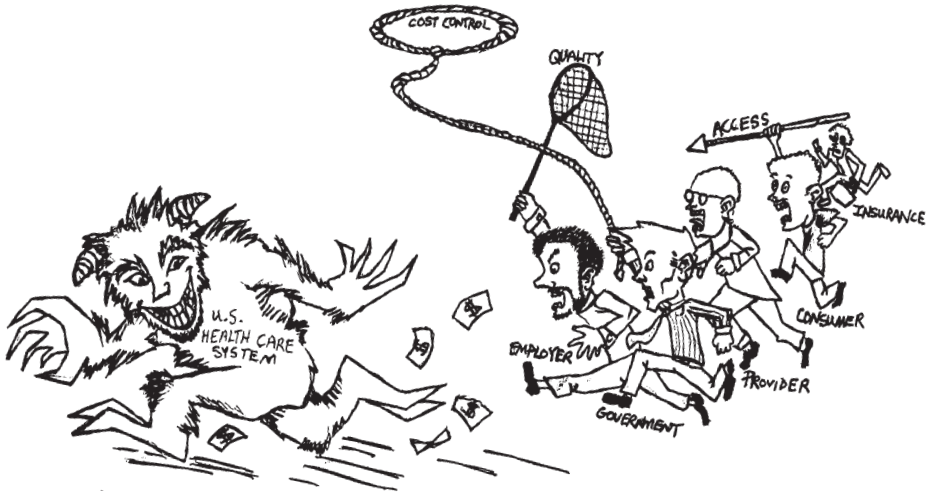
Chapter 1

A Distinctive System of Health Care Delivery

Learning Objectives

- To understand the basic nature of the US health care system
- To outline the four key functional components of a health care delivery system
- To discuss the primary characteristics of the US health care system from a free market perspective
- To emphasize why it is important for health care managers to understand the intricacies of the health care delivery system
- To get an overview of the health care systems in other countries
- To introduce the systems model as a framework for studying the health services system in the United States



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

Introduction

The United States has a unique system of health care delivery.* It is unlike any other health care system in the world. Most developed countries have national health insurance programs run by the government and financed through general taxes. Almost all citizens in such countries are entitled to receive health care services. Such is not the case in the United States, where not all Americans are automatically covered by health insurance. The US health care delivery system is not a system in the true sense, even though it is called a system when reference is made to its various features, components, and services. Hence, it may be somewhat misleading to talk about the American health care delivery "system" because a real system does not exist (Wolinsky 1988, 54). The US health care system is unnecessarily fragmented, which is perhaps its central feature (Shortell et al. 1996). The delivery system has continued to undergo periodic changes, mainly in response to concerns with cost, access, and quality. In spite of these efforts, providing at least a basic package of health care at an affordable cost to every man, woman, and child in America remains an unrealized goal. It is highly unlikely that this goal will materialize anytime soon, mainly because expanding access to health care, while containing overall costs and maintaining expected levels of quality, is a daunting challenge.

*The expressions "health care delivery" and "health services delivery" can have two slightly different meanings. In a broad sense, they collectively refer to the major components of the system and the process that enables people to receive health care. In a more restricted sense, they refer to the act of providing health care services to patients, such as in a hospital or physician's clinic. By paying attention to the context, the reader should be able to identify which meaning is intended.

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

The main objective of this chapter is to provide a broad understanding of how health care is delivered in the United States. The overview theme provided here introduces the reader to several concepts that are treated more extensively in later chapters.

An Overview of the Scope and Size of the System

Table 1–1 demonstrates the complexity of health care delivery in the United States. Many organizations and individuals are involved in health care. These range from educational and research institutions, medical suppliers, insurers, payers, and claims processors to health care providers. Multitudes of providers are involved in the provision of preventive, primary, subacute, acute, auxiliary, rehabilitative, and continuing care. An increasing number of managed care organizations (MCOs) and integrated networks now provide a continuum of care covering many of the service components.

The US health care delivery system is massive. Total employment in various health delivery settings is approximately 10 million, including approximately 744,000 professionally active doctors of medicine (MDs), 2.2 million active nurses, 168,000 dentists, 226,000 pharmacists, and more than 700,000

Table 1–1 The Complexity of Health Care Delivery

Education/ Research	Suppliers	Insurers	Providers	Payers	Government
Medical schools Dental schools Nursing programs Physician assistant programs Nurse practitioner programs Physical therapy, occupational therapy, speech therapy programs Research organizations Private foundations US Public Health Service (AHRQ, ATSDR, CDC, FDA, HRSA, IHS, NIH, SAMHSA) Professional associations Trade associations	Pharmaceutical companies Multipurpose suppliers Biotechnology companies	Managed care plans Blue Cross/ Blue Shield plans Commercial insurers Self-insured employers Medicare Medicaid VA Tricare	***Preventive Care*** Health departments ***Primary Care*** Physician offices Community health centers Dentists Nonphysician providers ***Subacute Care*** Subacute care facilities Ambulatory surgery centers ***Acute Care*** Hospitals ***Auxiliary Services*** Pharmacists Diagnostic clinics X-ray units Suppliers of medical equipment ***Rehabilitative Services*** Home health agencies Rehabilitation centers Skilled nursing facilities ***Continuing Care*** Nursing homes ***End-of-Life Care*** Hospices ***Integrated*** Managed care organizations Integrated networks	Blue Cross/ Blue Shield plans Commercial insurers Employers Third-party administrators State agencies	Public insurance financing Health regulations Health policy Research funding Public health

administrators in medical and health care settings. Approximately 325,000 physical, occupational, and speech therapists provide rehabilitation services. The vast array of health care institutions includes 5,760 hospitals, 16,100 nursing homes, and 4,300 inpatient mental health facilities. Nearly 1,000 federally qualified health center grantees, with over 5,700 clinical sites, provide preventive and primary care services to approximately 16 million people living in medically underserved rural and urban areas yearly. Various types of health care professionals are trained in 150 medical and osteopathic schools, 56 dental schools, 91 schools of pharmacy, and more than 1,500 nursing programs located throughout the country. There are 174.5 million Americans with private health insurance coverage, 41.7 million Medicare beneficiaries, and 42.5 million Medicaid recipients. Health insurance can be purchased from over 1,300 health insurance companies and 64 Blue Cross/Blue Shield plans. Multitudes 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 (National Center for Health Statistics 2006; Blue Cross Blue Shield Association 2007; America's Health Insurance Plans 2004; Kaiser Family Foundation Commission on Medicaid and the Uninsured 2005; Kaiser Family Foundation Medicare Policy Project 2005; American Association of Colleges of Pharmacy 2007; American Association of Medical Colleges 2007; American Association of Colleges of Osteopathic Medicine 2007; American Dental Education Association 2007; National Association of Community Health Centers 2006).

A Broad Description of the System

US health care does not consist of a network of interrelated components designed to work together coherently, which one would expect to find in a veritable ***system***. To the contrary, it is a kaleidoscope of financing, insurance, delivery, and payment mechanisms that remain unstandardized and loosely coordinated. Each of these basic functional components—financing, insurance, delivery, and payment—represents an amalgam of public (government) and private sources. Thus, government-run programs finance and insure health care for select groups of people who meet each program's prescribed criteria for eligibility. To a lesser degree, government programs also engage in delivering certain health services directly to the recipients of care, such as veterans, military personnel, and the uninsured who may depend on city and county hospitals or limited services offered by public health clinics. However, the financing, insurance, payment, and delivery functions are largely in private hands.

The market-oriented economy in the United States attracts a variety of private entrepreneurs driven by the pursuit of profits in carrying out the key functions of health care delivery. Employers purchase health insurance for their employees through private sources, and people receive health care services delivered by the private sector. The government finances public insurance through Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP) for a significant portion of the very low-income, elderly, disabled, and pediatric populations. But, insurance arrangements for many publicly insured people are made through private entities, such as HMOs, and health care services and are rendered by pri-

vate physicians and hospitals. The blend of public and private involvement in the delivery of health care has resulted in:

- a multiplicity of financial arrangements that enable individuals to pay for health care services
- numerous insurance agencies employing varied mechanisms for insuring against risk
- multiple payers that make their own determinations regarding how much to pay for each type of service
- a large array of settings where medical services are delivered
- numerous consulting firms offering their expertise in planning, cost containment, quality, and restructuring of resources

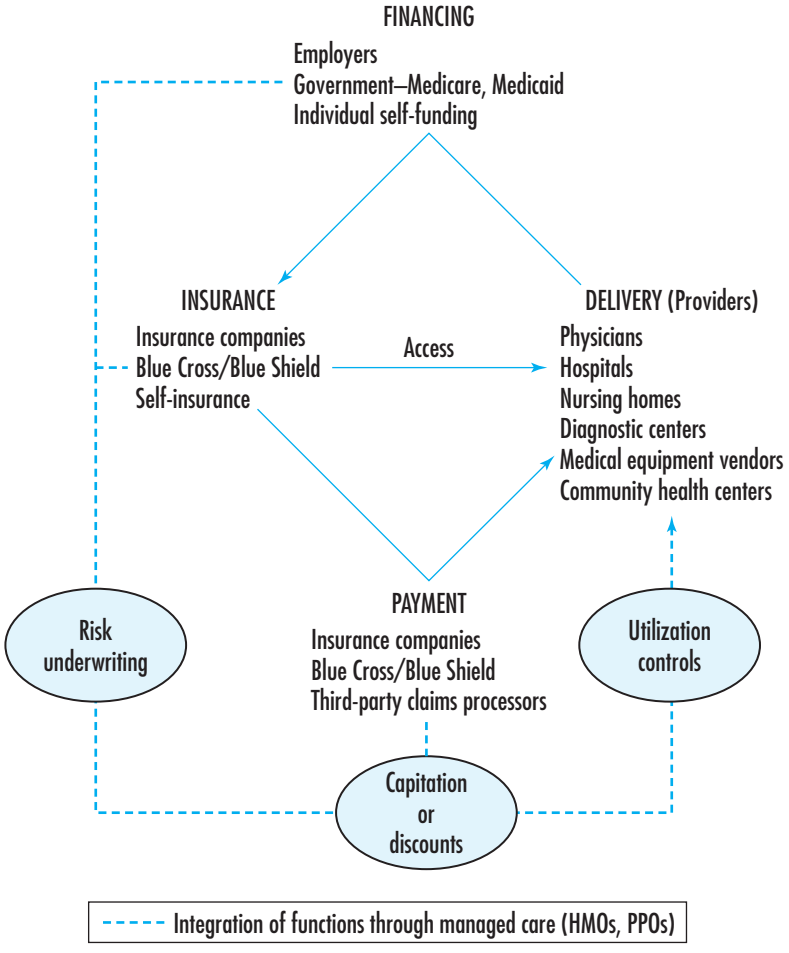
There is little standardization in a system that is functionally fragmented. The various system components fit together only loosely. Such a system is not subject to overall planning, direction, and coordination from a central agency, such as the government. Due to the missing dimension of system-wide planning, direction, and coordination, there is duplication, overlap, inadequacy, inconsistency, and waste leading to complexity and inefficiency. The system does not lend itself to standard budgetary methods of cost control. Each individual and corporate entity within a predominantly private entrepreneurial system seeks to manipulate financial incentives to its own advantage without regard to its impact on the system as a whole. Hence, cost containment remains an elusive goal. In short, the US health care delivery system is a behemoth that is almost impossible for any single entity to manage and control. It is also an economic megalith. The US economy is the largest in the world and, compared to other nations, consumption of health care services in the United States represents a greater proportion of the country's total economic output. While crediting the system with delivering some of the best medical care in the world, at least according to some standards, it falls short of delivering equitable services to every American.

An acceptable health care delivery system should have two primary objectives: (1) it must enable all citizens to access health care services, and (2) the services must be cost-effective and meet certain established standards of quality. In many ways, the US health care delivery system falls short of these ideals. On the other hand, certain features of US health care are the envy of the world. The United States leads the world in the latest and the best in medical technology, medical training, and research. It offers some of the most sophisticated institutions, products, and processes of health care delivery. These achievements are indeed admirable, but a lot more remains unaccomplished.

Basic Components of a Health Services Delivery System

As illustrated in Figure 1–1, a health care delivery system incorporates four functional components—financing, insurance, delivery, and payment that—that are necessary for the delivery of health services. The four functional components make up the ***quad-function model***. Health care delivery systems differ depending on the arrangement of the four components. The four functions generally overlap, but the degree of overlapping varies between

Figure 1–1 Basic Health Care Delivery Functions.



a private and a government-run system and between a traditional health insurance and managed care-based system. In a government-run system, the functions are more closely integrated and may even be indistinguishable. Managed care arrangements also integrate the four functions to varying degrees.

Financing

Health care often requires costly diagnostic tests and procedures and lengthy hospital stays. Financing is necessary to obtain health insurance or to pay for health care services. For most privately insured Americans, health insurance is employer-based; that is, health care is financed by their employers as a fringe benefit. A dependent's spouse or children may also be covered by the working spouse's, or parent's, employer. Most employers, except for the very large ones, purchase health insurance for their employees through an insurance company selected by the employer. In recent years, employers have shifted their purchases from traditional insurance companies to MCOs.

Insurance

Insurance protects the insured against catastrophic risks when needing expensive health care services. The insurance function also determines the package of health services the insured individual is entitled to receive. It specifies how and where health care services will be received. The insurance company or MCO also functions as a claims processor and manages the disbursement of funds to the providers of care.

Delivery

The term delivery refers to the provision of health care services and the receipt of insurance payments directly for those services. Common examples of ***providers*** who deliver care and services include physicians, dentists, optometrists, and therapists in private practices, hospitals, diagnostic and imaging clinics, and suppliers of medical equipment (e.g., wheelchairs, walkers, ostomy supplies, oxygen). With few exceptions, most providers render services to people who have health insurance.

Payment

The payment function deals with reimbursement to providers for services delivered. ***Reimbursement*** is the determination of how much to pay for a certain service. Funds for actual disbursement come from the premiums paid to the insurance company or MCO. In the case of an insurance company, when a covered individual receives health care services, the provider of services either requires payment up front or agrees to bill the insurance company on behalf of the patient. In the former case, the patient files a claim with the insurance company to be reimbursed for a portion of the fees and charges paid to the provider. The most common practice, however, is for the insurance company to pay its portion to the provider directly. When receiving services under a managed care plan, the patient is usually required to pay only a small out-of-pocket amount, such as $15 or $20, to see a physician. The remainder is covered by the managed care plan.

A Disenfranchised Segment

Since the United States has an employer-based financing system, it is not difficult to see why the unemployed generally have no health insurance. However, even some employed individuals may not have health insurance coverage for two main reasons: (1) In most states, employers are not mandated to offer health insurance to their employees; therefore, some employers, due to economic constraints, do not offer it. Some small businesses simply cannot get group insurance at affordable rates and therefore are not able to offer health insurance as a benefit to their employees. (2) In many work settings, participation in health insurance programs is voluntary and does not require employees to join when an employer offers health insurance. Some employees choose not to sign up mainly because they cannot afford the cost of health insurance premiums. Employers rarely pay 100 percent of the insurance premium; most require their employees to pay a portion of the cost, called ***premium cost sharing***. Others require their employees to pay the full cost, in which case health insurance becomes even more unaffordable. Even when the employee has to pay 100 percent of the premium, the benefit is that employees get group rates through their employer that are generally lower than what the rates

would be if the employees were to purchase health insurance on their own. Employees who do not have health insurance offered by their employers, or those who are self-employed, have to obtain health insurance on their own. Individual rates are typically higher than group rates and, in some instances, health insurance is unavailable when adverse health conditions are present.

In America, working people earning low wages are the most disenfranchised because most of them are not eligible for public benefits and they cannot afford premium cost sharing. The United States has a significant number of ***uninsured***—those without private or public health insurance coverage. In 2004, the proportion of Americans under age 65 without health insurance was estimated at 41.6 million, or 16–17 percent of the total population (National Center for Health Statistics 2006, 26). The US government finances health benefits for certain special populations, including government employees, the elderly (age 65 and over), people with disabilities, some people with very low incomes, and children from low-income families. The program for the elderly and certain disabled individuals is called ***Medicare***. The program for the indigent, jointly administered by the federal government and state governments, is named ***Medicaid***. The program for children from low-income families, another federal/state partnership, is called the State Children's Health Insurance Program (SCHIP). For such public programs, the government may function as both financier and insurer, or the insurance function may be carved out to an HMO. Private providers, with a few exceptions, render services to these special categories of people. The government pays for the services, generally by establishing contractual arrangements with selected intermediaries for the actual disbursement of payments to the providers. Thus, even in government-financed programs, the four functions of financing, insurance, delivery, and payment may be quite distinct.

Transition from Traditional Insurance to Managed Care

Under traditional insurance, the four basic health delivery functions have been fragmented; that is, the financiers, insurers, providers, and payers have often been different entities, with a few exceptions. For example, self-insured employers, Medicaid in some states, and most participants in Medicare have integrated the functions of financing and insurance. Commercial insurers have integrated the functions of insurance and payment. During the 1990s, however, health care delivery in the United States underwent a fundamental change involving a tighter integration of the basic functions of financing, insurance, payment, and delivery through managed care.

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

Managed care is a system of health care delivery that (1) seeks to achieve efficien-

cies 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. The primary financier is still the employer or the government, as the case may be. Instead of purchasing health insurance through a traditional insurance company, the employer contracts with an MCO, such as an HMO or a PPO, to offer a selected health plan to its employees. In this case, the MCO functions like an insurance company and promises to provide health care services contracted under the health plan to the enrollees of the plan. The term ***enrollee*** (member) refers to the individual covered under the plan. The contractual arrangement between the MCO and the enrollee—including the collective array of covered health services that the enrollee is entitled to—is referred to as the ***health plan*** (or "plan," for short). The health plan uses selected providers from whom the enrollees can choose to receive routine services. This primary care provider—often a physician in general practice—is customarily charged with the responsibility to determine the appropriateness of higher level or specialty services. The primary care provider refers the patient to receive specialty services if deemed appropriate.

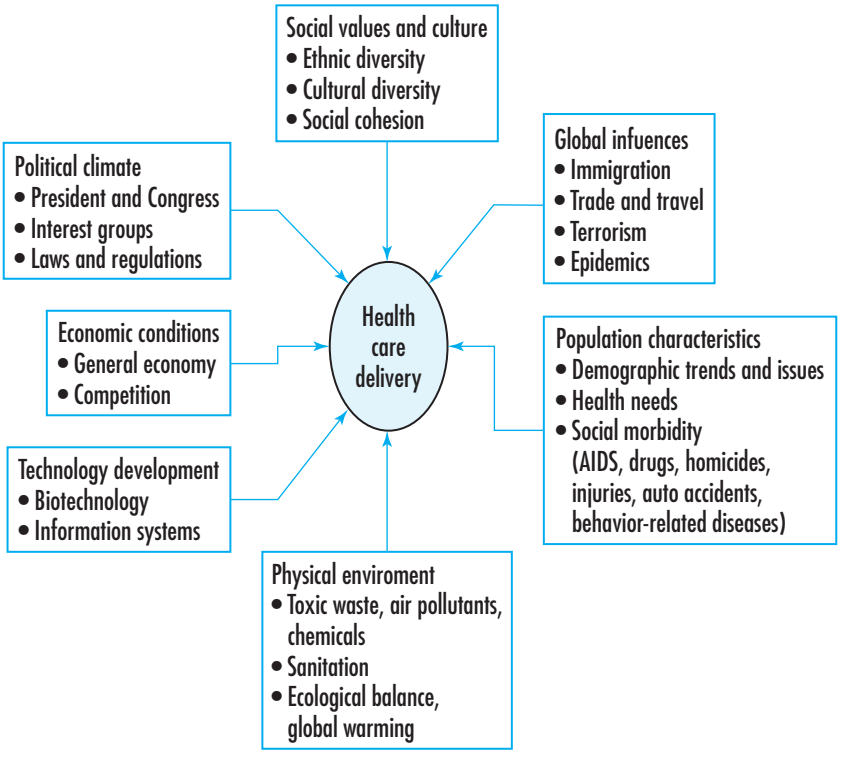
Managed care integrates the four basic functions of health care delivery. Even though financing is primarily through the employers, health plans set up negotiated fee arrangements through contracts with the providers. The negotiated fee arrangements are based on either capitation or discounts. ***Capitation*** is a payment mechanism in which all health care services are included under one set fee per covered individual. In other words, it is a predetermined fixed payment per member per month (PMPM). As an alternative to capitation, some MCOs negotiate discounts against the providers' customary fees. Generally, HMOs use capitation, whereas PPOs use discounts. Managed care topics are discussed in greater detail in Chapter 9.

Costs are also managed indirectly through control over utilization. The plan underwrites risk; that is, in setting the premiums, the plan relies on the expected cost of health care utilization. There is a risk that expenditures for providing health care services may exceed the premiums collected. The plan thus assumes the role of insurance. The plan pays the providers (through capitation or discounted fees) for services rendered to the enrollees and thus assumes the payment function. Delivery of services may be partially through the plan's own hired physicians, but most services deliver through contracts with external providers, such as physicians, hospitals, and diagnostic clinics.

Primary Characteristics of the US Health Care System

In any country, certain external influences shape the basic character of its health services delivery system. These forces consist of the political climate of a nation, economic development, technological progress, social and cultural values, physical environment, population characteristics, such as demographic and health trends, and global influences (Figure 1–2). The combined interaction of these environmental forces influences the course of health care delivery.

Figure 1–2 External Forces Affecting Health Care Delivery.



Ten basic characteristics differentiate the US health care delivery system from that of other countries:

1. No central agency governs the system.
2. Access to health care services is selectively based on insurance coverage.
3. Health care is delivered under imperfect market conditions.
4. Third-party insurers act as intermediaries between the financing and delivery functions.
5. Existence of multiple payers makes the system cumbersome.
6. Balance of power among various players prevents any single entity from dominating the system.
7. Legal risks influence practice behavior.
8. Development of new technology creates an automatic demand for its use.
9. New service settings have evolved along a continuum.
10. Quality is no longer accepted as an unachievable goal in the delivery of health care.

No Central Agency

The US health care system is not administratively controlled by a department or an agency of the government. Most other developed nations have national health care programs in which every citizen is entitled to receive a defined set of health care ser-

vices. Availability of "free" services can break a system financially. To control costs, these systems use ***global budgets*** to determine total health care expenditures on the national scale and to allocate resources within the budgetary limits. Availability of services as well as payments to providers is subject to such budgetary constraints. The government also controls the proliferation of health care services, especially costly medical technology. System-wide controls over the allocation of resources determine to what extent government-sponsored health care services are available to the citizenry. For instance, the availability of specialized services is restricted.

By contrast, the United States has mainly a private system of financing as well as delivery. Private financing, predominantly through employers, accounts for approximately 55 percent of total health care expenditures; the government finances the remaining 45 percent (National Center for Health Statistics 2006, 374). Private delivery of health care means that the majority of hospitals and physician clinics are private businesses, independent of the government. No central agency monitors total expenditures through global budgets and controls the availability and utilization of services. 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, SCHIP, and Medicare beneficiaries. The government also formulates ***standards of participation*** through health policy and regulation meaning that providers must comply with the standards established by the government to be certified to provide services to Medicaid, SCHIP, and Medicare beneficiaries. Certification standards are also regarded as minimum standards of quality in most sectors of the health care industry.

Partial Access

Countries with national health care programs provide ***universal access***; that is, health care is available to all citizens. Such is not the case in the United States. ***Access*** means the ability of an individual to obtain health care services when needed. In the United States, access is restricted to: (1) those that have health insurance through their employers, (2) those covered under a government health care program, (3) those who can afford to buy insurance out of their own private funds, and (4) those that are able to pay for services privately. Health insurance is the primary means for ensuring access. Even though the United States offers among the best medical care in the world, such care is generally available primarily to those adequately covered under a health insurance plan or have adequate means to pay for it privately.

As stated earlier, a relatively large segment of the US population is uninsured. For continuous basic and routine care—commonly referred to as ***primary care***—the uninsured are often unable to see a physician unless they can pay the physician's fees or unless they have access to a Federally-Qualified Health Center (FQHC). FQHCs provide primary care and enabling services in medically underserved urban and rural areas, regardless of patients' ability to pay. Uninsured patients, who cannot afford to pay for private physicians and do not have access to free care at a health center, often wait until health problems develop to seek care. At that point, they may be able to receive services in a hospital emergency department, for which the hospital does not receive any direct payments (unless the patient is able to

pay). 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 and Reinhardt 1996, 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 one of the main reasons why 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

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***, as described below. Hence, the system is best described as a quasi-market or an imperfect market. Following are some key features characterizing free markets.

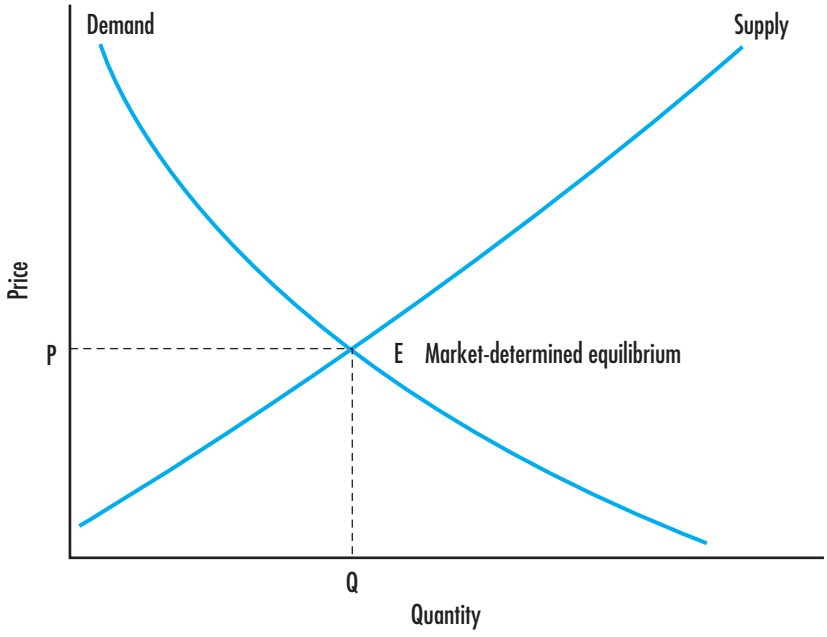
In a free market, multiple patients (buyers) and providers (sellers) act independently. In other words, in a free market, patients can choose to receive services from any provider. Providers neither collude to fix prices, nor are prices fixed by an external agency. Rather, prices are governed by the free and unencumbered interaction of the forces of supply and demand (Figure 1–3). ***Demand***, in turn, is driven by the prices prevailing in the free market. Under free market conditions, the quantity demanded will increase as the price is lowered for a given product or service. Conversely, the quantity demanded will decrease as the price increases.

At casual observation, it may appear that multiple patients and providers do exist. Most patients, however, are now enrolled either in a private health plan or in government-sponsored Medicare, Medicaid, or SCHIP programs if they meet the eligibility criteria. These plans act as intermediaries for the patients. Also, the consolidation of patients into health plans has the effect of shifting the power from the patients to the administrators of the plans. The result is that, in many respects, the health plans, not the patients, are the real buyers in the health care services market. Private health plans, in many instances, offer their enrollees a limited choice of providers rather than an open choice.

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

For the health care market to be free, unrestrained competition must occur among providers based on price and quality. Generally speaking, free competition exists among health care providers in the United States. The consolidation of buying power in the hands of private health plans, however, is forcing providers to form alliances and integrated delivery systems on the supply side. Integrated delivery systems (discussed in

Figure 1–3 Relationship between Price, Supply, and Demand under Free-Market Conditions.



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

Chapter 9) are networks of health services organizations. 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. In reality, patients do not always have adequate information about services. Technology-driven medical care has become highly sophisticated. New diagnostic methods, intervention techniques, and drugs that are more effective fall in the domain of the professional physician. Also, medical interventions are commonly required in a state of urgency. Hence, patients have neither the skills nor the time and other resources to obtain necessary information when needed. Channeling all health care needs through a primary care provider is likely to reduce this information gap when the primary provider acts as the patient's advocate or agent. On the other hand, the Internet is becoming a

prominent source of medical information. Pharmaceutical advertising is also having an impact on consumer expectations.

In a free market, patients have information on price and quality for each provider. The current system has other drawbacks that obstruct information-seeking efforts. Item-based pricing instead of package pricing is one such hurdle. Surgery is a good example to illustrate item-based pricing. Patients can generally obtain the fees the surgeon would charge for a particular operation. But the final bill, after the surgery has been performed, is likely to include charges for supplies, use of the hospital's facilities, and services performed by providers, such as anesthesiologists, nurse anesthetists, and pathologists. These providers, sometimes referred to as ***phantom providers*** functioning in an adjunct capacity, bill for their services separately. Item billing for such additional services, which sometimes cannot be anticipated in advance, makes it extremely difficult to ascertain the total price before services have actually been received. Package pricing and capitated fees can help overcome these drawbacks, but they have made relatively little headway for pricing medical procedures. ***Package pricing*** refers to a bundled fee for a package of related services. In the surgery example, this would mean one all-inclusive price for the surgeon's fees, hospital facilities, supplies, diagnostics, pathology, anesthesia, and postsurgical follow-up. As discussed earlier, with capitation all health care services are included under one set fee per covered individual. Capitation is more all encompassing than package pricing. Whereas package pricing covers services bundled together for one episode, capitation covers all services an enrollee may need during an entire year.

In recent years, quality of health care has received much emphasis. Performance rating of health plans has met some success. However, apart from some sporadic news stories and selectively published health plan, provider, and hospital "report cards," the public still 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 catastrophic events. Since 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. When you buy home insurance to protect your property against the unlikely event of a fire, you generally do not anticipate the occurrence of a loss. The probability that you will suffer a loss by fire is very small. Also, if a fire occurs and causes major damage, insurance will cover the loss, but the policy does not cover routine wear and tear on the house such as chipped paint or a leaking faucet. Health insurance, however, generally covers basic and routine services that are predictable. Health insurance coverage for minor services, such as colds and coughs, earaches, and so forth, amounts to prepayment for such services. Health insurance has the effect of insulating patients from the full cost of health care. There is a ***moral hazard*** that once 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 forgone 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 fac-

tors that severely limit the patient's ability to make health care purchasing decisions have already been discussed. Even with the best intentions, the circumstances surrounding sickness and injury generally prohibit comparative shopping based on price and quality. Further, such information is not easily available. 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, 74–75). Needs can also be based on self-evaluation of one's own health status. Second, the delivery of health care can result in demand creation. This follows from self-assessed need, which, coupled with moral hazard, leads to greater utilization. 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 and Fallon 1985), commonly referred to as ***supplier-induced demand*** or provider-induced demand. Functioning as the patients' agents, physicians exert enormous influence on the demand for health care services (Altman and Wallack 1996). Research studies have pointed to physicians' behavior of creating demand to their own financial benefit (see, for instance, the work of McGuire and Pauly 1991). Demand creation occurs when physicians prescribe medical care beyond what is clinically necessary. It can include practices such as making more frequent follow-up appointments than necessary, prescribing excessive medical tests, and performing unnecessary surgery (Santerre and Neun 1996, 369).

Third-Party Insurers and Payers

Insurance often functions as the intermediary among those who finance, deliver, and receive health care. As discussed earlier, health care is primarily financed by employers in the private sector and by the government in the public sector. Because the government is a large economic machine, it can self-insure against risk. Even though the government assumes the insurance function, payments to providers are generally handled through insurance intermediaries. Some large employers may also be able to self-insure; however, most private employers purchase health insurance from an insurance company or MCO. The employer's role is essentially relegated to selecting health plans and assisting employees with the enrollment process. The insurance company takes over most other administrative functions associated with the plan. The providers as well as the enrollees must comply with the policies set forth by the insurance company in matters associated with the provision of, and payment for, health services. Delivery of health care is often viewed as a transaction between the patient and the provider. But insurance and payment functions introduce a ***third party*** into the transaction (Griffith 1995, 279), the patient being the first party and the provider the second party.

The intermediary role of insurance creates a wall of separation between the financing and delivery functions so that quality of care often remains a secondary concern. In normal economic markets, the consumer is armed with the power to influence demand based on the price and quality of goods and services. Another way to illustrate this concept is to say that, in a free market, consumers vote with their dollar bills for

the best candidate among competing products, based on the price and quality of each product. The insurance intermediary generally does not have the incentive to be the patient's advocate on either price or quality. At best, employees can air their dissatisfactions with the plan to their employer, who has the power to discontinue the current plan and choose another company. In reality, however, employers may be reluctant to change plans if the current plan offers lower premiums compared to a new plan. National health care programs have even fewer incentives for promoting quality, although they can contain costs by artificially fixing prices.

Multiple Payers

A national health care system is also sometimes referred to as a ***single-payer system*** because there is generally one primary payer, the government. When delivering services, providers send the bill to an agency of the government that subsequently sends payment to each provider.

By contrast, the United States has a multiplicity of health plans and insurance companies because each employer is free to determine the type of health plan it offers. Each plan spells out the type of services the enrollee can receive. Some plans make an arbitrary determination of how much they will pay for a certain type of service. For Medicare and Medicaid recipients, the government has its own set of regulations and payment schedules.

Multiple payers often represent a billing and collection nightmare for the providers of services. Multiple payers make the system more cumbersome in several ways:

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

When all the costs of billing, collections, bad debts, and maintaining medical records are aggregated for the entire system, the

United States ends up spending far more in ***administrative costs*** than the national health care system of any country in the world.

Power Balancing

The US health services system involves multiple players (not just multiple payers). 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 its own economic interests to protect. Physicians, for instance, want to maximize their incomes and have minimum interference with the way they practice medicine; institutional administrators seek to maximize payment (commonly referred to as reimbursement) from private and public insurers. Insurance companies and MCOs are interested in maintaining their share of the health care insurance market; large employers want to minimize the costs they incur for providing health insurance as a benefit to their employees. The government tries to maintain or enhance existing benefits for select population groups and simultaneously reduce the cost of providing these benefits. The problem is that the self-interests of different players are often at odds. For example, providers seek to maximize government reimbursement for services delivered to Medicare, Medicaid, and SCHIP beneficiaries, but the government wants to contain cost increases. Employers dislike rising health insurance premiums. Health plans, under pressure from the employers, may constrain fees for the providers, who resent any cuts in their incomes.

The fragmented self-interests of the various players produce countervailing forces within the system. One positive effect of these opposing forces is that they prevent any single entity from dominating the system. On the other hand, each player has a large stake in health policy reforms. In an environment that is rife with motivations to protect conflicting self-interests, achieving comprehensive systemwide reforms is next to impossible, and cost containment remains a major challenge. Consequently, the approach to health care reform in the United States is often characterized as incremental or piecemeal.

Legal Risks

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

High Technology

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

Continuum of Services

Medical care services are generally classified into three broad categories: curative (e.g., drugs, treatments, and surgeries), restorative (e.g., physical, occupational, and speech therapies), and preventive (e.g., prenatal care, mammograms, and immunizations). Health care service settings are no longer confined to the hospital and the physician's office, where many of the aforementioned services were once delivered. Several new settings, such as home health, subacute care units, and outpatient surgery centers, have emerged in response to the changing configuration of economic incentives. Table 1–2 depicts the continuum of health care services.

Table 1–2 The Continuum of Health Care Services

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

Quest for Quality

Even though the definition and measurement of quality in health care are not as clear-cut as they are in other industries, the delivery sector of health care has come under increased pressure to develop quality standards and to demonstrate compliance with those standards. There are higher expectations for

improved health outcomes at the individual and the broader community levels. The concept of continuous quality improvement has also received much emphasis in managing health care institutions.

Trends and Directions

Since the final two decades of the 20th century, the US health care delivery system has continued to undergo certain fundamental shifts in emphasis summarized in Figure 1–4. Later chapters discuss these transformations in greater detail and focus on the factors driving them.

Promotion of health at lesser cost has been the driving force behind these trends. An example of a shift in emphasis is the concept of health itself; the focus is changing from illness to wellness. Such a change requires new methods and settings for wellness promotion, although the treatment of illness continues to be the primary goal of the health services delivery system. Many of these changes are interrelated. A change in one area requires a modification in other areas. For example, the system of managed care has been necessary for shifting the emphasis from illness to wellness, from acute care to primary care, and from inpatient to outpatient settings. These fundamental moves will shape the future of the health care system.

Figure 1–4 Trends and Directions in Health Care Delivery.

Significance for Health Care Practitioners and Policymakers

An understanding of the health care delivery system is essential for managers and policymakers. In fact, an understanding of the intricacies within the health services system would be beneficial to all those who come in contact with the system. In their respective training programs, health professionals, such as physicians, nurses, technicians, therapists, dietitians, pharmacists, and others, may understand their own individual roles, but remain ignorant of the forces outside their profession that could significantly impact current and future practices. An understanding of the health care delivery system can attune health professionals to their relationship with the rest of the health care environment. It can help them better understand changes and their potential impact on their own practice. Adaptation and relearning are strategies that can prepare health professionals to cope with an environment that will see ongoing change long into the future.

Policy decisions to address specific problems must also be made within the broader macro context because policies designed to bring about change in one health care sector can have wider repercussions, both desirable and undesirable, in other areas of the system. Policy decisions and their implementation are often critical to the future direction of the health care delivery system. However, in a multifaceted system, future issues will be best addressed by a joint undertaking that involves a balanced representation of the key players in health services delivery: physi-

cians, insurance companies, managed care organizations, employers, institutional representatives, and the government.

Significance for Health Care Managers

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

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

Positioning the Organization

Health services administrators need to understand their own organizational position within the macro environment of the system. Senior managers, such as chief executive officers, need to evaluate where their organization actually fits in the continuum of services. They must constantly gauge the nature and impact of the fundamental shifts illustrated in Figure 1–4. Managers need to consider which changes in the current configuration of financing, insurance, payment, and delivery might affect their organization's long-term stability. Middle and first-line managers also need to understand their role in the current configuration and how that role might change in the future. How should resources be realigned to effectively respond to those changes? For example, they need to evaluate whether certain functions in their departments will have to be eliminated, modified, or added. Would the changes involve further training? What processes are likely to change and how? What do they need to do to maintain the integrity of their institution's mission, the goodwill of the patients they serve, and the quality of their services? Regardless of the situation, a well thought through and appropriately planned change is likely to cause less turbulence for the providers as well as the recipients of care.

Handling Threats and Opportunities

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

Evaluating Implications

Managers are better able to evaluate the implications of health policy and new reform

proposals when they understand the relevant issues and how such issues link to the delivery of health services in the establishments they manage.

Planning

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

Capturing New Markets

Health care administrators are in a better position to capture new health services markets if they understand emerging trends in the financing, insurance, payment, and delivery functions of health care. New opportunities must be explored before any newly evolving segments of the market get overcrowded. An understanding of the dynamics within the system is essential to forging new marketing strategies to stay ahead of the competition and often to finding a service niche.

Complying with Regulations

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

Following the Organizational Mission

Knowledge of the health care system and its development is essential for effective management of health care organizations. By keeping up to date on community needs, technological progress, consumer demand, and economic prospects, managers can be in a better position to fulfill their organizational missions to enhance access, improve service quality, and achieve efficiency in the delivery of services.

Health Care Systems of Other Countries

Canada and most Western European countries have national health care programs that provide universal access. There are three basic models for structuring national health care systems.

1. In a system under ***national health insurance*** (NHI), such as in Canada, the government finances health care through general taxes, but the actual care is delivered by private providers. In the context of the quad-function

model, NHI requires a tighter consolidation of the financing, insurance, and payment functions coordinated by the government. Delivery is characterized by detached private arrangements.

2. In a ***national health system*** (NHS), such as the one in Great Britain, in addition to financing a tax-supported NHI program, the government also manages the infrastructure for the delivery of medical care. Under such a system, the government operates most of the medical institutions. Most health care providers, such as physicians, either are government employees or are tightly organized in a publicly managed infrastructure. In the context of the quad-function model, NHS requires a tighter consolidation of all four functions.
3. In a ***socialized health insurance*** (SHI) system, such as in Germany, government-mandated contributions, by employers and employees, finance health care. Private providers deliver health care. Private not-for-profit insurance companies, called sickness funds, are responsible for collecting the contributions and paying physicians and hospitals (Santerre and Neun 1996, 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.

In the remainder of this book, the terms "national health care program" and "national health insurance" are used generically and interchangeably to refer to any type of government-supported universal access health care program. Table 1–3 presents selected features of the national health care programs in Canada, Germany, and Great Britain compared to the United States. Following is a brief discussion of health care delivery in some selected countries from various parts of the world to illustrate the application of the three models discussed above and to provide a sample of the variety of healthcare systems in the world.

Australia

In the past, Australia switched from a universal national health care program to a privately financed system. Since 1984, it has returned to a national program called Medicare financed by income taxes and an income-based Medicare levy. The system is built on the philosophy of everyone contributing to the cost of health care according to his or her capacity to pay. In addition to Medicare, approximately 43 percent of Australians carry private health insurance (Australian Government 2004).This private health insurance covers gaps in public coverage, such as dental services, and covers care received in private hospitals (Willcox 2001). Acquiring private health insurance is voluntary, but is strongly encouraged by the Australian government through tax subsidies for purchasers and tax penalties for nonpurchasers (Healy 2002). Public hospital spending is funded by the government, but private hospitals offer better choice. Costs incurred by patients receiving private medical services, whether in or out of the hospi-

Table 1–3 Health Care Systems of Selected Industrialized Countries

	United States	Canada	Great Britain	Germany
Type	Pluralisitic	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 (DRG, 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 co-payment	Small to significant	Negligible	Negligible	Negligible

Note: RBRVS, resource-based relative value scale.

Source: Data from R.E. Santerre and S.P. Neun, *Health Economics: Theories, Insights, and Industry Studies,* p. 146, © 1996, Irwin.

tal, are reimbursed in whole or in part by Medicare (Healthcare Costs 2002). Private patients are free to choose and/or change their doctors. The well-organized medical profession in Australia is composed mainly of private practitioners who provide care predominantly on a fee-for-service basis (Hall 1999; Podger 1999).

Canada

Canada implemented its national health insurance system—referred to as Medicare—under the Medical Care Act of 1966. Currently, Medicare is composed of 13 provincial and territorial health insurance plans sharing basic standards of coverage as defined by the Canada Health Act (Health Canada 2006). The bulk of financing for Medicare comes from general provincial tax revenues; the federal government provides a constant amount that is independent of actual expenditures. The public pays for nearly 70 percent of total health care expenditures in Canada. The remaining 30 percent, paying for supplementary services such as drugs, dental care, and vision care, is financed privately (Canadian Institute for Health Information 2005). Provincial and territorial departments of health have the responsibility to administer medical insurance plans, determine reimbursement for providers, and

deliver certain public health services. Provinces are required by law to provide reasonable access to all medically necessary services and to provide portability of benefits from province to province. The program provides comprehensive coverage, but excludes dental care. Coverage for home health care and prescription drugs varies across the provinces. To cover these exclusions, many Canadians have supplemental coverage through private insurance provided by employers. Patients are free to select their providers (Akaho et al. 1998). Several provinces have established contracts with providers in the United States for certain specialized services. However, contrary to popular perceptions, few Canadians have to obtain health care services in the United States due to waiting times or unavailability of technology in their own country (Katz et al. 2002).

Nearly all the Canadian provinces (Ontario being one exception) have resorted to regionalization by creating administrative districts within each province. The objective of regionalization is to decentralize authority and responsibility to more efficiently address local needs and to promote citizen participation in health care decision-making (Church and Barker 1998). The majority of Canadian hospitals are operated as private nonprofit entities run by community boards of trustees, voluntary organizations, or municipalities, and most physicians are in private practice (Health Canada 2006). Most provinces use global budgets and allocate set reimbursement amounts for each hospital. Physicians are paid fee-for-service rates negotiated between each provincial government and medical association (MacPhee 1996; Naylor 1999).

Over the years, federal financial support to the provinces was drastically reduced. Under the increasing burden of higher costs, certain provinces, such as Alberta and Ontario, have started small-scale experimentation with privatization. However, in 2003, the Health Council of Canada, comprised of representatives of federal, provincial, and territorial governments, as well as health care experts, was established to assess Canada's health care system performance and establish goals for improvement. The Council's 2003 First Ministers' Accord on Health Care Renewal created a five-year, $16 billion Health Reform Fund targeted to improving primary health care, home care, and catastrophic drug coverage (Health Council of Canada 2005).

China

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

are largely uninsured. They can purchase individual or family plans in the private market or pay for services out of pocket.

In rural China, except for a few well-to-do communities, fee-for-service has replaced the cooperative medical system. Health insurance is not mandatory. In 2002, the Chinese government introduced a new basic insurance plan for poor, rural citizens. Under this plan, the government provides the equivalent of $2.50 a year to cover basic insurance, which the plan holder matches with $1.25. These plans do not cover primary care services or drugs; rather, they cover only inpatient services, with a very high deductible (Blumenthal and Hsiao 2005).

Health care delivery has also undergone significant changes. The former three-tier referral system (primary, second, tertiary) has been largely abolished. Patients can now go to any hospital of their choice as long as they are insured or can pay out of pocket. As a result, large (tertiary) hospitals are typically overutilized whereas smaller (primary and secondary) hospitals are underutilized. Use of large hospitals contributes to medical cost escalation and medical specialization. In rural China, the cooperative medical system run by "barefoot" doctors (peasant paramedics) has been abolished. "Barefoot" doctors either have changed their profession or have received further training to become licensed physicians to practice in rural hospitals or private clinics.

Major changes in health insurance and delivery have made access to medical care more difficult for the poor and uninsured. As a result, wide and growing disparities in health care access, quality, and outcomes are becoming apparent between rural and urban areas and between the rich and the poor. It remains uncertain whether China will continue its current course of medical specialization and privatization, or restore its previously integrated health care delivery system aimed at achieving universal access. The recent SARS epidemic serves as a wake-up call to the government, which now recognizes the importance of a well-developed public health infrastructure. To this end, the government has created an electronic disease reporting system based at the district level. In addition, each district in China now has a hospital dedicated to infectious disease. However, flaws in the system, particularly in monitoring infectious disease in the remote localities that comprise some districts, remain (Blumenthal and Hsiao 2005).

Germany

The German health care system is characterized by socialized health insurance (SHI) financed by pooling employer and employee premium contributions. Nonprofit sickness funds manage the social insurance pool. About 88 percent of the population has been enrolled in a sickness fund; another 11 percent of Germans either have private health insurance or are government workers with special coverage provisions. Less than 0.2 percent of Germans are uninsured (Busse 2002). Sickness funds act as purchasing entities by negotiating contracts with hospitals. To control costs, the system employs global budgets for the hospital sector and places annual limits on spending for physician services. During the 1990s, Germany adopted new legislation to promote competition among sickness funds (Brown and Amelung 1999).

Great Britain

Britain follows the national health system (NHS) model. Coincidentally, the British

health delivery system is also named NHS (National Health Service), which marked 50 years of existence in 1998. The NHS is founded on the principles of primary care and has a strong focus on community health services. The system owns its hospitals and employs its hospital-based specialists and other staff on a salaried basis. The primary care physicians, referred to as general practitioners (GPs), are mostly private practitioners.

Since 1991, the NHS has undergone some major transformations initiated by former Prime Minister Thatcher and continued by Tony Blair's Labor government. The quasi-market reforms initially resulted in the creation of primary care groups (PCGs), which brought local GPs, community nurses, and other health care and social services professionals under semiautonomous local health care delivery units. Local health authorities had fiscal and management responsibilities for most PCGs (Bindman et al. 2001).

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

It is also of interest to note that 11.5 percent of the British population holds private health care insurance (Dixon and Robinson 2002), and approximately 2.2 billion pounds are spent annually in the acute sector of private health care (Doyle and McNeilly 1999).

Israel

Until 1995, Israel had a system of universal access based on the German model of SHI financed through an employer tax and income-based contributions from individuals. The insurance function was managed by four sickness funds. In 1995, the country legislated an NHI program replacing the citizens' sickness fund contributions with a specific health tax, which is an earmarked payroll tax. In addition, general tax revenue supplements the health tax revenue. The contribution of general tax revenue toward the NHI depends on the yearly, government-determined level of NHI funding. The employer tax for health care was abolished in 1997; as a result, the share of general tax revenue as a percentage of total health care financing rose from 26 percent in 1995 to 46 percent in 2000 (Rosen 2003).

The insurance function and the delivery of care are still in the hands of the sickness funds. Citizens can enroll in any of the four sickness funds, which are nonprofit, independent legal entities operating within a regulatory framework defined by the government. The funds compete based on client satisfaction and provide a minimum, predefined basic package of health care services. The sickness funds also sell private health insurance to supplement the basic package.

Unlike Germany, approximately 85 percent of the general hospital beds in Israel are owned by the government and the General Sick Fund, the largest of the four sickness funds. Hospitals are reimbursed under the global budget model (Chinitz and Israeli 1997). There was a major effort in the early

1990s to shift hospitals from government ownership to independent, nonprofit trusts, but this endeavor failed due to the opposition of health care unions. Despite this, government hospitals have been granted far more autonomy in the intervening years (Rosen 2003).

Japan

Since 1961, Japan has been providing universal coverage to its citizens through two main types of health insurance schemes. The first one is an employer-based system modeled after Germany's SHI program. The second is a national health insurance program. Generally, large employers (with more than 300 employees) have their own health programs. Nearly 2,000 private, nonprofit health insurance societies manage insurance for large firms. Smaller companies either band together to provide private health insurance or belong to a government-managed plan. Day laborers, seamen, agricultural workers, the self-employed, and retirees are covered under the national health care program. Individual employees pay roughly 8 percent of their salaries as premiums and receive coverage for about 90 percent of the cost of medical services, with some limitations. Dependents get a little less than 90 percent coverage. Employers and the national government subsidize the cost of private premiums. Coverage is comprehensive, including dental care and prescription drugs. Patients are free to select their providers (Akaho et al. 1998; Babazono et al. 1998). Providers are paid on a fee-for-service basis with little control over reimbursement (McClellan and Kessler 1999).

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

Another recent policy development in Japan is hospitals' increased use of a new system of reimbursement for inpatient care services, called diagnosis-procedure combinations (DPCs). The DPC system, spearheaded by the Ministry of Health, Labor, and Welfare, started in 2003 with 82 hospitals. Using DPC, hospitals receive daily fees for each condition and treatment, regardless of actual provision of tests and interventions, proportionate to patients' length of stay. It is theorized that the DPC system will incentivize hospitals to provide more efficient, higher quality care to patients (Nomura and Nakayama 2005).

Singapore

Prior to 1984, Singapore had a British-style NHS program where medical services were provided mainly by the public sector and financed through general taxes. Since then, the nation has designed a system based on

market competition and self-reliance. Singapore has achieved universal access through government policy requiring mandatory private contributions but little government financing. The program, known as Medisave, mandates every working person, including the self-employed, to deposit a portion of earnings into an individual Medisave account. Employers are required to match employee contributions. These savings can only be withdrawn (1) to pay for hospital services and some selected expensive physician services, and (2) to purchase a government-sponsored insurance plan (called Medishield) for catastrophic (expensive and major) illness. For basic and routine services, people are expected to pay out of pocket. Those who cannot afford to pay receive government assistance (Hsiao 1995). In 2002, the government introduced ElderShield, which defrays out-of-pocket medical expenses for the elderly and severely disabled people requiring long-term care (Singapore Ministry of Health 2004). The fee-for-service system of payment to providers is prevalent throughout Singapore (McClellan and Kessler 1999).

Developing Countries

Developing countries containing 84 percent of the world's population, claim only 11 percent of the world's health spending. Yet, these countries account for 93 percent of the worldwide burden of disease. The six developing regions of the world are East Asia and the Pacific, Europe (mainly Eastern Europe) and Central Asia, Latin America and the Caribbean, the Middle East and North Africa, South Asia, and Sub-Saharan Africa. Of these, the latter two have the least resources and the greatest health burden. On a per capita basis, industrialized countries have six times as many hospital beds and three times as many physicians as developing countries. People with private financial means can find reasonably good health care in many parts of the developing world. The majority of the populations, however, have to depend on limited government services that are often of questionable quality as evaluated by Western standards. As a general observation, government financing for health services increases in countries with higher per capita incomes (Schieber and Maeda 1999).

The Systems Framework

A system consists of a set of interrelated and interdependent components designed to achieve some common goals, and 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 by using a systems model. The systems framework used here helps one understand that the structure of health care services in the United States is based on some foundations, provides a logical arrangement of the various components, and demonstrates a progression from inputs to outputs. The main elements of this arrangement are system inputs (resources), system structure, system processes, and system outputs (outcomes). In addition, system outlook (future directions) is a necessary element of a dynamic system. This system's framework has been used as the conceptual base for organizing later chapters in this book (see Figure 1–5).

Figure 1–5 The Systems Model and Related Chapters.

ENVIRONMENT

I. SYSTEM FOUNDATIONS

Cultural Beliefs and Values and Historical Developments

"Beliefs, Values, and Health" (Chapter 2)

"The Evolution of Health Services in the United States" (Chapter 3)

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System Features

II. SYSTEM RESOURCES

Human Resources

"Health Services Professionals" (Chapter 4)

Nonhuman Resources

"Medical Technology" (Chapter 5)

"Health Services Financing" (Chapter 6)

III. SYSTEM PROCESSES

The Continuum of Care

"Outpatient and Primary Care Services" (Chapter 7)

"Inpatient Facilities and Services" (Chapter 8)

"Managed Care and Integrated Organizations" (Chapter 9)

Special Populations

"Long-Term Care" (Chapter 10)

"Health Services for Special Populations" (Chapter 11)

↓

IV. SYSTEM OUTCOMES

Issues and Concerns

"Cost, Access, and Quality" (Chapter 12)

Change and Reform

"Health Policy" (Chapter 13)

FUTURE TRENDS

V. SYSTEM OUTLOOK

"The Future of Health Services Delivery" (Chapter 14)

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 health services delivery can fulfill its primary objective without deploying the necessary human and nonhuman resources. Human resources consist of the various types and categories of workers directly engaged in the delivery of health services to patients. Such personnel—that include physicians, nurses, dentists, pharmacists, other doctoral trained professionals, and numerous categories of allied health professionals—usually have direct contact with patients. Numerous ancillary workers, such as billing and collection agents, marketing and public relations personnel, and building maintenance employees, often play an important but indirect supportive role in the delivery of health care. Health care managers are needed to manage various types of health care services. This book discusses primarily the personnel engaged in the direct delivery 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 due to 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 mainly associated with processes referred to as ***outpatient care*** (Chapter 7). Institutional health services, or ***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 relation to its primary objective. As indicated earlier, 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 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 be forward-looking. 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.

Summary

The United States has a unique system of health care delivery. The basic features that characterize this system, or patchwork of subsystems, include: the absence of a central agency to govern the system, unequal access to health care services due to lack of health insurance for all Americans, health care delivery under imperfect market conditions, existence of multiple payers, third-party insurers functioning as intermediaries between the financing and delivery aspects of health care, balancing of power among various players, legal risks influencing practice behavior, new and expensive medical technology, a continuum of service settings, and a focus on quality improvement. No country in the world has a perfect system. Most nations with a national health care program also have a private sector that varies in size. The developing countries of the world face serious challenges due to scarce resources and strong underlying needs for services.

Health care administrators must understand how the health care delivery system works and evolves. Such an understanding improves their awareness of the position their organization occupies within the macro environment of the system. It also facilitates strategic planning and compliance with health regulations, enabling them to deal proactively with both opportunities and threats, and enabling them to effectively manage health care organizations. The systems framework provides an organized approach to an understanding of the various components of the US health care delivery system.

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

Test Your Understanding

Terminology

access
administrative costs
balance bill
capitation
defensive medicine
demand
enrollee
free market
global budget
health plan
inpatient care
managed care
Medicaid
Medicare
moral hazard
national health insurance
national health system
need
outpatient care
package pricing
phantom providers
premium cost sharing
primary care
provider
quad-function model
reimbursement
single-payer system
socialized health insurance
standards of participation
supplier-induced demand
system
third party
uninsured
universal access
utilization

Review Questions

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

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