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The American Health System – A primer

This issue brief will provide an overall description of the American health system. Our health system is a mixed government and private sector system which is heavily dominated by the private corporate health care sector. Especially because the private sector predominates, Americans spend twice as much on health care as people do in any other industrialized country; a significant number of Americans lack any health care coverage; and our system results in worse health care outcomes than do the systems in comparable industrialized nations.

Since 1965, the year that the United States enacted Medicare, Americans have seen yearly health care cost increases in excess of the growth of the rest of the economy. Health care's share of GDP went from 5 percent in 1960 to almost 18 % today with projections that it will rise to more than 20% by 2025.

A variety of factors have influenced this rapid and significant growth in cost including:

- Most significantly, Medicare and Medicaid were implemented initially without any effort to control costs, maximize quality, and/or encourage competition;
- The U.S. population has grown and so have the number and percentage of elderly people in the population;
- Key health care technologies with their related costs have increased;
- Allied health care professions have grown largely in response to dramatically improved technologies and other therapeutic options, particularly pharmaceuticals. CT scans, dialysis, angioplasty and medication to effectively treat blood pressure were all discovered in the past 50 years.

These factors have not significantly impacted the largely private American health delivery system. The American delivery system consists mostly of fixed structures providing inpatient care and different types of long term care, together with labor provided by a wide variety of health care professionals. Historically, physicians, in particular, could be independent actors in their relationships to the much more capital-intensive hospitals. However, in the last ten years, hospitals have gained significant political power over all health professionals. As a consequence, hospitals are hiring all types of health professionals to be part of increasingly powerful hospital systems. The hospital system itself is increasingly vertically integrated across all dimensions of health care including long term care. In addition, many hospital systems have recently merged with each other. Some have succeeded in their efforts to become virtual monopolies in their geographic markets.

While hospitals have succeeded in diminishing the role of private practice in the health professions, particularly physicians' private practices, large group practices still exist. Some of these large group practices, such as Kaiser, are also integrated delivery systems.

Many of these integrated delivery systems have become managed care organizations or MCOs. For the purposes of this issue brief, MCOs are defined as entities that not only commit to deliver care (either with health professionals on staff and/or though contractual relationships with private professionals in the community) but also to take on financial risk. These MCOs are assuming the insurance risk that in the past was traditionally assumed by insurance companies. In addition to MCOs assuming this risk, hospital systems are also increasingly assuming the insurance risk that was traditionally taken by commercial insurance companies.

It was the private sector that first introduced health insurance in the U.S. in the 1930s. The federal government only entered the health insurance system in 1965. when it introduced Medicare and Medicaid. The implementation of Medicare, in particular, contributed to the rise in health care costs because there was little effort until the 1980's to control health care costs and/or improve health care quality. While managed care organizations as defined above started almost 100 years ago, their presence in the insurance marketplace didn't accelerate till the 1990s. Now, with the exception of traditional Medicare, most Americans (in both private health insurance and Medicaid) are enrolled in some type of managed care organization (MCO). The largest of these, United Health Care, a private for-profit MCO, has over 100 million enrollees. MCOs combines insurance risk and contracts with

hospitals and health professionals to offer a complete health care network to prospective enrollees and/or consumers who are automatically enrolled.

The many companies that produce the technology needed by hospitals and health professionals to deliver care constitute the last dimension of the American health care system. Pharmaceutical companies, technology companies producing MRIs and other forms of durable medical equipment are among the many suppliers of these services. Despite efforts to control such costs, most of these attempts, especially those pertaining to pharmaceuticals, have come to naught.

Today, the American health care delivery system continues to be very costly and getting more so. Hospital systems continue to merge and attempt to create vertically and horizontally linked health care delivery systems. Many of these hospital systems have also taken on an insurance function. In so doing, hospital centered delivery systems are and attempting to freeze out insurance companies such as CIGNA, Humana and United Health Care. Many of these insurance companies such as United and Humana are in turn purchasing hospitals and medical group practices thus further blurring the lines between insurance and direct delivery of health care. Other issue briefs in this series highlight what can be done in response to these trends of ever increasing costs together with dramatic opportunities for quality improvement.