Anthony R. Kovner, PhD, is professor of health care management at New York University’s Robert F. Wagner Graduate School of Public Service. His research interests include evidence-based management, nonprofit governance, clinician leadership, and hospital service lines in geriatrics. He has been a senior manager in two hospitals, a nursing home, a group practice, a neighborhood health center, and a senior consultant for a large industrial union. Professor Kovner has written 11 books and 91 peer-reviewed articles, book chapters, and case studies. His newest texts include Evidence-Based Management in Health Care, with Richard D’Aquila and David Fine (2009), and Health Care Management: Cases, Readings and Commentary, with Ann McAlearney and Duncan Neuhauser, 9th edition (2009). He has been an editor or coeditor for several editions of Health Care Delivery in the United States. He has consulted with the New York-Presbyterian health system (nurse leadership), Robert Wood Johnson Foundation (swing beds), the WK Kellogg Foundation (clinician management education), Montefiore Medical Center (clinician management education), and the American Academy of Orthopaedics (governance). He was a Lutheran Medical Center board member for 26 years. He directs the NYU/Wagner Executive MPA for Nurse Leaders. Professor Kovner received his PhD in public administration from the University of Pittsburgh.

James R. Knickman, PhD, is the president and chief executive officer of New York State Health Foundation (NYSHealth), a private philanthropy that has a mission to improve public health and health care delivery in New York state. The Foundation supports innovative organizations working to improve the health of New Yorkers through systems reform, improvements in access to health care, and improvements in the quality of public health and medical care. Prior to joining NYSHealth, Dr. Knickman was vice president of research and evaluation at Robert Wood Johnson Foundation. He also was a faculty member at the New York University Robert F. Wagner Graduate School of Public Service for 16 years. He has served as chair of the Robert Wood Johnson University Hospital board and as board member of Academy Health. He is on the editorial boards for the Milbank Quarterly and Inquiry and has published widely on topics related to the financing and organization of health care services. Dr. Knickman received his PhD in public policy analysis from the University of Pennsylvania.
BRIEF CONTENTS

FOREWORD

Part I: Health Policy

1 THE CURRENT U.S. HEALTH CARE SYSTEM 3
1A AN OVERVIEW IN CHARTS 9
2 HEALTH POLICY AND HEALTH REFORM 25
3 HEALTH CARE FINANCING 47
4 COMPARATIVE HEALTH SYSTEMS 67

Part II: Population Health

5 POPULATION HEALTH 85
6 PUBLIC HEALTH: POLICY, PRACTICE, AND PERCEPTIONS 103
7 HEALTH AND BEHAVIOR 125
8 ACCESS TO CARE 151

Part III: Medical Care Delivery

9 ORGANIZATION OF MEDICAL CARE 181
10 INTEGRATIVE MODELS AND PERFORMANCE 205
11 HIGH QUALITY HEALTH CARE 233
12 HEALTH CARE COSTS AND VALUE 257
13 COMPARATIVE EFFECTIVENESS 277

Part IV: Support for Medical Care Delivery

14 GOVERNANCE, MANAGEMENT, AND ACCOUNTABILITY 299
15 HEALTH WORKFORCE 315
16 HEALTH INFORMATION TECHNOLOGY 331

Part V: The Future of Health Care Delivery

17 THE FUTURE OF HEALTH CARE DELIVERY IN THE UNITED STATES 353

APPENDIX 365
Major Provisions of the Patient Protection and Affordable Care Act of 2010
GLOSSARY 377
CONTENTS

Brief Contents vii
List of Tables and Figures xiii
Foreword, Steven Jonas, MD, MPH, MS, FNYAS xvii
Acknowledgments xix
Organization of This Book xxi
Contributors xxiii

Part I: Health Policy

1 THE CURRENT U.S. HEALTH CARE SYSTEM 3
   Anthony R. Kovner and James R. Knickman
   The Importance of Health and Health Care to American Life 4
   Defining Characteristics of the U.S. Health Care System 4
   Major Issues and Concerns Facing the Health Sector 5
   Constraints and Opportunities for Change 7
   Engagement at the Ground Level 8
   Discussion Questions 8
   Case Study 8

1A AN OVERVIEW IN CHARTS 9
   Victoria D. Weisfeld
   “Get Government Out of My Health Care!” 9
   The Department of Health and Human Services 10
   Health-Related Responsibilities of Other Federal Entities 12
   The U.S. Hospital and Physician Supply 14
   Costs of Care 17
   Where the Money Comes From 17
   Health Care Quality 19
   Satisfaction With Care 21
   The Health Care Workforce 23
2 HEALTH POLICY AND HEALTH REFORM  25
   Michael S. Sparer
   The Government as Payer: The Health Insurance Safety Net  26
   The Government as Regulator  36
   The Government as Health Care Provider  39
   Key Issues on the U.S. Health Care Agenda  42
   Discussion Questions  43
   Case Studies  43

3 HEALTH CARE FINANCING  47
   James R. Knickman
   General Overview of Health Care Financing  48
   What the Money Buys and Where It Comes From  51
   How Health Insurance Works  52
   How Health Reform May Affect the Financing System  58
   Reimbursement Approaches  59
   Current Policy Issues in Financing  61
   Conclusion  64
   Discussion Questions  65
   Case Study  65

4 COMPARATIVE HEALTH SYSTEMS  67
   Bianca K. Frogner, Hugh R. Waters, and Gerard F. Anderson
   Basic Health Care System Characteristics  68
   Health Care Quality Similarities Across Models  70
   Evolution of Health Care Systems  71
   Exploring Major Health System Models  73
   Common Challenges Facing Systems  78
   Conclusion  79
   Discussion Questions  79
   Case Study  80

Part II: Population Health

5 POPULATION HEALTH  85
   Pamela Russo
   The Population Health Model  86
   The Medical Model  88
   Comparing the Medical and Population Health Models  88
   The Influence of Social Determinants on Health Behavior and Outcomes  90
   Leading Determinants of Health: Weighting the Different Domains  94
   Health Policy and Returns on Investment  96
   Conclusion  99
6 **PUBLIC HEALTH: POLICY, PRACTICE, AND PERCEPTIONS**  
Laura C. Leviton, Scott D. Rhodes, and Carol S. Chang
- Who’s in Charge of Public Health? 103
- A Healthy Population Is in the Public Interest 105
- Core Functions of Public Health 108
- Governmental Authority and Services 110
- Challenges and Opportunities 114
- Discussion Questions 121
- Case Study 122

7 **HEALTH AND BEHAVIOR** 125
C. Tracy Orleans and Elaine F. Cassidy
- Behavioral Risk Factors: Overview and National Goals 126
- Changing Health Behavior: Closing the Gap Between Recommended and Actual Health Lifestyle Practices 131
- Changing Provider Behavior: Closing the Gap Between Best Practice and Usual Care 140
- Conclusion 145
- Discussion Questions 146
- Case Study 147

8 **ACCESS TO CARE** 151
John Billings, Joel C. Cantor, and Chelsea Clinton
- Economic Barriers to Care 154
- Noneconomic and Quasi-Economic Barriers to Care 160
- State and Federal Health Care Reforms 169
- The Future: Continuing and Emerging Issues 173
- Discussion Questions 175
- Case Study 175

Part III: Medical Care Delivery

9 **ORGANIZATION OF MEDICAL CARE** 181
Carol A. Caronna and Michael K. Ong
- Basic Framework of Medical Care Delivery 182
- Characteristics of the Medical Care Field 185
- Critical Issues Facing the Delivery System 192
- Pathways to Better Organized Care 194
- Barriers to Change 198
- Conclusion 200
<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td><strong>INTEGRATIVE MODELS AND PERFORMANCE</strong></td>
<td>205</td>
</tr>
<tr>
<td></td>
<td><em>Douglas McCarthy</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The Structure of Integration</td>
<td>206</td>
</tr>
<tr>
<td></td>
<td>Attributes of Organized Health Care Delivery</td>
<td>211</td>
</tr>
<tr>
<td></td>
<td>Cross-Cutting Themes: The “Methods” of Organized Delivery</td>
<td>221</td>
</tr>
<tr>
<td></td>
<td>The Value of Organized Delivery</td>
<td>224</td>
</tr>
<tr>
<td></td>
<td>Realizing the Potential</td>
<td>225</td>
</tr>
<tr>
<td></td>
<td>Conclusion</td>
<td>227</td>
</tr>
<tr>
<td></td>
<td>Discussion Questions</td>
<td>228</td>
</tr>
<tr>
<td></td>
<td>Case Study</td>
<td>228</td>
</tr>
<tr>
<td>11</td>
<td><strong>HIGH QUALITY HEALTH CARE</strong></td>
<td>233</td>
</tr>
<tr>
<td></td>
<td><em>Carolyn Clancy and Robert Lloyd</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Defining Quality</td>
<td>234</td>
</tr>
<tr>
<td></td>
<td>Quality Matters: How Are We Doing?</td>
<td>235</td>
</tr>
<tr>
<td></td>
<td>Measuring Quality</td>
<td>236</td>
</tr>
<tr>
<td></td>
<td>Practicing Quality Measurement in Health Care</td>
<td>237</td>
</tr>
<tr>
<td></td>
<td>The Quality Measurement Journey</td>
<td>238</td>
</tr>
<tr>
<td></td>
<td>Promising Initiatives</td>
<td>250</td>
</tr>
<tr>
<td></td>
<td>Future Directions</td>
<td>251</td>
</tr>
<tr>
<td></td>
<td>Core Competencies for Health Administrators</td>
<td>253</td>
</tr>
<tr>
<td></td>
<td>Discussion Questions</td>
<td>253</td>
</tr>
<tr>
<td></td>
<td>Case Study</td>
<td>254</td>
</tr>
<tr>
<td>12</td>
<td><strong>HEALTH CARE COSTS AND VALUE</strong></td>
<td>257</td>
</tr>
<tr>
<td></td>
<td><em>Herbert P. White</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The Value of Medical Spending</td>
<td>259</td>
</tr>
<tr>
<td></td>
<td>What Is Cost, Anyway?</td>
<td>260</td>
</tr>
<tr>
<td></td>
<td>Third-Party Payers</td>
<td>261</td>
</tr>
<tr>
<td></td>
<td>Employers</td>
<td>265</td>
</tr>
<tr>
<td></td>
<td>Providers</td>
<td>266</td>
</tr>
<tr>
<td></td>
<td>Suppliers</td>
<td>271</td>
</tr>
<tr>
<td></td>
<td>Role of the Individual</td>
<td>272</td>
</tr>
<tr>
<td></td>
<td>Conclusion</td>
<td>274</td>
</tr>
<tr>
<td></td>
<td>Discussion Questions</td>
<td>274</td>
</tr>
<tr>
<td></td>
<td>Case Study</td>
<td>275</td>
</tr>
<tr>
<td>13</td>
<td><strong>COMPARATIVE EFFECTIVENESS</strong></td>
<td>277</td>
</tr>
<tr>
<td></td>
<td><em>Amir Satvat and Jessica Leight</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>What Comparative Effectiveness Is All About</td>
<td>277</td>
</tr>
<tr>
<td></td>
<td>Comparative Effectiveness Program Models</td>
<td>278</td>
</tr>
</tbody>
</table>
Benefits of Comparative Effectiveness Systems 281
Public and Private Comparative Effectiveness Systems 282
The U.S. Debate on Comparative Effectiveness Systems 288
Comparative Effectiveness Systems: Guidelines for Design 290
Conclusion 291
Discussion Questions 291
Case Study 292

Part IV. Support for Medical Care Delivery

14 GOVERNANCE, MANAGEMENT, AND ACCOUNTABILITY 299
   Anthony R. Kovner
   Key Processes and Stakeholders 299
   Governance vs. Management 301
   Current Governance Issues 303
   Basic Managerial Functions and Successful Managers 306
   Current Management Issues 308
   Conclusion 311
   Discussion Questions 312
   Case Study 312

15 HEALTH WORKFORCE 315
   Richard Scheffler and Joanne Spetz
   Health Care Reform and the Health Care Workforce 317
   Physician Health Workforce 318
   The Crucial Nature of Primary Care 319
   The Supply of Nurses and Nurse Practitioners 321
   Conclusion 325
   Discussion Questions 326
   Case Studies 327

16 HEALTH INFORMATION TECHNOLOGY 331
   Roger Kropf
   Why Managing Information Is Important in Health Care 332
   How the Federal Government Is Involved in HIT Implementation 334
   Improving Clinical Quality Through HIT 336
   Improving Health Care Service Quality Through HIT 339
   Opportunities for Controlling Health Care Costs 341
   Current Issues 343
   Conclusion 346
   Discussion Questions 346
   Case Study 347
## Contents

### Part V: The Future of Health Care Delivery

17 **THE FUTURE OF HEALTH CARE DELIVERY IN THE UNITED STATES** 353

*James R. Knickman and Anthony R. Kovner*

- Definitions and Approaches to Forecasting 354
- Key Drivers of Change 356
- New Five-Year Trend Forecast 360
- Conclusion 363
- Discussion Questions 363
- Case Studies 363

### APPENDIX

- **Major Provisions of the Patient Protection and Affordable Care Act of 2010** 365

**Glossary** 377

**Index** 389
LIST OF TABLES AND FIGURES

Chapter 1A

Table 1A.1 President's FY2011 budget for principal agencies of the department of health and human services (in millions of dollars) 10
Table 1A.2 Responsibility for health is shared by many U.S. government departments and agencies 13
Table 1A.3 Prospects for growth in the U.S. health care workforce, 2008–2018 23
Figure 1A.1 Growth in federal health care responsibilities, 1798–2004 11
Figure 1A.2 Acute care hospital beds per 1,000 residents, 2006 15
Figure 1A.3 All physicians per 100,000 residents, 2006 16
Figure 1A.4 Per capita health care expenditures, by state of residence, 2004 18
Figure 1A.5 Percent of funds contributing to national health expenditures, by source, 2007 18
Figure 1A.6 Overall performance ranking of U.S. states, based on 38 indicators of access, quality, costs, and health outcomes 19
Figure 1A.7 Achieving long and healthy lives 21
Figure 1A.8 Satisfaction with local and national health care among OECD countries 22

Chapter 3

Table 3.1 U.S. national health expenditures (in billions of dollars), selected categories and years, 1970–2019 50
Table 3.2 Hospital sources of revenue 52
Figure 3.1 U.S. national health expenditures as a share of gross domestic product, 2004–2019 50
Figure 3.2 Medicaid enrollments and expenditures, FY2007 53
List of Tables and Figures

Chapter 5

Figure 5.1  A guide to thinking about determinants of population health  87
Figure 5.2  Gradients within gradients  93
Figure 5.3  Health-related behavior and education both affect health  94
Figure 5.4  County health rankings model  97

Chapter 6

Table 6.1  Differences between the roles of individual medical care and public health  107
Table 6.2  Ten essential public health services  114
Table 6.3  Who’s in charge of what? Public health protection every day  120
Figure 6.1  The circle of public health activities  110

Chapter 7

Table 7.1  Selected Healthy People 2010 objectives: behavioral risk factors  128
Table 7.2  The population-based intervention model  137
Figure 7.1  Comprehensive approach to changing provider practice  142

Chapter 8

Table 8.1  Characteristics of the U.S. uninsured population (in thousands), 2009  152
Table 8.2  Access problems reported by patients hospitalized for ambulatory care sensitive conditions  166
Figure 8.1  Changes in health insurance premiums and worker earnings, 1999–2009  155
Figure 8.2  Rates of uninsurance for nonelderly residents, by state, 2007–2008  156
Figure 8.3  Hospital admissions for ambulatory care sensitive conditions by race/ethnicity  167

Chapter 9

Figure 9.1  Percentage of Americans with one or more chronic conditions, by age, 2006  187
Figure 9.2  Percentage of total office visits to physicians by specialty, 1980–2007 (selected years) 188
Figure 9.3  Distribution of office-based physicians, 2005–2006 189
Figure 9.4  Average number of physicians and practice settings that Medicare beneficiaries visit each year 190

Chapter 10

Table 10.1  Models of organized health care delivery 208
Table 10.2  Six attributes of an ideal health care delivery system 211
Table 10.3  Core principles of a medical home at group health cooperative (Washington state) 216
Figure 10.1  Case study locations from the Commonwealth Fund’s study of high-performance health care 207
Figure 10.2  Model of organization and payment methods 226

Chapter 11

Table 11.1  Aim and methods associated with improvement, accountability, and research measurement 240
Figure 11.1  Milestones in the quality measurement journey 243
Figure 11.2  Example of the milestones in the quality measurement journey 244
Figure 11.3  Operational definition worksheet© 246
Figure 11.4  Elements of a run chart 248
Figure 11.5  Elements of a Shewhart chart 248
Figure 11.6  The sequence for improvement 249

Chapter 15

Table 15.1  Number of U.S. doctors of medicine, per 1000 population, 1949–2007 319
Figure 15.1  The market model for physician supply 316
Figure 15.2  Scope of practice regulations for nurse practitioners 324
In the beginning—that is in the mid-1970s—there was nothing like this book. It was then that our group of young health policy analysts came together to produce the first edition of Health Care Delivery in the United States, published by Springer Publishing Company in 1977. None of us, or any of our predecessors who had ever taught about the U.S. health care system to students had had a textbook to use. We all came in with stacks of reprints to hand out. But folks did not publish articles with titles like “Hospitals,” “Government,” “Financing,” and so on and so forth, describing the basics of each sector of the health care delivery system. So we set out to create such a book. And here we are at its 10th edition. What a special anniversary! It’s one that none of us could have foreseen back then.

Each of us had a major focus on the structure and function of one or more of the different sectors of the U.S. health care delivery system. We had a common perspective in terms of our values: first and foremost, the system’s primary functions should be to take care of sick people and try to help the healthy stay well. Other considerations, such as making profits, gaining and maintaining power, and earning prestige, should all be secondary.

We established a firm rule for the text—the bulk of it was to be descriptive. Surely we would discuss policy options—recognizing that all policy discussions are informed by the points of view of the discussants. But in the book those discussions would be treated as condiments. The meat and potatoes—nowadays, the fish, poultry, and vegetables—would be description. Perhaps the most important feature of the successive editions—first under my leadership, then under Dr. Kovner’s alone, then with me back in an editor’s chair, then with Dr. Kovner joined by Dr. Knickman—is that that rule has been consistently followed. Policy questions are raised and answered in the book. The separation between policy analysis and description is kept clear. Because although even “pure” description is informed by a point of view, one can still be reasonably objective in providing it. Therefore, before any attempts can be made to consider what, if anything, needs to be done, and how it should be done, the “what” and the objective “why’s,” in terms of health and sickness—how people are cared for and not cared for, and how that care is paid for and not paid for, must first to be understood.

To appreciate the importance of understanding the what and the why before policy recommendations are made, one only has to examine those recommendations currently on the political front burners. Few of them appear to be informed by any in-depth understanding of what our system is all about, in all of its complexity. Unfortunately, these comments apply equally to a number of the main features of the Patient Protection and Affordable Care Act of 2010.

The second major feature of the book is that the book has never had a rigid format. Over the years, we editors have always been open to new ideas about how to present the material, new features that ought to be added, and old features that should be condensed or even eliminated. And so, recent editions discussed features such as: a consideration of public health services and their importance; a consideration of health-related behavior and the enormous impact it has on the structure, function, and cost of the delivery system; growing interest on the part of the editors, as in the public and profession at large, on exploring the issue of quality of care; and
the specific role in determining the structure and function of the U.S. health care system that is played by pharmaceuticals and the industry that produces them. Continuity and change. We established that twosome as principles to guide us at the beginning, and they have remained with the book ever since.

Third in the list of major features of this book that have been maintained over the years has been the continuing freshening of the authorship by bringing new voices on board, which again this time has been done for a number of the chapters. Fourth has been the orientation of the book to compatibility with the computer age—something not even contemplated by most of us back in the 1970s. So, continuity and change, tradition coupled with new ideas and approaches have marked the march of our book over the past 30-plus years. I am so proud to continue to have my name associated with it.

Finally, let me add a personal note. Tony Kovner and I have known each other for more than 50 years. We first met socially, through a mutual friend. In the mid-60s, we had our first professional contact. We both worked at the ground-breaking Gouverneur Ambulatory Care Center of the New York City Health Services Administration. I was a preventive medicine resident with the New York City Health Department. Tony for a time was the acting director, on loan from the Beth Israel Hospital. We next became associated in the mid-1980s when I was preparing the 3rd edition of this book, and I felt that I needed new blood to take over my Hospitals chapter. Tony by that time had become the director of the program in Health Policy and Management at New York University. He was in the process of taking the program from its very early stages of formation to its present preeminence. And so, when it came time to create the 4th edition, and my own attention was being turned toward writing on sports, weight management, and regular exercise for the general public, I turned to Tony as my first choice to take over the book’s editorship. Was I gratified when he said “yes”? He was kind enough to invite me to come back to the book as an active editor for the 6th and 7th editions. Then, when I stepped down from active participation in the book for a second time, he was smart enough to ask Jim Knickman to join him.

And so, Tony and I have been friends and colleagues for many years. Making this relationship even more special than it would have been had we shared only a mutual interest in bettering the health and health care of the people of the United States, is our mutual support for a special four of New York’s professional sports teams: the Mets, the Knicks, the Rangers, and last, but certainly not least, the Giants. Regardless of what was happening with us, to the U.S. health care delivery system, and to our book, we could always have fun discussing the ups and downs of our favorites. Tony—it has been such a pleasure to work with you for lo these many years and an honor to have my name up there with yours on the masthead of this book. Let us hope that it will be many more years before our run together is over.

Steven Jonas, MD, MPH, MS, FNYAS
Stony Brook, NY
ACKNOWLEDGMENTS

The editors would like to express our deep appreciation to the team of people who put this book together at a time of rapid changes. After our conception of the book, we were fortunate to have an outstanding roster of experts in many health fields agree to do the actual work of writing chapters! Our managing editor, Victoria Weisfeld, edited all the chapters—even ours—and prepared the charts chapter. We also owe a debt of gratitude to Sheri Sussman for much aid and good advice on behalf of Springer Publishing Company. We appreciate her—and Springer’s—belief in us and in *Health Care Delivery in the United States* through our many editions. Thanks, too, to Steve Jonas who originated this book and has been a cheerleader as well as an author, including writing the generous foreword to this 10th edition.

And, finally, we must express our appreciation and admiration to our current and former chapter authors—some of whom have written for multiple editions—for their insights, inspiration, and shared commitment to improving the health of the American people.

Gerard F. Anderson
David Banta
Nancy R. Barhydt-Wezenaar
Lynne Barton
John Billings
Charles Brecher
Carol S. Brewer
Joel C. Cantor
Carol A. Caronna
Elaine F. Cassidy
Carol S. Chang
Mary Ann Chiasson
Carolyn Clancy
Chelsea Clinton
Michael Enright
Penny Hollander Feldman
Steven A. Finkler
Bianca Frogner
Ron Geigle
Thomas E. Getzen
Marc N. Gourevitch
Michal D. Gursen
Ruth S. Hanft
Paul Hofmann
Susan D. Horn
Kelly A. Hunt

Kelli A. Hurdle
Steven Jonas
Gary Kalkut
James R. Knickman
Lorrin Koran
Christine Kovner
Roger Kropf
Robert S. Lawrence
Jessica Leight
Laura C. Leviton
Jane Levitt
Robert Lloyd
John R. Lumpkin
Carol McCarthy
Douglas McCarthy
Andrew P. Mezey
Pamela Nadash
Jennifer Nelson
Michael Ong
C. Tracy Orleans
David A. Pearson
Carol Raphael
Lesley Reis
Scott D. Rhodes
Hila Richardson
Barbara Rimer
In addition, we would like to recognize individuals and organizations who have made particularly valuable contributions to this edition:

Amy A. Lee for research assistance in preparing Chapter 3, “Health Care Financing.”

Anne-Marie Audet, MD, MSc, and other current and former colleagues of Douglas McCarthy at The Commonwealth Fund who gave advice and contributed to previous publications from which Chapter 10, “Integrative Models and Performance,” is adapted in part. The views presented there are those of the author, Douglas McCarthy, and not necessarily those of The Commonwealth Fund or its directors, officers, or staff.

Finally, Chapter 12, “Health Care Costs and Value,” is partially based on Chapter 17 of the 9th edition of this text, which was authored by Thomas Getzen, PhD, and Steven Finkler, PhD, portions of which have been retained in this 10th edition.
This is the 10th edition of Jonas & Kovner’s Health Care Delivery in the United States, which, although its title has evolved in the last 35 years, has stayed true to its original purpose: helping instructors and students better understand the complicated, expensive, and ever-changing U.S. health care delivery system.

The recent national debates that led to the 2010 health care reform legislation, the Patient Protection and Affordable Care Act, provided disturbing and irrefutable evidence of how far short that understanding falls—not only for the average American, but for our political leaders, the news media, and others who shape public opinion. Health care is a substantial part of the nation’s economy and employment and important for those reasons alone. And, the manner in which health care services are delivered will affect all of us and our families at many points in our lives, for better or for worse. A more vital and dynamic area for study is difficult to imagine.

This text is divided into several sections—health policy, population health, medical care delivery, support for medical care delivery, and the future of health care delivery—in order to provide some coherence to this broad terrain.

In addition to the text, the editors have compiled an online Instructor’s Guide, which includes a variety of background materials teachers will find useful in guiding class discussion, offering students additional resources, and class projects. We encourage instructors to communicate with us about this edition, so that we may make the 11th edition even more useful to you. Please submit any comments or questions directly to Tony Kovner and he will get back to you. You can find us at HCDUS10@newassoc.com.

As always, we appreciate your suggestions.

Anthony R. Kovner, PhD
James R. Knickman, PhD

Note to Readers: Data in the chapters, tables, and figures in this book are the most recent available at the time the authors prepared them. Often, government sources, especially, update important health information annually. You may be able to find more recent data by searching online for the most recent edition of the same publication cited herein.
Gerard F. Anderson, PhD, is a professor of health policy and management and professor of international health at the Johns Hopkins University Bloomberg School of Public Health, professor of medicine at the Johns Hopkins University School of Medicine, director of the Johns Hopkins Center for Hospital Finance and Management, and co-director of the Johns Hopkins Program for Medical Technology and Practice Assessment. Dr. Anderson is currently conducting research on chronic conditions, comparative insurance systems in developing countries, medical education, health care payment reform, and technology diffusion. He has directed reviews of health systems for the World Bank and USAID in multiple countries. He has authored two books on health care payment policy, published over 200 peer reviewed articles, testified in Congress almost 50 times as an individual witness, and serves on multiple editorial committees. Prior to his arrival at Johns Hopkins, Dr. Anderson held various positions in the Office of the Secretary, U.S. Department of Health and Human Services, where he helped to develop Medicare prospective payment legislation.

John Billings, JD, is Associate Professor of Health Policy and Public Service at NYU Wagner Graduate School of Public Service, and he is currently director of the school’s Health Policy and Management Program. Professor Billings is principal investigator on numerous projects to assess the performance of the safety net for vulnerable populations and to understand the nature and extent of barriers to optimal health for vulnerable populations. Much of his work has involved analysis of patterns of hospital admission and emergency room visits as a mechanism to evaluate access barriers to outpatient care and to assess the performance of the ambulatory care delivery system. He has also examined the characteristics of high-cost Medicaid patients to help in designing interventions to improve care and outcomes for these patients. As a founding member of the Foundation for Informed Decision-Making, Professor Billings is helping to provide patients with a clearer mechanism for understanding and making informed decisions about a variety of available treatments.

Joel C. Cantor, ScD, directs the Center for State Health Policy and is professor of public policy at Rutgers University. Dr. Cantor’s research focuses on issues of health care coverage, financing, and delivery. His recent work includes studies of health insurance market regulation, state health system performance, and access to care for low income and minority populations. Dr. Cantor is a frequent advisor on health policy matters to New Jersey state government. He has published widely in the health policy and health services research literature and is a member of the editorial board of Inquiry. He currently leads several studies of policies requiring insurance companies to extend dependent coverage to young adults and strategies to improve health care delivery in low income urban areas. Prior to joining the Rutgers faculty in 1999, Dr. Cantor served as director of research at the United Hospital Fund of New York and director of evaluation research at Robert Wood Johnson Foundation. He received his doctorate in health policy and management from the Johns Hopkins University School of Public Health in 1988.
Carol A. Caronna, PhD, is an associate professor of sociology in the Department of Sociology, Anthropology, and Criminal Justice at Towson University. She currently serves on the editorial board of the *Journal of Health and Social Behavior* and is a past officer of the Medical Sociology section of the American Sociology Association. Her work focuses on health care organizations and institutions, with specific emphases on the evolution of health policy, the changing identity of health maintenance organizations, and entrepreneurship in the nonprofit sector. She has contributed to research methodology volumes, including *The SAGE Handbook of Qualitative Methods in Health Research* (2010). She is a coauthor of *Institutional Change and Healthcare Organizations: From Professional Dominance to Managed Care* and has published in numerous sociology journals. She received her PhD in sociology from Stanford University and, from 2000 to 2002, was a Robert Wood Johnson Scholar in Health Policy Research at the University of California, Berkeley, School of Public Health.

Elaine F. Cassidy, PhD, is a research and evaluation consultant at the OMG Center for Collaborative Learning, where she manages projects related to child and adolescent health promotion. Prior to joining OMG, she served as a program officer in research and evaluation at Robert Wood Johnson Foundation, where she oversaw research and evaluation activities for the Vulnerable Populations portfolio. Her work and professional interests focus primarily on child and adolescent health and risk behavior, violence prevention, and school-based interventions, primarily for young people living in low income, urban environments. She is a trained school psychologist and mental health clinician who has provided therapeutic care to children and families in school, outpatient, and acute partial hospitalization settings. She holds an MSEd in psychological services from the University of Pennsylvania and a PhD in school, community, and child-clinical psychology from the University of Pennsylvania.

Carol S. Chang, MPH, MPA, is the regional senior program director of Programs and Services at the American Red Cross of Central New Jersey. She oversees American Red Cross Emergency Services, Community Services, and Health and Safety Services programs across the Central New Jersey region. She was previously a program officer in the Research and Evaluation Unit at Robert Wood Johnson Foundation, where she worked on public health evaluations and developed initiatives with partner organizations to establish performance measures and benchmarks to improve public health agency performance and accountability. She also co-managed The Robert Wood Johnson Health and Society Scholars Program, a post-doctoral fellows program designed to build the nation’s capacity for research, leadership, and action to address the broad range of factors affecting the health of populations. Prior to her work at Robert Wood Johnson Foundation, she worked with CARE-International on emergency programs in Latin America, Asia, and Africa.

Carolyn M. Clancy, MD, is director of the federal Agency for Healthcare Research and Quality (AHRQ) and former director of AHRQ’s Center for Outcomes and Effectiveness Research. Dr. Clancy, a general internist and health services researcher, is a graduate of Boston College and the University of Massachusetts Medical School. Following clinical training in internal medicine, she was a Henry J. Kaiser Family Foundation Fellow at the University of Pennsylvania. She holds an academic appointment at the George Washington University School of Medicine and serves as senior associate editor for the
journal *Health Services Research*. She serves on multiple editorial boards, is a member of the Institute of Medicine, and was elected a Master of the American College of Physicians in 2004. In 2009, she was awarded the William B. Graham Prize for Health Services Research. Dr. Clancy’s major research interests include improving health care quality and patient safety and reducing disparities in care associated with race, ethnicity, gender, income, and education. As director of AHRQ, she launched the first annual report to Congress on health care disparities and health care quality.

**Chelsea Clinton, MPH, MPhil**, is currently a doctoral candidate at New York University’s Robert F. Wagner Graduate School of Public Service. She previously worked as an analyst for a financial services firm and an engagement manager at McKinsey and Company, both in New York.

**Bianca K. Frogner, PhD**, is an assistant professor in the Health Services Management and Leadership Department in the School of Public Health and Health Services at The George Washington University. Dr. Frogner has coauthored articles published in *Health Affairs* comparing health spending in industrialized countries. She is currently engaged in a project with the Kaiser Family Foundation to examine the health and economic impacts of U.S. global health investments using economic models. She is a consultant for the World Bank with a focus on provider, patient, and household surveys to evaluate the Ukrainian health system. Prior to her appointment at George Washington, Dr. Frogner was a postdoctoral fellow at the University of Illinois at Chicago School of Public Health. Dr. Frogner received a PhD from the Johns Hopkins Bloomberg School of Public Health in the Health Policy and Management Department with a concentration in Health Economics.

**Steven Jonas, MD, MPH, MS, FNYAS**, is professor of Preventive Medicine, School of Medicine and Professor, Graduate Program in Public Health, at Stony Brook University (NY). He is an elected Fellow of the New York Academy of Sciences, the Royal Society of Medicine (London), the American College of Preventive Medicine, the New York Academy of Medicine, and the American Public Health Association. He is editor-in-chief of the *American Medical Athletics Association Journal*. He is the recipient of the Duncan Clark Career Achievement Award of the Association for Prevention Teaching and Research (2006) and the Distinguished Alumnus Award of the Yale University School of Public Health (2010). Over the course of an academic career that began in 1969, his research has focused on health care delivery systems analysis, preventive medicine and public health, and personal health and wellness. He has authored, coauthored, edited, and coedited more than 30 books and published more than 135 papers in scientific journals, as well as numerous articles in the popular literature. In the mid-1970s he created *Health Care Delivery in the United States*.

**Roger Kropf, PhD**, is a professor in the Health Policy and Management Program at New York University’s Robert F. Wagner Graduate School of Public Service. Dr. Kropf is the author of two books on the application of information systems to health care management. *Strategic Analysis for Hospital Management* was written with James Greenberg, PhD, and published by Aspen Systems in 1984. *Service Excellence in Health Care through the Use of Computers* was published by the American College of Healthcare Executives in 1990. His most recent book is *Making Information Technology Work: Maximizing the Benefits for*
Contributors

Health Care Organizations, written with Guy Scalzi and published by AHA Press in 2007. He teaches graduate and executive education courses on information technology. More information on his work can be found at his Web site, www.nyu.edu/classes/kropf.

Jessica Leight, PhD, MPhil, is a third-year PhD candidate in economics at the Massachusetts Institute of Technology. Ms. Leight specializes in development economics, political economy, and health economics. Recently, Ms. Leight received a $1 million grant, as a co-principal investigator, to research maternal mortality in Nigeria. She previously received an MPhil in economics with distinction from Oxford University in 2008 as a Rhodes Scholar, receiving the George Webb Medley prize for excellence in the degree. Previous publications have included two Harvard Business School case studies, an article in the Journal of Latin American Studies, and a recent retrospective of public choice theory published in the volume Government and Markets: Toward a New Theory of Regulation.

Laura C. Leviton, PhD, is special advisor for evaluation at Robert Wood Johnson Foundation, Princeton, New Jersey. She has been with the foundation since 1999, overseeing more than 60 national and local evaluations. She was formerly a professor at two schools of public health, where she collaborated on the first randomized experiment on HIV prevention, and later on two large place-based randomized experiments on improving medical practices. She received the 1993 award from the American Psychological Association for Distinguished Contributions to Psychology in the Public Interest. She has served on two Institute of Medicine committees and was appointed by the secretary of DHHS to CDC’s National Advisory Committee on HIV and STD Prevention. Dr. Leviton was president of the American Evaluation Association in 2000 and has coauthored two books: Foundations of Program Evaluation and Confronting Public Health Risks. She received her PhD in social psychology from the University of Kansas and postdoctoral training in research methodology and evaluation at Northwestern University.

Robert Lloyd, MA, PhD, is executive director of performance improvement for the Institute for Healthcare Improvement (IHI). Dr. Lloyd provides leadership in the areas of performance improvement strategies, statistical process control methods, development of strategic dashboards, and quality improvement training. He serves as faculty for various IHI initiatives and demonstration projects in the United States and abroad. Before joining IHI, Dr. Lloyd was corporate director of Quality Resource Services for Advocate Health Care (Oak Brook, Ill.) and senior director of Quality Measurement for Lutheran General Health System (Park Ridge, IL). He directed the American Hospital Association’s Quality Measurement and Management Project (QMMP). Dr. Lloyd holds a master’s degree in regional planning and a doctorate in rural sociology, both from Penn State University. He has served as faculty for the Harvard School of Public Health, the American College of Healthcare Executives, the American Society for Quality (ASQ), The Joint Commission, and numerous other organizations. He is coauthor of Measuring Quality Improvement in Healthcare: A Guide to Statistical Process Control Applications, and his most recent book is Quality Health Care: A Guide to Developing and Using Indicators, published March 2004.

Douglas McCarthy, MBA, is president of Issues Research, Inc., in Durango, Colorado. As a senior research advisor to The Commonwealth Fund, he coauthors National and State Scorecards on Health System Performance, conducts case-study research on
high-performing health care organizations and initiatives, and is a contributing editor to the newsletter *Quality Matters*. His 25-year career has spanned research, policy, operations, and consulting roles for government, corporate, academic, and philanthropic organizations. *A Chartbook on the Quality of Health Care in the United States*, coauthored with Sheila Leatherman, was named by AcademyHealth as one of 20 core books in the field of health outcomes. He is a past research director for UnitedHealth Group's Center for Health Care Policy and Evaluation. He received a master's degree in health care management from the University of Connecticut. During 1996–97, he was a public policy fellow at the Humphrey Institute of Public Affairs at the University of Minnesota.

**Michael K. Ong, MD, PhD,** is an assistant professor in the Division of General Internal Medicine and Health Services Research at UCLA's David Geffen School of Medicine. Dr. Ong received his medical degree from the UC San Diego and a PhD in Health Services and Policy Analysis from the UC Berkeley. He completed the Primary Care Internal Medicine residency at the UC San Francisco and a VA Ambulatory Care Fellowship with the Center for Primary Care and Outcomes Research at Stanford University. He is currently a faculty scholar in the Robert Wood Johnson Foundation Physician Faculty Scholars Program. His research focuses on improving the delivery of appropriate and efficient health care by general internal medicine physicians, particularly with respect to hospital-based care, mental health, and smoking cessation. His recent research has focused on heart failure patients hospitalized at the five University of California Medical Centers and Cedars-Sinai Medical Center to better understand the wide variation in resource use they report. He also chairs the State of California Tobacco Education and Research Oversight Committee, which oversees the California Tobacco Control Program.

**C. Tracy Orleans, PhD,** is the senior scientist and distinguished fellow at Robert Wood Johnson Foundation (RWJF). She has led or co-led the Foundation's public policy and health care system-based grant-making in the areas of tobacco control, physical activity promotion, childhood obesity prevention, and chronic disease management. She has led Foundation working groups on tobacco, chronic disease, and health and behavior and has developed and led numerous RWJF national research initiatives in these areas, as well as substance abuse policy research, active living, healthy eating research, and teen obesity. A clinical health psychologist with a strong public health orientation, Dr. Orleans has authored or coauthored more than 225 publications, served on numerous journal editorial boards, national scientific panels, and advisory groups, including for the Institute of Medicine, National Commission on Prevention Priorities, and U.S. Preventive Services Task Force, Community Preventive Services Task Force, and as president of the Society of Behavioral Medicine. She is an elected member of the Academy of Behavioral Medicine Research and a recipient of the John Slade Tobacco Research Policy Award of the Society for Research on Nicotine and Tobacco and the Distinguished Scientist Award of the Society of Behavioral Medicine.

**Scott D. Rhodes, PhD, MPH, CHES,** is a behavioral scientist, whose research focuses on the integration of community development, community-campus partnerships, and health promotion and disease prevention in both rural and urban communities. He is an associate professor in the Department of Social Sciences and Health Policy, Wake Forest University School of Medicine in Winston-Salem, North Carolina. His research explores sexual health, HIV and sexually transmitted disease prevention, obesity prevention, and other health
disparities among vulnerable populations. Dr. Rhodes has broad experience in quantitative and qualitative data collection and analysis techniques; the design, implementation, and evaluation of multiple-level interventions for improved health outcomes; community-capacity development; community-based participatory research; exploratory evaluation; the application of behavioral theory; community-campus partnerships; PhotoVoice as a method for participatory action research; lay health advisor intervention approaches; the exploration of socio-cultural determinants of health; and internet research, including data collection, intervention delivery, and evaluation.

Pamela G. Russo, MD, MPH, is a senior program officer at Robert Wood Johnson Foundation (RWJF), Princeton, New Jersey. She was recruited to RWJF to lead the Population Health: Science and Policy team in 2000. Prior to RWJF, she was an associate professor of Medicine, director of the Clinical Outcomes Section, and program co-director for the Master’s Program and Fellowship in Clinical Epidemiology and Health Services Research at the Cornell University Medical Center in New York City. Dr. Russo earned her BS from Harvard College, with a major in the History and Philosophy of Science; her MPH in epidemiology from the University of California, Berkeley, School of Public Health; and her MD from the University of California, San Francisco. She completed a residency in general internal medicine at the Hospital of the University of Pennsylvania and a combined clinical epidemiology and rheumatology fellowship at Cornell and the Hospital of Special Surgery.

Amir Satvat, MPA, is a second-year MBA/MB candidate in health care management and biotechnology at the University of Pennsylvania’s Wharton School and Schools of Engineering and Arts and Sciences, respectively. Currently, Mr. Satvat is a teaching and research assistant in the Health Care Management department. He is coauthor with Professor Lawton Burns, head of the Wharton Health Care Management Department, of a book on organizational change in health care institutions (forthcoming). At Wharton, he received a Kaiser Foundation Scholarship (twice), the Ford Motor Company Fellowship for research on emerging technologies, and an award in the Walmart Better Living Business Plan Challenge. Mr. Satvat earned his MPA in health policy and management at New York University, where he was one of eight national finalists for the Roback Scholarship, the top national prize for policy studies. Previously, Mr. Satvat worked at Goldman Sachs as a health care investment banking analyst, where he completed the $9B UnitedHealth/PacifiCare acquisition. Finally, Mr. Satvat’s paper on a theory for a Board Rotation Principle for corporate governance, co-written with Mark Rogers, Oxford University, was published in the Monash Business Review.

Richard M. Scheffler, PhD, is distinguished professor of Health Economics and Public Policy at the School of Public Health and the Goldman School of Public Policy at the University of California, Berkeley. He also holds the chair in Healthcare Markets and Consumer Welfare endowed by the Office of the Attorney General for the State of California. Professor Scheffler is director of The Global Center for Health Economics and Policy Research as well as director of The Nicholas C. Petris Center on Health Care Markets and Consumer Welfare. He has been a Rockefeller and a Fulbright Scholar and served as president of the International Health Economists Association 4th Congress in 2004. Professor Scheffler has published more than 150 papers and edited and written six books, including his most recent, Is There a Doctor in the House? Market Signals and Tomorrow’s Supply of
Doctors, published by Stanford University Press, September 2008. He has conducted a recent review on Pay For Performance in Health for the World Health Organization and the OECD.

Michael S. Sparer, PhD, JD, is professor and chair in the Department of Health Policy and Management at the Mailman School of Public Health at Columbia University. Professor Sparer studies and writes about the politics of health care, with a particular emphasis on the health insurance and health delivery systems for low income populations, and the ways in which inter-governmental relations influence policy. He is a two-time winner of the Mailman School’s Student Government Association Teacher of the Year Award, as well as the recipient of a 2010 Columbia University Presidential Award for Outstanding Teaching. Professor Sparer spent 7 years as a litigator for the New York City Law Department, specializing in inter-governmental social welfare litigation. After leaving the practice of law, Sparer obtained a PhD in Political Science from Brandeis University. Sparer is a former editor of the Journal of Health Politics, Policy and Law, and the author of Medicaid and the Limits of State Health Reform, as well as numerous articles and book chapters.

Joanne Spetz, PhD, is a professor in the Departments of Community Health Systems and Social and Behavioral Sciences at the UCSF School of Nursing. She also is a faculty researcher at the UCSF Center for the Health Professions. She has led national and state surveys of registered nurses and nursing schools, evaluations of programs to expand the supply of nurses, research on the effects of health information technologies in hospitals, studies of hospital industry structure, and analysis of the effects of minimum nurse staffing regulations on patients and hospitals. Joanne was a member of the National Commission on VA Nursing and is an advisor to the Institute of Medicine Initiative on the Future of Nursing. She frequently provides testimony and technical assistance to state and federal agencies and policymakers. She has taught quantitative research methods for doctoral students and financial management and health economics for master’s students in nursing administration and public health.

Hugh R. Waters, PhD, is a health economist and associate professor of Health Policy and Management at the Johns Hopkins Bloomberg School of Public Health. Dr. Waters has 22 years’ experience working with public health programs and has worked extensively as a consultant with the World Bank, World Health Organization, and other international organizations. His areas of expertise are: (1) health insurance and health financing reforms; (2) evaluation of the effects of health financing mechanisms on access, equity, and quality; and (3) economic evaluation of public health policies and programs.

Victoria D. Weisfeld, MPH, has combined her academic training in public health and journalism in a career devoted to helping health care organizations plan and implement strategic communications programs. Major employers were Robert Wood Johnson Foundation, Princeton, and the Institute of Medicine, Washington, DC, where, in 1978, she co-wrote the first draft of Healthy People. Since 2005, she has been a principal in NEW Associates, LLC, a communications company she owns with her husband. Their clients include foundations, think tanks, and other nonprofit organizations. Sample projects: writing the report of the President’s Commission on Care for America’s Returning Wounded Warriors; editing more than 45 Brookings scholar papers on diverse national and international issues for the 2008 presidential campaign; white papers on nursing investment
opportunities for two Blues plans; and contributing to several major Institute of Medicine reports. She served as managing editor of *Health Care Delivery in the United States* for editions 9 and 10.

**Herbert White, MBA,** has more than 26 years of health care finance experience. He is currently the associate vice president of Finance for Temple University Health System. Mr. White is a board member of Core Solutions, Inc., a behavioral health software solutions firm. He is also a member of Temple University Health System’s Finance and Investment Committee and Health Partners of Philadelphia’s Finance and Audit Committee. He received a bachelor of science in Accounting from La Salle University and a master’s degree in Business Administration (Finance) from Temple University’s Fox School of Business. He is a fellow in the Healthcare Financial Management Association (HFMA) and has received HFMA’s Reeves and Follmer awards.
Jonas & Kovner’s

HEALTH CARE DELIVERY IN THE UNITED STATES

10th Edition
The first step in the policy making process is to understand the current system and how it affects patients, providers, and the overall economy, and the next step is pointing out the problems and challenges the health system faces. In Chapter 1, Tony Kovner and Jim Knickman describe the influence of the U.S. health care system on our lives, its defining characteristics, and the issues and concerns facing leaders and stakeholders. They specify who the leading stakeholders are and how their interests differ—from government; to pharmaceutical and insurance companies; to doctors, nurses and hospitals; to taxpayers and patients. Because issues take on different meanings when viewed by different stakeholders, it is extraordinarily difficult to make and implement fair and effective health care policy.

The 11 key charts that Victoria Weisfeld presents in Chapter 1A provide useful background on the health care system, including the history and breadth of federal activity in health matters. Charts illustrate issues touched on throughout the book—the supply of hospitals and doctors, costs, quality, and so on—and introduce the theme of geographic variation.

Michael Sparer focuses on the role of government in the U.S. health system in Chapter 2 on health policy and health reform, devoting a significant part of the chapter to the passage of health reform—the Patient Protection and Affordable Care Act (ACA)—in 2010. Sparer describes the achievements and limitations of the ACA and indicates the agenda going forward as the legislation is inevitably amended and shaped by its implementation. Sparer goes on to discuss the many roles of government in health care as payer, regulator, and provider of health care.

In Chapter 3, Jim Knickman explains how health care is paid for in the United States. Observers generally agree that our $2.3 trillion annual investment in the health sector has not been as effective as it should be in actually improving Americans’ health and that we need to obtain more value for this enormous expenditure. Knickman explains how health insurance works, how reimbursement approaches impact costs, and how health reform is intended to affect financial incentives. He concludes that aligning financial incentives to promote efficient investment of resources is the key to reducing future health care costs.

Bianca Frogner, Hugh Waters, and Gerry Anderson conclude Part I with a chapter comparing the U.S. health system with those of selected other nations. Part of the tremendous pressure to contain U.S. health care costs is the recognition that, relative to other developed countries, the United States spends at least twice as much on health care per person, but does not achieve better health results. The authors describe a few chief organizational models used by other nations and how each is addressing universal challenges—containing costs, population aging, increasing chronic disease rates, care coordination, and quality improvement.
In this first chapter of the 10th edition of Health Care Delivery in the United States, we present an overview of the U.S. health care system. Why and how do we organize health care the way that we do? What are the key problems and current issues in health care delivery? What is the role of the individuals and of providers in improving health care delivery and Americans’ health? What are the constraints and opportunities leaders face in trying to standardize quality outcomes, contain increases in health care costs, and improve access to health care? Many of these vital questions are discussed in detail in subsequent chapters of this volume and we hope you find them challenging and germane to the health care stories that you read about not only at the national level, but also in the communities where you work, live, and go to school.
Part I. Health Policy

The Importance of Health and Health Care to American Life

The health care enterprise is one of the most important parts of the U.S. social system and of our economic system as well. Good health care is an essential foundation for being able to function in society and to enjoy life. People view health and health care quite differently depending on whether they are sick or well or whether they have adequate health insurance. Millions of Americans work in health care delivery and the health care industry is the largest employer in many American cities. The incomes of many people—not just health care professionals, but also suppliers of equipment, pharmaceuticals, and supplies; a large part of the construction industry; and an array of supporting personnel such as kitchen workers, drivers, delivery workers, computer specialists, accountants, lawyers, maintenance personnel, laundry workers, security staff—rely on the continued economic vitality of this key sector.

Defining Characteristics of the U.S. Health Care System

The word “system” implies a purposeful and contained universe, with constituent parts all working together. This hardly describes the American health care system, which can more accurately be defined as a “situation,” “an “environment,” or an “enterprise.” The key idea here is the concept of a boundary line that separates what is “health” from what is “non-health.” Building cars and attending grade school is “not health,” whereas living in a nursing home and planning for health services is “health.”

Of course there are shades of gray. For example, is “health education” in grade schools part of “health” or part of “education”? Our view is that we don’t have a “health care system.” Rather we have many health care systems that, when put into the same framework, constitute a “system” for the purpose of studying health care, rather than for the purpose of organizing and delivering health care services.

A first defining characteristic of the health care enterprise is the line between activities directed at keeping people healthy and those directed at restoring health once a disease or injury occurs.

A first defining characteristic of the health care enterprise is the line between activities directed at keeping people healthy and those directed at restoring health once a disease or injury occurs. Keeping people healthy is the business of the public health system, activities associated with behavioral health, and actions associated with our social system. Public health includes activities to protect the environment, making sure water supplies, restaurants, and food supplies are safe, and providing preventive health services, such as vaccinations. Behavioral health helps people make better choices to improve or protect health—for example, not smoking, eating well, exercising, and reducing stress. Our social system creates the environment that supports healthy living. For example, making sure healthy food and safe places to be physically active are available in every community is part of our social policy. Similarly, being poor is perhaps the single largest determinant of health status; how we distribute income in America is part of social policy.

Once people become sick, the medical care sector delivers a wide variety of services and interventions to restore health and functioning. In general, changing an individual’s
behavior has much greater impact on health and mortality than does medical care. Despite excellent research documenting the importance of healthy lifestyles and healthy communities, as a country, we spend nine times more on medical care than on public and behavioral health. And, many communities do not have environments that encourage healthy lifestyles.

Additional defining features of the U.S. health care system include:

- **The importance of institutions in delivering care.** These include hospitals, nursing homes, community health centers, physician practices, and public health departments.

- **The role of professionals in running the system.** These include physicians, nurses, managers, policy advocates, researchers, technicians of many types, and those directing technology and pharmaceuticals businesses.

- **Medical technology, electronic communication, and new drugs that fuel changes in health care delivery.** New techniques in imaging, electronic communication, pharmaceuticals, and surgical procedures are remarkable and expensive ways of improving health care.

- **Tension between “the free market” and “government control.”** This tension shapes America’s culture. Relative to citizens of other countries and among ourselves, Americans differ more over whether health care, or certain health care services, are goods or rights. And part of the equation are nonprofit health care services, which make up an important part of the health sector. For example, most community hospitals are not-for-profit and nongovernmental.

- **The dysfunctional financing and payment system.** The financing and payment system is dysfunctional for all parties to it—providers, payers, patients, pharmaceutical companies, all of whom feel it either (a) costs too much or (b) brings too little revenue. How we pay health care providers does not provide adequate incentives to emphasize quality, value, and efficiency.

These defining characteristics make the health care system an important part of American life for consumers, taxpayers, and providers of care. Addressing the challenges of this health care enterprise is worth the best effort and thinking of tomorrow’s health care managers and policy makers.

**Addressing the challenges of this health care enterprise is worth the best effort and thinking of tomorrow’s health care managers and policy makers.**

**Major Issues and Concerns Facing the Health Sector**

The defining characteristics of the health care sector listed suggest the key challenges that have been the focus of health care leaders’ attention in recent years. Six of the most important are:

- **Improving quality:** Reliable studies indicate that between 44,000 and 98,000 Americans die each year because of medical errors. Other well-regarded studies show that fewer than half of people with costly and debilitating mental health or substance abuse problems, asthma, or diabetes receive care known to be effective.
Improving access and coverage: Some 50.7 million Americans lacked insurance coverage in 2009 and millions more had inadequate coverage. The 2010 health reform law is expected to insure 32 million of these. Even if the new law accomplishes its goal, nearly 20 million people will continue to lack insurance coverage, including many recent or undocumented immigrants. Lack of coverage is a peculiarly American problem. Why are we different from all other developed countries in this regard? Even when Americans have insurance coverage, access to health care is not always assured. Many rural areas have shortages of doctors, dentists, and other health professionals. Many doctors refuse to treat patients who have Medicaid—or even Medicare—coverage.

Slowing the growth of health care costs: Health care costs are the product of price of services multiplied by the volume of services. Health care costs are growing much more rapidly than the rest of the economy. The choices payers can make to contain health care costs include: not paying for services that are not medically effective or capping what providers are paid for them. For example, payers might limit payments for individual procedures or negotiate capitation rates at current amounts for large populations of insured people.

Encouraging healthy behavior: Healthy behavior can help people avoid disease and injury or prevent disease or disability from worsening. Unfortunately, for millions of Americans, leading healthy lives is not a high enough priority. The first step in efforts to improve healthy behavior is to make sure every community has an environment that supports healthy lifestyles, including access to healthy food and safe places for being physically active. Changing behavior also can be influenced either by limiting choices, such as what children are served in grade school cafeterias, or by penalizing unhealthy behavior, for example, by taxing sugar-laden soft drinks.

Improving the public health system: The public health system provides the infrastructure undergirding the health care delivery system. Largely a state-organized system of state and local health departments, these agencies monitor the health of the people in the state, provide public health services, and regulate health care providers. The effectiveness and funding of state health departments (and the municipal and county health departments within them) is widely variable.

Improving the coordination, transparency, and accountability of local systems of care: Problems of quality, cost, and access are largely attributable to the fragmentation and lack of coordination within the system. This lack of coordination exists within health care organizations as well as between them. It is affected by a lack of integrated and electronic record systems, but also by cultural traditions of independence. Each doctor practices independently and usually each hospital does, too. Little attention is paid to all the services that a patient may need to get well or return to functioning if they are found outside the walls of the doctor’s office or the hospital.

There are many other issues and concerns in health care delivery, such as addressing inequalities in health status among various income groups, social classes, and ethnic groups, or shortages in the health workforce, particularly in primary care. But many of these issues and concerns would be substantially ameliorated if there were progress in
dealing with the Big Six issues cited. For example, improvements in quality and coordination would reduce inequalities on health status among various groups.

Constraints and Opportunities for Change

STAKEHOLDERS WHO CONSTRAIN OR PROPEL CHANGE

Stakeholders with interests in health care delivery include:

- **Consumers and taxpayers.** Typically those who need medical care want more of it and more choice regarding how they get it, whereas taxpayers who are healthy are more likely to urge health care cost containment.

- **Doctors, nurses, hospitals, and other health providers.** All those who work in the health sector want to receive higher incomes for their work. All are in favor of improving the quality of care but they typically disagree as to how this may best be accomplished.

- **Pharmaceutical, insurance, and other for-profit companies.** These firms want to sell more of their product and increase their profits.

- **Payers and organizations that regulate or accredit health care providers.** These organizations want to slow the growth of costs, improve quality, and improve access. But they are not certain of the best ways to do this and may disagree with each other, as well as with the representatives of stakeholders whom they are regulating and accrediting. For example, government may wish to limit amounts paid to patients suffering from medical malpractice. Opinions vary as to the best method to do this. Should it be, for example, by capping awards, forcing medical arbitration, capping what attorneys can collect, or other measures?

Changes are constrained by forces operating at local, state, and national levels.

THE NEED FOR BETTER INFORMATION

Part of the problem is that we lack scientific explanations for the results of various suggested interventions. For example, what would happen if the federal government no longer supported doctors’ medical education and the services provided by resident physicians? Would that raise or lower the cost and quality of hospital care? To find out, do we conduct pilot demonstrations and evaluate the results? Where does the money come from to fund that research? And, how do policy makers and practitioners behave in the absence of these answers?

Opportunities exist for better (as well as worse) performance in all six key challenge areas. Some of the best results have been generated by accountable health care systems, many of them large, covering millions of Americans, such as Kaiser-Permanente, Mayo Clinic, Cleveland Clinic, Geisinger Health System, the Veterans Health Administration, Partners Health Care, and others. They have been able to improve quality, encourage healthy behavior, and improve the coordination, transparency, and accountability of health care delivery.

Other stakeholders can claim improvements, too. So have some locales. The Anesthesiology Professional Society has greatly improved outcomes from surgery. Medical
technology companies have standardized higher quality outcomes with robotic surgery. New drugs have helped to improve patient outcomes in heart disease and cancer. Government regulation has controlled the increase in hospital costs in Maryland. Local legislation against smoking has decreased smoking death rates in New York City.

Leadership counts. There is no substitute for better data produced by better research to justify the results of medical and management interventions and for better leadership to use that data to communicate and persuade effectively, in order to remove obstacles to implementation.

Engagement at the Ground Level

Today’s health care system challenges are exciting, especially as new possibilities open up with the implementation of the 2010 health reform law. The editors have enjoyed the privilege of working for many years as part of numerous efforts to improve health care in the United States. We remain optimistic that pragmatism, flexibility, consensus-building, and attention to objective, high-quality evidence can bring about positive change. We remain stimulated by the challenges and pleased that our choice of careers has allowed us to contribute to maintaining a viable and effective health care system for all Americans.

Certainly, we have observed that best practices are now being used to improve health care and health across a wide range of health care delivery settings in the United States and worldwide. But we need to speed the process of getting more parts of the system—including more professionals and more of our population—engaged in best practices. Our text gives readers the motivation, the information, and some of the skills to do so.

In the future, the U.S. health care delivery system will see improvements if committed and informed Americans choose to enter the field. We hope this book acquaints future leaders with not just the challenges, but also the promise of our nation’s health care system and inspires them to help create what all Americans have always wanted our health system to be—the best in the world.

DISCUSSION QUESTIONS

1. What is the real and perceived performance of the U.S. health care system? Are the views different among patients, providers, payers, and policy makers? Why or why not?
2. Why does the United States spend so much money on health care?
3. Why aren’t Americans healthier and how might the health system make them so?

CASE STUDY

You have an analyst’s position in the Department of Health and Human Services. The 2010 health reform law is expected to increase insurance coverage for a significant number of Americans. But many problems in the health care system remain unresolved. Write a one-page memorandum to your new supervisor describing what you believe are the most important of these, saying why they are important and suggesting how they might be approached.