

# Organization of Health Care Systems in the U.S.

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## Objective

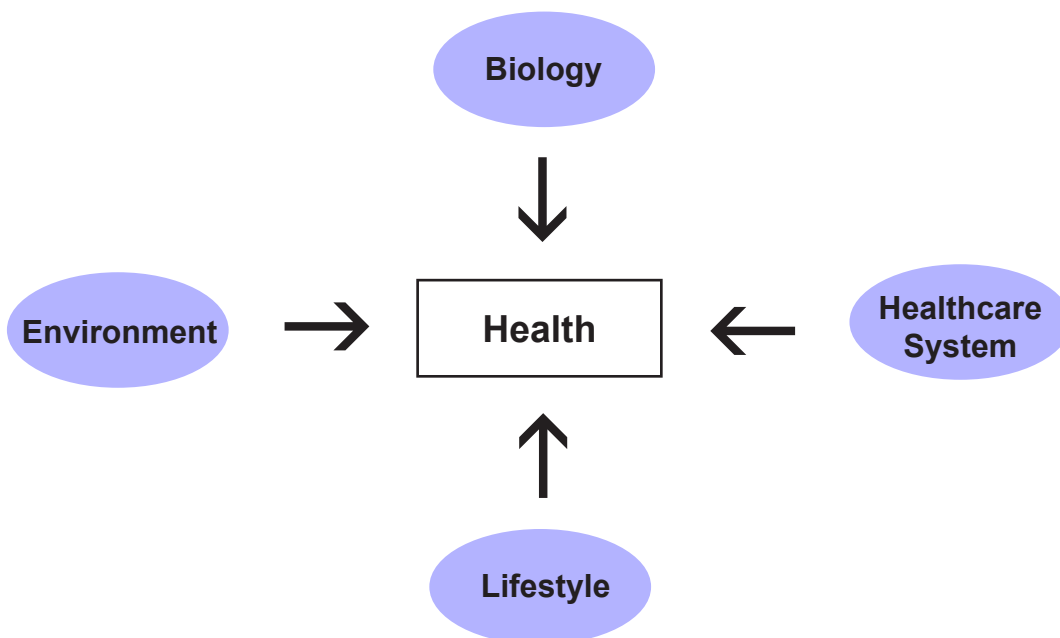
The objective of this session is to provide Health Institute participants with a framework for understanding the services, payment systems and current issues pertaining to U.S. health care services and how this relates to community health. Extension agents should, upon completion, be familiar/conversant with the major concerns and relevant terminology utilized by the health care community of interest. Participants will become familiar with both the traditional, or provider model, view of the health system and the expanded view of the social, environmental and supporting elements that contribute or detract from the health of their clientele and community.

## Key Definitions

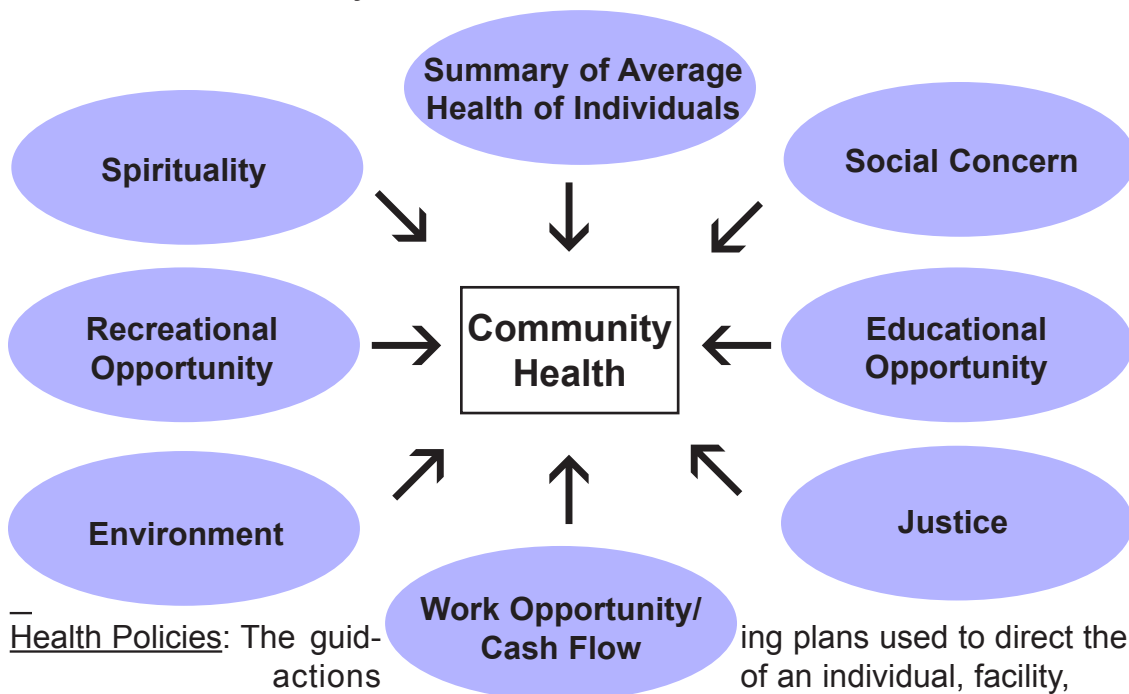
Community Health: Community health can be described in terms of collective health and safety problems and common individual health behaviors. It is reflected in the summary health or the average health of all individuals in the community. Healthy communities are often identified as the “kind of place I would like my children and grandchildren to grow up in,” reflecting community health as a major determinant of quality of life.

Health Care System: The arrangement of doctors, nurses, pharmacists, hospitals, clinics and other providers to deliver health care to individuals, the array of services offered, the policies that guide them, and the purchasing mechanisms.

## Determinants of Individual Health



## Determinants of Community Health



Health Policies: The guid-  
actions  
group, orga-  
nation.

ing plans used to direct the  
of an individual, facility,  
nization, community, state or

Examples of health policies include:

- ❖ New Year's resolution to lose weight
- ❖ Habit of keeping floors, tables and sink clean of crumbs to avoid attracting pests
- ❖ Declaration to perform blood pressure screening monthly at a church
- ❖ State law requiring hospitals to meet licensing criteria
- ❖ Federal Medicare regulations and HMO legislation

Health Care Access: Access to health care is a major issue in the health of individuals in a community.

Components of access include:

- ❖ Having health care providers available to the community
- ❖ Having ways for individuals to travel to and enter the health care system
- ❖ Having financial resources to pay for the care
- ❖ Having health care providers and systems that are culturally sensitive and appropriate to the populations in the community. Accessible primary care is important for any community.

### **Introduction/Overview Session**

In the United States, health care is delivered through a complex system of local, regional and national components. It can be described in terms of the health care providers, the types (levels) of care available, health-related government structures, and the methods of payment for services.

Health care is changing constantly in response to federal and state legislation, market forces, and cost-control efforts by the health care industry. In this time of unparalleled restructuring, new regulations, payment mechanisms, rapid mergers, and consolidation among hospitals, providers and insurers characterize health care. The health of individuals and entire communities are, without doubt, impacted by these changes.

In addition to health care services, the local health system is comprised of the environment and other human, organizational and financial assets. Since these assets and the structures of different state health systems vary widely, local leadership is necessary to address the gaps that negatively impact the health of community members. Without this local leadership and planning, the local health system is a collection of parts, which serves only a portion of community health needs.

Several different health systems may function in a single community within the parameters proscribed by state and federal legislation and funding. A well-planned and supported health care system can promote community and individual health. In such a system, careful coordination of services and community health policies can maximize the benefits of health care, provide social and environmental support for wellness, and encourage the appropriate use of medical resources.

Leadership may derive from a group of stakeholders working to create a strategy or local policies to improve the local health system. These stakeholders may be health care providers or key individual leaders who organize community support to address a particular health issue. Examples of possible professionals and informal leaders include:

- ❖ Hospitals
- ❖ Rural health clinics
- ❖ Community health clinics
- ❖ Free clinics
- ❖ Pharmacies
- ❖ Private practitioners
- ❖ Safety net providers
- ❖ Long-term care facilities
- ❖ Hospices

- ❖ Home health agencies
- ❖ EMS
- ❖ Fitness facilities
- ❖ Red Cross
- ❖ Disease affiliate organizations
- ❖ State and local departments of health
- ❖ Indian health service
- ❖ Primary care physicians
- ❖ Physician specialists
- ❖ Mid-level providers/physician extenders
- ❖ Nurses
- ❖ Allied health providers
- ❖ Emergency medical technicians
- ❖ Other emergency medical services; ambulance, air-ambulance, fire/rescue
- ❖ Elected officials
- ❖ Vitally concerned residents
- ❖ Health educators

### **Who Is Responsible for Community Health?**

With so many sectors of the community involved in health, there is usually competition to control aspects of the local health system(s). Physicians may claim leadership by virtue of their licensure, expertise, and the urgent need for their services. Hospitals also claim leadership through the control of the location and are often the employer of those who provide acute care. The insurance industry, both private and public, attempts to manage the health system through quality assurance, managed care, and reimbursement. Health departments have recognized, legislated authority in services related to issues of public health.

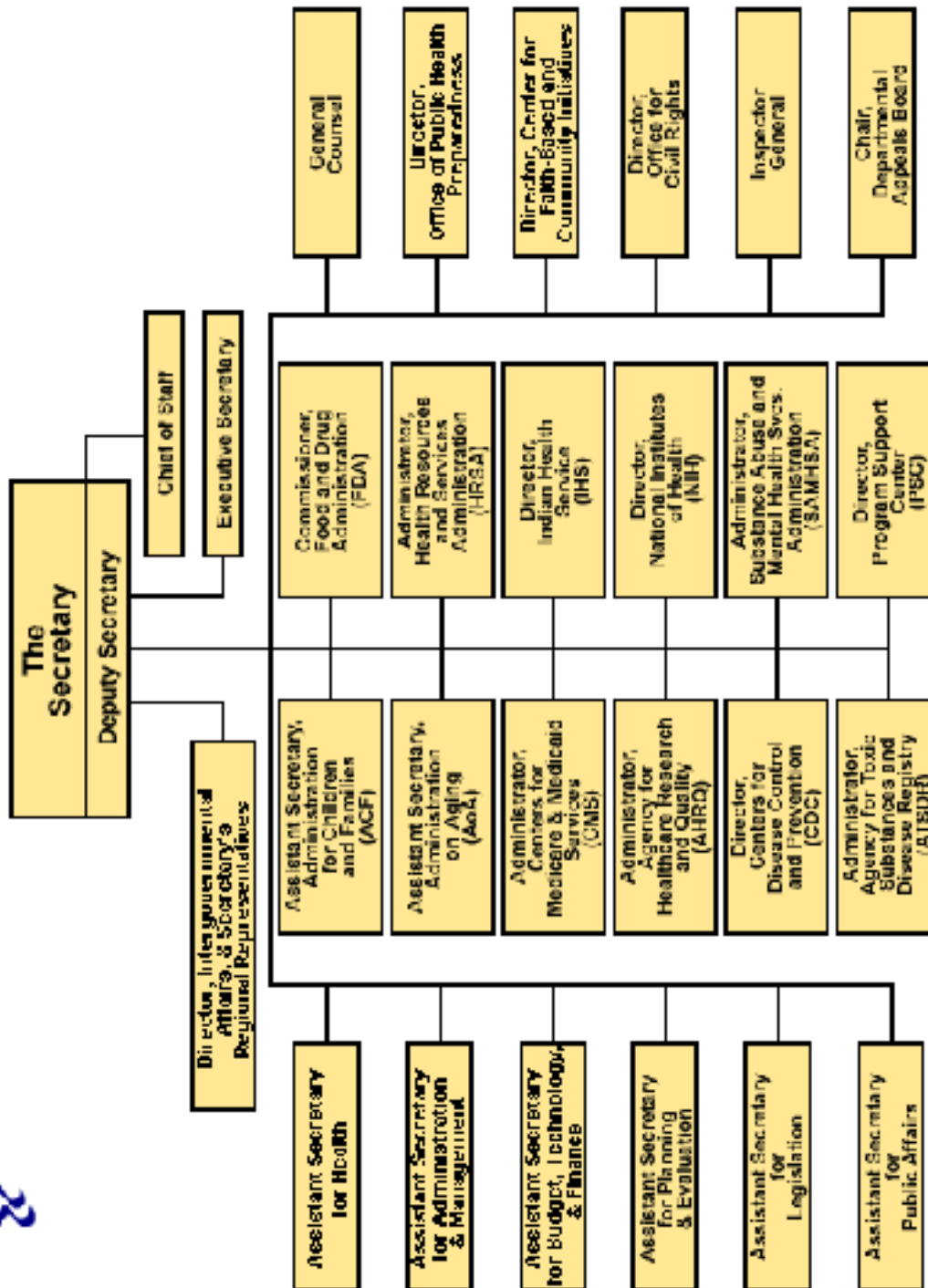
The reality is that many different entities and professionals, as well as the health consumer, have shared responsibilities in the health system. For example, a rural community might have one or more of the following: doctor or nurse practitioner office, dentist office, chiropractor office, community health center, public health clinic, satellite clinic from a regional hospital or doctor's group, pharmacy, small hospital, nursing home, visiting specialist clinic, mental health clinic, wellness center, home health agencies, and others.

As a general principle, local community stakeholders drawing experience from among the broad and diverse set of local interests are best able to match and coordinate the multiple, often-competing health care interests for the good of the community's development.

Several entities are briefly described here for purposes of role clarification.

### U.S. Department of Health and Human Services (DHHS)

DHHS is the major federal government organization of multiple health-related agencies. An organizational chart of these health-related agencies, or divisions, is shown here. Descriptions of all the DHHS operating can be found at



<http://www.hhs.gov/about/profile.html>.

### **Center for Disease Control and Prevention (CDC)**

This center is another agency in the U.S. Department of Health and Human Services that functions as a support agency to study and recommend care for threats to the health of the public. In cases of mass illness, the CDC will study the local “epidemic” and recommend public health intervention. In recent years, CDC has begun to focus attention on significant trends of chronic illness and has often involved local resource persons in study and intervention projects for heart disease, diabetes, HIV/AIDS, etc.

### **National Institutes of Health (NIH)**

A group of agencies for specific illnesses or conditions (heart, lung, cancer, aging, environmental health, etc.) that focus extensive attention on illnesses through research and demonstrative grants. Until recently, these agencies were perhaps more influential than any other source for determining the character of medical education. HMOs have altered their influence in many medical markets. These are a part of the U.S. Department of Health and Human Services (DHHS).

### **State Departments of Health**

If the health problem is common in a number of other communities in a particular state, it will probably attract the notice of the state health department. This DHHS affiliated state agency is charged with monitoring the health of the public and directing needed interventions such as immunization campaigns, environmental monitoring, or communicable disease control.

### **J-1 Visa Program**

This program administered by ARC and other agencies seeks to provide under-served areas with physicians by offering foreign doctors the opportunity to live in the United States by first serving two years in an under-served area. Under-served areas are designated by the agency, usually in consultation with the DHHS.

### **National Health Service Corps (NHSC)**

The NHSC is an agency in the DHHS that was established to supply physicians for work in under-served areas. In its early years, it accepted physicians to serve in lieu of military service and distributed them widely. In recent years, without a military draft, the NHSC has depended on scholarships to attract young physicians (and other primary care providers and dentists) into service. As data has shown decreased retention of “outsider” doctors, the NHSC has made greater effort to get local students for under-served areas to sign on for scholarships.

## **Health Care Providers**

In most communities different entities provide health care. public health and mental health clinics provide some individual health care to citizens, as state tax allocation allows for these services. Community health clinics and rural health clinics are federally subsidized to provide health care in some communities. Together, these clinics provide a safety net for the uninsured or underinsured public. Additional free clinics are often organized at the local level, and some private health care providers accept publicly funded reimbursement.

Private health care, however, makes up the largest segment of health care. Private health care could be described in terms of the many types of formal and informal contracts between hospitals, doctors, nurse practitioners, allied health providers, insurers, the medical industry, and health care consumers.

## **How Is Healthcare Provided?**

### **Guidelines for Care**

Guidelines for health care are efforts taken to decrease some of the variation in care given for certain illnesses and to create a more predictable cost of care including monetary, days lost from work, etc. Usually bodies of individuals with expertise in care for the illness convene to review evidence about best diagnostic and treatment options and then produce an expert or consensus opinion about how to carry out medical care. These opinions result in guidelines. Sometimes local health care providers will review their local options, generate a local consensus, and create local guidelines.

Guidelines are generalized across a certain population and are not specific advice to an individual. As such, they are sometimes useful in Extension health education. For example, the National Heart, Lung and Blood Institute Guidelines for the Management of Hypertension provide a baseline recommendation about daily sodium intake for people with hypertension. The Guidelines for Control of Diabetes by the American Diabetes Association recommends the regular measurement of HgbA1c. These guidelines are generally applicable for all those diagnosed with these diseases, yet they may be adapted by physicians for individualized medical management. Extension programs would use guidelines as a source of information for clients to discuss with the primary care provider.

### **Standards of Care**

These are the professional consensus opinions to which medical or nursing care is compared to determine if care being evaluated is of acceptable quality. Standards are created by custom based on training and experience.



These standards may be refined by the appearance of new technologies and new scientific or professional opinions regarding care. Local professional bodies, such as hospital staffs, nursing, and medical societies, set standards. Standards may also be created or adopted by health care organizations and regulating bodies.

### **Patient/Provider Partnerships**

As medical care moves from the acute/intense to the preventive/educational, the will of the patient becomes more and more important as to whether the care offered will be utilized. Behavioral change theories indicate that an active partnership rather than the authoritarian approach will be of greater value in these later cases. Patient/provider partnerships, sometimes formalized as written agreements, are particularly advocated in care where patient discretion is crucial to optimal care.

### **What Types of Health Services Are Provided?**

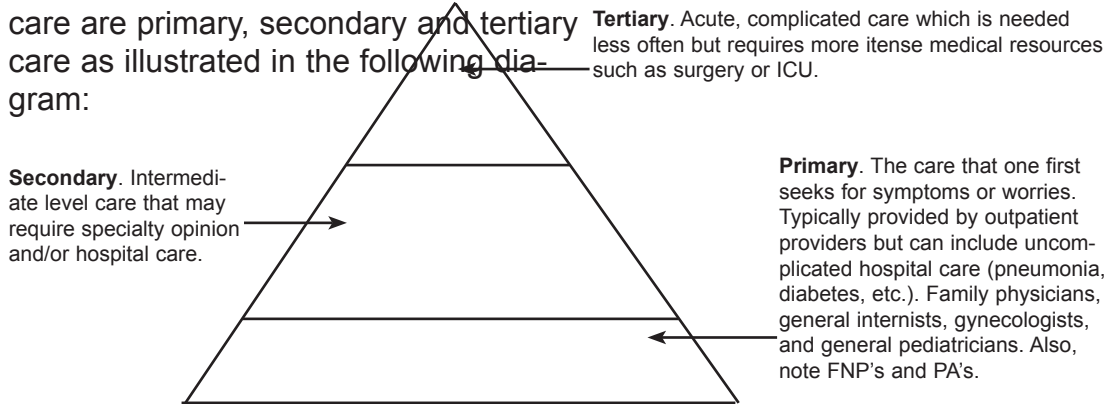
Health care can be defined as the prevention, diagnosis and treatment of chronic diseases, injuries and acute illnesses. Health education, or health promotion, is pertinent information for health consumers and the general public about risks and health-related life skills. Self-care is the effective use of health care services and health education to clients to prevent illness and injury, recognize health problems, handle minor health problems at home, and to utilize health care resources appropriately. A strong health system provides a way for communities to access all these services in some reasonable, affordable manner. Examples of specific health care and health promotion services include:

- ❖ Primary, secondary and tertiary acute medical care
- ❖ Chronic disease medical management
- ❖ Disease prevention and early detection
- ❖ Health education/Health promotion
- ❖ Rehabilitation
- ❖ First responders, first aid
- ❖ Emergency medical services/trauma care
- ❖ Ambulatory/Outpatient care
- ❖ Home health care agencies
- ❖ Alternative and complementary medicine
- ❖ Assisted living facilities
- ❖ Skilled nursing homes
- ❖ Dental care
- ❖ Mental health
- ❖ Hospice

Medical care can be described according to the level of care required, intensity of the services, and the locations in which they are provided.



The usual terms used for acute medical care are primary, secondary and tertiary care as illustrated in the following diagram:



As mentioned earlier, the same terms, primary, secondary and tertiary can also describe the levels of preventive care known also as health promotion/ education/wellness/disease prevention, early detection and prevention of complications, or rehabilitation. Whatever it is called, the costs associated with any given health service is greater as the level of care increases. Increasing levels of services also require greater expertise and preparation of the professionals involved.

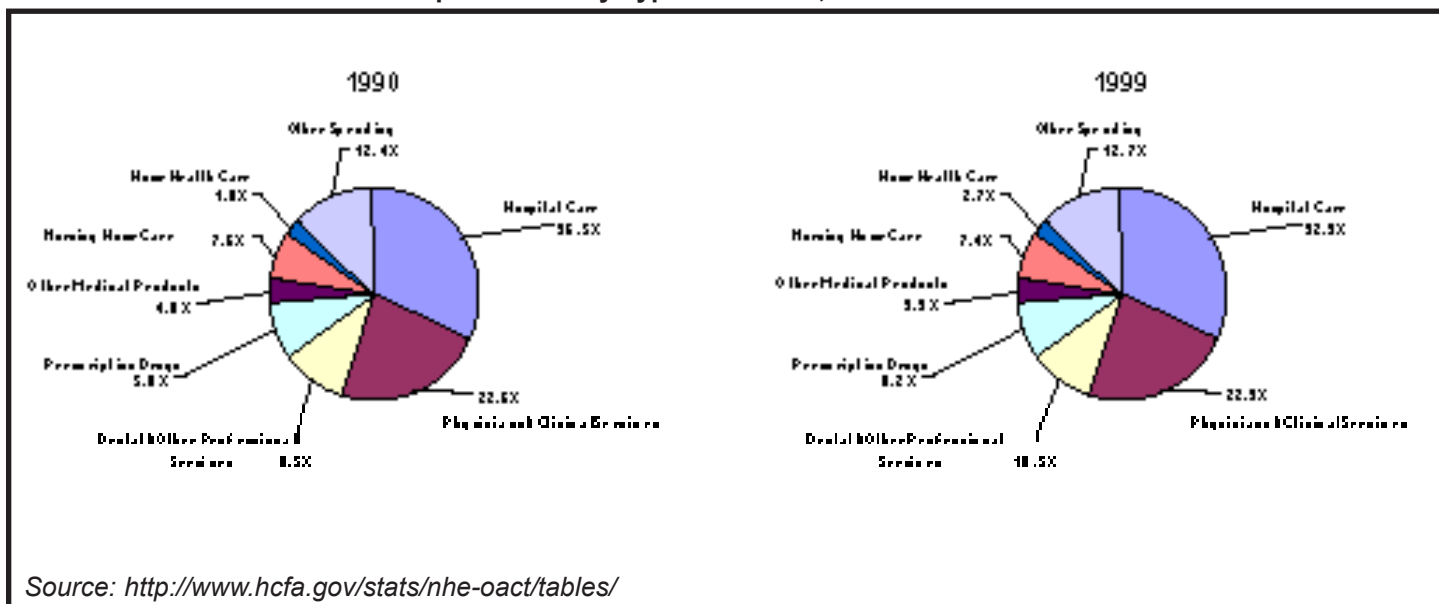
### **The Cost of Healthcare**

In 1970 the per capita national health expenditure was \$341 for a total of \$73.2 billion representing 7.1 percent of the gross domestic product. Projections of the Health Care Financing Administration (HCFA) for 2002 are for expenditures totaling \$1.54 trillion representing 13.9 percent of the gross domestic product (GDP). This equals an expenditure of \$5,415 per year for each person (*Health Affairs, Volume 20, Number 2, page 194*). Though the annual rate of growth has slowed since the 1980s, a sizeable portion of our economy is dedicated to the health care sector. HCFA has projected that health spending will account for 15.9 percent of the GDP by 2010. Where are those dollars going, and who is footing the bill?

The bulk of the expenditures are for hospital care and physician services, but note in the charts on the next page the decreasing percentage of hospital care and the corresponding increases in other categories, such as drugs and home health care, between 1990 and 1999.

Factors such as the increased use of managed care, changes in Medicare

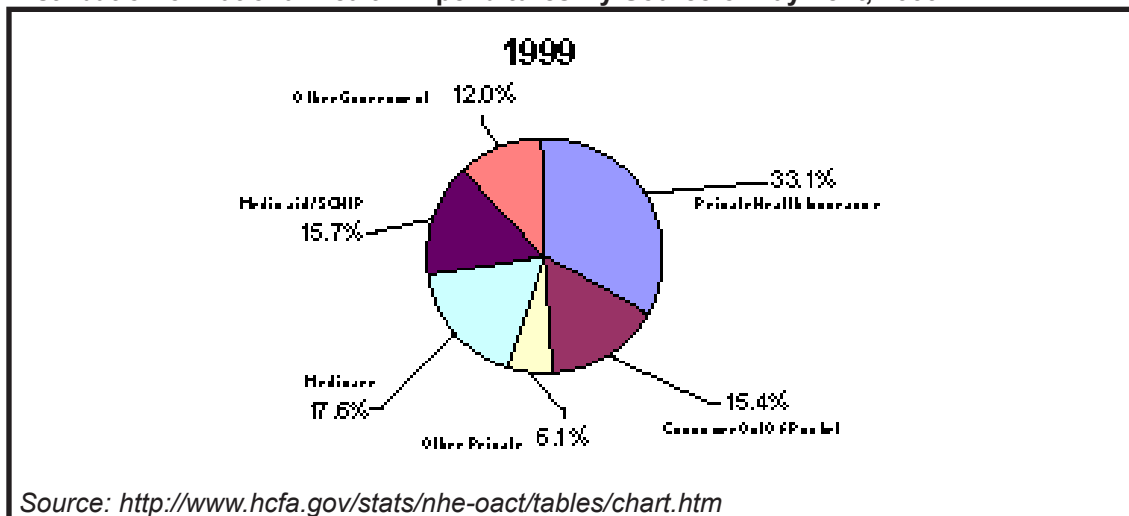
## Distribution of National Health Expenditures By Type of Service, 1990 vs. 1999



payment policies, the aging of the population, and the growth in demand for and availability of pharmaceuticals have, and will continue to, influence the distribution of health care spending.

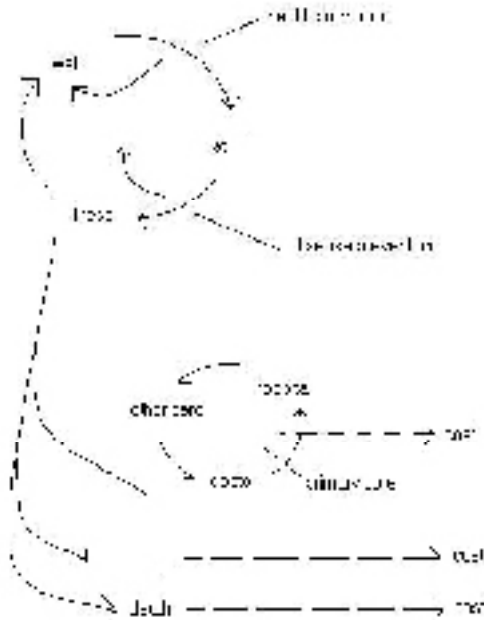
Whether the source of payment is through employer or personal health insurance, out of pocket expenses, or government sponsored programs such as Medicare and Medicaid, ultimately, health care is paid for by people. It is, how-

## Distribution of National Health Expenditures By Source of Payment, 1999



ever, instructive to look at the source of payments, as they will influence many of the payment and reimbursement policies that can impact the availability and ease of access to care. Following is a chart indicating the source of payments for expenditures in 1999:

In the U.S., the ability of medical science to produce almost endless ways to



diagnose, treat and monitor illnesses and the role of insurance in separating patients from the liability of paying have made costs for health care sky rocket. One way to look at cost takes into account medical expense, time lost from work, survivor benefits and similar factors.

The health-cost cycle is shown here.

In this illustration, the most effective cost saving approach is to avoid the large costs of sickness in the first place. Health promotion and disease prevention and better self-care are the hallmarks of this effort. The problem is that we live in a culture of illness, medical treatments, cures and diagnoses. Cultural change requires an effective education. The medical profession has not been sufficient to the task of this education.

What other mechanism is available to approach people on a personal basis, in the context of their daily lives, to provide information about health promotion and prevention that they understand and can use? The public health approach of laws and mass campaigns is effective and inexpensive. However, lifestyle disorders of cancer, heart disease, etc. are diseases of culture. A more personal, persistent educational approach is needed to assist individuals and families to take better care of themselves and make better health care decisions.

### How Is Healthcare Paid For?

A number of mechanisms, private and public, exist to facilitate the payment of health care services. First, let us look at a number of government sponsored programs.

## Medicare

Authorized in 1965 by Title XVIII of the Social Security Act, Medicare is a nationwide federally administered health insurance program.

Health insurance protection is available for the following eligible persons without regard to income:

- ❖ Persons 65 or older who are receiving or eligible for retirement benefits from Social Security or the Railroad Retirement Board;
- ❖ Persons under 65 who have received Social Security or Railroad Retirement disability benefits for 24 months; and
- ❖ Persons under 65 who have End-Stage Renal Disease.

Medicare is composed of two parts: Part A (hospital insurance, no cost to eligible enrollees) and Part B (medical insurance, \$50 monthly premium). The following chart provides an outline of benefits available with the traditional fee-for-service Medicare plan in 2001. Be aware that in some locations Medicare may be pro-

### Summary of Traditional Medicare Benefits for 2001

Part A	
Benefits	Beneficiary pays
Inpatient hospital Days 1-60 Days 61-90 60 lifetime reserve days	No coinsurance; deductible of \$792 \$198 a day \$396 a day
Skilled nursing facility* Days 1-20 Days 21-100 After 100 days	No coinsurance Up to \$99 a day No benefits
Home health*	No coinsurance 20% of approved amount for durable medical equipment
Hospice*	Small payment for outpatient drugs and inpatient respite care
Part B	
Benefits	Beneficiary pays
Deductible	\$100 a year
Physician and other medical services MD accepts assignment	20% coinsurance of Medicare approved amount
Outpatient hospital care	Coinsurance or fixed co-payment which may vary according to service
Ambulatory surgical facility services	20% coinsurance
Durable medical equipment (wheel chairs, hospital beds, oxygen, walkers)	20% coinsurance

Part B (continued)	
Benefits	Beneficiary pays
Outpatient Physical, Speech and Occupational Therapy	20% coinsurance
Clinical diagnostic laboratory services	No coinsurance
Home health care*	No coinsurance
Outpatient mental health services	50% coinsurance
Preventive services Flu shots; Pneumococcal vaccines; Colorectal cancer screenings; Prostate cancer screenings; Mammograms; Pap smears; Pelvic exams	See <i>Medicare and You</i> for coverage details. May or may not require 20% coinsurance and meeting of Part B deductible
Bone mass measurement, diabetes monitoring and self-management training	20% coinsurance

\*Certain conditions must be met for Medicare to cover these services

Source: <http://www.medicare.gov>, *Medicare and You 2001*, Health Care Financing Administration

vided through a managed care plan. These plans generally limit their enrollees to the use of doctors, hospitals and other providers in their network; however, they might provide additional benefits such as prescription drugs and eyeglasses. Approximately 85 percent of today's Medicare participants are enrolled in the traditional fee-for-service program (*Talking With Your Parents About Medicare and Health Coverage*, the Henry J. Kaiser Family Foundation, 1999).

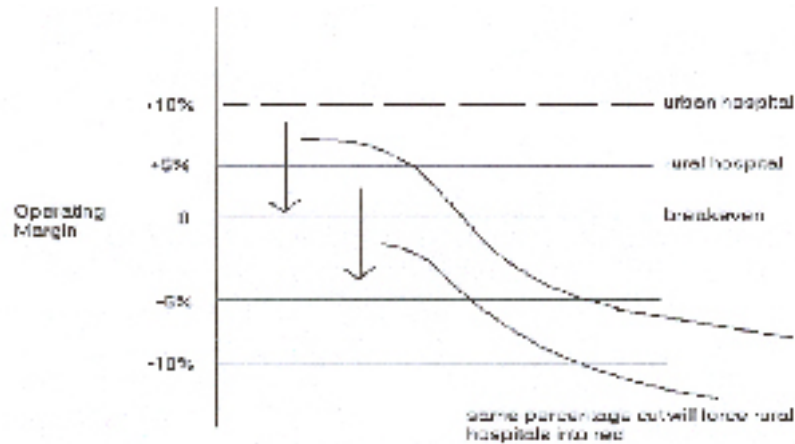
### **Medigap Policies**

Medigap plans are private health insurance policies available to Medicare beneficiaries to cover certain costs that would otherwise be paid by the beneficiary. Though these policies are commercial offerings, they are strictly regulated by federal requirements. A variety of Medigap plans exist to meet the individual needs of their subscribers; however, this variety is limited to 10 standardized plans. Some plans extend elements of the basic Medicare Part A and B benefits, and others include new benefits such as prescription drug coverage and foreign medical expenses. Though the 10 policies are standardized by coverage, rates will vary between states and by insurance carrier.

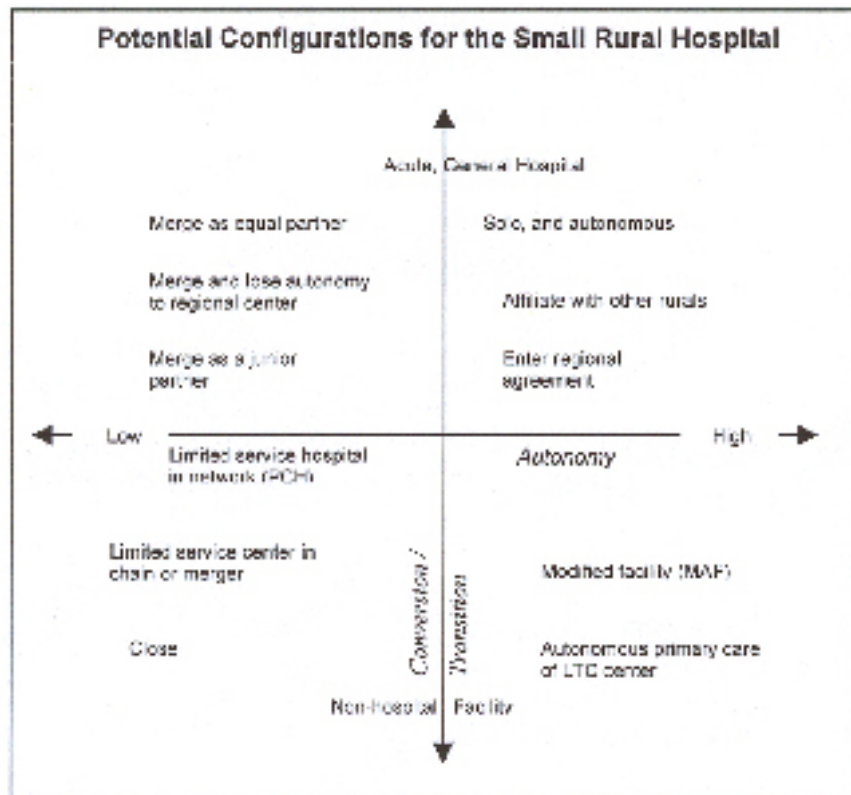
Whenever federal legislation changes Medicare payments to health care, institutions are targeted as the place to save large amounts of money. This is particularly hurtful to rural hospitals for several reasons. First, rural areas are more dependent on Medicare because of a greater proportion of elderly in the rural population. Second, rural hospitals are often the sponsors of other health care efforts that depend on Medicare so that Medicare cuts into the hospitals' cash flow from hospital and non-hospital services. Third, rural hospitals have fewer options for developing additional streams of cash flow. Finally, most rural hospitals operate with thinner margins of Medicare over expenses so that by design the budget cuts of the BBA will force many rural hospitals far into

the red.

Although attention is most often focused on the most dramatic changes — hospital closings — the real effects take place within the hospitals themselves, and in their communities. Rural hospitals are tightening their budgets and reconfiguring services. Some have opted to provide a wide continuum of



health care, from preventative care to long-term care. Some are converting to



Source: Tom Richetts, *Rural Health News*, Spring 1997

outpatient or long-term care facilities, with a minimal number of beds for acute inpatient care. Others are joining networks or affiliating with other hospitals, physicians or other providers. As the hospitals change, a community's health care may change along with its economic base and its structure of social services.

The chart below shows the infinite varieties of changes possible in a rural hospital. The horizontal axis indicates more or less acute care services.

### **Medicaid**

Authorized in 1965 by Title XIX of the Social Security Act, Medicaid pays for health care services of low-income individuals defined as medically or categorically needy. The categorically needy include the following low-income individuals:

- ❖ Aged poor
- ❖ Blind
- ❖ Disabled
- ❖ First-time pregnant women
- ❖ Families with dependent children

Some individuals qualify for Medicaid even when their annual income level exceeds the limits established for the categorically needy. These individuals, termed the medically needy, have very high expenses associated with their medical condition. The cost of care reduces their financial resources below established levels, thus qualifying their participation.

Medicaid is a federal/state cost share program based primarily on each state's per capita income. The federal government pays between 50 and 77 percent, and the states pay the balance. Broad general guidelines are established nationally. The states determine the benefits to be covered, program eligibility criteria, rates of payment for providers, and the method of administering the program. The inclusion of such optional services as prescription drugs, dental services, eyeglasses, and intermediate care facilities for the mentally retarded will vary significantly between states, whereas federally mandated services, such as family planning, will be available in all state Medicaid plans.

### **State Children's Health Insurance Program (CHIP)**

Authorized in 1997 by Title XXI of the Social Security Act, CHIP is the largest expansion of child health insurance since Medicaid was established in 1965. The plan was enacted to expand health insurance coverage for low-income children up to age 19. The plan covers children of the working poor as well as the unemployed.

CHIP is a voluntary program that enables states to provide health coverage for millions of uninsured children through a federal/state cost share arrange-



ment. The federal government has set aside \$24 billion over five years to help fund the program; state matching rates are at a lower percentage than those required for Medicaid. States may provide CHIP coverage by expanding Medicaid, establishing a new insurance program, or a combination of the two methods.

In 1998 approximately one in seven children had no health insurance; by 1999, 11.6 million children were without insurance. Federal CHIP regulations allow coverage for the following:

- ❖ Uninsured children in families with income above the Medicaid eligibility threshold but below 200 percent of the federal poverty level (the federal poverty level was set at \$17,650 for a family of four in 2001).

OR

- ❖ Uninsured children in families whose income is up to 50 percentage points over their state's current Medicaid income level for children (this results in states such as California and Rhode Island being able to provide coverage to children in families earning up to 250 percent of the federal poverty level)

States have chosen various income levels within the federal guidelines in determining eligibility for their individual CHIP programs. Federal regulations do, however, stipulate some uniform requirements regarding coverage. Though states are allowed to establish premium and copayment requirements, federal regulations set limits on the amount of patient out-of-pocket expenses. Cost sharing for well-baby, well-child or adolescent well visits, and immunizations are prohibited as well.

Federal funds have been allocated on both the national and state level for outreach efforts to increase the number of enrolled children. A toll-free number, 1-877-KIDS-NOW, automatically connects families anywhere in the country to their state's enrollment agency. Eligibility and state contact information can also be found on the web at <http://insurekidsnow.gov>. CHIP is a major step forward in improving the health of our children, but its success is dependent upon our ability to both enroll families and then assure that they have access to appropriate and timely care.

As we saw in the section on the cost of health care, government programs are the source of payment for much of our health services expenditures. However, approximately one-third of national health expenditures flow through private health insurance payments. The structure and policies of private insurance

plans, therefore, have a significant impact on how we receive care. As society seeks means to contain rising health expenditures, many of the methodologies used by private plans have been adopted by government-sponsored programs as well. Following is a brief review of some typical health plans.

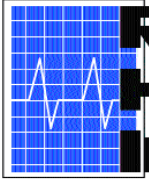
### **Health Maintenance Organizations (HMOs)**

An HMO is an organized system for the provision of a pre-determined set of basic and supplemental health maintenance and treatment services to its enrollees. Fees to the HMO are predetermined and prepaid. All covered services are delivered for this “capitated” payment. The payment is fixed and does not vary by the level, type or extent of actual services provided to an enrollee.

### **Preferred Provider Organizations (PPOs)**

A PPO is a system that incents insureds to select their healthcare providers from a designated group of physicians and hospitals. The incentives are usually in the form of reduced deductibles and copayments, broader coverage of services, or simplified claims filing. In contrast to typical HMO coverage, PPOs generally allow subscribers to use non-PPO providers, but without the incentives for in-network services. Providers participating in the PPO agree to accept the PPOs reimbursement structure and payment levels and other administrative requirements of the PPO.

Since 1847 when the first commercial insurance plan for accidents became available, many changes in the structure, breadth and degree of coverage have evolved. As we struggle to find ways to provide appropriate care to the greatest number, while controlling the growth of expenditures, new systems for the provision and payment of health services will surely emerge.



# **Rural Health Institute**

