Delivering Health Care in America

A SYSTEMS APPROACH **SEVENTH EDITION**

Leiyu Shi and
Douglas A. Singh

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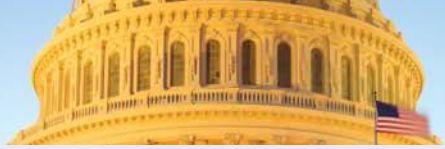

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Preface

With this *Seventh Edition*, we celebrate 20 years of serving instructors, students, policymakers, and others, both at home and overseas, with up-to-date information on the dynamic U.S. health care delivery system. Much has changed, and much will continue to change in the future, as the nation grapples with critical issues of access, cost, and quality. Indeed, much of the developing and developed world will also be contending with similar issues.

People in the United States, in particular, have just gotten a taste of a far-reaching health care reform through President Barack Obama's signature Affordable Care Act (ACA), nicknamed "Obamacare." To date, this law has produced mixed results that are documented in this new edition.

At the time this edition went to press, we were left with promises of another reform under the slogan "Repeal and replace Obamacare," a move championed by President Donald Trump, who had made it one of the centerpieces of his presidential campaign. Much remains to be seen as to how this promise will play out.

On May 4, 2017, the U.S. House of Representatives passed the American Health Care Act (AHCA) by a vote of 217 to 213, with Republican support. The bill is likely to undergo significant changes in the U.S. Senate. Hence, what the new law may eventually look like was unknown at the time this manuscript went to press. As was the case with the ACA, for which the Democratic Party played an exclusive role in its passage, contentious debates, partisanship, and deal making among both Republicans and Democrats have marked the progress in moving the new law through Congress.

Although we have chosen to sidestep any premature speculation about the fate of the ACA and the shape of its replacement, wherever possible, we have presented trends and facts that support certain conclusions. Mainly, experiences and outcomes under the ACA have been highlighted in this edition.

On his first day in office in January 2017, President Trump signed an executive order to "waive, defer, grant exemptions from, or delay the implementation of any provision or requirement of the [Affordable Care] Act that would impose a fiscal burden on any State or a cost, fee, tax, penalty, or regulatory burden on individuals, families, health care providers, health insurers, patients, recipients of health care services, purchasers of health insurance, or makers of medical devices, products, or medications." This executive order effectively repealed small portions of the ACA that deal with taxation and fees.

Going forward, the issues of universal coverage and affordability of insurance and health care will be critical. Under the ACA, approximately 27 million people remained uninsured, even though the uninsurance rate in the United States dropped from 13.3% to 10.9% between 2013 and 2016. The majority of the newly insured individuals were covered under Medicaid, the nation's safety net health insurance program for the poor.

Another thorny issue will be how to provide health care for the millions of illegal immigrants who obtain services mainly through hospital emergency departments, and through charitable sources to some extent. Is there a better, more cost-effective way to address their needs?

The affordability of health insurance in the non-employment-based private market was severely eroded under the ACA, mainly for those who did not qualify for federal subsidies to buy insurance. The reason for the rate hikes in this segment was that few young and healthy people enrolled in health care plans under the ACA. Consequently, for many people, premium costs rose to unaffordable levels in 2016. People who really needed to use health care enrolled in much larger numbers than healthier individuals. Such an adverse selection prompted the chief executive of Aetna Insurance, Mark Bertolini, to remark that the marketplace for individual health insurance coverage was in a "death spiral." Some large insurance companies either pulled out of the government-sponsored health care exchanges or were planning to do so because of financial losses sustained under the ACA.

New to This Edition

This edition continues to reference some of the main features of the ACA wherever it was important to provide contextual discussions from historical and policy perspectives. Several chapters cover the main provisions of the 21st Century Cures Act, which, after a long delay, was finally passed by Congress and signed by President Obama in December 2016.

As in the past, this text has been updated throughout with the latest pertinent data, trends, and research findings available at the time the manuscript was prepared. Copious illustrations in the form of examples, facts, figures, tables, and exhibits continue to make the text come alive. Following is a list of the main additions and revisions:

Chapter 1

- Updates the impact of the Affordable Care Act (ACA)
- Critical global health issues and health care reforms in other countries

Chapter 2

- Health insurance under the ACA
- Evaluation of progress made toward the *Healthy People 2020* goals
- Information on global pandemics and infectious diseases

Chapter 3

- Expanded section: Reform of mental health care
- Complete revision of the section: Era of health care reform

Chapter 4

- Major issues related to the health care workforce
- Updated information on nonphysician providers

Chapter 5

- New section: Electronic health records and quality of care
- Global trends in biomedical research and a new table on R&D expenditures
- New section: Drugs from overseas
- New section: Health care reform and medical technology

Chapter 6

- New section: Private coverage and cost under the Affordable Care Act
- New section: Medicaid experiences under the ACA

- New section: Issues with Medicaid
- New section: Long-term care hospital payment systems
- New section: Value-based reimbursement (discusses the MACRA and Medicare Shared Savings Program)
- Updated current directions and issues in financing

Chapter 7

- Research findings using the Primary Care Assessment Tool
- Measurement and achievement of the patient-centered medical home
- The impact of community health centers

Chapter 8

- New section: Comparative data from the Organization for Economic Cooperation and Development on hospital access and utilization
- Comparative hospital prices in selected countries
- New section: Factors that affect hospital employment
- New section: Rise in bad debts
- New section: State mental health institutions
- Update on physician-owned specialty hospitals
- Medicare designations of sole community hospitals and Medicare-dependent hospitals
- Patient outcomes at Magnet hospitals
- New section: Hospital costs

Chapter 9

- "Any willing provider" and "freedom of choice" laws under managed care regulations
- The latest on accountable care organizations

Chapter 10

- New section: Recent policies for community-based services

Chapter 11

- Updated information on vulnerable subpopulations
- Expanded coverage on chronically ill patients

Chapter 12

- Current issues in health care costs, access, and quality
- Pay-for-performance in health care
- Quality initiatives in both the public and private sectors

Chapter 13

- Current critical policy challenges
- Future health policy issues in both the United States and abroad

Chapter 14

- Almost all sections have been completely updated
- New section: No single payer
- New section: Reforming the reform
- New section: Universal coverage and access
- New section: Toward population health

As in the previous editions, our aim is to continue to meet the needs of both graduate and undergraduate students. We have attempted to make each chapter complete, without making it overwhelming for beginners. Instructors, of course, will choose the sections they decide are most appropriate for their courses.

As in the past, we invite comments from our readers. Communications can be directed to either or both authors:

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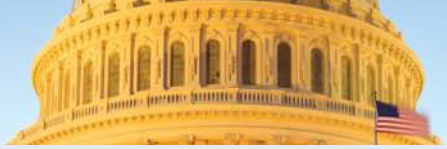

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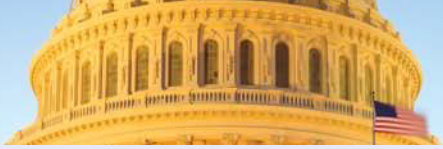

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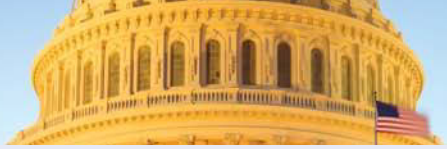

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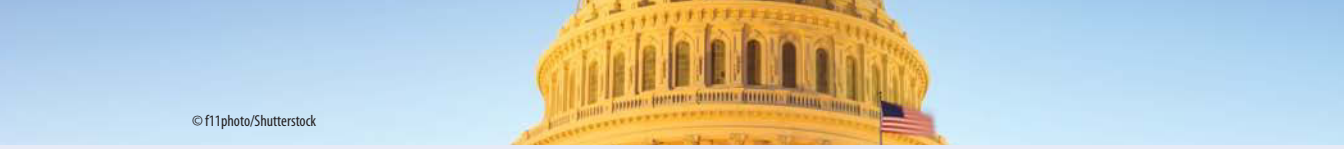


List of Abbreviations/Acronyms

A

AALL—American Association of Labor Legislation
AAMC—Association of American Medical Colleges
AA/PIs—Asian Americans and Pacific Islanders
AAs—Asian Americans
ACA—Affordable Care Act
ACNM—American College of Nurse-Midwives
ACO—accountable care organization
ACS—American College of Surgeons
ADA—American Dental Association
ADC—adult day care
ADLs—activities of daily living
ADN—associate's degree nurse
AFC—adult foster care
AHA—American Hospital Association
AHRQ—Agency for Healthcare Research and Quality
AIANs—American Indians and Alaska Natives
AIDS—acquired immunodeficiency syndrome
ALF—assisted living facility
ALOS—average length of stay
AMA—American Medical Association
AMDA—American Medical Directors Association
ANA—American Nurses Association
APCs—ambulatory payment classifications
APN—advanced practice nurse
ARRA—American Recovery and Reinvestment Act
ASPR—Assistant Secretary for Preparedness and Response

B

BBA—Balanced Budget Act
BPCI—bundled payments for care improvement
BSN—baccalaureate degree in nursing
BWC—Biological and Toxin Weapons Convention

C

CAH—critical access hospital
CAM—complementary and alternative medicine
CBO—Congressional Budget Office
CCAH—continuing care at home
CCRC—continuing care retirement center/community
CDC—Centers for Disease Control and Prevention
CDSS—clinical decision support system
CEO—chief executive officer
CEPH—Council on Education for Public Health
CER—comparative effectiveness research
CF—conversion factor
CHAMPVA—Civilian Health and Medical Program of the Department of Veterans Affairs
CHC—community health center
CHIP—Children's Health Insurance Program

CMGs—case-mix groups
C/MHCs—community and migrant health centers
CMS—Centers for Medicare and Medicaid Services
CNA—certified nursing assistant
CNM—certified nurse-midwife
CNS—clinical nurse specialist
COBRA—Consolidated Omnibus Budget Reconciliation Act
CON—certificate of need
COPC—community-oriented primary care
COTA—certified occupational therapy assistant
COTH—Council of Teaching Hospitals and Health Systems
CPI—consumer price index
CPOE—computerized provider order entry
CPT—Current Procedural Terminology
CQI—continuous quality improvement
CRNA—certified registered nurse anesthetist
CT—computed tomography

D

DC—Doctor of Chiropractic
DD—developmental disability
DDS—Doctor of Dental Surgery
DGME—Direct Graduate Medical Education
DHHS—U.S. Department of Health and Human Services
DHS—Department of Homeland Security
DMD—Doctor of Dental Medicine
DME—durable medical equipment
DO—Doctor of Osteopathic Medicine
DoD—Department of Defense
DPM—Doctor of Podiatric Medicine
DRA—Deficit Reduction Act
DRGs—diagnosis-related groups
DSM-5—*Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*
DTP—diphtheria/tetanus/pertussis (vaccine)

E

EBM—evidence-based medicine
EBRI—Employee Benefit Research Institute
ECG—electrocardiogram
ECU—extended care unit
ED—emergency department
EHRs—electronic health records
EMT—emergency medical technician
EMTALA—Emergency Medical Treatment and Active Labor Act
ENP—Elderly Nutrition Program
ERISA—Employee Retirement Income Security Act
ESRD—end-stage renal disease

F

FD&C Act—Federal Food, Drug, and Cosmetic Act
FDA—Food and Drug Administration
FMAP—Federal Medical Assistance Percentage
FPL—federal poverty level
FTE—full-time equivalent
FY—fiscal year

G

GAO—General Accounting Office
GDP—gross domestic product
GP—general practitioner

H

HAART—highly active antiretroviral therapy
HCBS—home- and community-based services
HCBW—home- and community-based waiver
HCH—Health Care for the Homeless
HCPCS—Healthcare Common Procedures Coding System
HDHP—high-deductible health plan
HDHP/SO—high-deductible health plan with a savings option
HEDIS—Healthcare Effectiveness Data and Information Set
HHRG—home health resource group
HI—hospital insurance
HIAA—Health Insurance Association of America
Hib—*Haemophilus influenzae* serotype b
HIO—health information organization
HIPAA—Health Insurance Portability and Accountability Act
HIT—health information technology
HITECH— Health Information Technology for Economic and Clinical Health Act
HIV—human immunodeficiency virus
HMO—health maintenance organization
HMO Act—Health Maintenance Organization Act
HPSAs—health professional shortage areas
HPV—human papillomavirus
HRA—health reimbursement arrangement
HRQL—health-related quality of life
HRSA—Health Resources and Services Administration
HSA—health savings account
HTA—health technology assessment
HUD—U.S. Department of Housing and Urban Development

I

IADLs—instrumental activities of daily living
ICF—intermediate care facility
ICF/IID—intermediate care facilities for individuals with intellectual disabilities
ICF/MR—intermediate care facilities for the mentally retarded
ID—intellectual disability
IDD—intellectual/developmental disability
IDEA—Individuals with Disabilities Education Act
IDS—integrated delivery systems
IDU—injection drug use
IHR—International Health Regulations
IHS—Indian Health Service
IME—Indirect Medical Education
IMGs—international medical graduates
IOM—Institute of Medicine
IPA—independent practice association
IRB—institutional review board
IRF—inpatient rehabilitation facility
IRMAA—Income-Related Monthly Adjustment Amount
IRS—Internal Revenue Service
IS—information systems
IT—information technology
IV—intravenous

L

LPN—licensed practical nurse
LTC—long-term care
LTCH—long-term care hospital
LVN—licensed vocational nurse

M

MA—Medicare Advantage
MA-PD—Medicare Advantage Prescription Drug Plan
MA-SNP—Medicare Advantage Special Needs Plan
MACPAC—Medicaid and CHIP Payment and Access Commission
MACRA—Medicare Access and CHIP Reauthorization Act
MBA—Master of Business Administration
MCOs—managed care organizations
MD—Doctor of Medicine
MDS—Minimum Data Set
MedPAC—Medicare Payment Advisory Commission
MEPS—Medical Expenditure Panel Survey
MERS—Middle East respiratory syndrome
MFP—Money Follows the Person
MHA—Master of Health Administration
MHS—multihospital system
MHSA—Master of Health Services Administration
MIPS—Merit-based Incentive Payment System
MLP—midlevel provider
MLR—medical loss ratio
MMA—Medicare Prescription Drug, Improvement, and Modernization Act
MMR—measles/mumps/rubella vaccine
MPA—Master of Public Administration/Affairs
MPFS—Medicare Physician Fee Schedule
MPH—Master of Public Health
MRHFP—Medicare Rural Hospital Flexibility Program
MRI—magnetic resonance imaging
MSA—metropolitan statistical area
MS-DRGs—Medicare severity diagnosis-related groups
MSO—management services organization
MSSP—Medicare Shared Savings Program
MUAs—medically underserved areas

N

NAB—National Association of Boards of Examiners of Long-Term Care Administrators
NAPBC—National Action Plan on Breast Cancer
NCCAM—National Center for Complementary and Alternative Medicine
NCCIH—National Center for Complementary and Integrative Health
NCHS—National Center for Health Statistics
NCQA—National Committee for Quality Assurance
NF—nursing facility
NGC—National Guideline Clearinghouse
NHC—neighborhood health center
NHE—national health expenditures
NHI—national health insurance
NHS—national health system
NHS—U.K. National Health Service
NHSC—National Health Service Corps
NICE—National Institute for Health and Clinical Excellence
NIH—National Institutes of Health
NIMH—National Institute of Mental Health
NP—nurse practitioner
NPP—nonphysician practitioner
NRP— National Response Plan

O

OAM—Office of Alternative Medicine
OBRA—Omnibus Budget Reconciliation Act
OD—Doctor of Optometry
OI—opportunistic infection
OPPS—Outpatient Prospective Payment System
OT—occupational therapist
OWH—Office on Women's Health

P

P4P—pay-for-performance
PA—physician assistant
PACE—Program of All-Inclusive Care for the Elderly
PAHPA—Pandemic and All-Hazards Preparedness Act
PASRR—Preadmission Screening and Resident Review
PBMs—pharmacy benefits managers
PCCM—primary care case management
PCGs—primary care groups
PCMH—patient-centered medical home
PCP—primary care physician
PDP—stand-alone prescription drug plan
PERS—personal emergency response system
PET—positron emission tomography
PFFS—private fee-for-service
PharmD—Doctor of Pharmacy
PhD—Doctor of Philosophy
PHI—personal health information
PHO—physician–hospital organization
PhRMA—Pharmaceutical Research and Manufacturers of America
PMPM—per member per month
POS—point-of-service (plan)
PPD—per-patient day (rate)
PPM—physician practice management
PPO—preferred provider organization
PPS—prospective payment system
PRO—peer review organization
PSO—provider-sponsored organization
PSRO—professional standards review organization
PsyD—Doctor of Psychology
PTA—physical therapy assistant
PTCA—percutaneous transluminal coronary angioplasty
PT—physical therapist

Q

QALY—quality-adjusted life year
QI—quality indicator
QIO—quality improvement organization

R

R&D—research and development
RBRVS—resource-based relative value scales
RN—registered nurse
RUGs—resource utilization groups
RVUs—relative value units
RWJF—Robert Wood Johnson Foundation

S

SAMHSA—Substance Abuse and Mental Health Services Administration
SARS—severe acute respiratory syndrome
SAV—small area variations
SES—socioeconomic status
SGR—sustainable growth rate
SHI—socialized health insurance
SMI—supplementary medical insurance
SNF—skilled nursing facility
SPECT—single-photon emission computed tomography
SSI—Supplemental Security Income
STD—sexually transmitted disease

T

TAH—total artificial heart
TANF—Temporary Assistance for Needy Families
TCU—transitional care unit

TEFRA—Tax Equity and Fiscal Responsibility Act
TPA—third-party administrator
TQM—total quality management

U

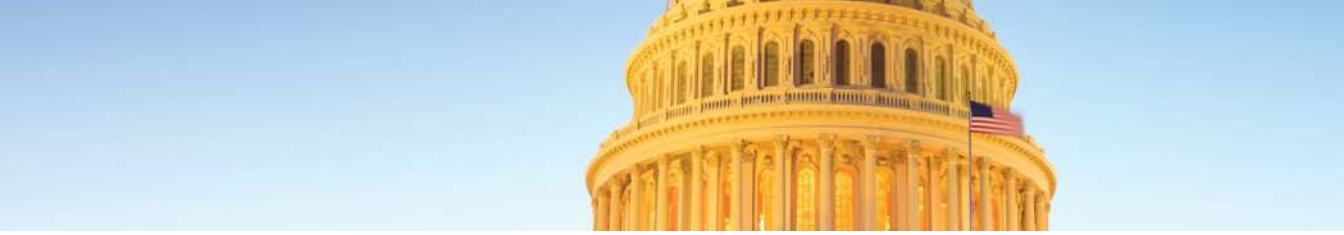
UCR—usual, customary, and reasonable
UR—utilization review

V

VA—Department of Veterans Affairs
VBP—Value-Based Purchasing
VHA—Veterans Health Administration
VISN—Veterans Integrated Service Network

W

WHO—World Health Organization
WIC—Special Supplemental Nutrition Program for Women, Infants, and Children



CHAPTER 1

An Overview of U.S. Health Care Delivery

LEARNING OBJECTIVES

- Understand the basic nature of the U.S. health care system.
- Outline the key functional components of a health care delivery system.
- Get a basic overview of the Affordable Care Act.
- Discuss the primary characteristics of the U.S. health care system.
- Emphasize why it is important for health care practitioners and managers to understand the intricacies of the health care delivery system.
- Get an overview of health care systems in selected countries.
- Point out global health challenges and reform efforts.
- Introduce the systems model as a framework for studying the health care system in the United States.

The U.S. 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 that is unlike any other health care system in the world. Almost all other developed countries have national health insurance programs run by the government and financed through general taxes. Nearly all citizens in such countries are entitled to receive health care services. Such is not yet the case in the United States, where Americans are not automatically covered by health insurance.

Though U.S. health care is often called a system because is has various features, components, and services, it may be misleading to talk about the American health care delivery "system," because a true, cohesive system does not exist (Wolinsky, 1988). Indeed, a major feature of the U.S. health care system is its fragmented nature, as different people obtain health care through different means. The system has continued to undergo periodic changes, mainly in response to concerns regarding costs, access, and quality.

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

The main objective of this chapter is to provide a broad understanding of how health care is delivered in the United States. Examples of how health care is delivered in other countries are also presented for the sake of comparison. The overview presented here introduces the reader to several concepts discussed 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. To name just a few: educational and research institutions, medical suppliers, insurers, payers, and claims processors to health care providers. A multitude of providers are involved in the delivery of preventive, primary, subacute, acute, auxiliary, rehabilitative, and continuing care. A large number of managed care organizations (MCOs) and integrated networks now provide a continuum of care, covering many of the service components.

The U.S. health care delivery system is massive, with total employment that exceeded 16.4 million people in 2010 in various health delivery settings. This number included more than 838,000 professionally active doctors of medicine (MDs), 70,480 osteopathic physicians (DOs), and 2.6 million active nurses (U.S. Census Bureau, 2012). The majority of health care and health services professionals (5.98 million) work in ambulatory health service settings, such as the offices of physicians, dentists, and other health practitioners, medical and diagnostic laboratories, and home health care service locations. Smaller proportions of these professionals are employed by hospitals (4.7 million) and nursing and residential

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 U.S. Public Health Service (Agency for Healthcare Research and Quality, Agency for Toxic Substances and Disease Registry, Centers for Disease Control and Prevention, Food and Drug Administration, Health Resources and Services Administration, Indian Health Service, National Institutes of Health, Substance Abuse and Mental Health Services Administration) 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 Veterans Affairs 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

care facilities (3.13 million). The vast array of health care institutions in the United States includes approximately 5,795 hospitals, 15,700 nursing homes, and 13,337 substance abuse treatment facilities (U.S. Census Bureau, 2012).

In 2015, 1,375 federally qualified health center grantees, with 188,851 full-time employees, provided preventive and primary care services to approximately 24.3 million people living in medically underserved rural and urban areas (Health Resources and Services Administration [HRSA], 2015). Various types of health care professionals are trained in 180 medical and osteopathic schools (Association of American Medical Colleges, 2017), 66 dental schools (American Dental Association, 2017), 136 schools of pharmacy (American Association of Colleges of Pharmacy, 2017), and more than 1,500 nursing programs located throughout the country. Multitudes of government agencies are involved with the financing of health care, medical research, and regulatory oversight of the various aspects of the health care delivery system.

A Broad Description of the System

U.S. health care delivery does not function as a rational and integrated network of components designed to work together coherently. To the contrary, it is a kaleidoscope of financing, insurance, delivery, and payment mechanisms that remain loosely coordinated. Each of these basic functional components represents an amalgam of public (government) and private sources. 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 deliver certain health care services directly to certain recipients, such as veterans, military personnel, American Indians/Alaska Natives, and some uninsured people. Nevertheless, the financing, insurance, payment, and delivery functions largely remain in private hands.

The market-oriented economy in the United States attracts a variety of private entrepreneurs that pursue profits by facilitating the key functions of health care delivery. Employers purchase health insurance for their employees through private sources, and employees receive health care services delivered by the private sector. The government finances public insurance through Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) for a significant portion of the country's low-income, elderly, disabled, and pediatric populations. However, insurance arrangements for many publicly insured people are made through private entities, such as health maintenance organizations (HMOs), and health care services are rendered by private physicians and hospitals. This blend of public and private involvement in the delivery of health care has resulted in the following characteristics of the U.S. system:

- A multiplicity of financial arrangements for health care services
- Numerous insurance agencies or MCOs that employ various mechanisms for insuring against risk
- Multiple payers that make their own determinations regarding how much to pay for each type of service
- A diverse array of settings where medical services are delivered

- Numerous consulting firms offering expertise in planning, cost containment, electronic systems, quality, and restructuring of resources

There is little standardization in a system that is functionally fragmented, and in which the various system components fit together only loosely. Because a central agency such as the government does not oversee the overall coordination of such a system, problems of duplication, overlap, inadequacy, inconsistency, and waste occur. Lack of system-wide planning, direction, and coordination leads to a complex and inefficient system. Moreover, the system as a whole does not lend itself to standard budgetary methods of cost control. Individual and corporate entities within a predominantly private entrepreneurial system seek to manipulate financial incentives to their own advantage, without regard to their impact on the system as a whole. Hence, cost containment remains an elusive goal.

In short, the U.S. health care delivery system is like a behemoth that is almost impossible for any single entity to manage or control. The United States consumes more health care services as a proportion of its total economic output than any other country in the world. The U.S. 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. Although the system can be credited for delivering some of the best clinical care in the world, it falls short of delivering equitable services to every American. It certainly fails in terms of providing cost-efficient services.

An acceptable health care delivery system should have two primary objectives: (1) enable all citizens to obtain needed health care services; and (2) ensure that services are cost-effective and meet certain established standards of quality. While the U.S. health care delivery system falls short of both these basic ideals, the United States leads the world in providing the latest and the best in medical technology, training, and research. It offers some of the most sophisticated institutions, products, and processes of health care delivery.

Basic Components of a Health Care Delivery System

FIGURE 1-1 illustrates that a health care delivery system incorporates four functional components—financing, insurance, delivery, and payment; hence, it is termed a **quad-function model**. Health care delivery systems differ depending on the arrangement of these components. The four functions generally overlap, but the degree of overlap varies between private and government-run systems, and between traditional health insurance and managed care–based systems. In a government-run system, the functions are more closely integrated and may be indistinguishable. Managed care arrangements also integrate the four functions to varying degrees.

Financing

Financing is necessary to obtain health insurance or to pay for health care services. For most privately insured Americans, health insurance is employment based; that is, the employers finance health care as a fringe benefit for their employees. A

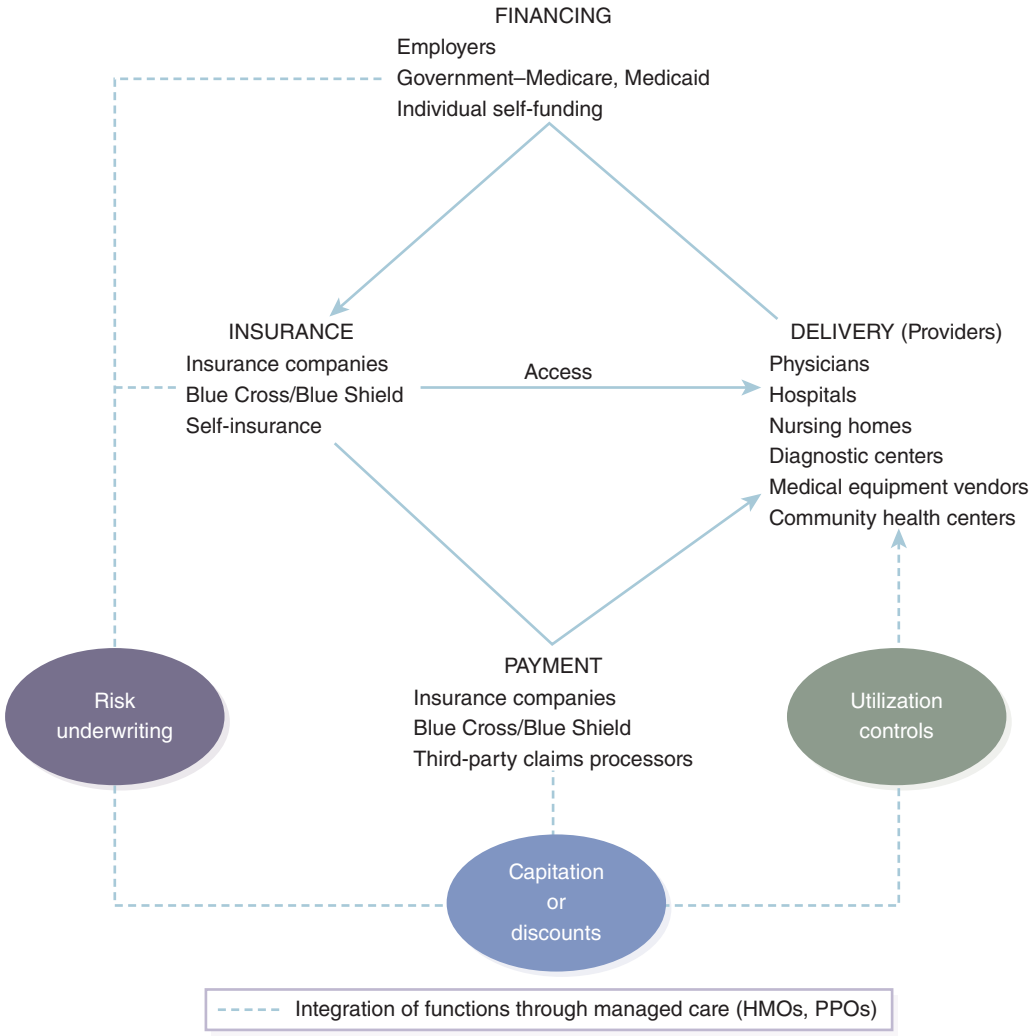


FIGURE 1-1 Basic health care delivery functions.

dependent spouse or children may also be covered by the working spouse's or working parent's employer. Most employers purchase health insurance for their employees through an MCO or an insurance company selected by the employer. Small employers may or may not be in a position to afford health insurance coverage for their employees. In public programs, the government functions as the financier; the insurance function may be carved out to an HMO.

Insurance

Insurance protects the insured against financial catastrophe by providing expensive health care services when needed. The insurance function determines the package of health services that the insured

individual is entitled to receive. It specifies how and where health care services may be received. The MCO or insurance company also functions as a claims processor and manages the disbursement of funds to the health care providers.

Delivery

The term "delivery" refers to the provision of health care services by various providers. The term **provider** refers to any entity that delivers health care services and either independently bills for those services or is supported through tax revenues. Common examples of providers include physicians, dentists, optometrists, and therapists in private practices, hospitals, and 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 and even those covered under public insurance programs receive health care services from private providers.

Payment

The payment function deals with **reimbursement** to providers for services delivered. The insurer determines how much is paid for a certain service. Funds for actual disbursement come from the premiums paid to the MCO or insurance company. At the time of service, the patient is usually required to pay an out-of-pocket amount, such as $25 or $30, to see a physician. The remainder is covered by the MCO or insurance company. In government insurance plans, such as Medicare and Medicaid, tax revenues are used to pay providers.

Insurance and Health Care Reform

The U.S. government finances health benefits for certain special populations, including government employees, the elderly (people ages 65 years and older), people with disabilities, some people with very low incomes, and children from low-income families. The program for the elderly and certain disabled individuals, which is administered by the federal government, is called **Medicare**. The program for the indigent, which is 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 Children's Health Insurance Program (CHIP).

However, the predominant employment-based financing system in the United States has left some employed individuals uninsured for two main reasons. First, 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. Second, in some work settings, participation in health insurance programs is voluntary, so employees are not required to join. Some employees choose not to sign up, mainly because they cannot afford the cost of health insurance premiums. Employers rarely pay 100% of the insurance premium; instead, most require their employees to pay a portion of the cost. This is called **premium cost sharing**. Self-employed people and other individuals who are not covered by employer-based plans have to obtain health insurance on their own. Individual rates are typically higher than