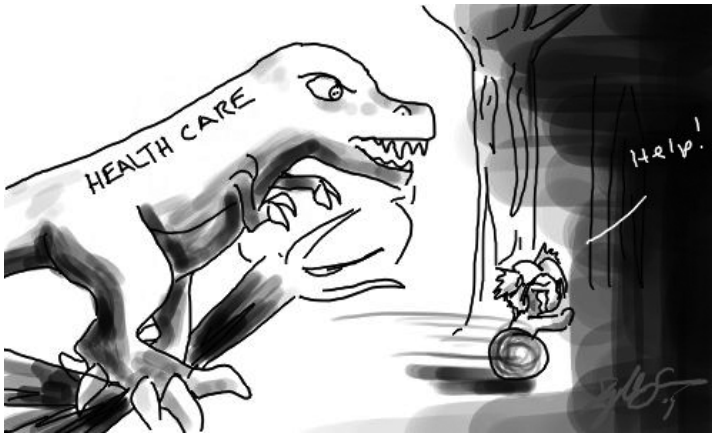


# Chapter 1

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



### INTRODUCTION

The United States has a unique system of health care delivery. For the purposes of this discussion, “health care delivery” and “health services delivery” can have slightly different meanings, but in a broad sense, both terms refer to the major components of the system and the processes that enable people to receive health care. In a more restricted sense, the terms refer to the act of providing health care services to patients. The reader can identify which meaning is intended by paying attention to context.

In contrast to the United States, most developed countries have national health insurance programs that are run by the government and financed through general taxes. Almost all of the citizens in such countries are entitled to receive health care services that include routine and basic health care. These countries have what is commonly referred to as universal access. All American citizens, on the other hand, are not entitled to routine

and basic health care services. Although the U.S. health care delivery system has evolved in response to concerns about cost, access, and quality, the system has been unable to provide universally a basic package of health care at an affordable cost. One barrier to universal coverage is the unnecessary fragmentation of the U.S. delivery system, which is perhaps its central feature (Shortell et al., 1996); however, the enormous challenge of expanding access to health care while containing overall costs and maintaining expected levels of quality continues to intrigue academics, policy makers, and politicians.

To make learning the structural and conceptual bases for the delivery of health services easier, this book is organized by the systems framework, which is presented at the end of this chapter. One of the main objectives of Chapter 1 is to provide a broad understanding of how health care is delivered in the United States.

The following overview introduces the reader to several concepts that are treated more extensively in later chapters. The U.S. health care delivery system is complex and massive. Interestingly, it is not actually a system in the true sense, although it is called a system when its various features, components, and services are referenced. Hence, it may be somewhat misleading to talk about the American health care delivery “system” (Wolinsky, 1988, p. 54), but the 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. Total employment in various health delivery settings is almost 14.4 million, including professionally active doctors of medicine (MDs), doctors of osteopathy (DOs), active nurses, dentists, pharmacists, and administrators. Approximately 382,000 physical, occupational, and speech therapists provide rehabilitation services. The vast array of institutions includes 5,700 hospitals, 15,900 nursing homes, almost 2,900 inpatient mental health facilities, and 11,000 home health agencies and hospices. Close to 800 programs include 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 144 medical and osteopathic schools, 56 dental schools, 109 schools of pharmacy, and more than 1,500 nursing programs located throughout the country.

There are 201.7 million Americans with private health insurance coverage, 40.3 million Medicare beneficiaries, and 38.3 million Medicaid recipients. Health insurance can be purchased from approximately 1,000 health insurance companies and 70 Blue Cross/Blue Shield plans. The managed care sector includes approximately 405 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, 1999; National Center for Health Statistics, 2007; U.S. Bureau of the Census, 1998; U.S. Census Bureau, 2007; Bureau of Labor Statistics, 2008).

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## SUBSYSTEMS OF U.S. HEALTH CARE DELIVERY

The United States does not have a universal health care delivery system enjoyed by everyone. Instead, multiple subsystems have developed, either through market forces or the need to take care of certain population segments. 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. It is the most dominant health care delivery system in the United States today and is available to most Americans (for more details on managed care, please refer to Chapter 9).

The employer or government is the primary financier of the managed care system. Instead of purchasing coverage from a traditional insurance company, the financier contracts with a managed care organization (MCO), such as an HMO or a PPO, to offer a selected health plan to employees. In this case, the MCO functions like an insurance company and promises to provide health care services contracted under the health plan to the enrollees of the plan.

The term enrollee (member) refers to the individual covered under the plan. The contractual arrangement between the MCO and the enrollee—including the collective array of covered health services that the enrollee is entitled to—is referred to as the health plan (or “plan” for short). The health plan uses selected providers from whom the enrollees can choose to receive routine services. Primary care providers or general practitioners typically manage routine services and determine appropriate referrals for higher level or specialty services, often earning them the name of gatekeeper. The choice of major service providers, such as hospitals, is also limited. Some of the 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 then 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 a discounted fee. 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. 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.

**Figure 1.1** illustrates the basic functions and mechanisms that are necessary for the delivery of health services within managed care. The key functions of financing, insurance, delivery, and payment make up the quad-function model. Managed care arrangements integrate 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 and also to 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. It is comprehensive and covers preventive as well as treatment services that are provided by salaried health care personnel, many of whom are themselves in the military or uniformed services. This system combines public health

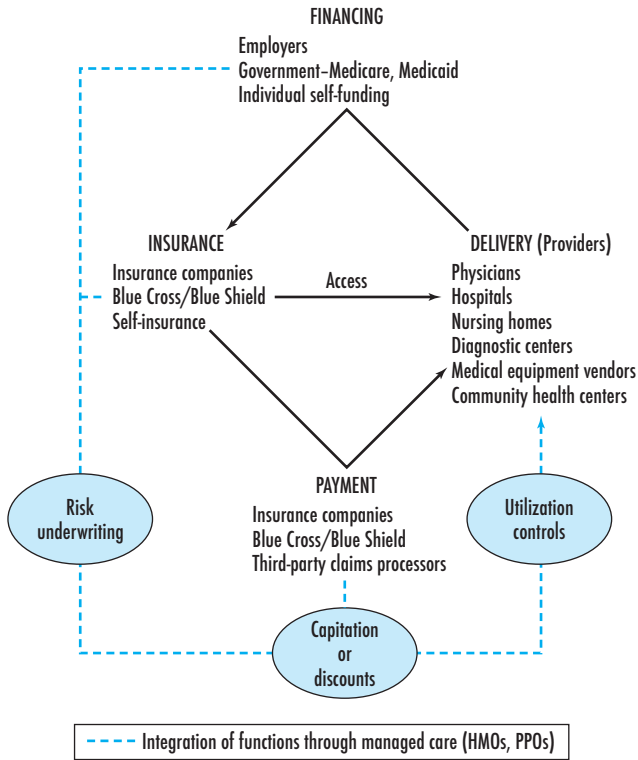


Figure 1.1 Managed Care: Integration of Functions

with medical services. Routine ambulatory care is provided close to the military personnel’s place of work at the dispensary, sick bay, first-aid station, or medical station. Routine hospital services are provided at base dispensaries, in sick bays aboard ship, and at base hospitals. Complicated hospital services are provided in regional military hospitals. Long-term care is provided through Veterans Administration (VA) facilities to certain retired military personnel. Although patients have little choice regarding how services are provided, in general, the military medical care system 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 military. This insurance plan permits the beneficiaries to receive care from private medical care facilities as well as military ones.

The VA health care system is available to retired veterans of previous military service, 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 (1946) 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 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, 732 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 is over \$30 billion, and it employs a staff of 263,350 as of 2007 (National Center for Veterans Analysis and Statistics, 2007). The entire VA system is organized into 22 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 unnecessarily duplicative services, by emphasizing preventive services, and by shifting services from costly inpatient care to less costly outpatient care.

## Subsystem for Vulnerable Populations

Vulnerable populations, particularly those who are poor and uninsured or of minority and immigrant status, live in geographically or economically disadvantaged communities and receive care from “safety net” providers. These providers include health centers, physicians’ offices, and hospital outpatient and emergency departments; of these, health centers are expressly designed to serve the underserved. Consistent with their unique role and mission, safety net providers offer comprehensive medical and enabling (e.g., language translation, transportation, outreach, nutrition and health education, social support services, case management, and child care) services targeted to the needs of vulnerable populations.

For example, for over 30 years, federally funded health centers have provided primary and preventive health services to rural and urban underserved populations. The Bureau of Primary Health Care (BPHC), located in 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 receiving Medicaid. By the end of calendar year 2002, the nationwide network of 843 reporting health centers delivered essential primary and preventive care at more than 3,500 sites, serving more than one fifth (more than 11 million) of the nation's 50 million underserved persons (Bureau of Primary Health Care, 2002). 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).

In addition to health centers, government health insurance programs, such as Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP), provide vulnerable populations with access to health care services.

Medicare is one of the largest sources of health insurance in the country, serving nearly 39 million people, who are either 65 years old or older and who are suffering from certain disabilities or are diagnosed with end-stage renal disease. Managed by the Health Care Financing Administration (HCFA), another division within the DHHS, Medicare is composed of three parts, Part A, Part B, and most recently Part D. Part A and Part B were the original divisions of the Medicare program. Part A covers health care received in hospitals, nursing facilities, hospice care, and some home health care with no monthly premiums, while Part B covers doctors' services and other outpatient care not included in Part A with an additional monthly premium, which in 2008 cost about \$96.40 per month. Part D, or the Medicare Prescription Drug Plan, provides coverage for brand-name and generic prescription drugs at pharmacies involved in the program. The program is designed to protect those in Medicare burdened with very high drug costs or unexpected prescription bills in the future.

In addition, Medicaid, the third largest source of health insurance in the country, provides coverage for low-income women, children, elderly

people, and individuals with disabilities, covering 12% of the U.S. population. The program offers these vulnerable populations health insurance and long-term care for older Americans and individuals with disabilities and also provides additional coverage for low-income Medicare recipients for services not provided in the Medicare Part A Plan, such as outpatient care and prescription drugs.

Finally, with the growing uninsured population, the government has taken the initiative to provide insurance to children in uninsured families through SCHIP. Established in 1997, it expands coverage to children in families who do not qualify for Medicaid but who have a modest income, although each state has its own rules of eligibility. For little or no cost, the insurance pays for the child's physician visits, immunizations, hospitalizations, and emergency room visits.

America's safety net, however, is by no means secure, and the availability of safety net providers varies from community to community. Vulnerable populations residing in communities without safety net providers have to forego care or seek care from hospital emergency departments if one is nearby. Safety net providers 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 third-party financing for core safety net providers, are restricted.

## 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 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 the 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 gives rise to different forms of IDSs (see Chapter 9).



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

The health care system of a nation is influenced by external factors, including the political climate, stage 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 influences 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 eight main areas of distinction (see [Exhibit 1.1](#)).

### 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. The centrally controlled universal health care system that most developed countries have authorizes the financing, payment, and delivery of health care to all residents. The U.S. system, however, is not centrally controlled and therefore has a variety of payment, insurance, and delivery mechanisms, and health care is financed both publicly and privately. Private financing, which is predominantly through employers, accounts for approximately 55% of total health care expenditures; the government finances the remaining 45% (National Center for Health Statistics, 2002).

**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 on cost, unequal in access, average in outcome
- Delivery of health care under imperfect market condition
- Legal risks influence practice behaviors
- Government as subsidiary to the private sector
- Market justice vs. social justice: conflict throughout health care
- Multiple players and balance of power
- Quest for integration and accountability
- Access to health care services is selectively based on insurance coverage

Centrally controlled health care systems are less complex. They are also less costly because they can manage total expenditures through global budgets and can govern the availability and utilization of services. Because the United States has such a large private system of financing as well as delivery, the majority of hospitals and physician clinics are private businesses, 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 in order 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 has been the 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: Patients assume that current technologies offer the best care; 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 by using it. 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 cost of highly technical interventions 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. Because there are limited resources to invest in the American health care system, it is essential to think twice before assuming that the best solution always involves technology. 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 on 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 (13%) of the nation's gross domestic product on health care, many U.S. residents have limited access to even the most basic care (Anderson et al., 2003).

Access means 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, and (4) are able to pay for services privately. Health insurance is the primary means for ensuring access. In 2000, the number of uninsured Americans—those without private or public health insurance coverage—was estimated to be 40.5 million or 16.8% of the U.S. population (National Center for Health Statistics, 2002). For consistent basic and routine care, commonly referred to as primary care, the uninsured are unable to see a physician unless they can pay the physician's fees. Those who cannot afford to pay generally wait until health problems develop, at which point they may be able to receive services free of charge in a hospital emergency department. Uninsured Americans therefore are able to obtain medical care for acute illness. Hence, one can say that the United States does have a form of universal catastrophic health insurance even for the uninsured (Altman & Reinhardt, 1996, p. xxvi).

It is well acknowledged that the absence of insurance inhibits the 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 the inadequate access to basic and routine primary care services is the main reason that the United States, in spite of being the most economically advanced country, lags behind other developed nations in measures of population health such as infant mortality and overall life expectancy.

## **Imperfect Market Conditions**

Under national health care programs, patients 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. The delivery and consumption of health care in the United States do not quite meet the basic tests of a free market. 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 it were this simple, patient choice would determine prices by the unencumbered interaction of supply and demand. Theoretically, at least, prices are negotiated between payers and providers; however, in many cases, the payer is not the patient but an MCO, Medicare, or Medicaid. Because prices are set by agencies external to the market, 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, 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 sectors of the country, a single giant medical system has taken over as the sole provider of major health care services, restricting competition. As the health care system continues to move in this direction, it appears that only in large metropolitan areas will there be more than one large integrated system competing to get the business of the health plans.

A free market requires that patients have information about the 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. Recently, health care consumers have taken the initiative to educate themselves with the use of Internet resources for

gathering medical information. Pharmaceutical product advertising is also having an impact on consumer expectations and increasing awareness of available medications.

In a free market, patients have information on price and quality for each provider. 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 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 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 recent years, the quality of care has received much attention. Performance rating of health plans has met with some success; however, apart from sporadic news stories, the public generally has scant information on the quality of health care providers.

In a free market, patients must directly bear the cost of services received. The purpose of insurance is to protect against the risk of unforeseen major events. Because the fundamental purpose of insurance is to meet major expenses when unlikely events occur, having insurance for basic and routine health care undermines the principle of insurance. Health insurance coverage for minor services such as colds, coughs, and earaches amounts to prepayment for such services. There is a moral hazard that after enrollees have purchased health insurance they will use health care services to a greater extent than if they were without health insurance. Even certain referrals to higher level services may be foregone if the patient has to bear the full cost of these services.

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. At least two additional factors limit the ability of patients to make decisions. First, decisions about the utilization of health

care are often determined by need rather than 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 (Feldstein, 1993, p. 74–75). Second, the delivery of health care can result in creation of demand. This follows from self-assessed need that, coupled with moral hazard, leads to greater utilization. This creates an artificial demand because prices are not taken into consideration. Practitioners who have a financial interest in additional treatments also create artificial demand (Hemenway & Fallon, 1985), 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 the provision of health care. In the United States, however, the private sector plays the dominant role. This can be explained to some degree 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 protections, support for research and training, and care of vulnerable populations.

### **Market Justice versus Social Justice: Conflict Throughout Health Care**

Market justice and social justice are two contrasting theories that govern the production and distribution of health care services in the United States. The principle of market justice places the responsibility for the fair distribution of health care on the market forces in a free economy. 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 would be considered unjust. A just distribution of benefits must be based on need, not simply one's ability to purchase them in the marketplace. In a partial public and private health care system, the two theories often work well hand in hand, contributing ideals from both theories; however, market justice principles tend to prevail. As mentioned before, Americans generally prefer market solutions to government intervention in

health care financing and delivery. Unfortunately, market justice results in the unequal allocation of health care services, neglecting critical human concerns that are not confined to the individual but have broader, negative impacts on society (see Chapter 2 for contrast between market and social justice).

## **Multiple Players and Balance of Power**

The U.S. health services system involves multiple players. The key players in the system have been physicians, administrators of health service institutions, insurance companies, large employers, and the government. Big business, labor, insurance companies, physicians, and hospitals make up the powerful and politically active special interest groups represented before lawmakers by high-priced lobbyists. Each player has a different economic interest to protect. The problem is that the self-interests of each player 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 reforms is next to impossible, and cost containment remains a major challenge. Consequently, the approach to health care reform in the United States is characterized as incremental or piecemeal and is sometimes regressive when administrations change followed by its ripple effect on government health agencies.

## **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, the model's development stalled before reaching its full potential. The envisioned role for primary care would include integrated health care by offering comprehensive, coordinated, and continuous services with a seamless delivery. Furthermore, the model emphasizes the importance of the patient-provider relationship and how it can best function to improve the

health of each individual and thus strengthen the population. Integral to the relationship is the concept of accountability. Accountability on the provider's behalf means ethically 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 Is Selectively Based on Insurance Coverage**

Unlike countries with national health plans providing universal access, the United States' access to health care services is limited. Access is granted only to individuals who (1) have health insurance through their employers, (2) are covered under a government health care program, (3) can afford to buy insurance with their own private funds, and (4) can pay for services privately. Although the United States offers some of the best medical care in the world, this care is often available only to individuals with health insurance plans that provide adequate coverage or sufficient resources to pay for the procedures themselves.

In addition, there is a relatively large population of uninsured in the country. In 2006, 47 million people (15.8% of the population) were uninsured, meaning they were not covered by any type of insurance program, public nor private (DeNavas-Walt et al., 2006). This statistic does not include individuals in the population who are underinsured or only intermittently insured in a given year.

The uninsured have limited options when seeking medical care. They can either (1) pay physicians out of pocket that are typically at higher rates than those paid by insurance plans, (2) access federally funded health centers, 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, necessary stabilizing treatment, and admitting when necessary, regardless of ability to pay. Unfortunately, the inappropriate use of emergency departments results in cost-shifting, where patients able to pay for services, privately insured individuals, employers, and the government ultimately cover the costs provided to the uninsured in the emergency room. Also, the lack of insurance restricts the patients' capability



to receive well-directed, coordinated, and continuous health care through access to primary care services, and when necessary, referral to specialty services.

## **Legal Risks Influence Practice Behaviors**

Americans as a society are quick to engage in lawsuits. Motivated by prospects of enormous jury awards, people are easily prompted to drag alleged offenders into the courtroom because of the slightest perceptions of incurred harm. Because private health care providers are increasingly becoming more susceptible to litigations, risk of malpractice lawsuits is a serious consideration in the practice of medicine. As a form of protection, most providers engage in what is known as defensive medicine by prescribing additional diagnostic tests, scheduling checkup appointments, and maintaining abundant documentation on cases. Many of these efforts are unnecessary and only drive up costs and inefficiency.

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## **HEALTH CARE SYSTEMS OF OTHER DEVELOPED COUNTRIES**

Most Western European countries have national health care programs that provide universal access. There are three basic models for structuring national health care systems. In a system under National Health Insurance, such as 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), National Health Insurance requires a tighter consolidation of the financing, insurance, and payment functions, which are coordinated by the government. Delivery is characterized by detached private arrangements.

In a national health system, such as the one in Great Britain, in addition to financing a tax-supported national health insurance program, the government also manages the infrastructure for the delivery of medical care. 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, a National Health System requires a tighter consolidation of all four functions, typically by the government.

In a socialized health insurance system, such as 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 a 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 in 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 fee-for-service and submit service claims directly to the health insurance plan for payment. The federal government is responsible for establishing the constitution that determines how health care is run, whereas provincial and territorial governments administer and deliver health care services and health insurance plans. In 1984, the addition of the Canadian Health Act solidified and defined five principles and criteria for territorial and provincial governments to meet in order to receive full funding for health insurance plans. 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% of 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.

## Great Britain

In Great Britain, universal health coverage is provided by the National Health Service (NHS), which is publicly funded and run, relying on the belief that every citizen is entitled to health care. Through this system, all basic services, visits to primary care physicians and specialists, inpatient care, or x-ray and pathology services are free, whereas other costs are covered by the patient in full or subsidized by the government. Additionally, the purchase of private health insurance is also a choice for individuals with 7 million, or 12%, of the population covered by these plans. The system comes with serious problems that vary in severity across the region involving funding, service, and staff. One of the largest concerns plaguing the NHS is referred to as “health tourism,” which is when individuals go into the country to get treated, escaping monetary fees and costing the agency almost £200 million each year. There are also long wait times for care, especially elective procedures, with 41.2% reporting a wait period of 12 or more weeks to see a specialist or receive surgical care, and much of the equipment used is outdated, as there is little funding directed towards technological innovations.

## Germany

Germany follows the Socialized Health Insurance system with the statutory health insurance (GKV) providing organizational framework for the delivery of public health care. Employees and employers are required to provide 50/50 contributions toward the system if the employed earns below a specific level of income (40,500 Euros per year in 2004). The health plan also covers the spouse and children (until a certain age) of the employee. If income is above the limit, the individual is given a choice between private health insurance or the state insurance. Over 90% of the population is covered by the national health insurance—the remainder is insured privately. Although this system prevents the growth of an uninsured population, it is met with mixed opinions. In 2003, the German health ministry concluded that the system suffers from lack of competition, superfluous, insufficient, or inappropriate care, and shrinking revenue, and an aging population.

**Table 1.1** presents selected features of the national health care programs 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	Great Britain	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

*Note:* DRGs, diagnosis-related groups; RBRVS, resource-based relative value scale.

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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 one understand that the structure of health care services in the United States is based on some foundations, provides a logical arrangement of the various components, and demonstrates a progression from inputs to outputs. The main elements of this arrangement are system inputs (resources), system structure, system processes, and system outputs (outcomes). In addition, system outlook (future directions) is a necessary element of a dynamic system. This systems framework has been used as the conceptual base for organizing later chapters in this book (see [Figure 1.2](#)).

### System Foundations

The current health care system is not an accident. Historical, cultural, social, and economic factors explain its current structure. These factors also affect forces that shape new trends and developments and those that impede change. Chapters 2 and 3 provide a discussion of the system foundations.

### 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 an important but indirect supportive role in the delivery of health care. Health care managers are needed to manage and coordinate various types of health care services. This book discusses primarily the personnel engaged in the direct delivery

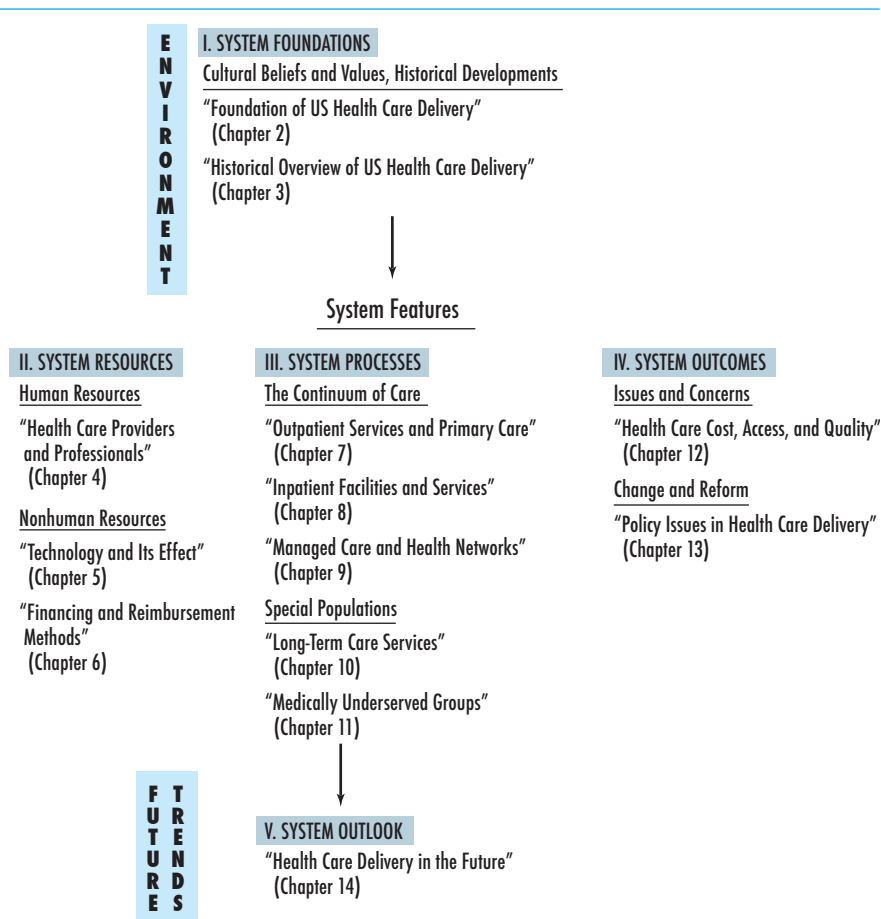


Figure 1.2 Systems Framework

of health care services (Chapter 4). The nonhuman resources include medical technology (Chapter 5) and health services financing (Chapter 6).

Resources are closely intertwined with access to health care. For instance, in certain rural areas of the United States, access is restricted because of a shortage of certain categories of health professionals. Development and diffusion of technology also determine the caliber of health care to which people may have access.

## System Processes

The system resources influence the development and change in physical structures, such as hospitals, clinics, and nursing homes. These structures 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 (Chapter 7). Institutional health services (inpatient care) are predominantly associated with acute care hospitals (Chapter 8). Managed care and integrated systems (Chapter 9) 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 (Chapter 10) and mental health (Chapter 11).

## 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 relationship to its primary objective. The primary objective of any health care delivery system is to provide to an entire nation cost-effective health services that meet certain established standards of quality. The previous three elements of the systems model (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 (Chapter 12). Issues and concerns regarding these criteria trigger broad initiatives for reforming the system through health policy (Chapter 13).

## 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. Chapter 14 discusses these future perspectives.

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## CONCLUSION

The United States has a unique system of health care delivery, but the 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 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 U.S. health care delivery system.

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