# Essentials of the U.S. Health Care System

Fourth Edition

Leiyu Shi
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# Preface

This text is a condensed and simplified version of our standard textbook on the U.S. health care system, *Delivering Health Care in America: A Systems Approach, Sixth Edition*, which has been widely used for teaching both undergraduate and graduate courses. While retaining the main themes of the larger book, this version covers the essential elements of U.S. health care in an easier to read format. This text leaves out much of the data and technical details found in the expanded version. Remaining comprehensive and focused, this condensed version is designed for maximum accessibility and flexibility.

This text retains the systems model to organize the major themes of U.S. health care delivery. The first three chapters lay the foundation that is necessary for understanding the U.S. health care delivery system, which is distinct from any other system in the world. "Major Characteristics of U.S. Health Care Delivery" (Chapter 1) gives an overview of U.S. health care and contrasts the American system with the three most commonly used models of health care delivery in other advanced nations, such as Canada, the United Kingdom, and Germany. "Foundations of U.S. Health Care Delivery" (Chapter 2) explains the different models for understanding health and its determinants. In the context of American beliefs and values, this chapter also discusses the issue of equity using the concepts of market justice and social justice and explains how health services are rationed in both market justice– and social justice–based systems. "Historical Overview of U.S. Health Care Delivery" (Chapter 3) traces the history of U.S. health care from colonial times to the present and includes an added section on health care reform. The key to understanding the nature of the

current health care system and its likely future direction is to understand its evolutionary past. This chapter also includes current trends in corporatization, information revolution, and globalization as they pertain to health care delivery.

The next three chapters are about the resources—both human and nonhuman—employed in delivering health care. "Health Care Providers and Professionals" (Chapter 4) addresses the roles played by some of the major types of personnel in health care delivery. It also discusses some key issues pertaining to the number and distribution of physicians and the effect these factors have on the delivery of health care. "Technology and Its Effects" (Chapter 5) discusses medical technology and the various issues related to its development and dissemination. "Financing and Reimbursement Methods" (Chapter 6) explains the concept of health insurance, the major private and public health insurance programs in the United States, and methods of reimbursing providers.

The next five chapters describe the system processes, beginning with outpatient and primary care services (discussed in Chapter 7). Hospitals are the focus of Chapter 8. "Managed Care and Integrated Systems" (Chapter 9) examines managed care and integrated organizations, such as integrated delivery systems and the emerging accountable care organizations, as well as the different types of arrangements found in integrated organizations. "Long-Term Care Services" (Chapter 10) explores the meaning and scope of long-term care and provides an overview of community-based and institution-based long-term care services. "Populations with Special Health Needs" (Chapter 11) highlights vulnerable populations and their special health care needs. This chapter also includes a section on mental health.

The next two chapters deal with the main outcomes of the health care system and the ways in which those outcomes are addressed through health policy. The main outcomes associated with health care are presented in Chapter 12, "Cost, Access, and Quality." "Health Policy" (Chapter 13) gives an overview of health policy, including the major participants in its development and the process by which it is created, in the United States.

Finally, "The Future of Health Services Delivery" (Chapter 14) explores the future of health care in the United States in the context of forces of future change, health care reform, conflicting issues of cost and access, future models of care delivery, global challenges, and technological innovations.

For easy reference, an Appendix, "Essentials of the Affordable Care Act," is found at the end of the 14 chapters. It provides a topical summary of the ACA.

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## New in the *Fourth Edition*

This edition has been updated with the latest health statistics and pertinent information available at the time the manuscript was prepared. Some key additions to the text include the following:

- Current status of managed care and integrated delivery system under the Affordable Care Act; current status of public health system; health care reform in selected countries (Chapter 1)
- Implementation of *Healthy People 2020*; assessment of the Healthy People initiative (Chapter 2)
- New sections: "Era of Health Care Reform" and "U.S. Health Care Today" discuss the current state of affairs in the context of historical developments (Chapter 3).
- Current U.S. physician workforce and challenges (Chapter 4)
- Addition of nanomedicine; clinical decision support systems; Health Information Technology for Economic and Clinical Health (HITECH) Act; update on remote monitoring; regulation of biologics; and the ACA and medical technology (Chapter 5)
- New sections: "The Affordable Care Act and Private Insurance"; "The Affordable Care Act and Public Insurance"; "The Affordable Care Act and Payment Reform" (Chapter 6)
- Community health centers' current scope, efficacy/values, and challenges (Chapter 7)
- Discussion on the performance of church-owned hospitals and physician-owned hospitals; new section: "The Affordable Care Act and Hospitals" (Chapter 8)
- Update on accountable care organizations; new section: "Managed Care and Organizational Integration Under the Affordable Care Act" (Chapter 9)

- New section: "The Affordable Care Act and Long-Term Care" (Chapter 10)
- Current disparities in literature (racial, socioeconomic status) in terms of access to care, quality of care, and health outcomes; programs (national, regional, local) that address disparities (racial, socioeconomic status) in terms of access to care, quality of care, and health outcomes (Chapter 11)
- Quality initiatives both from government (e.g., Agency for Healthcare Research and Quality) and private sectors and programs to contain health care costs (Chapter 12)
- Update health policy issues and challenges after ACA (Chapter 13)
- New section discusses the future of U.S. health care delivery in the context of forces of future change; challenges of coverage, access, and cost and future of health care reform—including prospects for a single-payer system—in the context of the Affordable Care Act; new section on care delivery of the future (Chapter 14)

# Acknowledgments

We gratefully acknowledge Sylvia Shi for creating the cartoons for this book. We are also grateful for the valuable assistance of Gaida Mahgoub and Geraldine Pierre Haile. Of course, all errors and omissions remain the responsibility of the authors.

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# Chapter 1

# Major Characteristics of U.S. Health Care Delivery


## INTRODUCTION

The United States has a unique system of health care delivery compared with other developed countries around the world. Almost all other developed countries have universal health insurance programs in which the government plays a dominant role. Almost all of the citizens in these countries are entitled to receive health care services that include routine and basic health care. In the United States, the Affordable Care Act[1] (ACA) has expanded health insurance, but it still falls short of achieving universal coverage. Besides insurance, adequate access to health care services and health care costs at both the individual and national levels continue to confound academics, policy makers, and politicians alike.

[1]Patient Protection and Affordable Care Act of 2010 as amended by the Health Care and Education Reconciliation Act of 2010, often shortened as the Affordable Care Act and nicknamed Obamacare.

The main objective of this chapter is to provide a broad understanding of how health care is delivered in the United States. The U.S. health care delivery system is both complex and massive. Ironically, it is not a system in the true sense because the components illustrated in **Figure 1.1** are only loosely coordinated. Yet, for the sake of simplicity, it is called a system when its various features, components, and services are referenced.

Organizations and individuals involved in health care range from educational and research institutions, medical suppliers, insurers, payers, and claims processors to health care providers. There are nearly 18.4 million people employed in various health delivery settings, including professionally active doctors of medicine (MDs), doctors of osteopathy (DOs), nurses, dentists, pharmacists, and administrators. Approximately 451,500

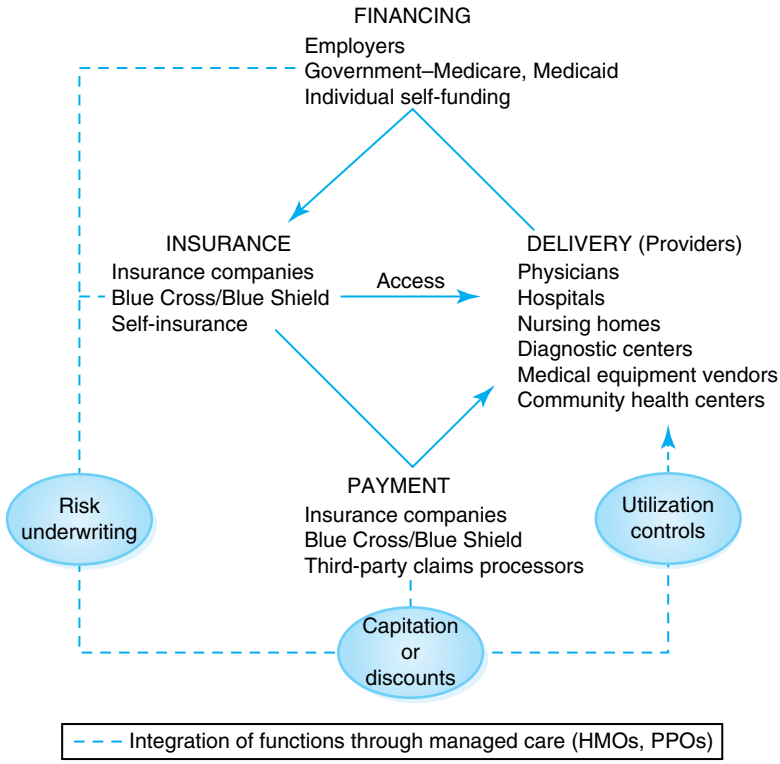


Figure 1.1 Managed Care: Integration of Functions

physical, occupational, and speech therapists provide rehabilitation services. The vast array of institutions includes 5,686 hospitals, 15,663 nursing homes, almost 2,900 inpatient mental health facilities, and 15,900 home health agencies and hospices. Nearly 1,200 programs support basic health services for migrant workers and the homeless, community health centers, black lung clinics, human immunodeficiency virus (HIV) early intervention services, and integrated primary care and substance abuse treatment programs. Various types of health care professionals are trained in 192 medical and osteopathic schools, 65 dental schools, 130 schools of pharmacy, and more than 1,937 nursing programs located throughout the country (Bureau of Labor Statistics, 2011; Bureau of Primary Health Care, 2011).

There are 201.1 million Americans with private health insurance coverage, most of whom are covered through their employers. An additional 103.1 million are covered under 2 major public health insurance programs—Medicare and Medicaid—managed by the U.S. government. Private health insurance can be purchased from approximately 1,000 health insurance companies. The private managed care sector includes approximately 452 licensed health maintenance organizations (HMOs) and 925 preferred provider organizations (PPOs). A multitude of government agencies are involved with the financing of health care, medical and health services research, and regulatory oversight of the various aspects of the health care delivery system (Aventis Pharmaceuticals, 2002; Bureau of Primary Health Care, 2011; Healthleaders, 2011; National Center for Health Statistics, 2007; Urban Institute, 2011; U.S. Bureau of the Census, 1998; U.S. Census Bureau, 2007).

## SUBSYSTEMS OF U.S. HEALTH CARE DELIVERY

In the United States, multiple subsystems of health care delivery have developed, either through market forces or through government action to address the special needs of certain population segments.

### Managed Care

*Managed care* seeks to achieve efficiency by integrating the basic functions of health care delivery, and it employs mechanisms to control (manage) utilization and cost of medical services. Managed care is the

dominant health care delivery system in the United States today. It covers most Americans in both private and public health insurance programs through contracts with a managed care organization (MCO), such as an HMO or a PPO. The MCO, in turn, contracts with selected health care providers—physicians, hospitals, and others—to deliver health care services to its enrollees. The term *enrollee* (member) refers to the individual covered under a managed care plan. The contractual arrangement between the MCO and the enrollee—including descriptions of the various health services to which enrollees are entitled—is referred to as the *health plan* (or *plan* for short).

The MCO pays providers either through a capitation (per head) arrangement, in which providers receive a fixed payment for each enrollee under their care, or via a discounted fee arrangement. Providers are willing to discount their services for MCO patients in exchange for being included in the MCO network and being guaranteed a patient population. As part of their planning process, health plans rely on the expected cost of health care utilization, which always runs the risk of costing more than the insurance 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 a managed care environment. The four key functions of financing, insurance, delivery, and payment make up the quad-function model. Managed care integrates the four functions to varying degrees.

## Military

The military medical care system is available mostly free of charge to active-duty military personnel of the U.S. Army, Navy, Air Force, and Coast Guard, as well as to members of certain uniformed nonmilitary services such as the Public Health Service and the National Oceanographic and Atmospheric Association. It is a well-organized system that provides comprehensive services, both preventive and treatment oriented. Services are provided by salaried health care personnel. Various types of basic services are provided at dispensaries, sick bays aboard ships, first aid stations, medical stations, and base hospitals. Advanced medical care is provided in regional military hospitals.

Families and dependents of active-duty or retired career military personnel are either treated at the hospitals or dispensaries or are covered by

*TriCare*, a program that is financed by the U.S. Department of Defense. This insurance plan permits the beneficiaries to receive care from both private and military medical care facilities.

The Veterans Administration (VA) health care system is available to retired veterans who have previously served in the military, with priority given to those who are disabled. The VA system focuses on hospital care, mental health services, and long-term care. It is one of the largest and oldest (dating back to 1930s) formally organized health care systems in the world. Its mission is to provide medical care, education and training, research, contingency support, and emergency management for the U.S. Department of Defense medical care system. It provides health care to more than 9.6 million individuals at over 1,100 sites that include 153 hospitals, 807 ambulatory and community-based clinics, 135 nursing homes, 209 counseling centers, 47 domiciliaries (residential care facilities), 73 home health care programs, and various contract care programs. The VA budget exceeds $55 billion, and it employed a staff of about 280,000 in 2010 (Department of Veterans Affairs, 2011; National Center for Veterans Analysis and Statistics, 2007).

The entire VA system is organized into 21 geographically distributed *Veterans Integrated Service Networks (VISNs)*. Each VISN is responsible for coordinating the activities of the hospitals 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 improved efficiency and cost containment.

## Subsystem for Special Populations

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

assistance, transportation, nutrition and health education, social support services, and child care—according to individual needs.

As an example, federally qualified health centers have provided primary and preventive health services to rural and urban underserved populations for more than 50 years. The Bureau of Primary Health Care (BPHC), located within the Health Resources and Services Administration in the Department of Health and Human Services (DHHS), provides federal support for community-based health centers that include programs for migrant and seasonal farm workers and their families, homeless persons, public housing residents, and school-aged children. These services facilitate regular access to care for patients who are predominantly minority, low income, uninsured, or enrolled in Medicaid, the public insurance program for the poor. In 2012, the nationwide network of 1,198 community health organizations served 22 million people across 8,100 service sites and handled a total of 83.8 million patient visits. Approximately 93% of this population was living on incomes that were less than 200% of the federal poverty level, and 36% were uninsured (National Association of Community Health Centers, 2014). Health centers have contributed to significant improvements in health outcomes for the uninsured and Medicaid populations and have reduced disparities in health care and health status across socioeconomic and racial/ethnic groups (Politzer et al., 2003; Shi et al., 2001).

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

*Medicaid*, the third largest source of health insurance in the country, covering approximately 17.3% of the U.S. population, provides coverage for low-income adults, children, the elderly, and individuals with disabilities (Smith and Medalia, 2014). This program is also the largest provider of long-term care to older Americans and individuals with disabilities. The program has seen significant expansion under the ACA.

In 1997, the U.S. government created the Children's Health Insurance Program (CHIP) to provide insurance to children in uninsured families. The program expanded coverage to children in families that have modest incomes but do not qualify for Medicaid. In 2014, the CHIP program spent $13 billion to cover approximately 8.1 million children (MACPAC, 2015).

Despite the availability of government-funded health insurance, the United States' safety net is by no means secure. The availability of safety net services varies from community to community. Vulnerable populations residing in communities without safety net providers must often forgo care or seek services from hospital emergency departments if available nearby. Safety net providers, in turn, face enormous pressure from the increasing number of poor and Medicaid-insured in their communities.

## Integrated Systems

Organizational integration to form *integrated delivery systems (IDSs)*, or health networks, started in the early 2000s. An IDS has been defined as a network of health care providers and organizations that provides or arranges to provide a coordinated continuum of services to a defined population and is willing to be held clinically and fiscally accountable for the clinical outcomes and health status of the population served (Shortell et al., 1996). By gaining ownership of or forming strategic partnerships with hospitals, physicians, and insurers, IDSs aim to deliver a range of services. The ACA includes payment reform initiatives that encourage physician–hospital integration and coordination of services. It is hoped that integrated and coordinated care will increase cost-effectiveness and quality. A newer model of integrated organization—called an accountable care organization—is expected to respond to new payment incentives and be held accountable for better quality outcomes at reduced costs under a new Medicare Shared Savings Program. The ACA is also aimed to address issues related to fragmented care for individuals who suffer from co-occurring serious mental illness and substance use disorders. The most important principles in delivering integrated care that is specific to vulnerable populations include: (1) an emphasis on primary care; (2) coordination of all care, including behavioral, social, and public health services; and (3) accountability for population health outcomes (Witgert & Hess, 2012).

## Long-Term Care Delivery

*Long-term care* (LTC) consists of medical and nonmedical care that are provided to individuals who have chronic health issues and disabilities that prevent them from doing regular daily tasks. Hence, LTC includes both health care and support services for daily living. It is delivered across a wide variety of venues, including patients' homes, assisted living facilities,

and nursing homes. In addition, family members and friends provide the majority of LTC services without getting paid for them. Medicare does not cover LTC; thus, costs associated with this form of care can impose a major burden on families. Medicaid covers several different levels of LTC services, but a person must be an indigent to qualify for Medicaid. LTC insurance is offered separately by insurance companies, but most people do not purchase these plans because premiums can be unaffordable. By 2020, more than 12 million Americans are projected to require LTC, which will impose a severe strain on the nation's financial resources (CMS, 2011a).

## Public Health System

The mission of the *public health system* is to improve and protect community health. The Institute of Medicine's *Future of Public Health in the 21st Century* has outlined the need for a more robust public health infrastructure and a population-based health approach for a healthier America (Centers for Disease Control and Prevention [CDC], 2013). The National Public Health Performance Standards Program identifies 10 essential public health services that a system needs to deliver:

1. Monitoring health status to identify and solve community health problems
2. Diagnosing and investigating health problems and hazards
3. Informing, educating, and empowering people about health problems and hazards
4. Mobilizing the community to identify and solve health problems
5. Developing policies and plans to support individual and community health efforts
6. Enforcing laws and regulations to protect health and safety
7. Providing people with access to necessary care
8. Assuring a competent and professional health workforce
9. Evaluating the effectiveness, accessibility, and quality of personal and population-based health services
10. Performing research to discover innovative solutions to health problems

In 2009, public health accounted for 3.1% of the nation's overall healthcare expenditures of $2.5 trillion (CMS, 2012). The amount of federal funding spent to prevent disease and improve health in communities varied

significantly from state to state in 2013, with a per capita low of $13.67 in Indiana to a high of $46.48 in Alaska (TFAH & RWJF, 2014). To bolster the nation's public health efforts, the ACA established the Prevention and Public Health Fund to provide expanded and sustained national investments in prevention and public health, to improve health outcomes, and to enhance health care quality.

Expanded efforts are needed to combat antibiotic resistance, fight obesity and heart disease, curb prescription drug overdose, and deal with emerging issues such as chikungunya and e-cigarettes. Advanced information systems and data sharing have become increasingly more important in assuring a strong public health system.

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

The health care system of a nation is influenced by external factors, including the political climate, level of economic development, technological 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 forces has influenced the course of health care delivery in the United States. This section summarizes the basic characteristics that differentiate the U.S. health care delivery system from that of other countries. There are 10 main areas of distinction (see **Exhibit 1.1**).

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

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