1

THE U.S. HEALTH CARE SYSTEM

An Overview

Starting Point

Go to www.wiley.com/college/pointer to assess your knowledge of health care industry basics.
Determine where you need to concentrate your effort.

What You'll Learn in This Chapter

- How large the U.S. health care industry is, based on expenditures
- The different types of health care organizations
- How health care organizations are structured into health systems
- The various industry sectors that comprise the U.S. health care system
- Triggers to health care utilization

After Studying This Chapter, You'll Be Able To

- Describe total health care expenditures and identify where the money goes
- Differentiate between the functions of private and public health organizations
- Identify differences between health systems
- Define health and disease
- Analyze factors affecting health care utilization
- Interpret the role of medical care research

Goals and Outcomes

- Understand the organization of the U.S. health industry
- Determine the role of health care organizations based on the organization's characteristics
- Explain the relationship between health sectors and health organizations
- Compare different health systems based on their affiliations with other health organizations
- Articulate how health care utilization factors impede or promote health care utilization

INTRODUCTION

The U.S. health care industry is vast. Understanding the basics of this industry—how large it is, how it's organized, what the various health sectors are—remains key to making sense of an industry that affects the lives of all people living in the United States. One of the largest enterprises in the United States, the health care industry represents over 15 percent of all goods and services produced in the country. The primary providers of health services are health care organizations (HCOs). HCOs seek to maximize the efficiency and cost-effectiveness of health care by combining organizations into coordinated units. The entire health care industry is intended to promote and protect the health and well-being of the U.S. population. However, how and when people access health care, as well as the factors influencing the availability of care, impact the overall health status of the nation.

The health care system in the United States is a combination of public and private services. It is the only health care system of the industrialized nations that is not a public system with all of its citizens provided basic health care coverage. The current estimates are that 1 of every 5 citizens does not have health insurance coverage. This lack of coverage challenges all aspects of the industry. Four main issues face health care today, driving one of the largest industries in the nation: cost, access, quality, and safety.

The "system" of health care used to be comprised of the physician, the nurse, the hospital, and the insurance plan, which was either private or public. Today the system is extremely complex and involves an ever-expanding continuum of care with new technology, new medications, new techniques, new sites for services. Some argue that with the lack of integration of services in the public sector, the private sector, and public/private sector, no true health care system exists in the United States.

1.1 Gauging the Size of the Health Care Industry

Today, health care is one of the U.S. economy's largest industries, employing more than 12 million people. This industry provides more than $1.8 trillion worth of **gross goods** (medications and medical supplies) and **services** (health care, public health initiatives, and so on). It is both an altruistic pursuit, enhancing citizens' well-being and quality of life, and a business enterprise, generating profits for private providers and suppliers.

Out-of-pocket expenses for a medical procedure or test, for a routine checkup or wellness exam, or for a prescription cost Americans quite a bit of money. The Office of the Actuary at the Centers for Medicare & Medicaid Services stated that Americans—individuals, insurers, and government agencies—spent nearly $1.9 trillion on health care in 2004. This amount is equal to 16 percent of the **gross domestic product (GDP)**—the total value of goods and services produced in the U.S.—which translates to $6,040 per capita, almost

Table 1-1: Projected National Health Care Expenditures, 2007

Good or Service	*Amount in Billions**
Hospital care	$709.1
Professional Services	
Physician and clinical service	$496.5
Other professional services	$ 64.0
Dental	$101.3
Other private health care	$ 67.8
Nursing Home and Home Health Care	
Home health care	$ 57.3
Nursing home care	$134.8
Retail Sales of Medical Products	
Prescription drugs	$236.8
Other medical products	$ 61.1
Government Expenses	
For administration and net cost of private insurance	$236.8
Public health activities	$ 61.1
Investment	
Research	$ 48.9
Structures and equipment	$105.5

Source: Information is based on projections produced by the Office of the Actuary at the Centers for Medicare & Medicaid Services.

*Numbers may not add up due to rounding.

twice the median amount spent by other industrialized nations. Table 1-1 shows where the bulk of the money is expected to go.

Every year, the Office of the Actuary at the Centers for Medicare & Medicaid Services produces a report projecting health care expenditures for the coming decade. These projections describe how much money the United States spends on health care, show where that money comes from, and indicate what factors drive the increase (or decrease) in spending.

As Table 1-1 illustrates, the health care industry includes more than doctors, patients, and medical procedures and medications—the components that are often most obvious to consumers. To this list, add government health initiatives

FOR EXAMPLE

Impacting Health Expenditures

According to the most recent projections published by the Centers for Medicare and Medicaid Services, health care expenditures are expected to grow 7.1 percent annually. By 2014, the nation will spend $3.6 trillion on health care, comprising almost 20 percent of the GDP. One of the most significant events impacting these projections is the new prescription drug benefit plan passed by Congress and in effect January 2006.

and subsidies, ongoing medical research by both private and public organizations, and building and administrative costs, and you can understand how broad the health care industry is.

SELF-CHECK

- Define **goods** and **gross domestic product.**
- Cite the top expenditure in national health care for 2004.

1.2 Balancing Public and Private Health: Health Care Organizations

There are two types of health care organizations (HCOs): *private* and *public*.

- **Private HCOs** provide services that are consumed by, and affect, individuals, such as a physician office visit or an inpatient hospital stay. The goal of these organizations is to protect and enhance the health and well-being of individuals.
- **Public HCOs** provide services that targeted the health and well-being of populations or communities.

These distinctions, however, can become confusing because of the fluid nature of health services in the United States and the various entities—federal, state, and local government agencies and programs; commercial organizations (whether for-profit or nonprofit); philanthropic institutions; medical educational systems; and private individuals—that health care involves. Nevertheless, although fluid, the distinctions are helpful in understanding the complex U.S. health system.

1.2.1 Protecting Populations: Public Health Care Organizations

As previously stated, public health care involves the health and well-being of populations and communities. To that end, federal, state, and local government agencies create public policy affecting health-related issues. Examples of this aspect of public health care include the following:

- Federal and state funding for health programs.
- Public policies relating to infectious diseases.
- Antismoking legislation.
- Federal nutrition and exercise guidelines.
- State licensing procedures for medical professionals.
- Community sanitation laws.
- Government intervention in the control of infectious diseases.
- Pollution standards and controls.
- Government-sponsored and funded medical research.

These aspects of public health policy have an impact on personal health issues, but the primary goal of such policies and programs is to foster and support the health and well-being of an entire community, since health-related issues have a tremendous impact on society as a whole, both in terms of productivity and expense. (You can find out more about the role of the U.S. government in public health in Chapter 13.)

1.2.2 Serving Individuals: Private Health Care Organizations

Private health care focuses on the individual, usually in regard to a person's entry into, interaction with, and movement through the U.S. health care system. Even though this journey might include public health policy programs or support (a child whose medical expenses are paid for through Medicaid, for example, or an elderly person who uses his Medicare prescription drug benefit, or a veteran who goes to a VA hospital for treatment), it still falls within the realm of private health care because the primary goal is the health of the individual.

According to the U.S. Census Bureau, there are approximately 470,000 establishments that provide private health care services. Two-thirds are physicians' and dentists' offices; only 2 percent are hospitals, even though hospitals account for about 40 percent of the health care industry's employment. The distribution of health care establishments is contained in Table 1-2.

One distinctive characteristic of private HCOs is that they provide services, not products. Whereas products are tangible items that are first manufactured and then used (they make the car before you buy and use it, for example), **services** are intangibles that are produced and used simultaneously. The care a physician provides isn't needed, in other words, until a patient accesses it.

Table 1-2: Distribution of Private Health Care Organizations

Type of Organization	*Percentage of All Establishments*
Physicians' offices	41
Dentists' offices	25
Offices of other health care practitioners	19
Nursing homes	6
Medical and dental laboratories	4
Other	3
Hospitals	2

Karl Marx (in *Das Capital*), displaying unusual humor, described them as something you can buy but can't drop on your foot.

In terms of private HCOs, the same is true even for medical supplies (which you *can* drop on your foot) or capacity (the availability of both tangible and intangible resources). Although a defibrillator, for example, may be a product to the medical supply company that sells it and the hospital that buys it, it is not a product to the patient. Why? Because the patient doesn't buy it, even though he may have need of it. In that way, the defibrillator represents health care service that is available if needed.

Because health care services cannot be stored, capacity (such as an unused hospital bed) is lost forever. As a consequence, demand must be either accurately predicted or carefully controlled for an HCO's resources to be productively deployed.

Services (particularly health care) are also custom-designed while they are being produced; their form and content vary from patient to patient. One patient's aching wrist, for example, may indicate a fracture, whereas another patient's aching

FOR EXAMPLE

Planning for the Unpredictable

"Planning for need" is a key component of financial viability for organizations that provide services rather than products. For an HCO to use its resources productively and cost-efficiently, demand must be accurately predicted, or it must be carefully controlled. The managed care movement in the United States is a direct result of the burgeoning health care expenses of the last decades.

wrist is the result of arthritis. The service each patient receives is tailor-made to that patient's need.

Beyond being service based, private HCOs also share the following characteristics in order to address the essential needs of their patients:

- **Fulfill basic needs:** Health care services fulfill basic needs rather than peripheral wants and desires. For this reason, these services are critical. They have a huge impact on clients' quality of life (and often their survival); when needed, few offerings are as important.
- **Involve the emotional and physical:** Health care services and procedures, because they focus on the self, are often physically and psychologically invasive. They are also provided when a person is most threatened, frightened, and vulnerable. As a consequence, their use has a high emotional and spiritual charge.
- **Make services accessible to all:** Because of how crucial health care services are, access to basic health care services is an issue. It is faced by every HCO. Consumption is thought to be a right, although government has not guaranteed this. Currently, incarcerated individuals, mentally ill individuals, those 65 years of age and older, those disabled, those meeting federally established poverty requirements, and veterans may receive health care provided through government funded or provided programs. Some states such as Massachusetts and Vermont have developed basic health coverage for their citizens so that basic care is available. To date, health care is not a government-guaranteed right.
- **Are paid for by someone other than the patient:** For most goods, those who use the product are also the ones who pay for it. This is often not the case for health care services. Although individuals use these services, the services are often paid for (or "purchased"), in whole or in part, by employers and the government. In the past, because the use of most health care services is insured, patients make few if any out-of-pocket expenditures at the point where they consume care. The trend for out-of-pocket expenses paid by the patient has been changing, with a cost shifting occurring and patients paying more of these expenses.
    - Because those who purchase the services are often not the ones who receive the services, private HCOs must respond to two sets of potentially conflicting expectations and demands, one from purchasers and another from customers. Those who pay for the services want to keep down the costs. Those who receive the services want access to any resources that can satisfactorily address their health concerns. The tension between these two positions has had a dramatic impact on health care in the United States. (See Chapter 11 for more on this.)

- **Deal with the complexity of the human body:** The process of producing health care services is complex because the workings of the human body are incompletely understood and the store of knowledge regarding diagnostic and therapeutic technology is vast and building daily.
- **Rely on professional staff:** The health care workforce is highly professional; professionals are characterized by extensive, intensive, and lengthy training. Far more so than in other occupations, medical professionals are granted (through such mechanisms as licensing laws) and expect or demand a high degree of autonomy, discretion, and control over their work and the context in which they practice.
- **Relinquish control of key factors affecting the organization's operation:** Organizations typically employ the most critical personnel needed to produce their products and services. Airlines, for example, hire pilots, flight attendants, and mechanics; restaurants employ chefs. HCOs are a notable exception. Most do not employ physicians, even though the medical staff has tremendous influence over an organization's operation: specifically, who will be admitted; the course of treatment; the amount and type of resources employed; and as a consequence, costs, productivity, and margins.
- **Have a low tolerance of error:** Mistakes made in HCOs often have negative and irreversible consequences, jeopardizing well-being and causing death. Safety has become a major concern for all of health care. The Institute of Medicine Report, *To Err Is Human,* alerted the nation to the safety issues in health care. Since 2000, a major effort has been under way to make patient and worker safety the priority in health care.[1]
- **Operate full time:** Most HCOs operate 24 hours a day, 7 days per week, 365 days a year; they never close, must be continuously staffed, and have no downtime.

SELF-CHECK

- Differentiate between **private** and **public health care organizations.**
- Give three examples of public HCOs.
- Give three examples of private HCOs.
- Name four characteristics of private HCOs.

1.3 Identifying Health Systems

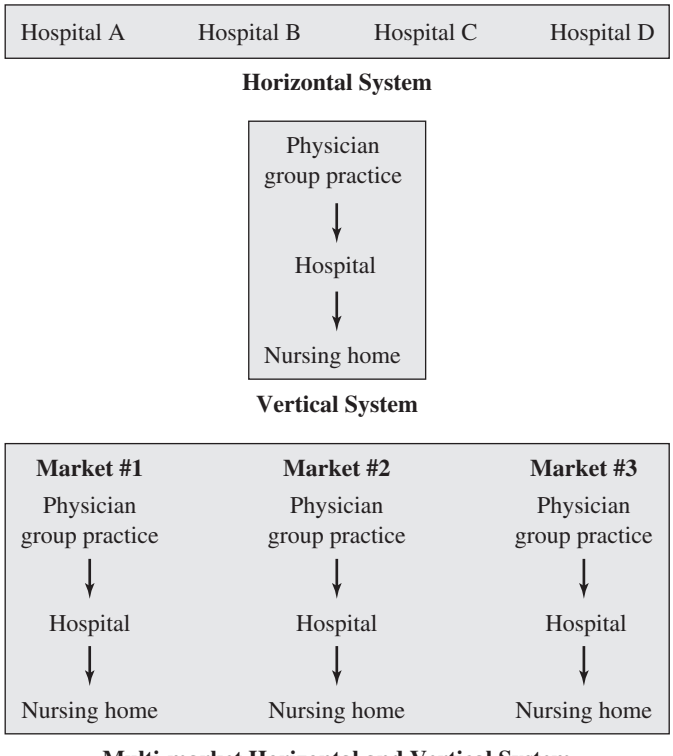
A health system combines into a single enterprise organizations that could function independently. Systems are typically defined or classified along two dimensions: the type of organizations that are combined and the way in which they are combined.

1.3.1 Types of Health Systems

There are two primary system types: *horizontal* and *vertical* (see Figure 1-1):

- **Horizontal systems** combine functionally similar organizations, such as groups of short-term general hospitals, physician practices, or nursing homes. Horizontal systems can be composed of similar organizations in a particular market (such as a city) or those spread across a number of markets (for example, hospitals located in various regions of the country).

Figure 1-1



Types of health systems: A horizontal system *(top)*, a vertical system *(middle)*, and a multi-market horizontal and vertical system *(bottom)*.

- **Vertical systems** combine functionally different organizations, where patient outputs of one organization in the system (a physician group practice) are inputs of another (a hospital). Vertical systems always combine organizations within a given market. The reason is that patient flow among combined organizations requires geographic proximity.

These two system types can also be combined, as with several vertical systems operating in different markets.

From the mid-1980s through the 1990s, the private health care segment of the industry underwent significant consolidation. Horizontal combinations, particularly among hospitals, sought to achieve economies of scale (where fixed overhead costs were spread across organizations) and build share in local markets to increase bargaining power with health insurance plans. Vertical combinations were undertaken to create a continuum of services ("one-stop shopping") attractive to patients and managed care contractors. These systems, whether horizontal, vertical, or a combination, must be concerned with the consistent demonstration of quality and safety for the patients they serve.

1.3.2 Forming Health Systems

Health systems can be formed through a variety of mechanisms. These mechanisms can be employed alone or in combination:

- **Ownership:** Organizations are built or acquired through a purchase or merger.
- **Affiliation:** Organizations agree among themselves to cooperate with each other.
- **Contracts:** An arrangement is made in which one organization manages another.
- **Joint venture:** Two organizations cooperate to undertake a single, specific goal. For example, a hospital and collection of physicians working together to create a health plan.

FOR EXAMPLE

Building a Health System through Acquisition

Community Health Systems is a private health organization that operates general acute care hospitals throughout the United States. Based in Tennessee, the company currently owns, leases, or operates hospitals in 21 states. One of its recent planned acquisitions is the purchase of Newport Hospital and Clinic in Newport, Arkansas, whose assets Community intends to combine with that of another hospital, also in Newport, that the company already owns.

▲ **Lease:** One organization assumes control of another operation for a specified period of time. An example of such an arrangement would be when a hospital assumes control of a nursing home.

SELF-CHECK

- Differentiate between the two primary health system types.
- List the five mechanisms that form HCOs.

1.4 Classifying Health Care Industry Sectors

The health care industry is a complex mix of governmental organizations, nonprofit and commercial organizations, and individuals. Each of these entities, or *sectors,* has a particular role in financing, providing, and regulating health care services. The following sections examine these sectors in more detail.

Keep in mind that these classifications are not exclusive: A particular agency may fall into two or more of the groups. A nursing home, for example, functions as an institutional provider (that is, it is an organization that provides health care services), but it also involves individual providers—the nurses, for instance, who actually care for the clients. Similarly, the federal Centers for Medicare and Medicaid Services (CMS) incorporates a financing function, a service provider function, and a regulatory function.

1.4.1 Financing

The *financing sector* reimburses health care providers. These can include any of the following:

▲ Federal agencies, such as the CMS.
▲ State programs, such as workers' compensation programs.
▲ Health insurance companies.
▲ Health maintenance organizations (HMOs).
▲ Employers both small (2–50 employees) and large (over 50 employees).
▲ Individuals.

Notice that, in the United States, those who reimburse health care providers are not necessarily the consumers of the goods or services (the patients). Although health care is, in the private sector, a business—that is, it sells products (medical services) for a profit—the person "buying" the product is often not the consumer, but an independent third party: the insurer. This insurer can be

a for-profit organization, a nonprofit organization, or a government agency. (To learn more about the financial aspect of the U.S. health care system and the role of insurers, see Chapter 4.) Costs related to the provision and delivery of health care services continues to be a concern for all Americans. All projections show an upward trend for costs.[2]

1.4.2 Institutional providers

Institutional providers include organizations that provide private health care services and includes but is not limited to the following:

- Physicians' offices.
- Medical groups.
- Emergency care organizations.
- Hospitals.
- Mental health facilities.
- Nursing homes.
- Home health agencies (agencies that deliver medical services in the home).

Institutional providers, by their nature and design, are staffed by individual providers (see Section 1.4.3) and offer multiple services falling within their area of expertise or specialization. Mental health facilities, for example, can offer an array of mental health services, including inpatient treatment and outpatient counseling, and may specialize in emotional, psychiatric, or substance abuse issues. How broad the service offering is depends on the organization's stated mission, as well as its size and the resources (human and financial) available to it.

1.4.3 Individual Providers

Individual providers are the professionals who offer private health care services. Examples of individual providers include but are not limited to the following:

- Physicians.
- Dentists.
- Chiropractors.
- Nurses.
- Pharmacists.
- Psychologists.
- Licensed independent practitioners (LIPs).

Individual providers are often associated with one or more institutional providers. A pediatric dentist, for example, may have his or her own practice, in addition to serving as a staff member for a local pediatric hospital.

1.4.4 Public Health Agencies

Public health agencies are government agencies that promote health and prevent disease in populations, as opposed to dealing with the wellness of specific individuals. Examples of public health agencies include the Centers for Disease Control and Prevention, as well as state and local health departments.

1.4.5 Enablers

Enablers are organizations that support and facilitate the provision of health services. Enablers include the following:

- Trade and professional associations (for example, the American Hospital Association and the American Medical Association).
- Special-interest groups (for example, the American Heart Association).
- Research organizations (for example, the National Institutes of Health).
- Educational institutions (that is, medical and nursing schools).

Although the type of support these groups offer depends on the group's area of specialization and stated mission, these groups perform a variety of support functions, including participating in the development of public health policy, funding medical research and the study of public health status, training medical professionals, and promoting awareness of health issues.

1.4.6 Suppliers

Suppliers are organizations that provide products and services to the health care industry. Examples include pharmaceutical manufacturers, hospital supply and equipment companies, and medical consulting firms.

1.4.7 Regulators

Regulators are government agencies and private organizations that regulate health care institutions and professionals. Examples of such entities include the following:

- **State licensing boards:** Their primary responsibility is to ensure the proper licensing and regulation of physicians and, in some jurisdictions, other health care professionals.
- **State insurance departments:** Provide information on state statutes and regulations, as well as register complaints and take disciplinary action against insurance companies.
- **Federal agencies:** Include agencies such as the
  - *Food and Drug Administration (FDA)*, which, among other things, regulates the availability of medications.
  - *Department of Energy, Environment, Safety, and Health (ESH)*, which includes worker protection programs.

FOR EXAMPLE

The FDA

The Food and Drug Administration is a regulatory agency overseeing the introduction of health care products to the U.S. market. Comprising the FDA are five major centers: the Center for Biologics Evaluation and Research; the Center for Devices and Radiological Health; the Center for Drug Evaluation and Research (which you are probably most familiar with); the Center for Food Safety and Applied Nutrition; and the Center for Veterinary Medicine. In concert with to its regulatory function, the FDA also conducts research to test the products under its scrutiny.

- *Environmental Protection Agency (EPA)*, which regulates environmental factors, such as pollution or the use of pesticides, that can impact human health.
- *Centers for Medicare and Medicaid Services (CMS)* that governs, regulates, and pays for services for citizens 65 years of age and older or disabled and those meeting federal poverty levels.

▲ **Medical specialty societies:** Include the American Academy of Neurology (AAN) and the American Psychiatric Association (APA), which are nonprofit professional organizations that set standards for membership, offer ongoing symposiums addressing issues and topics relating to their fields, and function as self-regulating entities for their members.

▲ **Nonprofit organizations:** Include the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), a private, nonprofit association that evaluates medical organizations seeking accreditation.

Again, the agencies in the regulatory sector, like organizations in the financing and health care provider sectors, include both public agencies and private nonprofit groups.

SELF-CHECK

- Define **financing sector, institutional provider, individual provider, public health agencies, enablers,** and **regulators.**
- List examples of each of these sectors.

1.5 Defining Health and Disease

Who takes advantage of the 470,000 private HCOs (as outlined in Section 1.2)? Obviously, people who are not in good health—an obvious answer that leads to another question, this one with a not-so-obvious answer: What does it mean to be healthy? Is it simply a lack of illness?

Health is defined by the World Health Organization as complete physical, mental, and social well-being. This definition is notable because health, as define by the WHO, is not merely the absence of disease or infirmity.

The **World Health Organization (WHO)** is the United Nations agency whose function is to act as a coordinating authority on global health issues. The United States is a member state (as are all United Nations states, with the exception of one—Leichtenstein, if you're curious) and as such sends a delegate to the World Health Assembly, WHO's governing body. Although WHO standards and policies may occasionally differ from U.S. health standards and policies, the goals of both are essentially the same: to foster the health and well-being of people and communities. As such, WHO's definition of health, if not actually adopted by the United States, strongly informs U.S. health policies.

1.5.1 Causes of Disease

Disease impairs the functioning of a person. It can be caused by any of the following:

- Genetic flaws.
- The natural, preprogrammed, and progressive breakdown in biological systems that increases with age.
- External agents (chemical, biologic, radiological).
- Trauma (such as accidents).
- Personal behavioral habits.

Although any of these factors can cause disease, they are not always solely responsible for the actual development of disease, nor are they solely responsible for the path a disease may take once developed. A person may be exposed to an external agent, such as a virus, for example. He may not develop the disease at all, or he may develop a mild version or have a full-blown attack. Obviously, other factors come into play. These other factors include the following (listed here in decreasing order of importance):

- Genetic predisposition.
- Age.
- Context (including things such as income level, education level, housing, nutrition, sanitation, and environment).

FOR EXAMPLE

The U.S. Health Ranking

In its *World Health Report* 2000, WHO ranked the United States 37 out of 191 nations in ability to achieve vital health goals, even though it spends more per person than any other country on the list. This ranking generated a significant amount of press upon its publication, and affirmed for many Americans what they were already feeling: that they were paying more than ever for health care and getting less than they bargained for. This, in addition to projections showing significant increases in health expenditures during a time of economic slowdown, prompted Congress to address growing concerns about the accessibility and expense of health care in the United States.

- Race.
- The use of health care services.

Genetics, age, context, and race have a far greater impact on a person's health status than the amount and type of health care services consumed. The reason is that health care services primarily come into play only after the horse is out of the barn—when an illness or condition has already occurred. Meanwhile, other factors affect the probability that an illness or condition will appear in the first place.

1.5.2 Analyzing U.S. Health and Disease Status

Various mechanisms exist to test and represent the health status of the U.S. population. Researchers look at factors such as life expectancy at birth, infant mortality rates, cause of death, percentage of people with particular medical conditions or conditions that can negatively impact health, and so on. Generally, healthier societies have high life expectancy rates, low infant mortality rates, and low instances of chronic or debilitating health problems.

Infant Mortality Rate

In the United States, white and Hispanic infants have the lowest infant mortality rates, black infants the highest. Table 1-3 shows the statistics for the infant mortality rate.

In comparison with other selected countries, the infant mortality ranking of the United States is 27. Interestingly in 2002—and for the first time since 1958—the infant mortality rate increased in the United States. Upon further analysis of the data, the National Center for Health Statistics noted that of the ten most common causes for infant deaths, two causes showed a significant increase: low birthrate (up 5.3 percent) and maternal complications (up 14.2 percent).

Table 1-3: U.S. Infant Mortality Rate

Ethnicity	*Deaths per 1,000 live births*
White	6
Black	14
Hispanic	6
Other	9

Source: National Vital Statistics Report, Vol. 53, No. 5, October 12, 2004.

Life Expectancy and Cause of Death

In the United States, the average life expectancy is 74 for men and 79 years for women. Compared to other countries, America is number 20. What's killing Americans?

Table 1-4 lists the more common causes.

Table 1-4: Cause of Death

Cause of Death	*Rate per 100,000 People*
Heart disease	241.7
Cancer	193.2
Stroke	56.4
Chronic lower respiratory disease	43.3
Accidents	37.0
Diabetes	25.4
Pneumonia and influenza	22.8
Alzheimer's	20.4
Kidney disease	14.2
Homicide and firearms	16.6
Motor vehicle accidents	15.7
Suicide	11.0
Chronic liver disease and cirrhosis	9.5
HIV	4.9

Source: ***National Vital Statistics Report,*** Vol. 53, No. 5, October 12, 2004.

Table 1-5: Percentage of Chronic Health Conditions

Condition	*Percentage*
Adults (ages 20–74) with hypertension	24
Adults (ages 20–74) with an unhealthy weight	58
Children (ages 6–19) who are overweight	11

Population with Chronic Health Conditions

Another indicator of health status is the percentage of Americans who have a chronic or limiting health condition.

Consider these statistics shown in Tables 1-5 and 1-6.

Table 1-6: Population with Limitation of Activity Caused by Chronic Conditions

Age	*Percentage*
Under 18	6
18 to 44	6
45 to 54	12
55 to 64	20
65 to 74	26
Over 74	45

SELF-CHECK

- Give WHO's definition of **health.**
- Name the four causes of disease.
- Identify three of the five factors impacting a person's health status.
- Identify three common indicators of public health.

1.6 Accessing Health Services in the United States

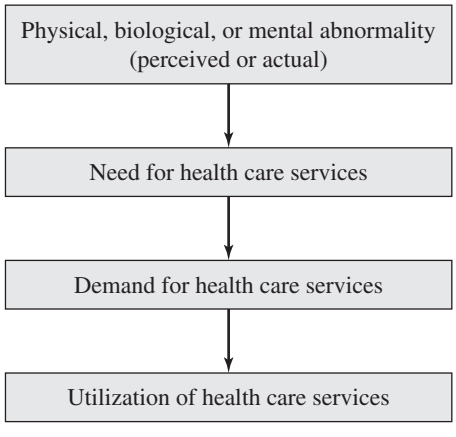
Accessing health services is an ongoing issue. It can be a problem because of finances and availability or lack of knowledge and understanding of how this vast industry operates. The U.S. health care industry has the ability to meet the demands of all who need it. Staffed with professionals and stocked with advanced medical equipment, this industry has the technology and expertise that most U.S. inhabitants in medical crisis need. So how do people access the services they need?

1.6.1 Triggers to Utilizing the Health Care System

What affects the utilization of health care services? Simply feeling unwell isn't enough. Generally, before a patient steps foot in a medical facility, a sequence of events has occurred (see Figure 1-2):

1. **Need:** A person recognizes an underlying abnormal condition and judges it to warrant care and treatment. This condition can be physical, biological, or mental and it may be perceived or actual. The important thing is that the person *feels* that something is wrong and this feeling is disturbing enough to propel the person to the next stage.
2. **Demand:** Because of the depth of the discomfort caused by the underlying condition, the person is motivated to seek medical care and has the means to do so.
3. **Utilization:** Once believing that he or she has a need for medical care, the person then receives and uses the available medical services.

Figure 1-2



Key determinants in health care utilization.

Keep in mind, however, that the presence of a disease or condition does not necessarily cause need. Need may not precipitate demand, and demand may not result in utilization:

- **When condition doesn't lead to demand:** A person may have a condition that goes undetected because it is asymptomatic (that is, without symptoms). Or the underlying condition may not be defined as a disease (as was the case for many mental disorders in the early part of the last century).
- **When need doesn't lead to demand:** Individuals may need care yet not demand it because the condition is thought to be inconsequential. Conversely, a person can demand care without needing it (as in the case of a hypochondriac).
- **When demand doesn't lead to utilization:** The conversion of demand into consumption of health care services is most affected by the two-sided coin of access: individual wherewithal (knowledge, time, and money); and by how health services are organized, financed, and provided (industry structure and functioning).

Individuals also access services to prevent disease such as with immunizations. Public programs often emphasize preventive measures to ensure public and individual health.

1.6.2 Factors Affecting Utilization

A host of factors have been shown to affect the demand for and the utilization of health care services. Here are a few important ones:

- **Age:** Data show that the younger the person, the less likely he or she is to have a regular source of care. Keep in mind, however, that this could

FOR EXAMPLE

Addressing Disparities

Minorities in the United States (African Americans, Hispanic Americans, and others) have not benefited at the same level as their white counterparts in regard to health care. They are more likely to suffer from and die of cancer, heart disease, stroke, diabetes, and HIV/AIDS, and are less likely to get available immunizations. Infant mortality rates are also higher for minorities. The U.S. Department of Health and Human Services has launched programs to address these disparities. These efforts include engaging racial and ethnic minority communities in the fight against specific diseases and conditions that have a major impact on health, as well as finding ways to ensure that these populations get the necessary screening, diagnoses, and follow-up care.

be the result of a number of factors: The person may have fewer health problems, or may be less likely to have the financial means or insurance necessary to secure health care.

- **Insurance coverage:** People without insurance are more than four times as likely as people with insurance to forgo regular health care.
- **Race/ethnicity:** Hispanics are almost twice as likely as whites to be without regular health care, whereas the difference between white and black Americans is less pronounced.
- **Number and distribution of providers:** The Institute of Medicine's (IOM) promise of accessible care is meant to include all geographic regions of the country. But data suggest that inner cities and rural America aren't adequately served and a key reason is the dearth of physicians and facilities in those areas. This topic is one of the challenges facing the U.S. health care system. You can read more about it, and other challenges, in Chapter 13.
- **Education level:** People with lower levels of formal education are less likely to utilize or have access to medical services.
- **Provider referral patterns:** Given the relatively recent advent of managed care (which is discussed in detail in Chapter 11), whether a patient gets a referral to a specialist—and to which specialist—is often dependent upon the referral agreements stipulated by the health management organization (HMO) that the patient has.
- **Income level:** For reasons that are obvious, people in the lower socioeconomic brackets have less access to and utilize health care resources less than those in higher socioeconomic brackets.
- **Attitudes and beliefs:** The attitudes hampering adequate access and utilization of health care resources can be the individual's (a fear of doctors, for example, or a tendency to not follow the doctor's suggestions) or the physician's (who may, because of personal biases, be less aggressive with some populations than with others).

Table 1-7 lists the percentage of adults who have no regular source of medical care, categorized by age, gender, race, and insurance status.

1.6.3 The Role of Health Services Administration Research

Medical science does not make its contributions in a vacuum. Because the value of U.S. health care can be significantly affected by other factors, such as those listed in the preceding section, those factors can impede individuals from attaining better health. For that reason, health services administration research has an important role to play in assessing needs and evaluating how well medical services are delivered.

Table 1-7: Adults (18–64 Years of Age) with No Regular Source of Care

Category	*Percentage*
All	18
Age	
18 to 24	27
25 to 44	20
45 to 54	12
55 to 64	9
Gender	
Male	24
Female	12
Race	
White	17
Black	19
Hispanic	31
Insurance Status	
Insured	11
Uninsured	47

Health services administration research does not focus on diseases, but on the social, psychological, cultural, economic, informational, administrative, and organizational factors that impact both negatively and positively access to and delivery of health care to individuals and communities.

Health services administration research focuses on finding answers to questions such as these:

- What factors govern the patients' assumption or rejection of the "sick" role, or the "patient" role?
- What are the patients' sources of help in understanding and coping with their health problems?
- How do patients select their physicians, and conversely, how do physicians select their patients?
- Under what circumstances do physicians refer patients to other physicians and to medical centers?

▲ What kinds of patients, problems, and diseases are seen at different health facilities? Do the "right" patients get to the "right" facilities at the "right" time? What factors determine which person in every 1,000 adults will be referred to a university medical center each month? Are these processes in the best interests of all patients?

Health services administration research is as concerned with the health of those who do not use medical care resources as with the health of those who do. In essence, it is concerned with medicine as a social institution.

SELF-CHECK

- List the process by which people access the health system.
- Cite the factors affecting utilization of the health care system.
- Describe the role of health services administration research in health care.

SUMMARY

Understanding health care in the United States requires becoming familiar with the size and scope of the health care industry. The health care industry is one of the largest and represents over 15 percent of all goods and services produced in the nation. Health care organizations (HCOs) provide most of the primary care in the United States. In an effort to enhance the efficiency and cost-effectiveness of the health industry, HCOs are combined to create health systems. The entire health industry relies on health sectors to fulfill its mission. Still, U.S. health status is impacted by factors beyond the size and organization of the health care industry: How and when people access care, as well as the overall availability of care, determine to a large extent how successful the health system is.

KEY TERMS

Enablers	Organizations that support and facilitate the provision of health services, such as trade and professional organizations and public interest groups.
Gross domestic product (GDP)	The total value of goods and services produced in the U.S.
Gross goods	Medications and medical supplies.

Horizontal systems	Combine functionally similar organizations; can be composed of similar organizations in a particular market or those spread across a number of markets.
Individual providers	The professionals who offer private health care services such as physicians, dentists, chiropractors, and nurses.
Institutional providers	Include organizations that provide private health care services, such as physician's offices, medical groups, hospitals and nursing homes.
Private HCOs	Provide services that are consumed by, and affect, individuals. The goal of these organizations is to protect and enhance the health and well-being of individuals.
Public HCOs	Provide services that targeted the health and well-being of populations or communities.
Public health agencies	Government agencies that promote health and prevent disease in populations, such as the Centers for Disease Control and Prevention.
Regulators	Government agencies and private organizations that regulate health care institutions and professionals, such as state licensing boards, state insurance agencies, and federal agencies.
Services	Intangibles that are produced and used simultaneously.
Suppliers	Organizations that provide products and services to the health care industry, such as pharmaceutical manufacturers, hospital supply and equipment companies, and medical consulting firms.
Vertical systems	Combine functionally different organizations, where patient outputs of one organization in the system are inputs of another. Vertical systems always combine organizations within a given market.
World Health Organization (WHO)	United Nations agency whose function is to act as a coordinating authority on global health issues; established in 1948.

ASSESS YOUR UNDERSTANDING

Go to www.wiley.com/college/pointer to evaluate your knowledge of health care industry basics.
Measure your learning by comparing pre-test and post-test results.

Summary Questions

1. Indicate how large the U.S. health care industry is in terms of gross domestic product.
   (a) approximately 25 percent of GDP
   (b) approximately 15 percent of GDP
   (c) approximately 5 percent of GDP
   (d) as a service, health care isn't figured into GDP
2. The services that account for the top three health care expenditures are hospital care, professional and clinical care, and _____.
   (a) prescription drugs
   (b) medical research
   (c) nursing home care
   (d) public health activities
3. The goal of private HCOs is to use government programs to promote and protect the health and well-being of communities. True or false?
4. Public HCOs are government agencies that make health care policy and implement public health care initiatives. True or false?
5. Which of the following is *not* an example of a private HCO?
   (a) veteran's hospital
   (b) FDA
   (c) inner-city health clinic
   (d) all of the above
6. Which of the following accurately defines a health system?
   (a) a health system is one of the four major systems—respiratory, circulatory, and so on—in the human body
   (b) a health system is an organization that combines into one enterprise HCO that could otherwise function independently
   (c) an organization that includes health care professionals from various fields and offers a variety of treatment options for its patients
   (d) all of the above
7. Which of the following is *not* a mechanism for forming a health system?
   (a) joint venture
   (b) lease

(c) association
(d) ownership

8. Health sectors are
(a) health regions throughout the country, as defined by the DHHS.
(b) specific roles that health care providers have in promoting and protecting health.
(c) types of health care (geriatric care, pediatric care, oncology, and so on).
(d) categories of disease as defined by the CDC.

9. Which of the following are examples of institutional providers?
(a) a nursing home specializing in Alzheimer's care
(b) a physician providing care in a hospital
(c) a government agency implementing public health policy
(d) a and c

10. The World Health Organization defines ***health*** as
(a) absence of disease or infirmity.
(b) complete physical well-being of both individuals and populations.
(c) complete physical, mental, and social well-being.
(d) the WHO doesn't define health, instead leaving the definition up to its member states.

11. Apart from the physical causes of disease, which of the following factors can impact the course a disease may take once developed?
(a) age
(b) genetic predisposition
(c) environment
(d) education
(e) all of the above

12. A sequence of events generally occurs before a person seeks medical attention. Which of the following most accurately represents this sequence?
(a) Demand => Need => Utilization
(b) Utilization => Demand => Need
(c) Need => Demand => Utilization
(d) none of the above

13. Which of the following factors affects utilization of health care?
(a) age
(b) insurance coverage
(c) income level
(d) education
(e) all of the above

Review Questions

1. The health care industry provides both goods and services. Of the following, explain which are goods and which are services.
   (a) medication
   (b) follow-up care
   (c) stethoscopes
2. As the U.S. population ages, what will be the impact on health care expenditures?
   (a) expenditures will stay roughly the same
   (b) expenditures will increase
   (c) expenditures will decrease
3. Cite three characteristics of private HCOs.
4. Private HCOs address health issues of the individual; public HCOs address the health needs of the population as a whole. In the following scenarios, state whether the situation includes a private HCO, a public HCO, or both.
   (a) a general practitioner working in a clinic diagnoses an elderly woman with breast cancer and refers her to an oncologist working in a hospital setting
   (b) FDA officials pull a popular cholesterol drug from pharmacy shelves because additional studies indicate it isn't safe
   (c) as part of a statewide "Smile" program, local dentists volunteer their time to give elementary school children dental checks at school
5. Indicate whether the following are examples of vertical health systems or horizontal health systems.
   (a) an organization comprised of several nursing homes throughout a geographic region
   (b) an organization comprised of dental offices within a city
   (c) an organization comprised of hospitals and nursing homes
6. In the mechanisms used to form health systems, identify the main difference between organizations that are formed through ownership and those formed through affiliation.
7. Indicate whether each of the following is a health sector.
   (a) enablers
   (b) providers
   (c) regulators
   (d) users
8. Describe the role of regulator.
9. What are the contextual factors impacting the status of disease?

10. Explain why the use of health care services has less of an impact on a person's health status than the other factors.
11. In what situations does a health care need *not* lead to demand?
12. What factors affect health care utilization?

Applying This Chapter

1. Evaluate the data in Table 1-1 and determine which sectors spend the most money. Given the aging population and upcoming changes in health policy (such as federal prescription drug plan for seniors), identify which areas may be most affected and briefly explain why.
2. Identify the type of health system being described in each of the following:
   (a) a clinic specializing in geriatrics refers a patient to a hospital for immediate care; the hospital, after stabilizing the patient, refers the patient to local nursing home facility for recuperation
   (b) an organization operates hospitals in several cities across a particular region
   (c) a managed care organization that contracts with general physicians practices, specialty practices, hospitals, and nursing care facilities in various regions
3. Identify which sectors each of the following falls into. Note that some may fall into more than one sector:
   (a) doctors in a health clinic
   (b) the research department of a community hospital
   (c) a company that sells syringes and other medical supplies
   (d) a state health department
   (e) a national health insurance company
   (f) a pharmacist
4. Good Samaritan Children's Hospital is a research, training, and treatment center for children with cancer and catastrophic diseases. Physicians from around the country refer children to this facility, and it also has an outreach program that works in partnership with research facilities and medical centers around the world. Describe this hospital in terms of
   (a) the type of HCO it is.
   (b) the type of health system it represents.
   (c) the health sectors it falls into.
5. Create a profile of a person *least* likely to access health care; of a person *most* likely to access health care.

YOU TRY IT

Gauging the Size of the Health Care Industry

You are responsible for identifying the source of health care expenditures. Indicate what components you would include in your report.

Balancing Public and Private Health: Health Care Organizations

Of all the HCOs, hospitals account for only 2 percent, yet they employ over 40 percent of the total HCO workforce. Explain why this seeming discrepancy exists and extrapolate what that means in terms of where hospitals stack up in terms of expenditures.

Identifying Health Systems

Draw up your own plan for a health system that provides services to elderly people. Indicate the services you intend to provide and identify the type of health system you've created.

Classifying Health Care Industry Sectors

As a director of a nursing home that employs registered nurses and provides services to patients with dementia (such as Alzheimer's), indicate what other type of health care sectors you would be involved with.

Defining Health and Disease

Based on the data regarding the health status of U.S. citizens, if you were charged with reducing preventable causes of death and improving the overall health of Americans, what issue(s) would you target? Explain why.

Accessing Health Services in the United States

Health care is available to all. Defend or refute this statement, using information from this chapter to support your position.