American Society of Internal Medicine (2001) pointed out, "People without health insurance tend to live sicker and die younger than people with health insurance."

There is a reciprocal relationship between health care costs and drops in health insurance. Just as people without insurance use the system in ways that cost more in the long run, rising health care costs correlate to drops in health insurance coverage (Kaiser Family Foundation, 2004).

While most hospitals, especially government-owned institutions, write off a portion of their



"We can contain health insurance costs if you're willing to let your coworkers diagnose you with information they find on the Internet."

Source: © Randy Glasbergen, used with permission from www.glasbergen.com.

costs for treating the uninsured, shifting the costs of treating the uninsured to those who are insured is common. This results in increased costs for taxpayers and higher premiums for those with private insurance.

In March 2010, President Barack Obama signed into law the Health Care and Education Reconciliation Act of 2010. This act was the result of the conference report of the two branches of Congress relating to the Patient Protection and Affordable Care Act that made some changes to the PPACA. We refer to the legislation as the HCERA/PPACA. The health care reform law seeks to reduce the number of uninsured Americans. Some of the key provisions that went into effect soon after passage include offering tax credits to small businesses to make employee coverage more affordable, prohibiting new health plans from denying coverage to children with **preexisting conditions** and providing access to affordable insurance for those who are uninsured because of preexisting conditions, banning insurance companies from dropping people from coverage when they get sick, and extending coverage for young people up to their twenty-sixth birthday through their parents' insurance.

Another issue facing the American health care system is the aging of the population. The "Baby Boomer" generation, the largest cohort of the population, is reaching retirement age. With age comes higher prevalence of chronic diseases and greater need for medical care. This means more health care providers will be necessary. Yet the United States does not have national policies to guide the training, supply, and distribution of health care providers to meet future needs for particular specialties of medicine, such as primary care (American College of Physicians, 2008).

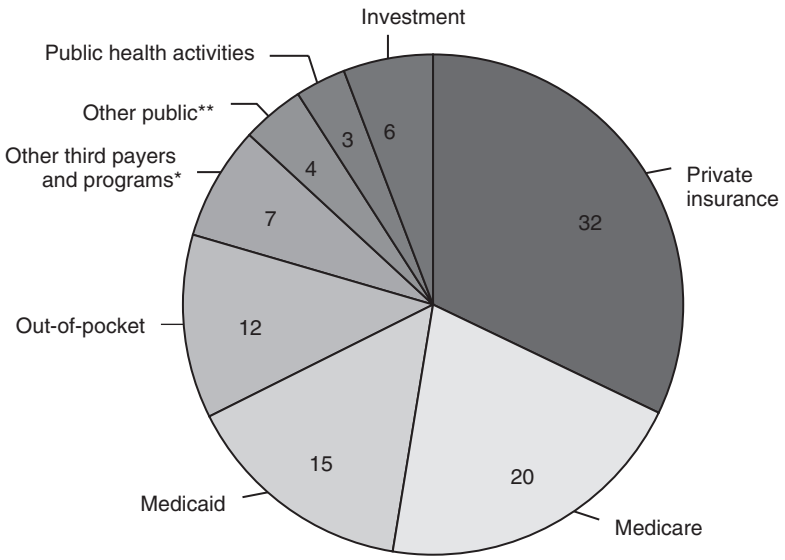
Technological innovation is a major strength of American medicine. It has provided some of the most clinically effective diagnostic and treatment options in the history of medical practice. Yet that same strength has a downside. Technology is expensive and contributes to driving up the cost of medical care. The more technology is disseminated into practice, the higher the per capita utilization and the more the spending. The United States has no effective public policies to control the spread of technology, which often occurs before adequate evaluation of its effectiveness (American College of Physicians, 2008). Technological progress accounts for a large share of the rise in the U.S. health care expenditures illustrated in Table 2.1 (Cutler & McClellan, 2001).

Before new technology hits the practice setting, it should be evaluated at least for clinical effectiveness and possibly for cost effectiveness. The United States has no centralized authority for conducting or coordinating these evaluations. Various public and private organizations, including the Agency for Healthcare Research and Quality, the Medicare Coverage Advisory Committee, the Veterans Administration, and the Blue Cross/Blue Shield Association, conduct technological assessments. Evaluations of clinical effectiveness and determinations of best practices are also offered by professional organizations, including the American College of Physicians and nongovernmental organizations such as the American Heart Association. A coordinated assessment system would reduce duplication of efforts, thus cutting costs.

Access to health technology and its use is mostly controlled by health insurers and **health maintenance organizations** (HMOs). These organizations are usually for-profit businesses. They are free to base their coverage decisions on any available evaluations, to make their own assessments or purchase them from private companies, or to ignore research findings. These decisions to purchase or use technology may be based to a large extent on profit rather than on best medical practices.

The source of all of this money is another issue of interest. Figure 2.3 depicts the sources of health care funding. About 46 percent of the costs of health care are currently paid in some form by the taxpayer, either through state, federal, or Social Security taxes. Noteworthy is the fact that even with a major percentage of costs borne by government programs, mostly Medicare and Medicaid, federal government underpayment to the 5,010 community hospitals totaled $32.4 billion (American Hospital Association, 2009a).

The HCERA/PPACA was passed with the promise to bring down health care costs. One



*Includes worksite health care, other private revenues, Indian Health Service, workers' compensation, general assistance, maternal and child health, vocational rehabilitation,Substance Abuse and Mental Health Services Administration, school health, and other federal and state local programs.

**Includes Veterans Administration, Department of Defense, and CHIP

Figure 2.3 Percentage of sources of the U.S. health care dollar, 2009

Note: Out-of-Pocket includes copays, deductibles, and treatments not covered by private health insurance.

Source: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Services Group. Retrieved from http://www.cms.gov/NationalHealthExpendData/downloads/PieChartSources Expenditures2009.pdf.

of the measures included is a requirement that health plans annually report on the share of premium dollars spent on medical care. If those in the individual and small group market spend less than 80 percent of premiums on medical services, and plans in the large group market fail to spend at least 85 percent of premiums on medical services, they will be required to provide rebates to policy holders. There are also provisions that will crack down on fraud, waste, and abuse in the Medicare, Medicaid, State Children's Health Insurance Program, and private insurance.

Key Indicators for Measuring Performance of the Health System

International comparisons on most key indicators of the public's health have shown that the United States has poorer health outcomes in the aggregate than many other industrialized countries (American College of Physicians, 2008).

The Commonwealth Fund Commission on a High Performance Health System (2008; Schoen, Davis et al., 2006) identified 37 indicators of "high performance" for measuring health care systems. The Commission then arranged the indicators into five main groups and rated the U.S. system according to the five groups with a composite score. When compared with international benchmarks on a scale of 1 to 100, the U.S. 2008 ratings were:

Healthy lives	72
Quality	71
Access	58
Efficiency	53
Equity	71
Total	65

The Commission concluded that the quality of care in the United States is highly variable, and opportunities are routinely missed to prevent disease, disability, hospitalization, and mortality. Let us examine the Commission's findings further.

Healthy Lives

The Commission developed several performance indicators to reflect the system's ability to achieve the goal of helping "everyone, to the extent

possible, lead long, healthy, and productive lives," including preventable mortality, life expectancy, and certain health-related limitations faced by adults and children. The United States scored 72 out of 100 in this area overall in 2008, up slightly over 2006. Among 19 industrialized countries, the United States ranked fifteenth in 2006 on "mortality from conditions amenable to health care," or deaths before age 75 that are potentially preventable with timely, effective care (Schoen, Davis et al., 2006). The U.S. rate was more than 30 percent worse than the Commission's benchmark—the top three countries. The United States also ranked at the bottom for healthy life expectancy and last on infant mortality in 2006. The U.S. fell to last place in 2008 among 19 industrialized nations on deaths that might have been prevented with timely and effective care (The Commonwealth Fund, 2008).

Quality of Care

A high-performance health care system provides care that is necessary, appropriate, and of high quality. The standard of care would be practicing medicine consistent with evidence of clinical effectiveness. Errors would be kept to a minimum. Indicators of high quality include provision of patient-centered care, low nursing home admissions and readmission rates, low rates of medical errors, and low preventable death rates. The United States scored well in 2006 on providing the "right care" for a given condition and for provision of preventive care like Pap smears and mammograms, but low on long-term care management, safe care, and patient-centered care.

The Commission's conclusions were backed up by two published studies. According to data on medical records from 12 metropolitan areas of the United States, children received about 46.5 percent of the care they needed, including 67.6 percent of the indicated care for acute medical problems, 53.4 percent of the indicated care for chronic medical conditions, and 40.7 percent of the preventive care (Mangione-Smith et al., 2007). Examination of adults' medical records in 12 metropolitan areas revealed that the recommended care was offered and delivered only 54.9 percent of the time, with little difference in the proportion of recommended acute care, care for chronic conditions, screening, and follow-up (McGlynn et al., 2003).

Access

In a high-performance health care system, services would be available and accessible to all members of the population. The Commonwealth Fund Commission identified indicators of access to care that included affordability, health insurance coverage, ability to see a physician and obtain the needed medical attention, families spending less than 10 percent of income on out-of-pocket medical costs and premiums, minimal number of patients with problems with medical bills and debts, and health system participation. Between 2006 and 2008 the access score of the United States dropped from 67 to 58. The poor score was attributed to the rising rates of uninsured and underinsured Americans and the rise in health care costs in relation to the growth in income. As of 2007, 75 million adults ages 19 to 64—42 percent—were either uninsured or underinsured during the year (The Commonwealth Fund, 2008). By 2009, 50.7 million Americans were not insured at all, including 7.5 million children under 18 (DeNavas-Walt, Proctor, & Smith, 2010). The health reform legislation of 2010 may eventually influence the causes of uninsurance and underinsurance.

Primary care, such as well child care given children, is critical to quality, equity, and efficiency of a health care system.

Efficiency

The Commonwealth Fund Commission's indicators of efficiency included low rates of overuse, inappropriate use, or waste; minimal expenditures for administrative and regulatory cost; and use of information tools, such as electronic medical records, to support care. These indicators illustrate that quality, access, and costs are interconnected—i.e., poor quality contributes to higher costs, and poor access undermines quality, while simultaneously contributing to less efficient care. The Commission (2008) reported that U.S. patients were three to four times more likely than patients in other developed countries to have duplicate tests or that medical records or test results were not available at the time of their appointment. The United States lags far behind the leading nations in the use of electronic medical records. Less than 15 percent of U.S. hospitals have electronic capabilities to store and use physician notes, less than 17 percent use electronic systems for computerized physician order entry for medications, and about 60 percent have electronic alert systems for drug allergies and drug-drug interactions (American Hospital Association, 2009b). U.S. health insurance administrative costs are much higher than in other countries with mixed private/public insurance systems, when viewed as a share of total health spending. The Commonwealth Fund Commission (2006b) noted that the United States has poor performance in terms of measures of national health expenditures, administrative costs, the use of information technology, and the use of multidisciplinary teams.

Equity

The Commission used several measures of equity, including differences based on income, insurance status, and geography (urban or rural), as well as differences among demographic characteristics such as age, gender, race, and ethnicity. Minimal differences among groups in terms of access to and quality of health services would be expected in a well-operating health system. Among the nations studied, the United States ranked last in equity in 2006. A major inequity was demonstrated in access and quality based on income. Differences were especially obvious between low-income or uninsured populations and high-income and insured populations. In the United States, access to health care is directly related to income and race (Battista & McCabe, 1999). Minorities, low-income, or uninsured adults and children are more likely to wait when sick, to encounter delays and poorly coordinated care, and to have untreated dental caries, uncontrolled chronic disease, avoidable hospitalizations, and worse outcomes than white, higher-income, or insured counterparts (The Commonwealth Fund, 2008).

The Commission found that compared with citizens in five other industrialized nations, Americans face higher out-of-pocket costs, are less apt to have a long-term physician, are less able to see a doctor on the same day when sick, and are less apt to get their questions answered or receive clear instructions from a doctor.

The Commonwealth Fund Commission found that the capacity to innovate and improve the system is a critical element in attaining high performance. Such a system would include a skilled and motivated workforce, emphasizing primary care. It would support a culture of quality improvement and continuous learning that rewards recognition of opportunities to reduce errors and improve outcomes. Investment in public health initiatives, research, information necessary to inform and drive health care decisions, and having an infrastructure that supports and encourages innovation and prepares sufficient numbers of well-trained health care professionals would surely pay off in quality over time. The Commission concluded that their evaluation results make a compelling case for change. Simply put, we fall far short of what is achievable on all major dimensions of health system performance. The overwhelming picture that emerges is one of missed opportunities—at every level of the system—to make U.S. health care truly the best that money can buy (The Commonwealth Fund, 2006b).

Billions of dollars in waste could be saved if our health care system were improved. The Commonwealth Fund Commission (2008) estimated that $100 billion a year could be saved

by lowering insurance administrative costs. Hundreds of thousands of deaths could be prevented by improving system quality, accessibility, and efficiency.

Improving America's Health Care System

The HCERA/PPACA, while open to amendments, repeal, or legal challenges before full enactment, is directed at alleviating many of the problems in the U.S. health care system. This section will address some solutions to the problems in the system, including some of those embedded in the legislation.

Primary care is key to a quality health care system. Systems that have a high level of primary health care are associated with better overall mortality rates, including premature death from asthma and bronchitis, emphysema and pneumonia, and cardiovascular diseases (Macinko, Starfield, & Shi, 2003). The U.S. system has seen a reduction in the number of **primary care physicians** and fewer medical students committed to that career track. Currently, about one-third of physicians work in primary care (Docteur, Suppanz, & Woo, 2003).

Promoting patient-centered primary care is offered as a way of making the system more effective (Davis, Schoen, Guterman, & Shih, 2007). However, before this can be attained, there must be incentives for physicians to go into primary care, a field that has less earning potential than specialties such as cardiology, surgery, and neurology.

The United States has very limited control over the supply of physicians and the specialties they choose. The government has limited funding to support primary care training programs and scholarship programs with service obligations, such as the National Health Service Corps and the Indian Health Service. However, the federal government can influence physician supply somewhat through Medicare reimbursement of graduate medical education residency training positions. In Canada and the United Kingdom, the government has much more leverage to manipulate the health care workforce supply, including controlling both training capacity and employment opportunities. This type of control over the supply of different types of physicians is a characteristic of health care systems that perform well. The HCERA/PPACA contains provisions to encourage aspiring medical students to practice primary care medicine. The laws support development of training programs that focus on primary care such as medical homes, team management of chronic disease, and models that integrate physical and mental health services.

Increasing the ratio of primary to specialty care physicians would make it easier and more efficient to implement preventive health care. It is obvious that preventing illness is preferable to treating that illness from both humanitarian and financial perspectives. Primary care physicians, because of their regular contact with patients, can be more effective at preventive medicine.

Controlling the type of physician being prepared is intertwined with controlling the supply of physicians. In recent years, many physicians have exited the profession for a variety of reasons that include high medical malpractice insurance premiums and reduced professional satisfaction because of increased influence of insurance companies on the practice of medicine. While the HCERA/PPACA may affect a portion of the problem, more incentives must be provided to make the arduous training period required to be a physician worthwhile in terms of both income and job satisfaction.

Related to control of supply of physicians is the need for a societal investment in the education of health professionals, including nurses, physician assistants, and physical therapists. This could ensure a robust workforce of health care providers that are well trained and present in sufficient numbers. The HCERA/PPACA increases the capacity for nursing education, supporting training programs, providing loan repayment and retention grants, and creating a career ladder to nursing. There are grants to employ and provide training to family nurse practitioners who provide primary care in federally qualified health centers and nurse-managed health clinics.

As we have seen, there are tremendous disparities in the health care received by different groups of people. The HCERA/PPACA attempts to maximize funding for health care professionals who commit to practice in underserved areas. The laws provide state grants to providers in medically underserved areas. There is increased flexibility in the use of funding to support training in outpatient settings and to ensure the availability of residency programs in underserved, including rural, areas. There is funding to recruit and train providers in rural areas.

Currently, much control over care is exerted by the insurance or **managed care** organizations (MCOs; see Chapter 4). Before performing a test or procedure, physicians often must verify that an insurer will cover the cost. This is essentially asking for permission to practice in a manner consistent with the physician's training and professional judgment. This situation is exacerbated by the fact that often the company representative who makes the determination is not a physician. Replacing physicians' judgment with that of a company who is committed to making profits is a recipe for failure. An important key to reforming the American health care system is removing health care decisions from those who have a financial interest in delivering fewer services.

Many consumers view managed care as "managed costs," under the assumption that managed care companies are more interested in controlling costs than ensuring the appropriate and high-quality care we expect. Yet, it does not appear that managed care companies manage costs very well. According to 1996 Medical Expenditure Panel Survey data, there were no statistically significant differences in the concentration of health care expenses between those enrolled in health maintenance organizations and other types of gatekeeper plans than those enrolled in **indemnity insurance** or **preferred provider organizations** (Berk & Monheit, 2001).

Immediate Cost-Saving Measures in the Health Care and Education Reconciliation Act of 2010

Many of the provisions of the act will be delayed for several years. However, some went into effect within months of the signing of the bill. By encouraging preventive care, primary prevention, fairness, and other cost-effectiveness measures, these immediate effects can, in the long term, reduce costs.

- Free preventive care under Medicare by eliminating copayments for preventive services and exempting preventive services from deductibles under Medicare
- Incentives to Medicare and Medicaid beneficiaries to complete behavior modification programs
- Requirement of new plans to provide preventive services with no copayments and required exemption of preventive services from deductibles, including immunizations; preventive care for infants, children, and adolescents; and additional preventive care and screenings for women
- A Prevention and Public Health Fund to expand and sustain funding for prevention and public health programs
- Requirement of Medicaid coverage for tobacco cessation services for pregnant women
- Access to effective internal and external appeals processes regarding decisions by the health insurance plan for subscribers to new plans
- Requirement of plans in individual and small group markets to spend 80 percent of premium dollars on medical services, and of plans in large group markets to spend 85 percent

(continues)

- Increased funding for community health centers so that more patients can receive services at these low-cost facilities
- Grants to small employers that establish wellness programs
- New investment to increase the number of primary care practitioners
- New programs to support school-based health centers and nurse-managed health clinics
- Assistance to states in establishing offices of health insurance consumer assistance to help people with filing complaints and appeals

Sources: The White House. (2010). *Key provisions of health reform that take effect immediately.* Retrieved from http://www.whitehouse.gov/healthreform/immediate-benefits

Emergency Nurses Association. (2010). *Patient Protection and Affordable Care Act & Health Care and Education Reconciliation Act.* Retrieved from http://www.ena.org/government/healthcarereform/Documents/AnalysisFinalHRCBills.pdf

Health education is closely linked with preventive medicine. More physicians, clinics, and hospitals should employ and utilize the services of professionally trained health educators. It is not enough to assume that a health care practitioner has the skills to provide adequate health education. The HCERA/PPACA established a grant program to support the delivery of evidence-based and community-based prevention and wellness services. Health education should be an integral part of any such effort.

The Institute of Medicine's Committee on the Consequences of Uninsurance (2004), after extensive study of the health care system, concluded that lack of health insurance coverage is a major stumbling block to having the best possible system. The Committee offered the following principles for guiding the debate and evaluating various strategies:

1. Health care coverage should be universal.
2. Health care coverage should be continuous.
3. Health care coverage should be affordable to individuals and families.
4. The health insurance strategy should be affordable and sustainable for society.
5. Health insurance should enhance health and well-being by promoting access to high-quality care that is effective, efficient, safe, timely, patient-centered, and equitable.

Equity and continuous access are important components of a well-performing health care system. Health insurance coverage is a critical element in those components. Without health insurance, many people postpone treatment until a minor illness becomes worse, harming their health and producing greater costs. The health reform legislation was promoted on the promise of reducing the number of uninsured in the United States by two-thirds.

A **single-payer health care** system has the potential to reduce administrative costs. However, the HCERA/PPACA did not initiate such a system. Nevertheless, reducing the costs of insurance administration should be a priority. This would increase competition and lower costs. The HCERA/PPACA contains provisions for achieving these ends.

Improving access to information on the quality and costs of health care, and promoting better information on the cost effectiveness of health care technology and procedures, would increase the effectiveness of the market. Information allowing the application of market principles would bring down costs.

Highest level systems are based on models that emphasize and deliver care that stresses coordination and integration. In these systems, there are decision-support systems for clinicians, seamless care transitions, and integration at every level of care (The Commonwealth Fund, 2006a). These characteristics are gradually making their way into American medicine. The specialist known as a **hospitalist** completes medical school, usually specializing in internal medicine, family

practice, or pediatrics. Hospitalists coordinate or assume much of the care of a hospitalized patient. There are many advantages of hospitalists in the care of hospitalized patients. One advantage is that hospitalists have more expertise in caring for complicated hospitalized patients on a daily basis. They are also more available most of the day in the hospital to meet with family members and are able to follow up on tests, answer nurses' questions, and deal with problems that may arise. In many instances, hospitalists may see a patient more than once a day to ensure that care is going according to plan and to explain test findings to patients and family members (Nabili, 2010). The use of hospitalists seems to improve patient safety, reduce financial strains on primary care physicians, and improve efficiency and cost effectiveness of hospitals.

The United States lags behind better performing health care systems in the implementation of electronic health records (EHR), or electronic medical records, and systems. EHR systems are an important element in an integrated health care system. They can be used to order tests, prescribe medications, and access patients' test results. They can provide electronic alerts to physicians and other care providers about potential problems concerning drug interactions and dosages. They can issue reminders to patients about preventive or follow-up care and can even be used to provide patients with test results. EHR systems can generate lists of patients who are due for tests or preventive care or sort patients by diagnosis or by health risk. Denmark has developed a comprehensive EHR system that connects nearly all physician practices and hospitals electronically, allowing physicians to electronically prescribe and share patient information. In 2006, between 79 percent and 98 percent of physicians in Australia, New Zealand, the United Kingdom, and the Netherlands, all nations with high-performing systems, had sophisticated EHR systems. Less than half of physicians in the United States had EHR systems (Schoen, Davis et al., 2006). Hand-scrawled prescriptions and misread test orders have resulted in countless negative patient episodes. EHR systems have the potential for greatly reducing these errors. The HCERA/PPACA mandates the development of a plan to integrate reporting on quality of care with reporting of meaningful use of EHR.

Currently, the market power of insurers, providers, pharmaceutical companies, device manufacturers, and other suppliers allows them to set prices above competitive market levels. The ability of government to negotiate prices, especially for prescription medications, is an important key to controlling health care costs and for ensuring that patients get the medications they need. This is the case in Belgium, Canada, Japan, and with the U.S. Veterans Administration. However, when Congress passed legislation that authorized Medicare Part D, a program to provide prescription drug coverage, it specifically prohibited the government from negotiating prices with the pharmaceutical companies. With the huge volume that the Medicare program generates, the savings could be substantial. The Veterans Administration has negotiated drug prices for years, saving billions of taxpayer dollars.

Tort reform has been a conversation piece in the U.S. Congress for decades. Currently, the health care system and its malpractice insurers are operating in an environment that encourages avoidance of lawsuits, often leaving physicians to deliver elements of care out of fear of being sued as much as in the best interests of the patient. Americans have become very litigious. Health care providers are often the target of these lawsuits. In the real world, babies are born with problems and people die. We often react to these events by seeking legal counsel. While there is no doubt that health care providers sometimes make errors, often resulting in catastrophic outcomes, it is also true that the system that allows for a high number of questionable lawsuits and enormous financial awards is driving up costs of health care. Physicians may order tests just to make sure that "all the bases are covered" or perform a Caesarian section at the first sign of fetal stress in case they would ever have to mount a defense against a malpractice charge. Often, even if the insurer thinks the physician acted responsibly, the insurer will

reach a negotiated settlement with the plaintiff rather than incur the legal expenses of defending the physician. This may lead to increases in the physician's premiums for medical malpractice insurance that may be passed on to patients or to patients' insurance companies. The HCERA/PPACA awards five-year demonstration grants to states to develop, implement, and evaluate alternatives to current tort litigations. There is no easy answer to this problem, but it is time that we have a national discussion about it and its implications. The demonstrations funded by HCERA/PPACA are a tentative first step toward that discussion.

Quality Assurance

Hospitals and health plans are accredited by private accreditation organizations. For example, The Joint Commission (TJC) develops standards of performance for a wide range of health care facilities and awards accreditation based on compliance with those standards. Accreditation is a coveted achievement for hospitals and other facilities.

Hospitals that are accredited by TJC must have professional review committees composed of active physicians who evaluate selected cases to ensure the quality of care at the hospital. A utilization committee determines the appropriateness of hospital admissions and lengths of hospital stays. Audit committees look for defective or unnecessary care. Tissue committees review the work done in surgery.

Hospitals may discipline physicians by reducing, suspending, or revoking hospital treatment privileges. These actions could substantially affect a doctor's ability to practice and earn, especially in communities with few hospitals.

Local, county, and state medical societies do not have the power to take away a physician's right to practice medicine. However, they may reprimand or expel members who violate accepted medical practice or in other ways defame the profession. This action is an embarrassment because it is brought about by peers in the full view of colleagues. In the case of specialists, it may reduce their referrals.

Physicians are certified by specialty boards that are independent of the medical societies. To maintain board certification, the physician participates in an extensive process that involves completing accredited education and specialty training and periodic oral and written exams to demonstrate competency (American Board of Medical Specialties, 2008).

In order to practice medicine, a physician must be licensed in the state in which he or she wishes to practice. State licensing boards have the authority to revoke or suspend a license. Revocation by one state does not necessarily disqualify a physician from practicing in other states. In recent years, licensing laws have been tightened somewhat.

The National Practitioner Data Bank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB) are government data banks. NPDB was created by Congress. According to the NPDB-HIPDB Web site (2008): "The intent [of NPDB] is to improve the quality of health care by encouraging State licensing boards, hospitals and other health care entities, and professional societies to identify and discipline those who engage in unprofessional behavior; and to restrict the ability of incompetent physicians, dentists, and other health care practitioners to move from State to State without disclosure or discovery of previous medical malpractice payment and adverse action history. Adverse actions can involve licensure, clinical privileges, professional society membership, and exclusions from Medicare and Medicaid."

The NPDB is primarily an alert or flagging system intended to facilitate a comprehensive review of health care practitioners' professional credentials. The information contained in the NPDB is intended to direct discrete inquiry into, and scrutiny of, specific areas of a practitioner's licensure, professional society memberships, medical malpractice payment history, and record of clinical privileges. Licensing boards, professional societies, hospital administrators, and malpractice insurance carriers are required to report certain

actions against physicians to the NPDB. New regulations went into effect on March 1, 2010, requiring the NPDB Public Use Data File to include selected variables from reports on adverse licensing actions against all health care practitioners and health care entities and certain actions taken by peer review organizations and private accreditation organizations in addition to selected variables from medical malpractice payment, clinical privileges, professional society membership, U.S. Drug Enforcement Administration (DEA) reports, and Medicare and Medicaid exclusion actions taken by the U.S. Department of Health and Human Services Office of Inspector General (NPDB-HIPDB, 2010).

The HIPDB was created by the secretary of the U.S. Department of Health and Human Services, acting through the Office of Inspector General (OIG), as directed by the Health Insurance Portability and Accountability Act of 1996 to combat fraud and abuse in health insurance and health care delivery. The HIPDB collects information about criminal convictions, license and certification actions, civil judgment related to health care but not malpractice, and exclusion from federal and state health care programs. State and federal agencies and health plans may access and review the information held by the HIPDB. The HIPDB is primarily a flagging system that may serve to alert users that a comprehensive review of a practitioner's, provider's, or supplier's past actions may be prudent. The HIPDB is intended to augment, not replace, traditional forms of review and investigation, serving as an important supplement to a careful review of a practitioner's, provider's, or supplier's past actions (NPDB-HIPDB, 2009).

States regulate insurance companies, but the federal government regulates self-insured employer benefit plans. According to Kofman and Pollitz (2006), "Because of the importance of health insurance to the general public welfare, states have been regulating private health insurance companies and products since the late 19th century. State insurance regulation has sought to promote several policy objectives, such as assuring the financial solvency of insurance companies, promoting risk spreading, protecting consumers against fraud, and ensuring that consumers are paid the benefits that they are promised." The federal government has historically respected the state's role in regulating insurance. In 1944, the U.S. Congress explicitly recognized this role in the McCarran-Ferguson Act, which said "the business of insurance … shall be subject to the laws of the several States…." Since the early 1970s, however, the federal government has taken a more active role in areas of insurance regulation that traditionally had been reserved by the states. In 1974, the federal government became the primary regulator of health benefits provided by employers. In the 1980s and 1990s, Congress established minimum national standards for group health insurance.

Every state has adopted certain basic standards for health insurance that apply to all types of health insurance products, including requiring insurers to be financially solvent and capable of paying claims. Standards require prompt payment of claims and other fair claims handling practices. Other aspects of health insurance regulation, however, vary by state and by the type of coverage purchased. These include external review and appeals, covered benefits, access to health insurance, and rating patients based on projections of future health care needs. As a result of a 1974 federal law called the Employee Retirement Income Security Act (ERISA), health benefits offered by private employers are not regulated by states. While ERISA allows states to regulate health insurance policies that employers may purchase, employers that self-insure are not subject to state regulation. The types of state consumer protections discussed above do not apply to self-insured job-based health coverage (Kofman & Pollitz, 2006).

The federal government has more recently gotten involved in the regulation of health insurance. Congress has adopted standards for employer-sponsored group health plans. Most of these have been incorporated into ERISA and the federal tax code. The most significant were added by the

Consolidated Omnibus Budget Reconciliation Act (COBRA) in 1986 and by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). COBRA applies to employers with 20 or more employees and gives workers and their dependents a right to continue job-based health coverage under certain circumstances. HIPAA was written to improve access to health insurance and to prohibit discrimination against people with medical needs. Generally, HIPAA sets a minimum federal floor of consumer protections to apply to all private health insurance, with exceptions for state and local government employers. Enforcement is by both state and federal governments.

Medicare, private insurers, and employers are starting to use pay-for-performance programs to pay hospitals and physicians based on the quality of services provided. Some states, along with private and public insurers, have made performance ratings of hospitals available to the public, and a few health plans are beginning to rate physician groups and individual physicians (Citizens' Health Care Working Group, 2005). The agencies that administer Medicare and Medicaid may terminate a practitioner's participation in those programs. Typical grounds for exclusion are fraud and overutilization. The HCERA/PPACA established a hospital value-based purchasing program in Medicare to pay hospitals based on performance on quality measures.

Managed care organizations, being nongovernmental, have more leverage. They can terminate the participation of a provider or refuse to renew a contract if the provider does not meet the MCO's standards.

Universal Health Care

Reforming the American health care system has been discussed for decades. Rhetoric intensified as the costs of health care continued to grow and more and more Americans were without health insurance. During the 2008 presidential campaign, health reform took center stage. Universal coverage and a "public option" were proposed. Neither was included in the HCERA/PPACA.

Proponents argue that health care is a basic human right and that a country as wealthy as the United States should make sure that all of its citizens have access to health care. They point out that the United States is the only industrialized nation that does not have universal health care and offer examples of individuals whose lives have been shattered because of inability to obtain or keep health insurance. They frequently point out the accessibility and convenience of the universal health care systems in Canada and Great Britain. They claim that freedom to choose health care providers would be enhanced because people are now often forced to see only providers on their insurer's panel.

Supporters also point out that nations that have a national universal health care system spend less of their wealth on health care even as their citizens have higher levels of health as measured by several indicators. Recall that the United States spent over 17 percent of GDP on health care in 2009, a far higher percentage than other countries.

Those who oppose a universal health care system do so on ideological grounds, claiming that such a system is "socialized medicine." They also note that the only way to support it is through taxation and that everyone's tax burden would increase. Many in the opposition believe that costs would increase, especially during the implementation phase. Opponents also claim that people who live in nations with universal health care often have to wait for long periods of time for surgeries and other procedures. Another point of disagreement is the notion that individuals may lose the freedom to choose their own physicians.

There are two models that have been discussed for over 30 years in the United States. The two models are the "national health service" and the "single-payer model." The Patient Protection and Affordable Care Act of 2010 included neither of these models, but it contained a compromise known as "health insurance exchanges." Nevertheless, we will explore the two models because other industrialized countries have them and much of the HCERA/PPACA will not be implemented for years, leaving time for changes.

National Health Service

This is the approach taken by Great Britain. Under this model, the government is both the health care deliverer and the insurer. If a national health service were implemented in the United States, the government might own or lease facilities—e.g., hospitals, laboratories, and clinics. It could own office buildings or lease them to physician groups. Health care providers would be either employees of the government or independent contractors. The system would be funded by taxes. While other countries with this type of system do not usually do so, the government could also impose **deductibles** and **copayments**. Having a national health service does not necessarily mean the total elimination of health insurance companies. Some individuals in Great Britain opt for private insurance.

Some physicians have experience with this type of employment. In the 1970s, after passage of the Health Maintenance Organization Act, some HMOs contracted with physicians to work as employees of the company in the so-called closed panel model.

In this model, doctors receive a fixed salary and have fixed working hours, much like other employees. Physicians do not have to maintain their own offices with the attendant costs of leasing, utilities, and staff. However, the earning potential of physicians could be lessened in this approach. It is not clear how physicians' legal liability would be impacted by the change in employment status. The government would probably assume most of the responsibility for medical malpractice insurance premiums.

It is less likely that physicians would practice defensive medicine in a national health service. Questionable and unnecessary tests would probably be done less frequently. This would reduce costs. In addition, there would be much less administrative cost associated with this model.

Critics claim that choice of physicians and treatment locations would be reduced. They also worry that, given that there is no or little cost that the patient would experience directly at the time of the service, people would abuse and overuse the system.

Single-Payer Model

This is the model that is practiced in Canada. In this model, the role of insurance companies is eliminated. Physicians and other health care providers operate in a **fee-for-service** paradigm. If this model were adopted in the United States, facilities would remain as they are under the current system—i.e., some private, some state or locally owned. There would be a single conduit for paying for services, funded by taxes. This conduit could be a part of the federal government, similar to Medicare.

This model would virtually eliminate the lobbying power of the insurance industry. Instead of private insurance companies determining prices and fees, either the government or a diverse board representing consumers, providers, business, and government would assume that role.

Both the U.S. General Accounting Office and the Congressional Budget Office have issued reports stating that a single-payer system would pay for itself due to reduced administrative costs, as well as having universal access to health care, especially preventive care (Physicians for a National Health Program, 1999). Proponents also assert that it would reduce fraud and waste by concentrating the financial aspects in a single payer with authority to monitor costs, records, and performance. Finally, they contend that the model is not socialized medicine, because it is a payment system, not a health care delivery system.

Opponents to the single-payer system point out that the federal government has been unable to control fraud and waste in other programs, including Medicare and Medicaid. Therefore, it makes little sense to assume that the government will be any more effective with a much larger program and responsibility.

Insurance Exchanges

A third model for making health care more universal is contained in the HCERA/PPACA. Under provisions of the acts, the states will be eligible for federal financial support for developing statewide or multiple substate **exchanges** or forming multistate, regional exchanges. These

exchanges would be a menu of insurance plans. A state may also contract with a private, nonprofit entity to operate its exchange. If a state fails to act or to meet minimum standards, the federal government may operate within the state. The HCERA/PPACA allows and encourages individuals who are not covered by employer-based health insurance to enroll in a health insurance plan through the exchange. At annual enrollment, each participating employee would choose among the various health plans offered in the exchange. The employee would pay more or less depending on the premium of the chosen plan.

Once the exchanges begin to operate, they will want to offer leading health plans to attract and serve subscribers. The health plans will want to meet the exchanges' requirements and specifications, in order to gain access to customers. This, if it goes as planned, will offer a marketplace of insurance coverage and choices for individuals and families. Choice intensifies competition among health plans by making comparison shopping easy and by lowering barriers for new competitors. Exchange choice also would serve to increase competition and lower cost.

Selecting a Health Care Facility

Most of us will have to use a hospital, nursing home, or other health care facility in our lifetimes. Perhaps we will have to make these decisions for ourselves, our family members, or others for whom we have assumed responsibility. As we have seen, medical errors plague the system; not all hospitals are equal in this regard. Since these facilities are integral parts of the health care system, we shall discuss some of the elements that can assist us in choosing a facility. Keep in mind that the steps in decision making discussed in Chapter 1 apply here.

Selecting a Hospital

If your doctor recommends hospital treatment, there are a number of questions that good physicians welcome and that patients should ask. For example:

- How did the physician arrive at the diagnosis? Would it be appropriate to order additional tests to confirm the diagnosis?
- What are the treatment options and what are the risks and benefits of each?
- Are there outpatient options? What are the risks and benefits of them as compared with inpatient treatment?
- Why is this hospital the physician's choice?
- Does the treatment require highly technical or sophisticated treatment? Can this hospital deliver this treatment? Could another?
- What are the side effects and complications that could occur with the treatment? Do they require specialized treatment? Will the staff and facilities at this hospital be able to deliver this care?
- What is the hospital's experience with the type of health problem and required treatment? Does it require specialized skills on the part of the staff? Are there hospitals that have more experience and higher success rates with this diagnosis and treatment?

Patients have a role to play in selecting hospitals. However, much of the responsibility for choosing a hospital rests with the physician. This is a good reason to select a physician in whom you have confidence. Most physicians have admitting privileges at only one or a few hospitals; this limits choice. If your primary care physician refers you to a specialist, you have the opportunity to inquire about which hospitals the specialist uses. This is a good point for patient input in the selection of the specialist and the hospital. The PCP will usually favor specialists who practice in one of his or her hospitals and with whom the PCP is familiar. This works in the patient's favor if he or she wants the PCP to remain involved in the care.

It is important to choose a physician who practices at a highly rated hospital for two reasons. First, this will enhance your chances of being

admitted to such a hospital if the need arises. Second, it enhances your chances that your doctor will be a top-quality professional. Superior hospitals attract superior physicians. Similarly, it is important to choose a health insurance plan that allows use of highly rated hospitals. Patients should check with both the physician and the insurer to make sure that the insurer will cover costs charged by the hospital. This is crucial if you are in a network with a limited choice of facilities.

Patients can obtain much information well before the actual need for hospitalization, such as the accreditation status of nearby hospitals. Patients can also find impartial rating information about hospitals. *U.S. News & World Report* publishes an annual report on the quality of care at hospitals that offer highly specialized and complex services as well as more routine ones. *Consumers' Checkbook* is a nonprofit consumer information and services resource. It provides ratings for nearly every short-term hospital for acute inpatient care in the United States except veterans and military hospitals. HealthGrades offers ratings of physicians, hospitals, and nursing homes. Ratings are presented by locality and health problem.

Selecting a Senior Living Facility

Most of us will have to deal with the stressful issues relating to entering or assisting a family member to enter a retirement community or nursing home. Eldercare Locater (http://www.eldercare.gov) provides information and referral services for those seeking local and state support resources for the elderly; it is a good place to start. The decision-making process described in Chapter 1 is applicable to this situation. For every family, there are specific factors that affect the choice. These factors include location, costs, payment method, medical needs, availability of special care units, mobility of the resident, and need for social interaction. Location is one of the most important factors. Residents and their families often prefer a facility that is close to the family's home. Another consideration is the special services or features of the facility. For those with disabilities, specialized care units may be a requirement.

There are several choices for the elderly if they are leaving their primary residence. Retirement communities or homes form one option. These are generally reserved for people who can take care of their basic needs but want to live around people of similar age and with similar interests. Residents live in private dwellings, often apartments. Food service is usually available but the resident is free to prepare meals in his or her residence. Some level of health care is available and there is usually an arrangement with a hospital or clinic to provide medical care if necessary. Assisted living communities provide more health care, although residents may have as much independence as they choose. These facilities can provide help with the activities of daily living, such as bathing, dressing, and grooming. They also coordinate services by outside health care providers, administer medications if necessary, and monitor resident activities to help to ensure their health, safety, and well-being. For those requiring the highest level of care, there are nursing homes or skilled nursing facilities. These facilities have registered nurses who help provide around-the-clock care to people who can no longer care for themselves due to physical, emotional, or mental conditions. A physician supervises each patient's care, and a nurse or other medical professional is almost always on the premises. Skilled care may also include physical, occupational, or speech therapy. Nursing homes also provide custodial care, such as bathing, toileting, eating, and getting in and out of bed.

Whenever possible, the person who is moving to the facility should be involved in the choice. The first step in making the decision is determining the needs of the senior. This usually requires the advice of the PCP. Second, obtaining referrals can be very helpful. They may come from the family physician, social workers, hospital discharge planners, clergy, and family friends who have firsthand knowledge about choosing a facility.

Once the level of care is decided, the type of facility can be determined. At that point, based on referrals and information searches, the family can reduce the choices to a relative few. The best way to determine an appropriate match of a facility

with patient needs is through visits. The first visit and tour should be arranged with the administrator so that you can ask specific questions about costs, insurance, staffing, management of volunteers, and medical care. All questions should be answered to your satisfaction. Make unannounced visits at various times of the day and different days of the week. Introduce yourself to family members you see arriving and departing and ask them the pros and cons of the facility. Ask residents what they like and dislike about the facility. The following are some issues to be explored on your visits:

- Licensure and accreditation: Does the facility hold a current license from the state? Does the administrator hold a state license? (If not, cross the facility off the list.) Ask to see the last three inspection reports. What credentials do caregivers possess? The Commission on Accreditation of Rehabilitation Facilities gives approval to aging services.
- Location: Are the senior and the family happy with the location? Is it close to a hospital? Is the area safe and free from crime? Are there shopping centers and entertainment opportunities nearby?
- Patient services: Does the facility have a written description of patient and family rights and responsibilities that is readily available? Does the patient's physician make regular visits to the facility? Does the facility have an arrangement with a nearby hospital for emergency transportation and admission? Are the physical therapy staff all academically prepared for the job? Is a social worker available to assist patients and family? Is there a 24-hour emergency response system? Ask to see it. Is a registered nurse available at all times? If not, what are the qualifications of the staff in his or her absence? Are barbers and beauticians available? May patients worship as they choose on a regular basis? Are arrangements made to assist residents who celebrate religious holidays?
- Facility appearance: Is the entire facility clean? Are there unpleasant odors? Do you feel welcome when you enter the facility? Are the grounds neat and well kept? Are there outside areas that the residents can use comfortably? Is there a room for private visits with family and friends? Are exterior doors locked during daytime and evening hours?
- Staff attitudes: Is the environment warm and pleasant? Do staff members demonstrate interest, respect, and affection for residents? Do staff members respond quickly to calls for assistance? Are visiting hours convenient? Do administrators take the time to answer questions and discuss problems?
- Dining and food service: Is the dining room attractive? Are the tables and chairs comfortable and safe? Can wheelchairs easily navigate the room? Does a dietician help in meal planning? Is the food varied, tasty, fresh, and attractively served? Is there enough time to eat? Is the quantity sufficient? If residents need help eating, is it cheerfully provided? If needed, is food delivered to residents' rooms? Are beverages and healthy snacks available all day?
- Living quarters: Does each bedroom have a window? If there are more than one resident in a room, is there a privacy curtain? Is there a nurse call button? Are personal items encouraged in the rooms? Is the bed easily accessible? Are bathrooms easily accessible to the bedroom? Do bathrooms have hand rails and call buttons? Is there a walk-in shower? Do tubs have no-slip surfaces and bathing chairs if needed?
- Activities: Are activities planned? Are all residents encouraged to participate? Are patients' preferences included in activity planning? Are outside trips planned? Are there intergenerational events with local schools, scout troops, and youth organizations? Do volunteers work with patients? Make sure the volunteers are trained.

- Costs: Are meals covered in the basic fee? Are most services covered in the basic rate? If not, what services are not covered? Does the facility accept Medicare, Medicaid, and/or other insurance? What is the policy on returning advance payments?

Nursing Home Compare, operated by the U.S. Department of Health and Human Services, will help you compare facilities in many states. The URL is http://www.medicare.gov/nhcompare/home.asp.

Once you have gained all the information you need, it is time to compare the facilities' pros and cons. It may be necessary to have another conversation with the family member's physician. It is very important that the resident be involved in the gathering of information and the selection of the facility.

Admissions contracts are complicated legal documents. It is advisable to have an attorney review them before signing.

Summary

The health care system of the United States is a multilayered entity. Spending on health care in the United States is higher on a per capita basis than in any other nation, and the cost is rapidly rising. The quality of the system, according to authoritative estimates using a variety of measures, is much less than other industrialized nations and much worse than it should be, given the costs.

Racial and ethnic minorities and low-income populations suffer serious disparities in access to health care. Too many Americans are denied access to health care because of lack of health insurance.

Quality assurance is attempted on several levels. Accreditation is a way to improve institutional quality. Individual practitioners are subject to licensing requirements and discipline by professional societies and hospitals where they practice.

A number of steps could be implemented to improve the system, including models that would provide universal health care. Among these steps are increasing the number of primary care practitioners, providing incentives for people to purchase health insurance and for insurers to make it more widely available, implementing widespread use of electronic health records, and increasing preventive services and health education.

After extensive study, a panel at the University of Maine (2001) concluded:

> There is a growing recognition that the major problems of rising costs and lack of access constitute a real crisis. However, the search for solutions has not been easy or clear cut. Policymakers often attempt to address the symptoms of our health care crisis through short-term, patchwork solutions, under the pressure of time and the constraints of political decision-making, rather than analyzing the system itself as a whole.

Passed in 2010, the Patient Protection and Affordable Care Act, together with the Health Care and Education Reconciliation Act, form effort to reduce these inequities and increase the quality of health care while reducing overall costs.

Key Terms

Access to health care: the availability and timely use of health services to produce the optimum outcomes

Acute care clinics: facilities, open to patients with less serious injuries, that accept patients without appointments

Community hospitals: nonfederal, short-term general and special hospitals whose facilities and services are available to the public

Copayment: a flat fee that an insured person pays for each use of the health care system

Deductible: the amount of money a policy holder pays each year before the health insurance policy begins paying

Exchange: a marketplace of health insurance plans from which consumers may choose

Fee-for-service: a plan in which charges are made for each single service that is provided

Health maintenance organization: type of prepaid medical service in which subscribers pay

a monthly or yearly fee for all health care and the organization controls costs and access to specific services

Hospice care: medical services, emotional support, and spiritual resources for family members and people who are in the last stages of a terminal illness

Hospitalist: a physician who coordinates or assumes much of the care of a hospitalized patient

Indemnity insurance: a type of health insurance that requires the subscriber to pay certain charges, such as copayments and deductibles, and which allows the insured to choose his or her health care provider

Managed care: a system of health care delivery with the goal of reducing costs and use

Preexisting condition: a health problem existing before your health insurance goes into effect

Preferred provider organization: a type of managed care organization of health care providers and hospitals that have contracted with an insurer or a third-party administrator to provide health care at reduced rates to the insurer's or administrator's clients

Primary care: the entry point for patients into the health care system; it includes diagnosis and treatment of acute and chronic illnesses and is performed and managed by a personal physician in collaboration with other health professionals

Primary care physician: the physician who handles most of your care and who makes referrals to specialists

Single-payer health care: a system in which there is one insurer of health care, the government

STUDY QUESTIONS

1. Describe the training and education of a physician.
2. What are some weaknesses of the U.S. health care system?
3. What are some problems related to lack of health insurance?
4. Why are health disparities a major focus of the health care system?
5. How are health insurance and health disparities related?
6. How does the United States compare with other industrialized nations in financial expenditures for health care?
7. What are some steps that we could take to improve the U.S. health care system?
8. How is quality assured in the health care system?
9. What are some arguments for and against a universal health care system in America? What is your opinion?
10. Do you think the Patient Protection and Affordable Care Act of 2010 will improve the U.S. health care system? Why or why not? What provisions do you think are positive? Are there any provisions that will have negative impact?
11. How do you select a hospital?
12. How do you select a living facility for an elderly person?

REFERENCES

Agency for Healthcare Research and Quality. (2009). *National healthcare disparities report, 2008*. Rockville, MD: U.S. Department of Health and Human Services.

Alemayehu, B., & Warner, K. E. (2004). The lifetime distribution of health care costs. *Health Services Research*, *39*(3), 627–643.

American Board of Medical Specialties. (2008). *The importance of board certification*. Retrieved from http://www.abms.org/Who_We_Help/Consumers/importance.aspx

American College of Physicians. (2008). Achieving a high-performance health care system with universal access: What the United States can learn from other countries. *Annals of Internal Medicine*, *148*(1), 55–75.

American College of Physicians—American Society of Internal Medicine. (2001). *Statement for the record of the Ways and Means Subcommittee hearing on the nation's uninsured*. Retrieved from http://acponline.org/hpp/ways_means.htm

American Hospital Association. (2007). *Fast facts on US hospitals.* Retrieved from http://aha.org/aha/resource-center/Statistics-and-Studies/fast-facts.html

American Hospital Association. (2009a). *American Hospital Association underpayment by Medicare and Medicaid fact sheet*. Retrieved from http://www.americanhealthsolution.org/assets/Uploads/Blog/09medicunderpayment1.pdf

American Hospital Association. (2009b). *Annual Survey with Information Technology Supplement*. Washington, DC: American Hospital Association.

American Hospital Association. (2010a). *AHA Rapid Response Survey, Telling the Hospital Story Survey*. Chicago: American Hospital Association.

American Hospital Association. (2010b). *Chartbook: Trends affecting hospitals and health systems*. Retrieved from http://www.aha.org/aha/research-and-trends/chartbook/index.html

Ayanian, J. Z., Weissman, J. S., Schneider, E. C., Ginsburg, J. A., & Zaslavsky, A. M. (2000). Unmet health needs of uninsured adults in the United States. *JAMA*, *284*(16), 2061–2069.

Battista, J. R., & McCabe, J. (1999). *The case for universal health care in the United States*. Retrieved from http://cthealth.server101.com/the_case_for_universal_health_care_in_the_united_states.htm

Berk, M. L., & Monheit, A. C. (2001). The concentration of health expenditures, revisited. *Health Affairs*, *20*(2), 9–18.

Bierman, A., Magari, E. S., Jette, A. M., Splaine, M., & Wasson, J. H. (1998). Assessing access as a first step toward improving the quality of care for very old adults. *Journal of Ambulatory Care Management*, *121*(3), 17–26.

Citizens' Health Care Working Group. (2005). *The health report to the American people*. Retrieved from http://govinfo.library.unt.edu/chc/healthreport/healthreport.php

The Commonwealth Fund Commission on a High Performance Health System. (2006a). *Framework for a high performance health system for the United States: An ambitious agenda for the next president.* Retrieved from http://www.commonwealthfund.org/usr_doc/AmbitiousAgenda_1075.pdf?section=4039

The Commonwealth Fund Commission on a High Performance Health System. (2006b). *Why not the best? Results from a national scorecard on U.S. health system performance*. Retrieved from http://www.commonwealthfund.org/usr_doc/Commission_whynotthebest_951.pdf

The Commonwealth Fund Commission on a High Performance Health System. (2008). *Why not the best? Results from the National Scorecard on U.S. Health System Performance, 2008*. New York: The Commonwealth Fund.

Conwell, L. J., & Cohen, J. W. (2005). *Characteristics of people with high medical expenses in the U.S. civilian noninstitutionalized population, 2002.* Statistical Brief #73. Agency for Healthcare Research and Quality, Rockville, MD. Retrieved from http://www.meps.ahrq.gov/PrintProducts/PrintProdLookup.asp?ProductType=StatisticalBrief

Cutler, D. M., & McClellan, M. (2001). Is technological change in medicine worth it? *Health Affairs*, *20*(1), 11–29.

Davis, K., Schoen, C., Guterman, S., & Shih, T. (2007). *Slowing the growth of U.S. health care expenditures: What are the options?* Retrieved from http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=449510

DeNavas-Walt, C., Proctor, B. D., & Smith, J. C. (2010). U.S. Census Bureau, Current Population Reports, P60-238. *Income, poverty, and health insurance coverage in the United States: 2009*. Washington, DC: U.S. Government Printing Office.

Docteur, E., Suppanz, I. I., & Woo, J. (2003). *The U.S. health system: An assessment and prospective directions for reform*. Paris: Organisation for Economic Co-operation and Development.

Health Care and Education Reconciliation Act of 2010, Pub. L. 111–152, 124 stat. 1029.

HealthReform.gov. (2009). *Health disparities: A case for closing the gap*. Retrieved from http://www.healthreform.gov/reports/healthdisparities/index.html

Institute of Medicine. (1999). *To err is human: Building a safer health system*. Washington, DC: National Academy Press.

Institute of Medicine, Committee on the Consequences of Uninsurance. (2004). *Insuring America's health: Principles and recommendations*. Washington, DC: National Academies Press.

Kaiser Family Foundation. (2004). *The uninsured: A primer, key facts about Americans without health insurance*. Retrieved from http://www.kff.org/uninsured

Kaiser Family Foundation. (2009). *Medicaid and the uninsured*. Washington, DC: Kaiser Family Foundation.

Kane, C. (2004). *The practice arrangements of patient care physicians.* American Medical Association, Physician Marketplace Report no. 2004-02.

Keehan, S. P., Lazenby, H. C., Zezza, M. A., & Catlin, A. C. (2004). *Health care financing review*. 1:1. Web Exclusive. Retrieved from http://www.cms.hhs.gov/NationalHealthExpendData/downloads/keehan-age-estimates.pdf

Klevins, R. M., Edwards, J. R., Richards, C. L., Horan, T. C., Gaynes, R. P., Pollock, D. A., & Cardo, D. M. (2007). Estimated healthcare-associated infections and deaths in U.S. hospitals, 2002. *Public Health Reports, 122*(2), 160–166.

Kofman, M., & Pollitz, K. (2006). *Health insurance regulation by states and the federal government: A review of current approaches and proposals for change*. Washington, DC: Health Policy Institute, Georgetown University.

Macinko, J., Starfield, B., & Shi, L. (2003). The contribution of primary care systems to health outcomes within Organization for Economic Co-operation and Development (OECD) Countries, 1970–1998. *Health Services Research, 38*(3), 831–865.

Mangione-Smith, R., DeCristofaro, A. H., Setodji, C. M., Keesey, J., Klein, D. J., Adams, J. L., & McGlynn, E. A. (2007). The quality of ambulatory care delivered to children in the United States. *New England Journal of Medicine*, *357*(15), 1515–1523.

McGlynn, E. A., Asch, S. M., Adams, J., Keesey, J., Hicks, J., DeCristofaro, A., & Kerr, E. A. (2003). The quality of health care delivered to adults in the United States. *New England Journal of Medicine*, *348*(26), 2635–2645.

McWilliams, J. M., Meara, E., Zaslavsky, A. M., & Ayanian, J. Z. (2007). Use of health services by previously uninsured Medicare beneficiaries. New *England Journal of Medicine*, *357*(2), 143–153.

Nabili, S. (2010). *What is a hospitalist?* Retrieved from http://www.medicinenet.com/script/main/art.asp?articlekey=93946

National Practitioner Data Bank–Healthcare Integrity and Protection Data Bank. (2008). *Why the NPDB was created*. Retrieved from http://www.npdb-hipdb.hrsa.gov/npdb.html

National Practitioner Data Bank–Healthcare Integrity and Protection Data Bank. (2009). *Healthcare Integrity and Protection Data Bank*. Retrieved from http://www.npdb-hipdb.hrsa.gov/hipdb.html

National Practitioner Data Bank–Health Integrity and Protection Data Bank. (2010). *Public Use Data File*. Retrieved from http://www.npdb-hipdb.hrsa.gov/publicdata.html

Organisation for Economic Co-operation and Development. (2005). *0ECD health data 2006: Most frequently requested data*. Retrieved from http://www.oecd.org/document/16/0,2340.en_2649_37407_2085200_1_1_1_37407.00.html

Organisation for Economic Co-operation and Development. (2009). *Health at a glance: 2009 0ECD indicators*. Retrieved from http://www.oecd.org/health/healthataglance

Patient Protection and Affordable Care Act of 2010, Pub. L. 111–148, 124 stat. 119.

Physicians for a National Health Program. (1999). *How much does single payer national health care cost?* Retrieved from http://thirdworldtraveler.com/Health/HowMuchSPCost.html

Schoen, C., Davis, D., How, S. K. H., & Schoenbaum, S. C. (2006). U.S. health system performance: A national scorecard. *Health Affairs, 25*(6), W457–475 (September 20, 2006), doi:10.1377/hlthaff.25.w457

Schoen, C., Doty, M. M., Collins, S. R., & Holmgren, A. L. (2005). Insured but not protected: How many adults are underinsured? *Health Affairs*, (Suppl Web Exclusive), W5–289.

Schoen, C., Osborn, R., Doty, M. M., Bishop, M., Peugh, J., & Murukutla, N. (2007). Toward higher-performance health systems: Adults' health care experiences in seven countries, 2007. *Health Affairs*, *26*(6), W717–W734.

University of Maine. (2001). *The U.S. health care system: Best in the world, or just the most expensive?* Retrieved from http://dll.umaine.edu/ble/U.S.%20HCweb.pdf

U.S. Bureau of the Census. (2008). *Income, poverty, and health insurance coverage in the United States: 2007*. Washington, DC: U.S. Department of Commerce, Bureau of the Census.

U.S. Central Intelligence Agency. (2010). *The world factbook*. Retrieved from http://www.cia.gov/library/publications/the-world-factbook

U.S. Department of Health and Human Services. (2000). *Healthy people 2010: Understanding and improving health*. Washington, DC: USDHHS.

U.S. Department of Health and Human Services. (2009). *Healthy people 2020 framework.* Retrieved from http://healthypeople.gov/hp2020/Objectives/framework.aspx

Vanlandingham, B., Powe, N. R., Marone, B., Diener-West, M., & Rubin, H. R. (2005). The shortage of on-call specialist physician coverage in U.S. hospitals. Presented at the Academy Health Meeting, Boston, MA.

Woolhandler, S., & Himmelstein, D. U. (1997). Costs of care and administration at for-profit and other hospitals in the United States. *New England Journal of Medicine*, *336*(11), 769–774.

World Health Organization. (2000). *The world health report—health systems: Improving performance*. Retrieved from http://www.who.int/whr/2000/en/index.html