Jonas & Kovner’s

HEALTH CARE DELIVERY IN THE UNITED STATES

10th Edition
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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.

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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.

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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*

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**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.
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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.

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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.
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.

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

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**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.

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Problems of quality, cost, and access are largely attributable to the fragmentation and lack of coordination within the system.

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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.