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Introduction: The State of Health Care Delivery in the United States

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LEARNING OBJECTIVES

- ☐ Understand defining characteristics of the American health care delivery system.
- ☐ Identify issues and concerns with the current delivery system.
- ☐ Understand the causes of current issues and concerns.
- ☐ Analyze stakeholder interests in health care delivery.
- ☐ Identify goals for health care delivery that are realistic and politically feasible.

TOPICAL OUTLINE

Defining characteristics of the American health care delivery system
Issues and concerns
Stakeholder interests in health care delivery
Goals for health care delivery

KEY WORDS

health care delivery, life expectancy, infant mortality, quality of care, chronic care, health care providers, Medicare, national health insurance, stakeholders, comprehensive coverage, universal health insurance, access

This introduction shall give a brief overview of some of the distinguishing characteristics of the American *health care delivery* system, review issues and concerns, and make recommendations for change in health care delivery. As long ago as 1932, a presidential commission studied the American system and pointed out that the United States had the economic resources to provide satisfactory medical service to all the people at costs that they can meet (Committee on the Costs of Medical Care, 1932/1970, p. 2). It still does. We wish to address the question of why we still have a system that doesn't do better for all Americans. If we do not come up with our own satisfactory answers to why we have the system that we do, it is likely that we can only devise unrealistic recommendations for change, that will not be implemented by the powers that be. Of course, the powers that be could fall, as did the Berlin Wall (and the powers that were in the USSR). That, however, is an alternative way of looking at things that we choose not, at this time, to consider.

Defining Characteristics of the American Health Care Delivery System

Americans spend a lot of money on health care, over $4,300 per capita, much more than any developed country. At the same time, over 44 million Americans lack financial coverage for basic health services, again a much higher percentage than is found in any developed country. We have the most highly developed medical technology, the most expensive hospitals, and the most highly paid doctors in the world, so that Americans who can afford it have access to the best that medical treatment can offer.

Issues and Concerns

But what value do we, as a population, get for the money that we spend? Is the health of Americans overall better than that of people in other developed countries? No. For example, among the world's developed countries the United States is not among the leaders in *life expectancy* from birth (U.S. Census Bureau [USCB], 1999, Table 1352). Nor are we among the leaders in low *infant mortality* rates. We lead the rest of the world in only one health statistic, life expectancy after the age of 80. There are several possible causes for this occurrence. It might be due to the better underlying health status of the survivors. It might be due to the better access to high technology for those who can afford care.

There are other distressing aspects of our health care delivery system beyond excessive cost and less than the best population health outcomes. The *quality of care* is uneven. Too much money is spent on administration, in major part because the financing of care is so extraordinarily complex. Too little money is spent on *chronic care*. There is fragmentation and

discontinuity of care. In part because of the complexity of the financing system, there is overregulation of *health care providers* by government and insurers. Millions of Americans follow poor health practices: smoking too much tobacco and drinking too much alcohol, for example. There are also those who engage in acts of violence, with easy access to firearms. And there are those who eat too much of the wrong foods. In addition, millions of Americans are poor and cannot read—these characteristics create health problems such as the lack of knowledge about good health practices and how to gain access to services.

Part of the problem is that millions of Americans are ambivalent about a healthy lifestyle, what it consists of, and how to implement it. Americans want to look and feel terrific—but to what extent are we Americans willing to change our behaviors so that we get enough sleep and proper exercise, eat the proper amount of the right foods, and do not use tobacco or abuse alcohol?

What Most of Us Can Agree On

Of the leading priorities, national health care system reform was not a top voting issue in the 1998 congressional elections, ranking well below where it did in 1992. More narrowly focused issues such as *Medicare* reform, coverage for the uninsured and dealing with managed care are seen as the highest health care priorities by voters (Blendon, Benson, Brodie, Altman, James, & Hugick, 1999). We think that most Americans in principle agree upon the following: (1) all Americans should have access to basic health services, (2) the country can afford to provide all Americans with such access, and (3) we need to improve the effectiveness of the government in holding the private health sector accountable for providing better value for the dollars that we spend. But in the legislative arena, health care is never dealt with in principle. With regard to specifics, those whose interests benefit from the status quo simply don't want to make changes, or if they do the changes they support are designed to support their interests rather than those of the consumer and taxpayer. Americans don't agree about how we should pay for providing all Americans with access to basic health services. Nor do we agree upon what "basic health services" are; for example, to what extent are nonmedical services to the frail elderly a health service, to be afforded all Americans?

Why Do We Have the System That We Have?

Readers of this text are primarily students in the various health care professions, who have their own opinions on many of these issues and concerns. Some would argue that the answer to "not getting enough value for the dollars we spend and for insuring all Americans" is the creation of a *national health insurance* system that assures basic health benefits to all,

and that will contain health care costs by government regulation. Before reaching conclusions as to what "treatments" are indicated for what diagnoses, however, it is useful to understand the reasons that many of the various *stakeholders* in the health care delivery system prefer the system for the most part the way that it is now, to be changed only in certain ways that would be more favorable to their interests. Stakeholders are groups who can affect or who are affected by the current system. For the purposes of this book, we shall divide health care stakeholders into the six groups listed in Table 1.1.

Table 1.1, of course, drastically oversimplifies a complex political economy. For example, patients who require chronic care have different interests than those who are basically healthy; nurses have interests that are different from physicians, as do generalist from specialist physicians; whereas the interests of insurance plans, educators, consultants, researchers, and unions and trade organizations (all included above as vendors and suppliers) are often very different from each other. Note also that in this Table, "the people" appear in two different categories, "taxpayer" and "patient." This is because, of course, most of the time most people are not sick and don't think about what it's like to be sick and lacking insurance. We must not forget that health expenditures equal health incomes, that every dollar spent on someone in health care is also revenue or income for someone else. Provider interests narrowly focus on bottom-line issues much of the time. They are usually more effective in influencing the kinds of governmental legislation they desire than are more broadly focused consumer interests.

What we learn from Table 1.1 is that there are groups of stakeholders who favor *comprehensive coverage* (patients, vendors and suppliers, and providers), and other stakeholder groups who favor limits on payments to providers (taxpayers, and employers and payers). Of course, the same individuals in these stakeholder groups can belong to different interest groups depending on, for example, whether the individual or the provider is healthy or sick.

We are not saying that both expressed preferences for comprehensive—but not unlimited—insurance coverage, and adequate—but limited—payments to providers cannot be solved by one solution, such as national health insurance. We are saying that typically no one stakeholder group favors policies that include *both* comprehensive coverage *and* limited payments to providers. And given the risk of losing what a stakeholder group has, whether this is adequate health insurance at work or an adequate income as a health care provider, the major provider/payment system interest groups have demonstrated no interest in even a compromise solution, such as to provide full basic coverage for everyone at some reasonable cost.

What Is to Be Done?

Let us assume that we could agree on the desirability of achieving the three goals we have highlighted: (a) access to basic health care for all Americans,

TABLE 1.1 Stakeholder Interests in Health Care Delivery

Stakeholder groups	Policies they favor	Policies they oppose
Taxpayers	Limits on provider payment	Higher taxes
Patients	Comprehensive coverage Quality of care Lower out-of-pocket costs	Limited access to care Increased patient payments
Providers	Income maintenance Autonomy Comprehensive coverage	Limits on provider payment
Vendors and suppliers	Comprehensive coverage Research funding	Limits on provider payment
Employers and payers	Cost containment Administrative simplification Elimination of cost shifting	Governmental regulation
Regulators (government)	Disclosure and reporting by providers Cost containment Access to care Quality of care	Provider autonomy

(b) *universal health insurance* coverage for all Americans, and (c) more effective governmental regulation of private providers, in a system that would be financed at a reasonable level. What must we do to make attainment of these goals a reality? First, we have to define in measurable terms what we mean by these statements of purpose. For example, how should *basic* health care and *necessary* primary care services be defined? We could define basic health care as what is covered in a typical employer's benefit plan, or in a typical plan for governmental employees. But there is a lot of disagreement even here. For example, to what extent should nursing home and home care be covered? But we have to start somewhere and cost it out. We can have whatever specific coverages are politically preferable but we can't have everything covered at a price American voters are willing to pay.

Second, we have to measure how well the system is performing now with regard to the three issues. For example, who doesn't have *access* to basic health care, and what are the consequences to how many of those involved, and for the rest of us, in paying for subsequent care?

Third, we have to have an acceptable plan to implement the recommendations. For example, to finance the additional coverages, either we have

to provide narrower coverages or lower payments to providers, or raise additional revenues from other sources. This is not the place to discuss these implementation issues. You will find them discussed in greater depth in the chapters that follow (for example, those on financing, cost containment, access, and futures).

It's Up To You

Every reader of this text is a stakeholder in the American health care delivery system. We believe that after you have read this book, you will wish the American health care delivery system to move, faster, in the direction of greater access, universal insurance, and more effective (not more) governmental regulation.

We hope our text will provide you with data and perspectives so that you can form your own conclusions and develop future lines of inquiry so that you can get answers to your own questions about these issues. We have been fascinated in our own teaching, learning, and undertaking of research over the years, by the difficulty in finding satisfactory solutions. We have been humbled by the tremendous pace of change in the delivery of health care in terms of new technologies and therapies, new demands and consumer preferences, and new ways of organizing services and training the health care workforce. At the same time, the underlying problems of lack of coverage, fragmentation of services, and grossly uneven access remain virtually unchanged. The journey to understanding and changing the world's most complicated, expensive and often dysfunctional, or at least wasteful, health care delivery system is both exhilarating and exhausting. We hope that you will enjoy it.

CASE STUDY

Politicians have suggested extending Medicare to the rest of the American population. They intend to pay for increasing the population eligible for these benefits by increasing payroll taxes and premiums. Discuss which groups or interests in American society are likely to favor or oppose such legislation, and for what reasons.

DISCUSSION QUESTIONS

1. What are the characteristics of the American health care delivery system?
2. What are the problems and issues resulting from these characteristics?
3. What are the reasons for these problems and issues?

4. What are some suggestions to overcome the opposition of certain interest groups to national health insurance for all Americans?
5. What is likely to be the response from these interests to your suggestions?

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