Essentials of the US Health Care System

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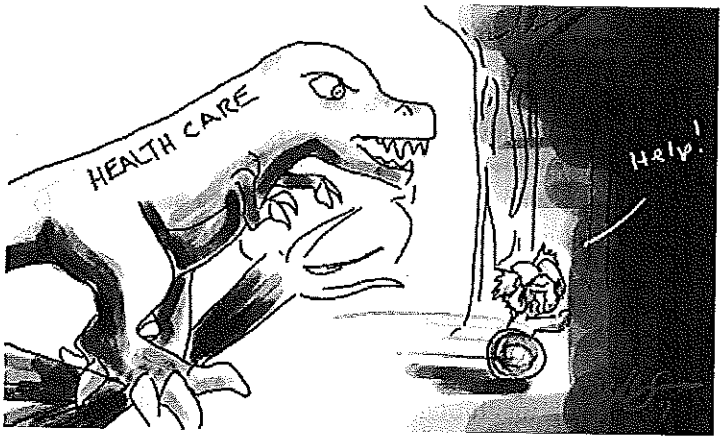
Chapter 1

Major Characteristics of US Health Care Delivery



INTRODUCTION

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

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

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

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

The following overview introduces the reader to several concepts that are treated more extensively in later chapters. The US health care delivery system is complex and massive. Interestingly, it is not actually a system in the true sense, although it is called a system when its various features, components, and services are referenced. Hence, it may be somewhat misleading to talk about the American health care delivery "system" (Wolinsky 1988, p. 54), but the term will nevertheless be used throughout this book.

Organizations and individuals involved in health care range from educational and research institutions, medical suppliers, insurers, payers, and claims processors to health care providers. Total employment in various health delivery settings is almost 9.7 million, including professionally active doctors of medicine (MDs), doctors of osteopathy (DOs), active nurses, dentists, pharmacists, and administrators. Approximately 455,000 physical, occupational, and speech therapists provide rehabilitation services. The vast array of institutions includes 6,200 hospitals, 16,700 nursing homes, almost 5,400 inpatient mental health facilities, and 13,500 home health agencies and hospices. Close to 800 programs include basic health services for migrant workers and the homeless, community health centers, black lung clinics, human immunodeficiency virus (HIV) early intervention services, and integrated primary care and substance abuse treatment programs. Various types of health care professionals are trained in 142 medical and osteopathic schools, 54 dental schools, 78 schools of pharmacy, and more than 1,500 nursing programs located throughout the country.

There are 187.4 million Americans with private health insurance coverage, 35.2 million Medicare beneficiaries, and 31.5 million Medicaid

recipients. Health insurance can be purchased from approximately 1,000 health insurance companies and 70 Blue Cross/Blue Shield plans. The managed care sector includes approximately 540 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; BPHC 1999; Health Insurance Association of America 1994; US Bureau of the Census 1998).

SUBSYSTEMS OF US HEALTH CARE DELIVERY

The United States does not have a universal health care delivery system enjoyed by everyone. Instead, multiple subsystems have developed, either through market forces or the need to take care of certain population segments. Discussion of the major subsystems follows.

Managed Care

Managed care is a system of health care delivery that (1) seeks to achieve efficiency by integrating the basic functions of health care delivery, (2) employs mechanisms to control (manage) utilization of medical services, and (3) determines the price at which the services are purchased and, consequently, how much the providers get paid. It is the most dominant health care delivery system in the United States today and available to most Americans (for more detail on managed care, please refer to Chapter 9).

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

The term enrollee (member) refers to the individual covered under the plan. The contractual arrangement between the MCO and the enrollee—including the collective array of covered health services that the enrollee is entitled to—is referred to as the health plan (or "plan" for short). The health plan uses

selected providers from whom the enrollees can choose to receive routine services. Primary care providers or general practitioners typically manage routine services and determine appropriate referrals for higher-level or specialty services, often earning them the name of gatekeeper. The choice of major service providers, such as hospitals, is also limited. Some of the services may be delivered through the plan's own hired physicians, but most are delivered through contracts with providers such as physicians, hospitals, and diagnostic clinics.

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

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

Military

The military medical care system is available free of charge to active-duty military personnel of the US Army, Navy, Air Force, and Coast Guard and also to certain uniformed nonmilitary services such as the Public Health Service and the National Oceanographic and Atomspheric Association (NOAA). It is a well-organized, highly integrated system. It is comprehensive and covers preventive as well as treatment services that are provided by salaried health care personnel, many of whom are themselves in the military or uniformed services. This system combines public health with medical services. Routine ambulatory care is provided close to the military personnel's place of work at the dispensary, sick bay, first-aid station, or medical station. Routine hospital services are provided at base dispensaries, in sick bays aboard ship, and at base hospitals. Complicated hospital services are provided in regional military hospitals. Long-term

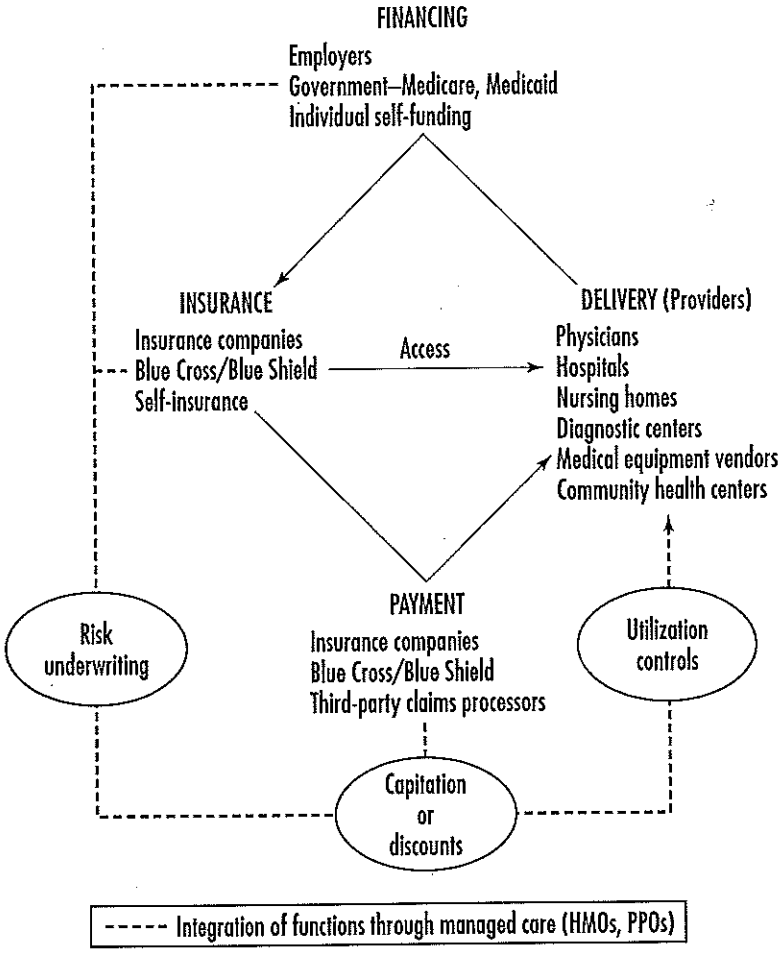


Figure 1.1 Managed Care: Integration of Functions

care is provided through Veterans Administration (VA) facilities to certain retired military personnel. Although patients have little choice regarding how services are provided, in general the military medical care system provides high-quality health care.

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

TRICARE, a program that is financed by the military. This insurance plan permits the beneficiaries to receive care from private medical care facilities as well as military ones.

The VA health care system is available to retired veterans of previous military service, with priority given to those who are disabled. (See http://www.military.com/Resources/ResourcesContent/0,13964,30982-mil_status_veteran-1,00.html.) The VA system focuses on hospital care, mental health services, and long-term care. It is one of the largest and oldest (1946) formally organized health care systems in the world. Its mission is to provide medical care, education and training, research, contingency support, and emergency management for the Department of Defense medical care system. It provides health care to more than 3.6 million persons at over 1,100 sites, including 172 hospitals, over 600 ambulatory and community-based clinics, 132 nursing homes, 206 counseling centers, 40 domiciliaries (residential care facilities), 73 home health care programs, and various contract care programs. The VA budget is over $20 billion, and it employs a staff of 182,000 (as of 1999: 13,000 physicians, 53,000 nurses, and more than 3,500 pharmacists). (Kizer et al. 2000). The entire VA system is organized into 22 geographically distributed Veterans Integrated Service Networks (VISNs). Each VISN is responsible for coordinating the activities of the hospitals, outpatient clinics, nursing homes, and other facilities located within its jurisdiction. Each VISN receives an allocation of federal funds and is responsible for equitable distribution of those funds among its hospitals and other providers. VISNs are also responsible for improving efficiency by reducing unnecessarily duplicative services, by emphasizing preventive services, and by shifting services from costly inpatient care to less costly outpatient care.

Subsystem for Vulnerable Populations

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

health education, social support services, case management, and child care) services targeted to the needs of vulnerable populations.

For example, for over 30 years, federally funded health centers have provided primary and preventive health services to rural and urban underserved populations. The Bureau of Primary Health Care (BPHC), located in the Health Resources and Services Administration in the Department of Health and Human Services (DHHS), provides federal support for community-based health centers that include programs for migrant and seasonal farm workers and their families, homeless persons, public housing residents, and school-aged children. These services facilitate regular access to care for patients who are predominantly minority, low-income, uninsured, or receiving Medicaid. By the end of calendar year 2002, the nationwide network of 843 reporting health centers delivered essential primary and preventive care at more than 3,500 sites, serving more than one fifth (>11 million) of the nation's 50 million underserved persons (BPHC 2002). Health centers have contributed to significant improvements in health outcomes for the uninsured and Medicaid populations and have reduced disparities in health care and health status across socioeconomic and racial/ethnic groups (Politzer et al. 2003; Shi et al. 2001).

However, it must be pointed out that America's safety net is by no means secure, and the availability of safety net providers varies from community to community. Vulnerable populations residing in communities without safety net providers have to forego care or seek care from hospital emergency departments if there is one nearby. Safety net providers face enormous pressure from the increasing number of uninsured and poor in their communities. The inability to shift costs for uncompensated care onto private insurance has become a significant problem as revenues from Medicaid, the primary source of third-party financing for core safety net providers, are restricted.

Integrated Delivery

Over the last decade, the hallmark of the US health care industry has been organizational integration to form integrated delivery systems (IDS) or networks. An IDS represents various forms of ownership and other strategic linkages among hospitals, physicians, and insurers. Its objective is to have one health care organization deliver a range of services. An IDS can be defined as a network of organizations that provides or arranges to provide a coordinated continuum of services to a defined population and that is

willing to be held clinically and fiscally accountable for the outcomes and health status of the population. From the standpoint of integration, the major participants or players in the health care delivery system are physicians, hospitals, and insurers. The key strategic position that physicians, hospitals, and insurers hold gives rise to different forms of IDSs (see Chapter 9).

CHARACTERISTICS OF THE US HEALTH CARE SYSTEM

The health care system of a nation is influenced by external factors, including the political climate, stage 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 environmental forces influences the course of health care delivery in the United States. This section will summarize the basic characteristics that differentiate the US health care delivery system from that of other countries. There are eight main areas of distinction (see Exhibit 1.1).

No Central Governing Agency; Little Integration and Coordination

The US health care system stands in conspicuous contrast to the health care systems of other developed countries. The centrally controlled universal health care system that most developed countries have authorizes the financing, payment, and delivery of health care to all residents. The US sys-

Exhibit 1.1 Main Characteristics of the US Health Care System

- No central governing agency and little integration and coordination
- Technology-driven delivery system focusing on acute care
- High on cost, unequal in access, average in outcome
- Delivery of health care under imperfect market conditions
- Government as subsidiary to the private sector
- Market justice vs social justice: conflict throughout health care
- Multiple players and balance of power
- Quest for integration and accountability

tem, however, is not centrally controlled, and therefore has a variety of payment, insurance, and delivery mechanisms, and health care is financed both publicly and privately. Private financing, which is predominantly through employers, accounts for approximately 55% of total health care expenditures; the government finances the remaining 45% (National Center for Health Statistics 2002).

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

Technology Driven and Focusing on Acute Care

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

Although technology has ushered in a new generation of successful interventions, the negative outcomes resulting from its overuse are many. For example, the cost of highly technical interventions adds to the rising costs of

health care, making it more difficult for employers to extend insurance to part-time workers or for insurance companies to lower their premiums. Because there are limited resources to invest in the American health care system, it is essential to think twice before assuming that the best solution always involves technology. Considering the broad benefits of primary care in preventing acute conditions that ultimately require technological intervention, it seems essential to strive for a balanced investment in both high- and low-technology medicine.

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

The United States spends more than any other developed country on health care (primarily medical care), and costs continue to rise at an alarming rate. Despite spending such a high percentage (13%) of the nation's gross domestic product on health care, many US residents have limited access to even the most basic care (Anderson et al. 2003).

Access means the ability of an individual to obtain health care services when needed. In the United States, access is restricted to those who 1) have health insurance through their employers, 2) are covered under a government health care program, 3) can afford to buy insurance out of their own private funds, and 4) are able to pay for services privately. Health insurance is the primary means for ensuring access. In 2000, the number of uninsured Americans—those without private or public health insurance coverage—was estimated to be 40.5 million or 16.8% of the US population (National Center for Health Statistics 2002). For consistent basic and routine care, commonly referred to as primary care, the uninsured are unable to see a physician unless they can pay the physician's fees. Those who cannot afford to pay generally wait until health problems develop, at which point they may be able to receive services free of charge in a hospital emergency department. Uninsured Americans therefore are able to obtain medical care for acute illness. Hence, one can say that the United States does have a form of universal catastrophic health insurance even for the uninsured (Altman and Reinhardt 1996, p. xxvi).

It is well acknowledged that the absence of insurance inhibits the patient's ability to receive well-directed, coordinated, and continuous health care through access to primary care services and, when needed, referral to specialty services. Experts generally believe that the inadequate access to basic and routine primary care services is the main reason 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 Conditions

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

In a free market, multiple patients (buyers) and providers (sellers) act independently. In a free market, patients should be able to choose their provider based on price and quality of services. If it were this simple, patient choice would determine prices by the unencumbered interaction of supply and demand. Theoretically, at least, prices are negotiated between payers and providers. However, in many cases, the payer is not the patient but an MCO, Medicare, or Medicaid. Because prices are set by agencies external to the market, they are not freely governed by the forces of supply and demand.

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

A free market requires that patients have information about the availability of various services. Free markets operate best when consumers are educated about the products they are using, but patients are not always well

informed about the decisions that need to be made regarding their care. Choices involving sophisticated technology, diagnostic methods, interventions, and pharmaceuticals can be difficult and often require physician input. Acting as an advocate, primary care providers can reduce this information gap for patients. Recently, health care consumers have taken the initiative to educate themselves with the use of Internet resources for gathering medical information. Pharmaceutical product advertising is also having an impact on consumer expectations and increasing awareness of available medications.

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

In recent years, the quality of care has received much attention. Performance rating of health plans has met with some success. However, apart from sporadic news stories, the public generally has scant information on the quality of health care providers.

In a free market, patients must directly bear the cost of services received. The purpose of insurance is to protect against the risk of unforeseen major events. Because the fundamental purpose of insurance is to meet major expenses when unlikely events occur, having insurance for basic and routine health care undermines the principle of insurance. Health insurance coverage for minor services such as colds, coughs, and earaches amounts to prepayment for such services. There is a moral hazard that 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 foregone if the patient has to bear the full cost of these services.

In a free market for health care, patients as consumers make decisions about the purchase of health care services. The main factors that severely limit the patient's ability to make health care purchasing decisions have already been discussed. At least two additional factors limit the ability of patients to make decisions. First, decisions about the utilization of health care are often determined by need rather than price-based demand. Need has generally been defined as the amount of medical care that medical experts believe a person should have to remain or become healthy (Feldstein 1993, p. 74–75). Second, the delivery of health care can result in creation of demand. This follows from self-assessed need 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 provider-induced demand.

Government as Subsidiary to the Private Sector

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

Market Justice vs Social Justice: Conflict Throughout Health Care

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

based on need, not simply one's ability to purchase them in the marketplace. In a partial public and private health care system, the two theories often work well hand in hand, contributing ideals from both theories. However, market justice principles tend to prevail. As mentioned before, Americans generally prefer market solutions to government intervention in health care financing and delivery. Unfortunately, market justice results in the unequal allocation of health care services, neglecting critical human concerns that are not confined to the individual but have broader, negative impacts on society (see Chapter 2 for contrast between market and social justice).

Multiple Players and Balance of Power

The US health services system involves multiple players. The key players in the system have been physicians, administrators of health service institutions, insurance companies, large employers, and the government. Big business, labor, insurance companies, physicians, and hospitals make up the powerful and politically active special interest groups represented before lawmakers by high-priced lobbyists. Each player has a different economic interest to protect. The problem is that the self-interests of each player are often at odds. For example, providers seek to maximize government reimbursement for services delivered to Medicare and Medicaid patients, but the government wants to contain cost increases. The fragmented self-interests of the various players produce counteracting forces within the system. One positive effect of these opposing forces is that they prevent any single entity from dominating the system. In an environment that is rife with motivations to protect conflicting self-interests, achieving comprehensive 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 characterized as incremental or piecemeal and sometimes regressive when administrations change followed by its ripple effect on government health agencies.

Quest for Integration and Accountability

Currently in the United States, there is a drive to use primary care as the organizing hub for continuous and coordinated health services. Although this model gained popularity with the expansion of managed care, the model's development stalled before reaching its full potential. The envisioned role for primary care would include integrated health care by offering comprehensive, coordinated, and continuous services with a seamless delivery. Furthermore, the model emphasizes the importance of the patient–provider relationship and

how it can best function to improve the health of each individual and thus strengthen the population. Integral to the relationship is the concept of accountability. Accountability on the provider's behalf means ethically providing quality health care in an efficient manner. On the patient's behalf, it means safeguarding one's own health and using available resources sensibly.

HEALTH CARE SYSTEMS OF OTHER DEVELOPED COUNTRIES

Most Western European countries have national health care programs that provide universal access. There are three basic models for structuring national health care systems. In a system under National Health Insurance, such as Canada, the government finances health care through general taxes, but the actual care is delivered by private providers. In the context of the quad-function model (see Figure 1.1), National Health Insurance requires a tighter consolidation of the financing, insurance, and payment functions, which are coordinated by the government. Delivery is characterized by detached private arrangements.

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

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

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

Table 1.1 Health Care Systems of Selected Industrialized Countries

	United States	Canada	Great Britain	Germany
Type	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 (DRGs, negotiated fee-for-service, per diem, capitation)	Global budgets	Global budgets	Per diem payments
Reimbursement (physicians)	RBRVS, fee-for-service	Negotiated fee-for-service	Salaries and capitation payments	Negotiated fee-for-service
Consumer Copayment	Small to significant	Negligible	Negligible	Negligible

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

SYSTEMS FRAMEWORK

A system consists of a set of interrelated and interdependent components designed to achieve some common goals. The components are logically coordinated. Even though the various functional components of the health services delivery structure in the United States are at best only loosely coordinated, the main components can be identified with a systems model. The systems framework used here helps one understand that the structure of health care services in the United States is based on some foundations, provides a logical arrangement of the various components, and demonstrates a progression from inputs to outputs. The main elements of this arrangement are system inputs (resources), system structure, system processes, and system outputs (outcomes). In addition, system outlook (future directions) is a necessary element of a dynamic system. This systems framework has been used as the conceptual base for organizing later chapters in this book (see Figure 1.2).

System Foundations

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

System Resources

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

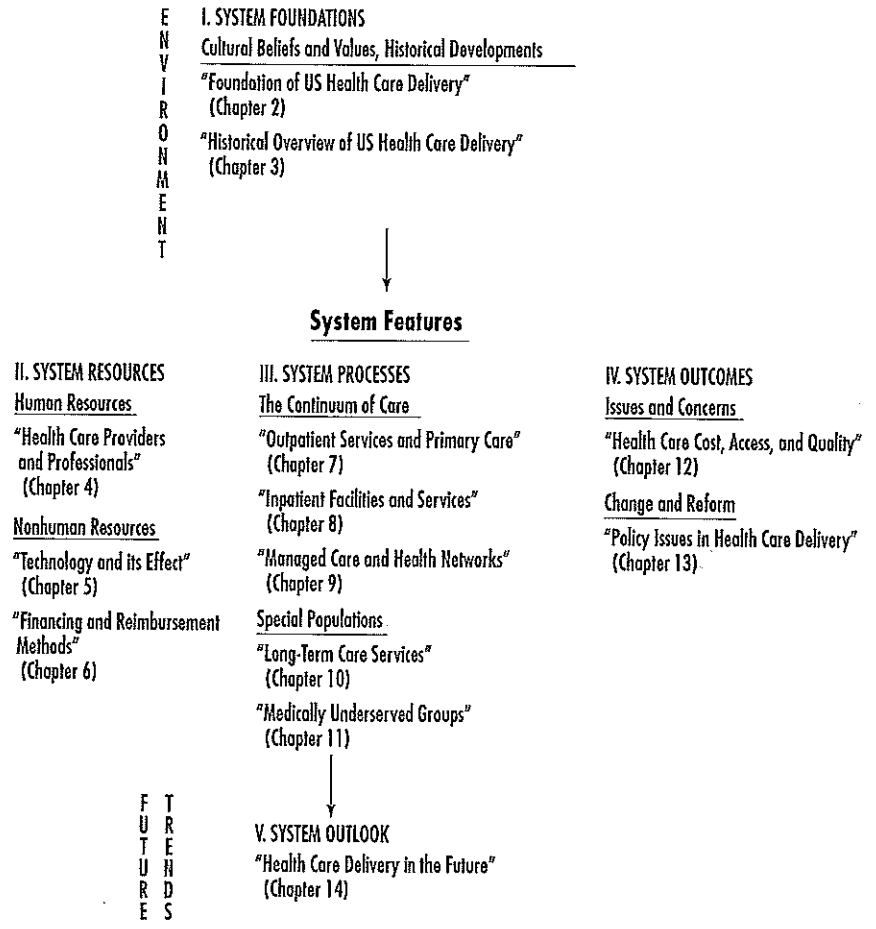


Figure 1.2 Systems Framework

indirect supportive role in the delivery of health care. Health care managers are needed to manage and coordinate various types of health care services. This book discusses primarily the personnel engaged in the direct delivery 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, which are mainly associated with processes referred to as outpatient care (Chapter 7). Institutional health services (inpatient care) are predominantly associated with acute care hospitals (Chapter 8). Managed care and integrated systems (Chapter 9) represent a fundamental change in the financing (including payment and insurance) and delivery of health care. Even though managed care represents an integration of the resource and process elements of the systems model, it is discussed as a process for the sake of clarity and continuity of the discussions. Special institutional and community-based settings have been developed for long-term care (Chapter 10) and mental health (Chapter 11).

System Outcomes

System outcomes refer to the critical issues and concerns surrounding what the health services system has been able to accomplish, or not accomplish, in relation to its primary objective. The primary objective of any health care delivery system is to provide, to an entire nation, cost-effective health services that meet certain established standards of quality. The previous three elements of the systems model (foundations, resources, and processes) play a critical role in fulfilling this objective. Access, cost, and quality are the main outcome criteria for evaluating the success of a health care delivery system (Chapter 12). Issues and concerns regarding these criteria trigger broad initiatives for reforming the system through health policy (Chapter 13).

System Outlook

A dynamic health care system must look forward. In essence, it must project into the future the accomplishment of desired system outcomes in

view of anticipated social, cultural, and economic changes. Chapter 14 discusses these future perspectives.

CONCLUSION

The United States has a unique system of health care delivery, but the system lacks universal access. Therefore, continuous and comprehensive health care is not enjoyed by all Americans. Health care delivery in the US is characterized by a patchwork of subsystems developed either through market forces or the need to take care of certain population segments. These include managed care, the military and VA systems, the system for vulnerable populations, and the emerging IDSs.

No country in the world has a perfect system. Most nations with a national health care program have a private sector that varies in size. The systems framework provides an organized approach to an understanding of the various components of the US health care delivery system.

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