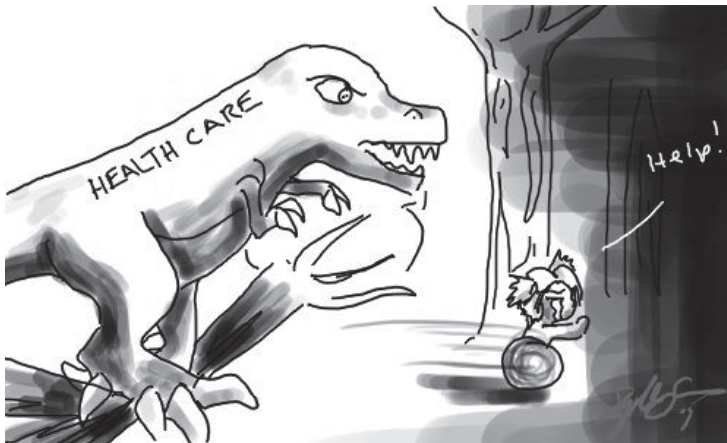


# Chapter 1

## Major Characteristics of U.S. Health Care Delivery



### INTRODUCTION

The United States has a unique system of health care delivery compared with other developed countries around the world. Almost all other developed countries have universal health insurance programs in which the government plays a dominant role. Almost all of the citizens in these countries are entitled to receive health care services that include routine and basic health care. In contrast, only insured Americans have been able to obtain routine and basic health care services on a continuous basis. The passage of the Patient Protection and Affordable Care Act in 2010 (ACA of 2010) holds the promise of universal coverage under government mandates. However, expansion of health insurance at an affordable cost will likely remain a major challenge. Expanding access to health care while containing overall costs and maintaining expected levels of quality continues to confound academics, policy makers, and politicians alike.

To facilitate understanding of the structural and conceptual bases for the delivery of health services, this book is organized according to the systems framework presented at the end of this chapter. One of the main objectives of this chapter is to provide a broad understanding of how health care is delivered in the United States.

The overview presented here introduces the reader to several concepts that are discussed more extensively in later chapters. As this discussion will make clear, the U.S. health care delivery system is both complex and massive. Interestingly, it is not actually a “system” in the true sense because the components illustrated in Figure 1.2 are only loosely coordinated. Yet it is called a system when its various features, components, and services are referenced. Although it may be somewhat misleading to talk about the American health care delivery “system” (Wolinsky, 1988, p. 54), for the sake of simplicity, this term will nevertheless be used throughout this book.

Organizations and individuals involved in health care range from educational and research institutions, medical suppliers, insurers, payers, and claims processors, to health care providers. There are nearly 16.4 million people employed in various health delivery settings, including professionally active doctors of medicine (MDs), doctors of osteopathy (DOs), nurses, dentists, pharmacists, and administrators. Approximately 410,000 physical, occupational, and speech therapists provide rehabilitation services. The vast array of institutions includes 5,815 hospitals, 16,000 nursing homes, almost 2,900 inpatient mental health facilities, and 11,000 home health agencies and hospices. Nearly 1,200 programs support basic health services for migrant workers and the homeless, community health centers, black lung clinics, human immunodeficiency virus (HIV) early intervention services, and integrated primary care and substance abuse treatment programs. Various types of health care professionals are trained in 151 medical and osteopathic schools, 56 dental schools, 102 schools of pharmacy, and more than 1,500 nursing programs located throughout the country (Bureau of Labor Statistics, 2011; Bureau of Primary Health Care, 2011).

There are 195 million Americans with private health insurance coverage. An additional 105 million are covered under two major public health insurance programs—Medicare and Medicaid—financed by the U.S. government. Private health insurance can be purchased from approximately 1,000 health insurance companies and 70 Blue Cross/Blue Shield plans. The private managed care sector includes approximately 452 licensed health maintenance

organizations (HMOs) and 925 preferred provider organizations (PPOs). A multitude of government agencies are involved with the financing of health care, medical and health services research, and regulatory oversight of the various aspects of the health care delivery system (Aventis Pharmaceuticals, 2002; Bureau of Primary Health Care, 2011; Healthleaders, 2011; National Center for Health Statistics, 2007; Urban Institute, 2011; U.S. Bureau of the Census, 1998; U.S. Census Bureau, 2007).

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## SUBSYSTEMS OF U.S. HEALTH CARE DELIVERY

In the United States, multiple subsystems of health care delivery have developed, either through market forces or as a result of the need to take care of certain population segments often referred to as special populations. Discussion of the major subsystems follows.

### Managed Care

*Managed care* is a system of health care delivery that (1) seeks to achieve efficiency by integrating the basic functions of health care delivery, (2) employs mechanisms to control (manage) utilization of medical services, and (3) determines the price at which the services are purchased and, consequently, how much the providers get paid. Managed care is the dominant health care delivery system in the United States today and covers most Americans in both private and public health insurance programs.

The employer or government is the primary financier of the managed care system. The financier contracts with a managed care organization (MCO), such as an HMO or a PPO, to offer a selected health plan to employees, and, in case of public health insurance, to Medicare and Medicaid beneficiaries. The MCO functions like an insurance company and promises to provide health care services, contracted under the health plan, to the enrollees of the plan.

The term *enrollee* (member) refers to the individual covered under the plan. The contractual arrangement between the MCO and the enrollee—including the collective array of covered health services to which the enrollee is entitled—is referred to as the *health plan* (or “plan” for short). The health plan designates selected providers from whom the enrollees can choose to receive routine services. Primary care providers or general practitioners typically deliver routine medical services and make decisions about

referrals for higher-level or specialty services. Hence, primary care physicians are often referred to as “gatekeepers.” The choice of major service providers, such as hospitals, is also limited under health plans. Some services may be delivered through the plans’ own hired physicians, but most are delivered through contracts with providers such as physicians, hospitals, and diagnostic clinics.

Although the employer finances the care by purchasing a plan from an MCO, the MCO is responsible for negotiating with providers. Providers are typically paid either through a capitation (per head) arrangement, in which providers receive a fixed payment for each patient or employee under their care, or via a discounted fee arrangement. Providers are willing to discount their services for MCO patients in exchange for being included in the MCO network and being guaranteed a patient population. As part of their planning process, health plans rely on the expected cost of health care utilization, which always runs the risk of costing more than the premiums collected. By underwriting this risk, the plan assumes the role of insurer.

As of 2009, there were 66.21 million people enrolled in health maintenance organizations (HMO), 53.20 million people enrolled in preferred provider organizations (PPO), 8.87 million people enrolled in point-of-service (POS) plans, and 7.09 million people enrolled in high-deductible health plans (Kaiser Family Foundation and Health Research & Educational Trust, 2009; U.S. Department of Labor 2009).

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

## Military

The military medical care system is available free of charge to active-duty military personnel of the U.S. Army, Navy, Air Force, and Coast Guard, as well as to members of certain uniformed nonmilitary services such as the Public Health Service and the National Oceanographic and Atmospheric Association (NOAA). It is a well-organized, highly integrated system that provides comprehensive services. It covers both preventive and treatment services, which are provided by salaried health care personnel, many of whom are themselves in the military or uniformed services. This system combines public health with medical care. Routine ambulatory care

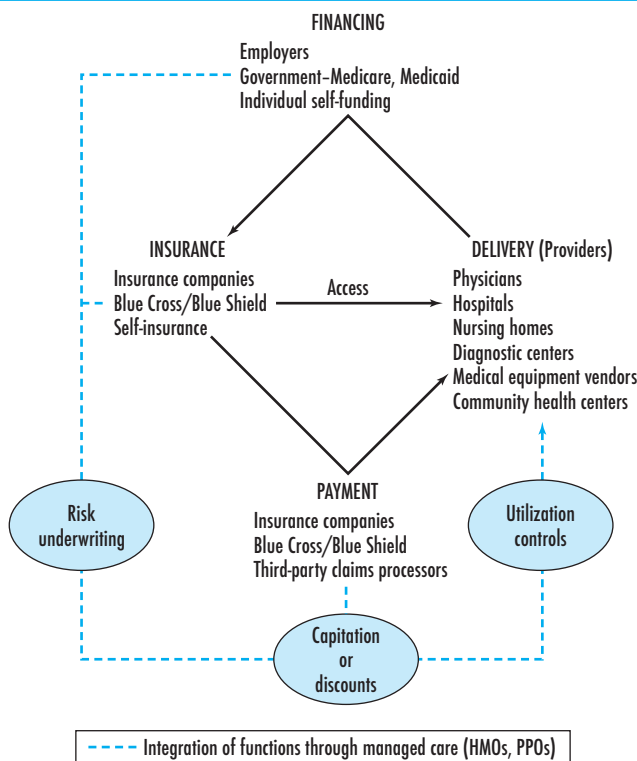


Figure 1.1 Managed Care: Integration of Functions

is provided close to the military personnel's place of work at the dispensary, sick bay, first aid station, or medical station. Routine medical services are provided at base dispensaries, in sick bays aboard ship, and at base hospitals. Advanced hospital services are provided in regional military hospitals. Although patients have little choice regarding how services are provided, the military medical care system generally provides high-quality health care.

Families and dependents of active-duty or retired career military personnel are either treated at the hospitals or dispensaries or are covered by *TriCare*, a program that is financed by the U.S. Department of Defense.

This insurance plan permits the beneficiaries to receive care from both private and military medical care facilities.

The Veterans Administration (VA) health care system is available to retired veterans who have previously served in the military, with priority given to those who are disabled. The VA system focuses on hospital care, mental health services, and long-term care. It is one of the largest and oldest (dating back to 1930s) formally organized health care systems in the world. Its mission is to provide medical care, education and training, research, contingency support, and emergency management for the U.S. Department of Defense medical care system. It provides health care to more than 5.5 million persons at over 1,100 sites, including 153 hospitals, 807 ambulatory and community-based clinics, 135 nursing homes, 209 counseling centers, 47 domiciliaries (residential care facilities), 73 home health care programs, and various contract care programs. The VA budget exceeds \$40 billion, and it employed a staff of nearly 280,000 as of 2010 (Department of Veterans Affairs, 2011; National Center for Veterans Analysis and Statistics, 2007).

The entire VA system is organized into 23 geographically distributed *Veterans Integrated Service Networks (VISNs)*. Each VISN is responsible for coordinating the activities of the hospitals, outpatient clinics, nursing homes, and other facilities located within its jurisdiction. Each VISN receives an allocation of federal funds and is responsible for equitable distribution of those funds among its hospitals and other providers. VISNs are also responsible for improving efficiency by reducing duplicative services, emphasizing preventive services, and shifting services from costly inpatient care to less costly outpatient care.

## Subsystem for Special Populations

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

comprehensive medical and enabling services (e.g., language translation, transportation, outreach, nutrition and health education, social support services, case management, and child care) targeted to the unique needs of vulnerable populations.

As an example, federally funded health centers have provided primary and preventive health services to rural and urban underserved populations for more than 30 years. The Bureau of Primary Health Care (BPHC), located within the Health Resources and Services Administration in the Department of Health and Human Services (DHHS), provides federal support for community-based health centers that include programs for migrant and seasonal farm workers and their families, homeless persons, public housing residents, and school-aged children. These services facilitate regular access to care for patients who are predominantly minority, low income, uninsured, or enrolled in Medicaid, the public insurance program for the poor. In 2010, the nationwide network of 1,124 community health organizations served 19.5 million people across 8,100 service sites, and handled a total of 77 million patient visits. Approximately 93 percent of this population was living on incomes that were less than 200% of the poverty level, and 38% were uninsured (Bureau of Primary Health Care, 2011). Health centers have contributed to significant improvements in health outcomes for the uninsured and Medicaid populations and have reduced disparities in health care and health status across socioeconomic and racial/ethnic groups (Politzer et al., 2003; Shi et al., 2001).

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

*Medicaid*, the third largest source of health insurance in the country, covering approximately 16% of the U.S. population, provides coverage for low-income adults, children, the elderly, and individuals with disabilities. This program is also the largest provider of long-term care to older Americans and individuals with disabilities.

In 1997, the U.S. government created the Children's Health Insurance Program (CHIP) to provide insurance to children in uninsured families. The program expanded coverage to children in families who have modest incomes but do not qualify for Medicaid. In 2009, the CHIP program

spent \$10 billion to cover approximately 7.7 million children (Centers for Medicare and Medicaid Services [CMS], 2011b). At little or no cost to the patient, CHIP pays for children's physician visits, immunizations, hospitalizations, and emergency room visits.

Despite the availability of government-funded health insurance, the United States' safety net is by no means secure. The availability of safety net services varies from community to community. Vulnerable populations residing in communities without safety net providers must often forego care or seek services from hospital emergency departments if available nearby. Safety net providers, in turn, face enormous pressure from the increasing number of uninsured and poor in their communities. The inability to shift costs for uncompensated care onto private insurance has become a significant problem as revenues from Medicaid—the primary source of financing for core safety net providers—have been declining because of limitations in public budgets.

## Integrated Delivery

Over the last decade, the hallmark of the U.S. health care industry has been organizational integration to form *integrated delivery systems (IDSs)*, or health networks. An IDS represents various forms of ownership and other strategic linkages among hospitals, physicians, and insurers. Its objective is to have one health care organization deliver a range of services. An IDS can be defined as a network of organizations that provides or arranges to provide a coordinated continuum of services to a defined population, and that is willing to be held clinically and fiscally accountable for the outcomes and health status of that population. From the standpoint of integration, the major participants or players in the health care delivery system are physicians, hospitals, and insurers. The key strategic position that physicians, hospitals, and insurers hold has given rise to many different forms of health networks.

As quality improvement and cost control receive increasing emphasis, integrated delivery is becoming more important to the delivery of health care in the United States. Integrated delivery is increasingly seen as a way to enhance efficiency by having one health delivery organization provide a wide variety of health care services to its surrounding community. Recent studies of highly integrated health delivery systems in the United States have shown that hospitals within such systems provide a higher quality of care compared to nonintegrated hospitals (Leibert, 2011). Although the difference between the two delivery systems in terms of cost-effectiveness is



negligible, clinical quality performance improves significantly in the highly integrated hospitals. Integration of communication among providers within a highly integrated system may be one reason that such systems can deliver high-quality services.

## Long Term Care Delivery

*Long-term care* (LTC) consists of medical and nonmedical care that is provided to individuals who are chronically ill or who have a disability. LTC includes not only health care but also support services for daily living, and is delivered across a wide variety of venues, including patients' homes, assisted living facilities, and nursing homes. In addition, family members and friends provide the majority of LTC services without getting paid for them. Medicare does not cover LTC; thus, costs associated with this form of care can impose a major burden on families. Medicaid covers several different levels of LTC services, but a person must be an indigent to qualify for Medicaid. LTC insurance is offered separately by insurance companies, but most people do not purchase these plans because premiums can be unaffordable. By 2020, more than 12 million Americans are projected to require LTC, which will impose a severe strain on the nation's financial resources (CMS, 2011a).

## Public Health System

The mission of the *public health system* is to improve and protect community health. The Institute of Medicine's *Future of Public Health in the 21st Century* has outlined the need for a more robust public health infrastructure and a population-based health approach for a healthier U.S. population (Centers for Disease Control and Prevention [CDC], 2011). The National Public Health Performance Standards Program identifies ten essential public health services that a system needs to deliver:

1. Monitoring health status to identify and solve community health problems
2. Diagnosing and investigating health problems and hazards
3. Informing and educating people about health problems and hazards
4. Mobilizing the community to solve health problems
5. Developing policies to support individual and community health efforts

6. Enforcing laws and regulations to support health safety
7. Providing people with access to necessary care
8. Assuring a competent and professional health workforce
9. Evaluating the effectiveness, accessibility, and quality of personal and population-based health services
10. Performing research to discover innovative solutions to health problems

## CHARACTERISTICS OF THE U.S. HEALTH CARE SYSTEM

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

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

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

## **No Central Governing Agency; Little Integration and Coordination**

The U.S. health care system stands in conspicuous contrast to the health care systems of other developed countries. Most developed countries have centrally controlled universal health care systems that authorize the financing, payment, and delivery of health care to all residents. In contrast, the U.S. system is not centrally controlled; it is financed both publicly and privately and, therefore, features a variety of payment, insurance, and delivery mechanisms. Private financing, predominantly through employers, accounts for approximately 54% of total health care expenditures; the government finances the remaining 46% (National Center for Health Statistics, 2009).

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

## **Technology Driven and Focusing on Acute Care**

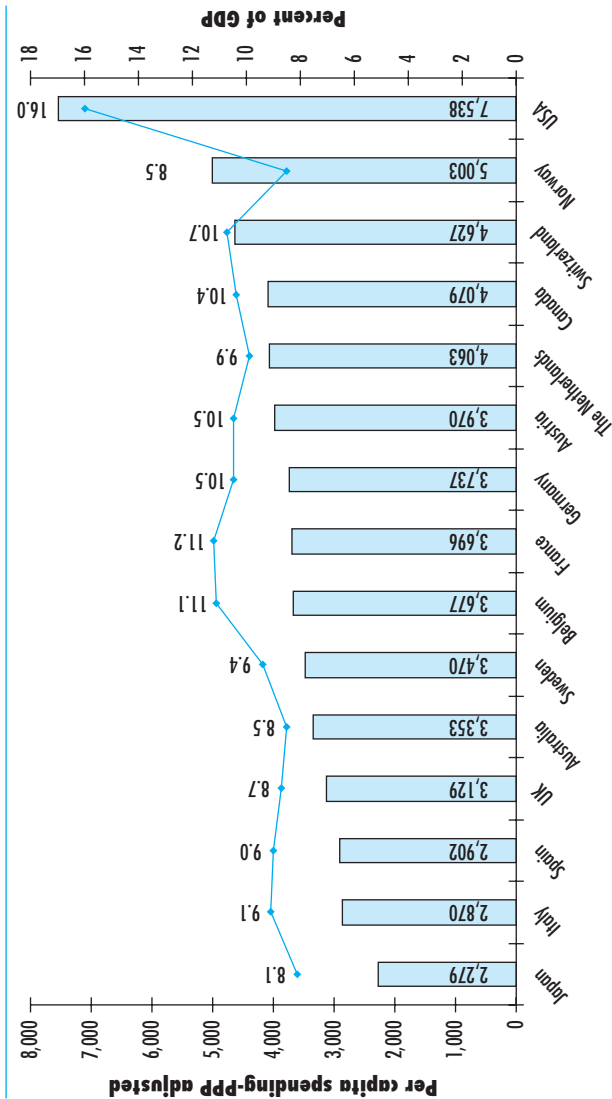
The United States is a hotbed of research and innovation in new medical technology. Growth in science and technology often creates a demand for new services despite shrinking resources to finance sophisticated care. Other factors contribute to increased demand for expensive technological care. For example,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

Although technology has ushered in a new generation of successful interventions, the negative outcomes resulting from its overuse are many. For example, the use of high technology adds to the rising costs of health care, making it more difficult for employers to extend insurance to part-time workers or for insurance companies to lower their premiums. It is essential to think twice before assuming that the best solution always involves technology, given that there are limited resources to invest in the American health care system. Considering the broad benefits of primary care in preventing acute conditions that ultimately require technological intervention, it seems essential to strive for a balanced investment in both high- and low-technology medicine.

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

The United States spends more than any other developed country on health care (primarily medical care), and costs continue to rise at an alarming rate. Despite spending such a high percentage of the nation's gross domestic product (16% in 2008 and 17.6% in 2009) on health care, many U.S. residents have limited access to even the most basic care (Anderson et al., 2003) (see [Figure 1.2](#)).

*Access* refers to the ability of an individual to obtain health care services when needed. In the United States, access is restricted to those who (1) have health insurance through their employers, (2) are covered under a government health care program, (3) can afford to buy insurance out of their own private funds, (4) are able to pay for services privately, or (5) can obtain services through safety net providers. Health insurance is the primary means for ensuring access. In 2010, the number of uninsured Americans—those without private or public health insurance coverage—was estimated to be 48.2 million, representing 18.2% of the U.S. population (National Center for Health Statistics, 2011). For consistent basic and routine care, commonly referred to as primary care, the uninsured are unable to see a physician unless they can pay on an out-of-pocket basis. Those who cannot afford to pay generally wait until health problems develop, at which point they may be able to receive services in a hospital emergency department. It is well acknowledged that the absence of insurance inhibits a patient's ability to receive well-directed, coordinated, and continuous health care through access to primary care services and, when needed, referral to specialty services. Experts generally believe that inadequate access to basic and routine primary care services is the main reason that the United States lags behind



**Figure 1.2** Total Health Expenditure per Capita and as a Share of GDP, United States and Selected Countries, 2008  
Source: Data from Organization for Economic Cooperation and Development. OECD health data. OECD Health Statistics [database], 2010. doi: 10.1787/dats-00350-en. Accessed June 30, 2011.

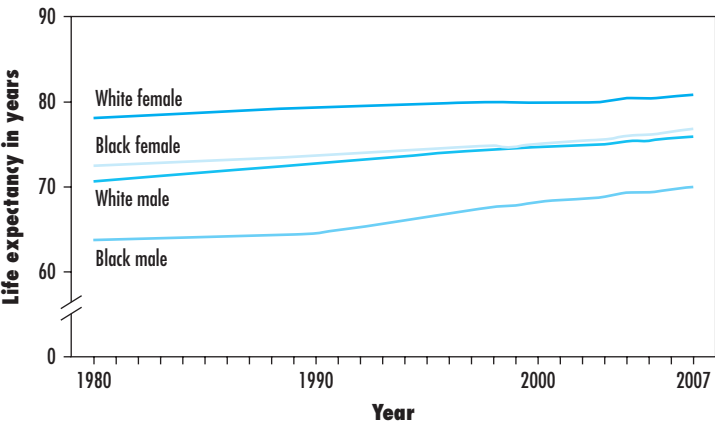
other developed nations in measures of population health, such as infant mortality and overall life expectancy (see [Figure 1.3](#) and [Figure 1.4](#)).

### Imperfect Market Conditions

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

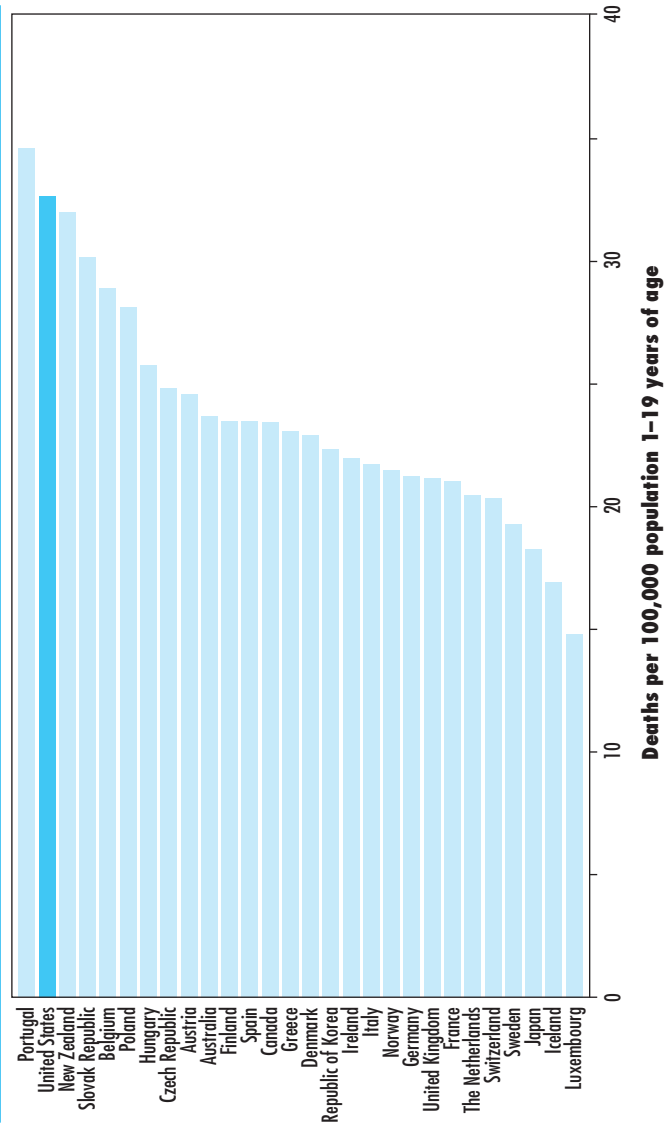
In a free market, multiple patients (buyers) and providers (sellers) act independently. In a free market, patients should be able to choose their provider based on price and quality of services. If matters were this simple, patient choice would determine prices by the unencumbered interaction of supply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

For the health care market to be free, unrestrained competition must occur among providers on the basis of price and quality. Generally speaking,



**Figure 1.3** Life Expectancy at Birth

Source: Centers for Disease Control and Prevention, National Center for Health Statistics. *Health, United States, 2010*, Figure 1. Data from the National Vital Statistics Systems.



**Figure 1.4** Death Rates among Children 1–19 Years of Age, by OECD Country. Notes: OECD: Organization for Economic Cooperation and Development. Data shown are 3-year average of most recent data, 2001–2006. Data for Belgium are for 1995–1997; data for Denmark are for 1999–2001. Source: Centers for Disease Control and Prevention, National Center for Health Statistics. *Health, United States, 2010*, Figure 26. Data from the National Vital Statistics Systems.

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

A free market requires that patients have information about the availability of various services. Free markets operate best when consumers are educated about the products they are using, but patients are not always well informed about the decisions that need to be made regarding their care. Choices involving sophisticated technology, diagnostic methods, interventions, and pharmaceuticals can be difficult and often require physician input. Acting as an advocate, primary care providers can reduce this information gap for patients. Increasingly, health care consumers have begun to take the initiative to educate themselves through the use of Internet resources for gathering medical information. Pharmaceutical product advertising (i.e., direct-to-consumer advertising) also has altered consumer expectations and increased awareness of available medications.

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

In a free market, patients must directly bear the cost of services received. The fundamental purpose of insurance is to cover major expenses when unlikely events occur; but health insurance covers even basic and routine services, which undermines this fundamental principle. Health insurance



coverage for minor services such as colds, coughs, and earaches amounts to pre-payment for such services. A moral hazard exists, in that after enrollees have purchased health insurance, they typically use health care services to a greater extent than they would without health insurance.

In a free market for health care, patients as consumers make decisions about the purchase of health care services. The main factors that severely limit the patient's ability to make health care purchasing decisions have already been discussed, but at least two additional factors limit this ability to make decisions. First, decisions about the utilization of health care are often determined by need rather than by price-based demand. *Need* has generally been defined as the amount of medical care that medical experts believe a person should have to remain or become healthy. Second, the delivery of health care can result in creation of demand. This outcome follows from self-assessed need that, coupled with moral hazard, leads to greater utilization. The result is a creation of an artificial demand because prices are not taken into consideration. Practitioners who have a financial interest in additional treatments may also create artificial demand, commonly referred to as "provider-induced demand."

## Government as Subsidiary to the Private Sector

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

## Fusion of Market Justice and Social Justice

Market justice and social justice are two contrasting theories that govern the production and distribution of health care services. The principle of *market justice* places the responsibility for fair distribution of health care on market forces in a free economy. In such a system, medical care and its benefits are distributed on the basis of people's willingness and ability to pay (Santerre & Neun, 1996, p. 7). In contrast, *social justice* emphasizes the well-being of the community over that of the individual; thus the inability to obtain medical services because of a lack of financial resources is considered

unjust. In a system that blends public and private resources, the two theories often work well together, contributing ideals from both theories. As an example, employed individuals with middle-class incomes obtain employer-sponsored health insurance, whereas the most needy members of society depend on government-sponsored programs. On the other hand, the two principles of justice also create conflicts. For example, many of the small employers in the United States do not offer health insurance or, if it is offered, many employees cannot afford the cost. Yet, these individuals do not qualify for government-sponsored health insurance which is available mainly to the elderly, the disabled, and the poor. Such uninsured individuals and their families may have difficulty obtaining health care when needed because safety net services are also not widely available throughout the nation.

### Multiple Players and Balance of Power

The U.S. health services system involves multiple players such as physicians, administrators of health service institutions, insurance companies, large employers, and the government. Big business, labor, insurance companies, physicians, and hospitals make up a set of powerful and politically active special-interest groups represented before lawmakers by high-priced lobbyists. Each player has a different economic interest to protect; however, problems frequently arise because the self-interests of the various players are often at odds. For example, providers seek to maximize government reimbursement for services delivered to Medicare and Medicaid patients, but the government wants to contain cost increases. The fragmented self-interests of the various players produce counteracting forces within the system. One positive effect of these opposing forces is that they prevent any single entity from dominating the system. In an environment that is rife with motivations to protect conflicting self-interests, achieving comprehensive, system-wide health care reforms is next to impossible, and cost containment remains a major challenge. Consequently, the approach to health care reform in the United States is best characterized as incremental or piecemeal and can sometimes be regressive when presidential administrations change. (Note: the health care reform under the ACA of 2010 is really an example of incremental health care financing reform.)

### Quest for Integration and Accountability

Currently in the United States, there is a drive to use primary care as the organizing hub for continuous and coordinated health services. Although this

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

### **Access to Health Care Services Selectively Based on Insurance Coverage**

Unlike in countries with national health plans providing universal coverage, access to health care services in the United States is limited. Although the United States offers some of the best medical care in the world, this care is often available only to individuals who have health insurance plans that provide adequate coverage or who have sufficient resources to pay for the procedures themselves.

In addition, as mentioned earlier, there is a relatively large population of uninsured in the country. The uninsured have limited options when seeking medical care. They can either (1) pay physicians out of pocket at rates that are typically higher than those paid by insurance plans, (2) seek care from safety net providers, or (3) obtain treatment for acute illnesses at a hospital emergency department for which hospitals do not receive direct payments unless patients have the ability to pay. The Emergency Medical Treatment and Labor Act of 1986 requires screening and evaluation of every patient, provision of necessary stabilizing treatment, and hospital admission when necessary, regardless of ability to pay. Unfortunately, the inappropriate use of emergency departments results in cost-shifting, whereby patients able to pay for services, privately insured individuals, employers, and the government ultimately cover the costs of medical care provided to the uninsured in emergency rooms.

### **Legal Risks Influence Practice Behaviors**

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

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

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## HEALTH CARE SYSTEMS OF OTHER DEVELOPED COUNTRIES

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

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

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

### Canada

Canada's national health insurance system, referred to as Medicare, was initially established by the Medical Care Act of 1966, providing 50/50

cost sharing for provincial or territorial medical insurance plans. The system provides universal coverage with free care at the point of contact and is publicly funded through taxes, although it is privately run. Most doctors are private practitioners who are paid on a fee-for-service basis and submit service claims directly to the health insurance plan for payment. The federal government determines how health care is run, whereas provincial and territorial governments administer and deliver health care services and health insurance plans.

To receive full funding for health insurance, the provincial governments in Canada must meet five criteria. Care must be (1) available to all eligible residents of Canada, (2) comprehensive in coverage, (3) accessible without financial and other barriers, (4) portable within the country and while traveling abroad, and (5) publicly administered.

Canada's health care system relies heavily on primary care physicians, who account for 51 percent of all active physicians in the country. These physicians serve two key functions. First, they provide first-contact health care services, and second, they coordinate patient health care services across the system to ensure continuity. Primary physicians arrange patient access to specialists, hospital admissions, and diagnostic testing and prescription drug therapy.

Canada has recently established wait time guarantees in an effort to decrease the wait times for patients. It is also putting an emphasis on improving health information technology to improve efficiency. In 2005, the Supreme Court of Canada ruled that provinces cannot prohibit private health insurance being offered for medically necessary services. Because of the long waiting lists, a significant increase in private health insurance is likely in the future of Canadian health care.

## **Great Britain**

In Great Britain, universal health coverage is provided by the National Health Service (NHS), which is publicly funded and run, and whose operation reflects the principle that every citizen is entitled to health care. Additionally, the purchase of private health insurance is a choice for individuals, with 7 million people (12% of the population) being covered by these plans.

The NHS has been plagued by serious problems that vary in severity across the country involving funding, service, and staff. One of the largest concerns plaguing the NHS is referred to as "health tourism," which occurs

when individuals travel into the country to get treated, escaping monetary fees and costing the agency almost £200 million (or US\$300 million) each year. There are also long wait times for care, especially elective procedures, with 41.2% of patients reporting a wait period of 12 or more weeks to see a specialist or receive surgical care. Finally, much of the medical equipment used is outdated, as there is little funding directed toward technological innovation.

Due to rising fiscal constraints, Great Britain may see a major shift in the way in which health care is delivered in coming years. The plan is to shift care from the bureaucracy of the central government to doctors on a more local level. In this way, the British government hopes to reduce administrative costs by as much as 45% and to deliver care more efficiently. The NHS also hopes that by shifting decision making to the local level, more power will be given to patients in the health decision-making process (Department of Health, 2010).

## Germany

Under government mandates, German employees and employers are required to provide 50/50 contributions if the employed individual earns less than a specific level of income (€40,500 per year in 2004 or US\$55,000). The health plan also covers the employee's spouse and children (up to a certain age). If the employee's income exceeds the statutory limit, the individual is given a choice between paying for private health insurance or the state insurance. More than 90 percent of the population is covered by national health insurance, while the remainder is privately insured. Although this system prevents the growth of an uninsured population, it has met with mixed results. In 2003, the German health ministry concluded that the system suffers from a lack of competition, superfluous, insufficient, or inappropriate care, shrinking revenue, and an aging population.

Recently, Germany has been trying to move toward a system with more integrated delivery of health care, particularly because of the rising levels of chronic disease in an aging population. In addition, the implementation of integrated care may help combat the growing perceptions of low quality of care by the German people and lower the cost of delivering care (Amelung & Wolf, 2011).

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

Table 1.1 Health Care Systems of Selected Industrialized Countries

	United States	Canada	United Kingdom	Germany
Type	Pluralistic	National health insurance	National health system	Socialized health insurance
Ownership	Private	Public/private	Public	Private
Financing	Voluntary, multipayer system (premiums or general taxes)	Single-payer (general taxes)	Single-payer (general taxes)	Employer–employee (mandated payroll contributions and general taxes)
Reimbursement (hospital)	Varies (DRGs, negotiated fee-for-service, per diem, capitation)	Global budgets	Global budgets	Per diem payments
Reimbursement (physicians)	RBRVS, fee-for-service	Negotiated fee-for-service	Salaries and capitation payments	Negotiated fee-for-service
Consumer copayment	Small to significant	Negligible	Negligible	Negligible
Life expectancy for women	83	82.7	81.8	80.4
Infant mortality per 1,000 live births	5.1	3.9	4.7	6.8
Expenditures as a percentage of GDP	10.0	8.4	10.5	16.0

Note: DRGs, diagnosis-related groups; RBRVS, resource-based relative value scale. Data from Organization for Economic Cooperation and Development. OECD health data. OECD Health Statistics [database], 2010. doi: 10.1787/data-00350-en. Accessed June 30, 2011.

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## SYSTEMS FRAMEWORK

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

### System Foundations

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

### System Resources

No mechanism for the delivery of health services can fulfill its primary objective without the necessary human and nonhuman resources. Human resources consist of the various types and categories of workers directly engaged in the delivery of health services to patients. Such personnel—including physicians, nurses, dentists, pharmacists, other professionals trained at the doctoral level, and numerous categories of allied health professionals—usually have direct contact with patients. Numerous ancillary workers, such as those involved in billing and collection, marketing and public relations, and building maintenance, often play important but indirect supportive roles in the delivery of health care. Health care managers are needed to manage and coordinate various types of health care services.

### System Processes

The system resources influence the development and change in physical structures, such as hospitals, clinics, and nursing homes. These structures



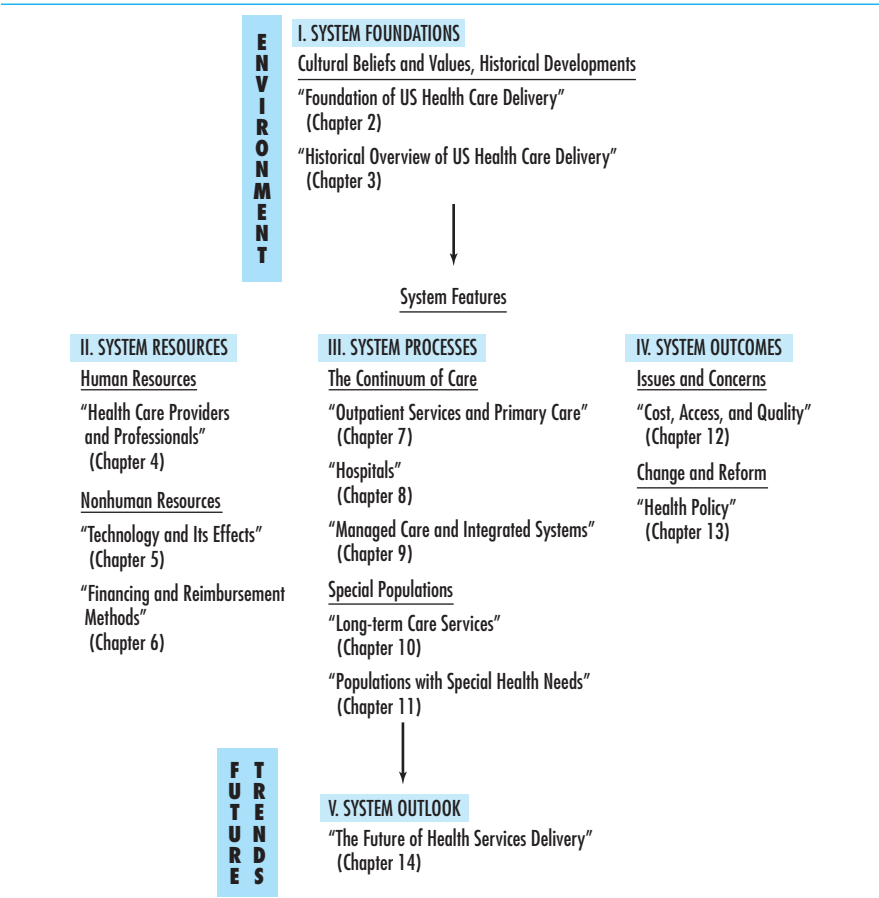


Figure 1.5 Systems Framework

are associated with distinct processes of health services delivery, and the processes are associated with distinct health conditions. Most health care services are delivered in noninstitutional settings, which are mainly associated with processes referred to as outpatient care. Institutional health services (inpatient care) are predominantly associated with acute care hospitals. Managed care and integrated systems represent a fundamental change in the financing (including payment and insurance) and delivery

of health care. Even though managed care represents an integration of the resource and process elements of the systems model, it is discussed as a process for the sake of clarity and continuity of the discussions. Special institutional and community-based settings have been developed for long-term care and mental health.

## System Outcomes

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

## System Outlook

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

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## CONCLUSION

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

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