TABLE 7-1 The Complexity of Healthcare Delivery

Education/Research	Suppliers	Insurers	Providers	Payers	Government
Medical schools Dental schools Nursing programs Physician assistant programs Nurse practitioner programs Physical therapy, occupational therapy, speech therapy programs Research organizations Private foundations U.S. Public Health Service (Agency for Healthcare Research and Quality, Agency for Toxic Substances and Disease Registry, Centers for Disease Control and Prevention, Food and Drug Administration, Health Resources and Services Administration, Indian Health Service, National Institutes of Health, Substance Abuse and Mental Health Services Administration) Professional associations Trade associations	Pharmaceutical companies Multipurpose suppliers Biotechnology companies	Managed care plans Blue Cross/Blue Shield plans Commercial insurers Self-insured employers Medicare Medicaid Veterans Affairs Tricare	***Preventive care*** Health departments ***Primary care*** Physician offices Community health centers Dentists Nonphysician providers ***Subacute care*** Subacute care facilities Ambulatory surgery centers ***Acute care*** Hospitals ***Auxiliary services*** Pharmacists Diagnostic clinics X-ray units Suppliers of medical equipment ***Rehabilitative services*** Home health agencies Rehabilitation centers Skilled nursing facilities ***Continuing care*** Nursing homes ***End-of-life care*** Hospices ***Integrated*** Managed care organizations Integrated networks	Blue Cross/Blue Shield plans Commercial insurers Employers Third-party administrators State agencies	Public insurance financing Health regulations Health policy Research funding Public health

Description

The U.S. healthcare delivery system is massive, with total employment that exceeded 16.8 million people in 2020 in various health delivery settings (Kaiser Family Foundation, 2020). This number includes more than 8 million health practitioners and individuals in technical and healthcare support occupations (U.S. Bureau of Labor Statistics, n.d.). In 2020 registered nurses held approximately 3.1 million jobs with the majority (61%) employed in general medical and surgical hospital settings (U.S. Bureau of Labor Statistics, 2022). The vast array of healthcare institutions in the United States includes approximately 13,944 hospitals, 15,600 nursing homes, and 14,500 substance abuse treatment facilities (Bureau of Labor Statistics, 2020; Centers for Disease Control and Prevention, 2016; National Institute on Drug Abuse, 2018). In 2018, 1,375 federally qualified health center grantees provided preventive and primary care services to approximately 28.4 million people living in medically underserved rural and urban areas (Health Resources and Services Administration, 2018). Various types of healthcare professionals are trained in 180 medical and osteopathic schools (Association of American Medical Colleges, 2017), 67 dental schools (American Dental Association, n.d.), 141 schools of pharmacy (American Association of Colleges of Pharmacy, n.d.), and more than 1,500 nursing programs located throughout the country. Multitudes of government

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agencies are involved with the financing of health care, medical research, and regulatory oversight of the various aspects of the healthcare delivery system.

A Broad Description of the System

U.S. healthcare delivery does not function as a rational and integrated network of components designed to work together coherently. To the contrary, it is a kaleidoscope of financing, insurance, delivery, and payment mechanisms that remain loosely coordinated. Each of these basic functional components represents an amalgam of public (government) and private sources. Government-run programs finance and insure health care for select groups of people who meet each program's prescribed criteria for eligibility. To a lesser degree, government programs also deliver certain healthcare services directly to certain recipients, such as veterans, military personnel, American Indians/Alaska Natives, and some uninsured people. Nevertheless, financing, insurance, payment, and delivery functions largely remain in private hands.

The market-oriented economy in the United States attracts a variety of private entrepreneurs that pursue profits by facilitating the key functions of healthcare delivery. Employers purchase health insurance for their employees through private sources, and employees receive healthcare services delivered by the private sector. The government finances public insurance through Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) for a significant portion of the country's low-income, elderly, disabled, and pediatric populations. However, insurance arrangements for many publicly insured people are made through private entities, such as health maintenance organizations (HMOs), and healthcare services are rendered by private physicians and hospitals. This blend of public and private involvement in the delivery of health care has resulted in the following characteristics of the U.S. system:

- A multiplicity of financial arrangements for healthcare services
- Numerous insurance agencies or MCOs that employ various mechanisms for insuring against risk
- Multiple payers that make their own determinations regarding how much to pay for each type of service
- A diverse array of settings where medical services are delivered
- Numerous consulting firms offering expertise in planning, cost containment, electronic systems, quality, and restructuring of resources

There is little standardization in a system that is functionally fragmented and in which the various system components fit together only loosely. Because a central agency such as the government does not oversee the overall coordination of such a system, problems of duplication, overlap, inadequacy, inconsistency, and waste occur. Lack of systemwide planning, direction, and coordination leads to a complex and inefficient system. Moreover, the system as a whole does not lend itself to standard budgetary methods of cost control. Individual and corporate entities within a predominantly private entrepreneurial system seek to manipulate financial incentives to their own advantage, without regard to their impact on the system as a whole. Hence, cost containment remains an elusive goal.

In short, the U.S. healthcare delivery system is like a behemoth that is almost impossible for any single entity to manage or control. The United States consumes more healthcare

services as a proportion of its total economic output than any other country in the world. The U.S. economy is the largest in the world, and compared to other nations, consumption of healthcare services in the United States represents a greater proportion of the country's total economic output. Although the U.S. system can be credited for delivering some of the best clinical care in the world, it falls short of delivering equitable services to every American. It certainly fails in terms of providing cost-efficient services.

An acceptable healthcare delivery system should have two primary objectives: (1) enable all citizens to obtain needed healthcare services and (2) ensure that services are cost effective and meet certain established standards of quality. Although the U.S. healthcare delivery system falls short of both these basic ideals, the United States leads the world in providing the latest and the best in medical technology, training, and research. It also offers some of the most sophisticated institutions, products, and processes of healthcare delivery.

Basic Components of a Healthcare Delivery System

Figure 7-1 illustrates that a healthcare delivery system incorporates four functional components: financing, insurance, delivery, and payment. Hence, it is termed a *quad-function model*. Healthcare delivery systems differ depending on the arrangement of these components. The four functions generally overlap, but the degree of overlap varies between private and government-run systems and between traditional health insurance and managed care-based systems. In a government-run system, the functions are more closely integrated and may be indistinguishable. Managed care arrangements also integrate the four functions to varying degrees.

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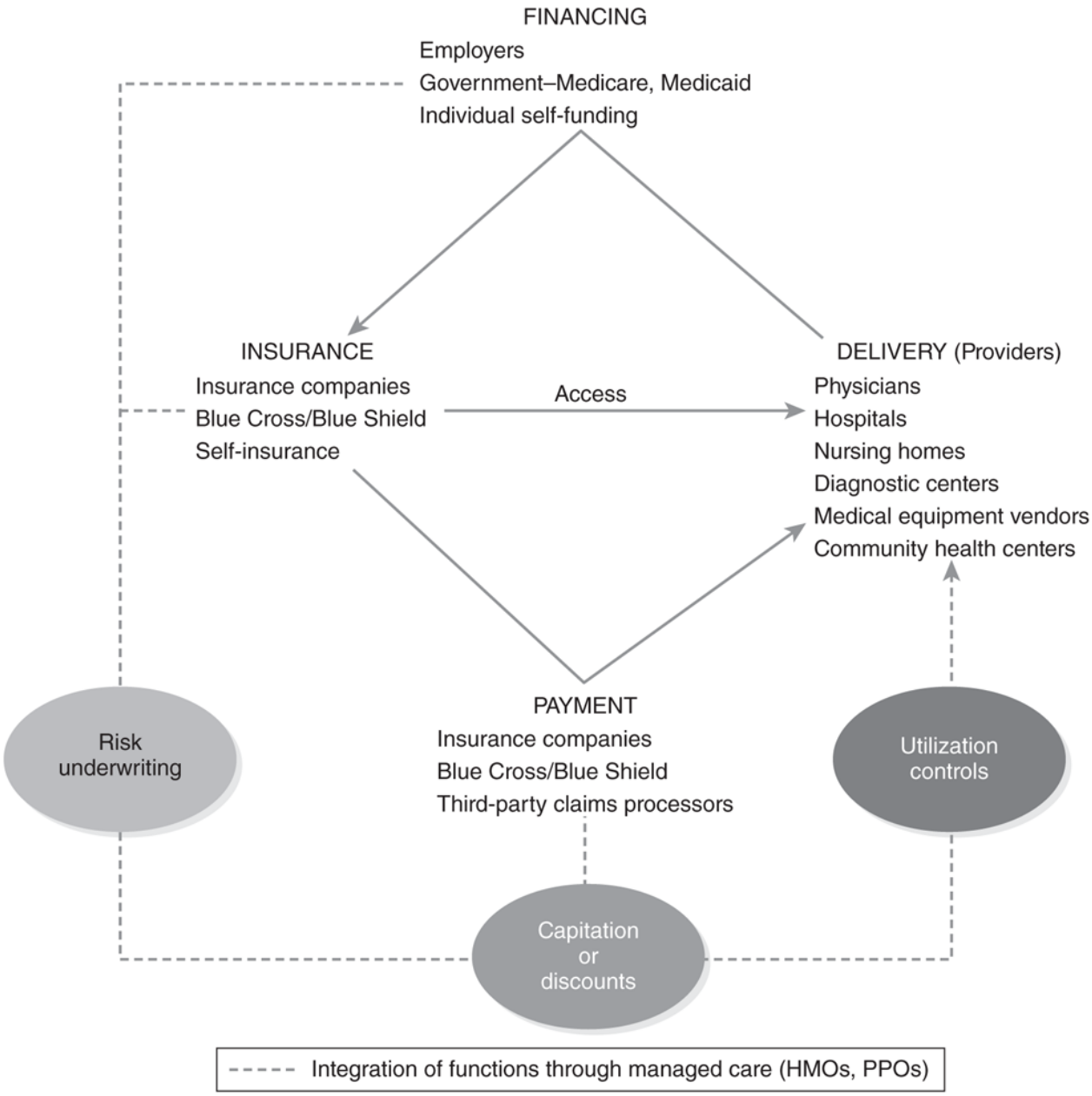

FIGURE 7-1 Basic healthcare delivery functions.

Description

Financing

Financing is necessary to obtain health insurance or to pay for healthcare services. For most privately insured Americans, health insurance is employment based; that is, employers finance health care as a fringe benefit for their employees. A dependent spouse or children may also be covered by the working spouse's or working parent's employer. Most employers purchase health insurance for their employees through an MCO or an insurance company selected by the employer. Small employers may or may not be in a position to afford health insurance coverage for their employees. In public programs, the government functions as the financier; the insurance function may be carved out to an HMO.

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Insurance

Insurance protects the insured against financial catastrophe by providing expensive healthcare services when needed. The insurance function determines the package of health services that the insured individual is entitled to receive. In addition, it specifies how and where healthcare services may be received. The MCO or insurance company also functions as a claims processor and manages the disbursement of funds to the healthcare providers.

Delivery

The term "delivery" refers to the provision of healthcare services by various providers. The term *provider* refers to any entity that delivers healthcare services and either independently bills for those services or is supported through tax revenues. Common examples of providers include physicians, nurse practitioners, dentists, optometrists, and therapists in private practices, hospitals, and diagnostic and imaging clinics, and suppliers of medical equipment (e.g., wheelchairs, walkers, ostomy supplies, oxygen). With few exceptions, most providers render services to people who have health insurance, and even those covered under public insurance programs receive healthcare services from private providers.

Payment

The payment function deals with *reimbursement* to providers for services delivered. The insurer determines how much is paid for a certain service. Funds for actual disbursement come from the premiums paid to the MCO or insurance company. At the time of service, the patient is usually required to pay an out-of-pocket amount, such as $25 or $30, to see a physician. The remainder is covered by the MCO or insurance company. In government insurance plans, such as Medicare and Medicaid, tax revenues are used to pay providers.

Insurance and Healthcare Reform

The U.S. government finances health benefits for certain special populations, including government employees, the elderly (people ages 65 years and older), people with disabilities, some people with very low incomes, and children from low-income families. The program for the elderly and certain disabled individuals, which is administered by the federal government, is called *Medicare*. The program for indigent people, which is jointly administered by the federal government and state governments, is named *Medicaid*. The program for children from low-income families, another federal–state partnership, is called the Children's Health Insurance Program.

However, the predominant employment-based financing system in the United States has left some employed individuals uninsured for two main reasons. First, some small businesses simply cannot get group insurance at affordable rates and, therefore, are not able to offer health insurance as a benefit to their employees. Second, in some work settings, participation in health insurance programs is voluntary, so employees are not required to join. Some employees choose not to sign up, mainly because they cannot afford the cost of health insurance premiums. Employers rarely pay 100% of the insurance premium; instead, most require their employees to pay a portion of the cost. This is called *premium cost sharing*. Self-employed people and other individuals who are not covered by employer-based plans have to obtain health insurance on their own. Individual rates are

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typically higher than group rates available to employers. In the United States, working people earning low wages have been the most likely to be uninsured because most cannot afford premium cost sharing and are not eligible for public benefits.

A further vulnerability under employment-based insurance becomes evident when a crisis slows down or even stops business, such as what occurred during the COVID-19 pandemic. As a result of economic pressures, companies may have to lay off large numbers of employees to remain solvent. Those unemployed will soon lose insurance coverage because it is tied to the employer. The disruption in insurance coverage is especially damaging because the newly uninsured face challenges in accessing needed care, including care related to the crisis itself, such as testing and treatment for the coronavirus.

In the U.S. context, *healthcare reform* refers to the expansion of health insurance to cover the *uninsured*—those without private or public health insurance coverage. The Patient Protection and Affordable Care Act of 2010, more commonly known as the Affordable Care Act (ACA), was the most sweeping healthcare reform in recent U.S. history. One of the main objectives of the ACA was to reduce the number of uninsured. The ACA was rolled out gradually starting in 2010, when insurance companies were mandated to start covering children and adults younger than age 26 under their parents' health insurance plans. Most other insurance provisions went into effect on January 1, 2014, except for a mandate for employers to provide health insurance, which was postponed until 2015. The ACA required that all U.S. citizens and legal residents must be covered by either public or private insurance. The law also relaxed standards to qualify additional numbers of people for Medicaid, although many states chose not to implement the Medicaid expansion based on a 2012 ruling by the U.S. Supreme Court.

Under the ACA, individuals without private or public insurance had to obtain health insurance from participating insurance companies through Web-based, government-run exchanges; if they failed to do so, they had to pay a tax. The exchanges—also referred to as health insurance marketplaces—would determine whether an applicant qualified for Medicaid or CHIP programs. If an applicant did not qualify for a public program, the exchange would enable the individual to purchase a government-approved health plan offered by private insurers through the exchange. Federal subsidies enabled low-income people to partially offset the cost of health insurance.

A predictive model developed by Parente and Feldman (2013) estimated that, at best, full implementation of the ACA would reduce the number of uninsured by more than 20 million. Nevertheless, by its own design, the ACA failed to achieve *universal coverage* that would enable all citizens and legal residents to have health insurance.

By March 2015, approximately 16.5 million uninsured Americans had gained health insurance coverage due to the Affordable Care Act ("Impact of Obamacare on Coverage," 2016). By 2016, an estimated 20 million had gained coverage (Uberoi et al., 2016), and by 2022, 39 states and the District of Columbia had expanded Medicaid through the ACA's provisions (Kaiser Family Foundation, 2022). The uninsured rate declined among all race/ethnicity categories, with the greatest decreases seen among African Americans and Hispanics, compared to Whites (Uberoi et al., 2016). The uninsured rate declined from 22.4% to 10.6% among African Americans, from 41.8% to 30.5% among Hispanics, and from 14.3% to 7.0% among Whites (Uberoi et al., 2016). Additionally, women experienced a greater decline in their uninsured rate (49.7% decline) compared to men (37.6% decline). Specifically, the uninsured rate among women decreased from 18.9% to 9.5%, whereas the

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uninsured rate among men decreased from 21.8% to 13.6% (Uberoi et al., 2016). Despite these gains, however, the ACA left more than 27.3 million Americans uninsured in 2016 (Cohen et al., 2016).

During his first week in office in January 2017, President Donald Trump signed an Executive Order to repeal and replace the ACA (commonly referred to as Obamacare) in an effort to minimize the ACA's economic and regulatory burdens and to waive any requirement imposing a fiscal burden on states or families, individuals, healthcare providers, insurers, or other parties. By 2019, the Trump administration was able to alter significant portions of the ACA through administrative means (Simmons-Duffin, 2019). As a result, the number of uninsured soared. From 2017 to 2018, the number of uninsured grew by almost 500,000 people for the second year in a row (Tolbert et al., 2019).

Role of Managed Care

Under traditional insurance, the four basic health delivery functions have been fragmented in the United States; with few exceptions, the financiers, insurers, providers, and payers have been different entities. However, during the 1990s, healthcare delivery in the country underwent a fundamental change involving a tighter integration of the basic functions through managed care.

Previously, fragmentation of the four functions meant a lack of control over utilization and payments. The quantity of health care consumed refers to *utilization* of health services. Traditionally, determination of the utilization of health services and the price charged for each service had been left up to the insured individuals and the providers of health care. However, due to rising healthcare costs, current delivery mechanisms have instituted some controls over both utilization and price.

Managed care is a system of healthcare delivery that (1) seeks to achieve efficiency by integrating the four functions of healthcare delivery discussed earlier, (2) employs mechanisms to control (manage) utilization of medical services, and (3) determines the price of services and, consequently, how much the providers are paid. The primary financier is still the employer or the government. Instead of purchasing health insurance through a traditional insurance company, the employer contracts with an MCO, such as an HMO or a preferred provider organization (PPO), to offer a selected health plan to its employees. In this case, the MCO functions like an insurance company and promises to provide healthcare services contracted under the health plan to the enrollees of the plan. The term *enrollee* (member) refers to the individual covered under the plan. The contractual arrangement between the MCO and the enrollee—including the collective array of covered health services that the enrollee is entitled to—is referred to as the *health plan* (or "plan," for short). The health plan uses selected providers from whom the enrollees can choose to receive services.

Compared with health services delivery under fee-for-service plans, managed care was successful in accomplishing cost control and greater integration of healthcare delivery. By ensuring access to needed health services, emphasizing preventive care, and maintaining a broad provider network, managed care can implement effective cost-saving measures without compromising access and quality, thereby achieving a healthcare budget predictability unattainable by other kinds of healthcare delivery.

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Major Characteristics of the U.S. Healthcare System

In any country, certain external influences shape the basic character of the health services delivery system. These forces consist of the national political climate, economic development, technological progress, social and cultural values, physical environment, population characteristics (i.e., demographic and health trends), and global influences (**Figure 7-2**). The combined interactions of these environmental forces influence the course of healthcare delivery.

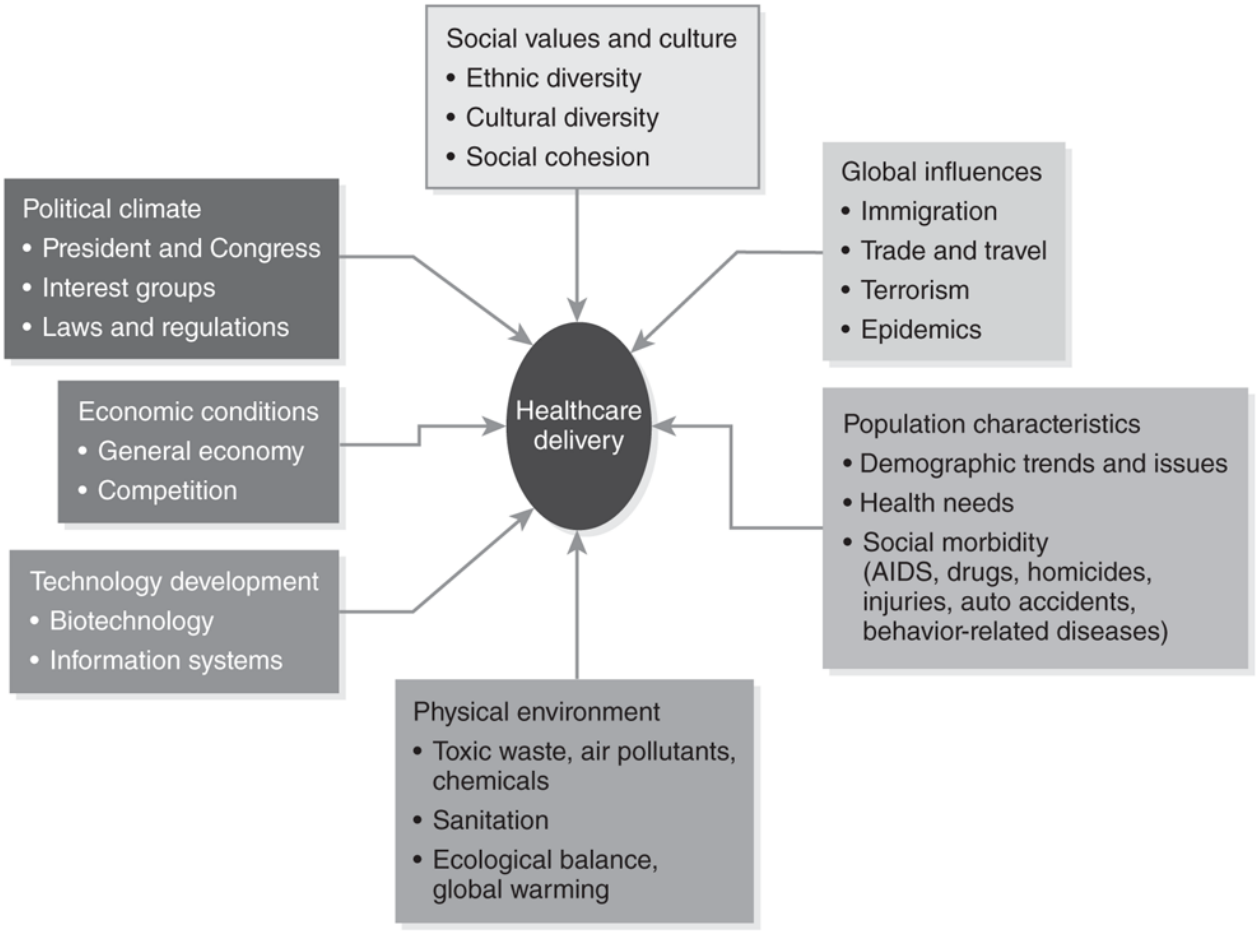

FIGURE 7-2 External forces affecting healthcare delivery.

Description

Ten basic characteristics differentiate the U.S. healthcare delivery system from most other countries:

1. No central agency governs the system.
2. Access to healthcare services is selectively based on insurance coverage.

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3. Health care is delivered under imperfect market conditions.
4. Insurers from a *third party* act as intermediaries between the financing and delivery functions.
5. The existence of multiple payers makes the system cumbersome.
6. The balance of power among various players prevents any single entity from dominating the system.
7. Legal risks influence the practice behavior of physicians.
8. Development of new technology creates an automatic demand for its use.
9. New service settings have evolved along a continuum.
10. Quality and value are fast becoming the hallmarks of care delivery.

No Central Agency

Unlike healthcare systems in most developed nations, the U.S. healthcare system is not administratively controlled by a department or agency. Most other developed nations have a national healthcare program in which citizens are entitled to receive a defined set of healthcare services. To control costs, these systems use *global budgets* that determine total healthcare expenditures on a national scale and allocate resources within budgetary limits. As a consequence, both availability of services and payments to providers are subject to budgetary constraints. The governments of these nations also control the proliferation of healthcare services, especially costly medical technology. Systemwide controls over the allocation of resources determine the extent to which government-sponsored healthcare services are made available to citizens. For instance, the availability of specialized services is restricted.

By contrast, the United States has a highly private system of financing and delivery. Private health insurance, predominantly through employers, accounts for approximately 28% of total healthcare expenditures; the government finances another 36% (Centers for Medicare and Medicaid Services, 2021). Private delivery of health care means that the majority of hospitals and physician clinics are private businesses, which operate independently of the government. No central agency monitors total expenditures through global budgets or controls the availability and utilization of services. Nevertheless, federal and state governments play important roles in healthcare delivery. They determine public-sector expenditures and reimbursement rates for services provided to Medicare, Medicaid, and CHIP beneficiaries. The federal government also formulates *standards of participation* through health policy and regulation, meaning providers must comply with the standards established by the government to be certified to provide services to Medicare, Medicaid, and CHIP beneficiaries. Certification standards are regarded as minimum standards of quality in most sectors of the healthcare industry.

Partial Access

Access means the ability of an individual to obtain healthcare services when needed, which is not the same as having health insurance. Americans can access healthcare services if they (1) have health insurance through their employers, (2) are covered under a government healthcare program, (3) can afford to buy insurance with their own private funds, (4) are able to pay for services privately, or (5) can obtain charity or subsidized care.

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Health insurance is the primary means for ensuring access. Although the uninsured can access certain types of services, they often encounter barriers to obtaining needed health care. For example, although federally supported health centers provide physician services to anyone regardless of ability to pay, such centers and free clinics are located only in certain geographic areas and provide limited specialized services. However, under U.S. law, hospital emergency departments are required to evaluate a patient's condition and render medically needed services for which the hospital does not receive any direct payments unless the patient is able to pay. Therefore, even uninsured individuals are able to obtain medical care for acute illness. Although one can say that the United States does have a form of universal catastrophic health insurance, it does not guarantee the uninsured access to continual basic and routine care, commonly referred to as *primary care* (Altman & Reinhardt, 1996).

Countries with national healthcare programs provide universal coverage. However, even in these countries, access to services may be restricted because no healthcare system has the capacity to deliver every type of service on demand. Hence, *universal access*—the ability of all citizens to obtain health care when needed—remains mostly an aspirational concept.

As previously mentioned, having coverage does not necessarily equate to having access. The cost of insurance and care and availability of services have continued to present barriers to receiving healthcare services in a timely manner.

Imperfect Market

Though the U.S. healthcare delivery system is largely in private hands, this system is only partially governed by free-market forces. The delivery and consumption of health care in the United States do not quite pass the basic test of a *free market*, so the system is best described as a quasi-market or an imperfect market.

In a free market, patients (buyers) and providers (sellers) act independently, with patients able to choose services from any provider. Providers do not collude to fix prices, and prices are not fixed by an external agency. Rather, prices are governed by the free and unencumbered interaction of the forces of supply and demand (**Figure 7-3**). *Demand*—the quantity of health care purchased—is driven by the prices prevailing in the free market. Under free-market conditions, the quantity demanded will increase as the price for a given product or service declines. Conversely, the quantity demanded will decrease as the price increases.

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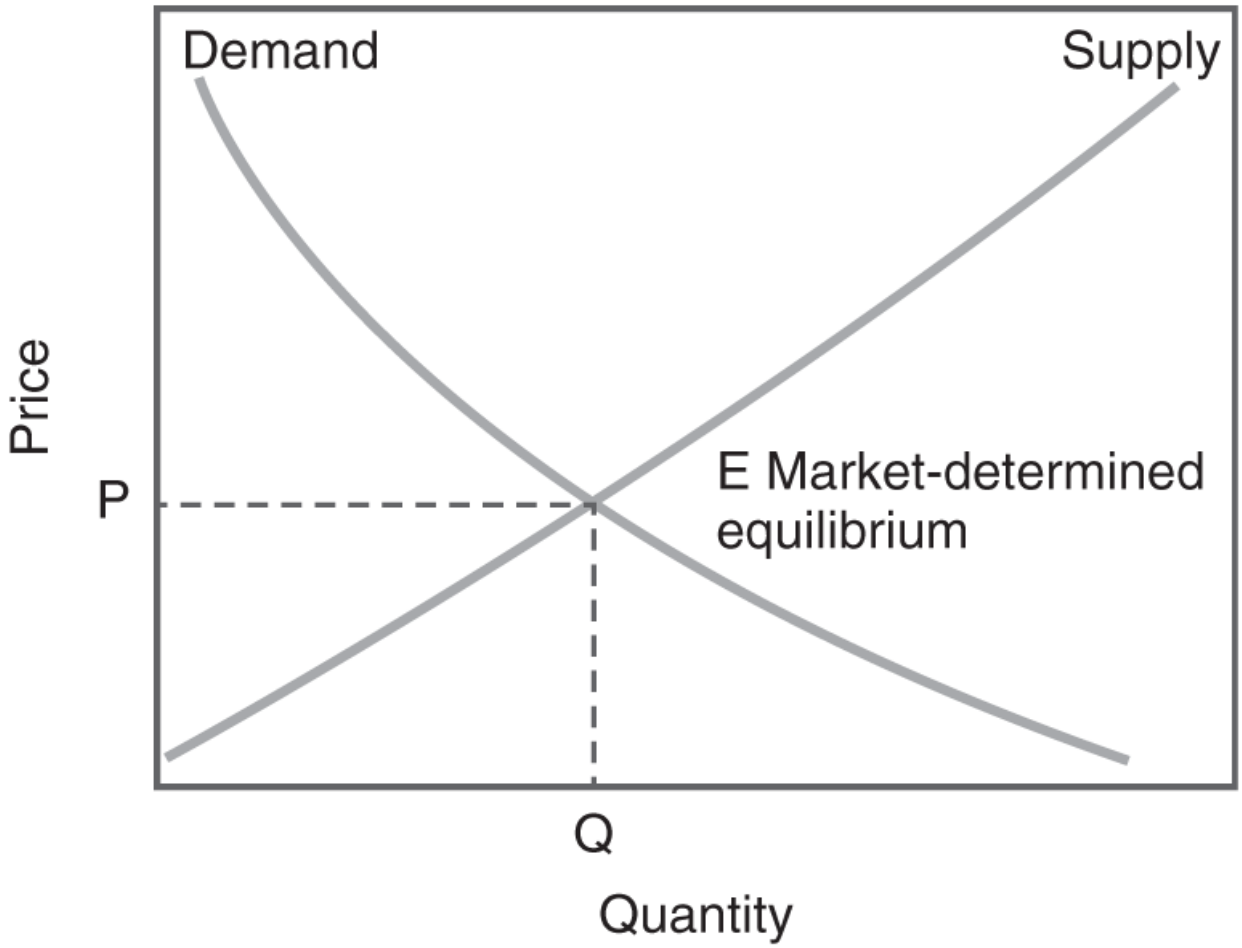

FIGURE 7-3 Relationship between price, supply, and demand under free-market conditions.

Note: Under free-market conditions, there is an inverse relationship between the quantity of medical services demanded and the price of medical services. That is, quantity demanded goes up when the prices go down, and vice versa. In contrast, there is a direct relationship between price and the quantity supplied by the providers of care. In other words, providers are willing to supply higher quantities at higher prices, and vice versa. In a free market, the quantity of medical care that patients are willing to purchase, the quantity of medical care that providers are willing to supply, and the price reach a state of equilibrium. This equilibrium is achieved without the interference of any nonmarket forces. However, these conditions exist only under free-market conditions, which are not characteristic of the U.S. healthcare market.

Description

At first glance, it might appear that multiple patients and providers do exist. Most patients in the United States, however, are now enrolled in either a private health plan or one or more government-sponsored programs. These plans act as intermediaries for the patients, and the enrollment of patients into health plans has the effect of shifting power from the patients to the administrators of the plans. The result is that the health plans—not the patients—are the real buyers in the healthcare services market. Private health plans, in many instances, offer their enrollees a limited choice of providers rather than an open choice.

Theoretically, prices are negotiated between the payers and providers. In practice, prices are determined by payers, such as MCOs, Medicare, and Medicaid. Because prices are set

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by agencies external to the market, they are not governed by the unencumbered forces of supply and demand.

For the healthcare market to be free, unrestrained competition must occur among providers based on price and quality. However, the consolidation of buying power in the hands of private health plans has forced many providers to form alliances and integrated delivery systems on the supply side. In certain geographic sectors of the country, a single giant medical system has taken over as the sole provider of major healthcare services, restricting competition. As the overall U.S. healthcare system continues to move in this direction, it appears that only in large metropolitan areas will there be more than one large integrated system competing to get the business of the health plans.

A free market requires that patients have information about the appropriateness of various services to their needs. Such information is difficult to obtain because technology-driven medical care has become highly sophisticated. Knowledge about new diagnostic methods, intervention techniques, and more effective drugs is part of the domain of the professional physician, not the patient. Moreover, because medical interventions are commonly required in a state of urgency, patients have neither the skills nor the time and resources to obtain accurate information when needed. Channeling all healthcare needs through a primary care provider can reduce this information gap when the primary care provider acts as the patient's advocate or agent. In recent years, consumers have been seizing some measure of control over the flow of information: the Internet is becoming a prominent source of medical information for patients, and medical advertising is influencing consumer expectations.

In a free market, patients must directly bear the cost of services received. The purpose of insurance is to protect against the risk of unforeseen catastrophic events. Because the fundamental purpose of insurance is to reimburse major expenses when unlikely events occur, having insurance for basic and routine health care undermines the principle of insurance. When you buy home insurance to protect your property against the unlikely event of a fire, you do not anticipate the occurrence of a loss. The probability that you will suffer a loss by fire is very small. If a fire does occur and causes major damage, insurance will cover the loss—but insurance does not cover routine wear and tear on the house, such as chipped paint or a leaky faucet. However, unlike other types of insurance, health insurance generally covers basic and routine services that are predictable. Coverage for minor services, such as colds and coughs, earaches, and so forth, amounts to prepayment for such services. In this sense, health insurance has the effect of insulating patients from the full cost of health care. This situation may also create a *moral hazard* in that, once enrollees have purchased health insurance, they may use more healthcare services than if they were to pay for these services on an out-of-pocket basis.

At least two additional factors limit patients' ability to make decisions in the healthcare system. First, decisions about the utilization of health care are often determined by need rather than by price-based demand. *Need* has been defined as the amount of medical care that medical experts believe a person should have to remain or become healthy (Feldstein, 1993). Second, the delivery of health care can itself create demand. This follows from self-assessed need, which, coupled with moral hazard, leads to greater utilization, producing an artificial demand because prices are not taken into consideration. Practitioners who have a financial interest in additional treatments may also create artificial demand (Hemenway & Fallon, 1985), a scenario referred to as *provider-induced demand*, or supplier-induced demand. Functioning as patients' agents, physicians exert enormous

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influence on the demand for healthcare services (Altman & Wallack, 1996). Demand creation occurs when physicians prescribe medical care beyond what is clinically necessary—for example, by making more frequent follow-up appointments than necessary, prescribing excessive medical tests, or performing unnecessary surgery (Santerre & Neun, 1996).

In a free market, patients have information on the price and quality of each provider. The current system, however, has drawbacks that obstruct information-seeking efforts. Item-based pricing is one such hurdle. Surgery is a good example that illustrates item-based (also known as fee-for-service) pricing. Patients can generally find information on the fees the surgeon would charge for a particular operation. But the final bill, after the surgery has been performed, is likely to include charges for supplies, use of the hospital's facilities, and services performed by other providers, such as anesthesiologists, nurse anesthetists, and pathologists. These providers, sometimes referred to as *phantom providers*, function in an adjunct capacity and bill for their services separately. Item billing for such additional services, which sometimes cannot be anticipated, makes it extremely difficult to ascertain the total price before services have actually been received.

Package pricing can help overcome these drawbacks, but it has made relatively little headway as a means of pricing medical procedures. *Package pricing* refers to a bundled fee charged for a package of related services. In the surgery example, this would mean one all-inclusive price for the surgeon's fees, hospital facilities, supplies, diagnostics, pathology, anesthesia, and postsurgical follow-up.

Third-Party Insurers and Payers

Insurance often functions as the intermediary among those who finance, deliver, and receive health care. The insurance intermediary does not have an incentive to be the patient's advocate on either price or quality. At best, employees can air their dissatisfactions with the plan to their employer, which has the power to discontinue the current plan and choose another company. In reality, however, employers may be reluctant to change plans if the current plan offers lower premiums than a different plan.

Multiple Payers

A national healthcare system is sometimes referred to as a *single-payer system* because it features one primary payer, the government. When delivering services, providers send the bill to a government agency, which subsequently sends payments to each provider. By contrast, the United States has a multiplicity of health plans. Multiple payers often represent a billing and collection nightmare for the providers of services, and they make the system more cumbersome in several ways:

- It is extremely difficult for providers to keep tabs on numerous health plans. It is challenging for providers to keep up with which services are covered under each plan and how much each plan will pay for those services.
- Providers must hire claims processors to bill for services and monitor receipt of payments. Billing practices are not standardized, and each payer establishes its own format.

- Payments can be denied for not precisely following the requirements set by each payer.
- Denied claims necessitate rebilling.
- When only partial payment is received, some health plans may allow the provider to *balance bill* the patient for the amount the health plan did not pay—that is, the difference between provider charges and insurance payment. Other plans prohibit balance billing. Even when the balance billing option is available to the provider, it triggers a new cycle of billings and collection efforts.
- Providers must sometimes engage in lengthy collection efforts, including writing collection letters, turning delinquent accounts over to collection agencies, and finally writing off as bad debt amounts that cannot be collected.
- Government programs have complex regulations for determining whether payment is made for services actually delivered. Medicare, for example, requires that each provider maintain lengthy documentation on services provided. Medicaid is known for lengthy delays in paying providers.

It is generally believed that the United States spends far more on *administrative costs*—costs associated with billing, collections, bad debts, and maintaining medical records—than do the national healthcare systems in other countries (Himmelstein, 2014; Himmelstein et al., 2020).

Power Balancing

The U.S. healthcare system involves multiple players, not just multiple payers. The key players in the system have traditionally been physicians, administrators of health service institutions, insurance companies, large employers, and the government. Big business, labor, insurance companies, physicians, and hospitals make up the powerful and politically active special-interest groups represented before lawmakers by high-priced lobbyists. Each set of players has its own economic interests to protect. Physicians, for instance, want to maintain their incomes and have minimum interference with the way they practice medicine; institutional administrators seek to maximize reimbursement from private and public insurers; insurance companies and MCOs are interested in maintaining their share of the health insurance market; large employers want to contain the costs they incur providing health insurance to their employees; the government tries to maintain or enhance existing benefits for those covered under public insurance programs and simultaneously contain the cost of providing these benefits. The problem is that the self-interests of different players are often at odds. For example, providers seek to increase government reimbursement for services delivered to Medicare, Medicaid, and CHIP beneficiaries, but the government wants to contain cost increases. Employers dislike rising health insurance premiums. Health plans, under pressure from the employers, may limit fees for the providers, who then resent these cuts.

The fragmented self-interests of the various players produce competing forces within the system. In an environment that is rife with motivations to protect conflicting self-interests, achieving comprehensive systemwide reform has proved next to impossible, and cost containment has remained a major challenge. Consequently, the approach to healthcare reform in the United States has been characterized as incremental or piecemeal, and the focus of reform initiatives has been confined to health insurance

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coverage and payment cuts to providers rather than focusing on better provision of health care.

Litigation Risks

The United States is a litigious society. Motivated by the prospects of enormous jury awards, many Americans are quick to drag an alleged offender into a courtroom at the slightest perception of incurred harm. Private healthcare providers, too, have become increasingly susceptible to litigation, and the risk of malpractice lawsuits is a real consideration in the practice of medicine. To protect themselves against the possibility of litigation, practitioners may engage in *defensive medicine*, the practice of prescribing additional diagnostic tests, scheduling return checkup visits, and maintaining copious documentation. Many of these additional efforts may be unnecessary, costly, and inefficient.

High Technology

The United States has long been a hotbed of research and innovation in new medical technology. The resulting growth in science and technology often creates demand for new services despite shrinking resources to finance sophisticated care. People generally equate high-tech care with high-quality care. They want "the latest and the best," especially when health insurance will pay for new treatments. Physicians and technicians want to try the latest gadgets. Hospitals compete on the basis of having the most modern equipment and facilities. Once capital investments in these new services are made, those costs must be recouped through utilization. Legal risks for providers and health plans may also play a role in discouraging denial of new technology. Thus, several factors promote the use of costly new technology once it is developed.

Continuum of Services

Medical care services are classified into three broad categories: curative (i.e., drugs, treatments, and surgeries), restorative (i.e., physical, occupational, and speech therapies), and preventive (i.e., prenatal care, mammograms, and immunizations). Healthcare settings are no longer confined to the hospital and the physician's office. Additional settings, such as home health, subacute care units, and outpatient surgery centers, have emerged in response to the changing configuration of economic incentives. **Table 7-2** describes the continuum of healthcare services. The healthcare continuum in the United States remains lopsided, with a heavier emphasis on specialized services than on preventive services, primary care, and management of chronic conditions.

TABLE 7-2 The Continuum of Healthcare Services

Types of Health Services	Delivery Settings
Preventive care	Public health programs Community programs Personal lifestyles Primary care settings

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Primary care	Physician's office or clinic Community health centers Self-care Alternative medicine
Specialized care	Specialist provider clinics
Chronic care	Primary care settings Specialist provider clinics Home health Long-term care facilities Self-care Alternative medicine
Long-term care	Long-term care facilities Home health
Subacute care	Special subacute units (hospitals, long-term care facilities) Home health Outpatient surgical centers
Acute care	Hospitals
Rehabilitative care	Rehabilitation departments (hospitals, long-term care facilities) Home health Outpatient rehabilitation centers
End-of-life care	Hospice services provided in a variety of settings

Quest for Quality and Value

Even though the definition and measurement of quality in health care are not as clear-cut as they are in other industries, the delivery sector of health care has come under increased pressure to develop quality standards and demonstrate compliance with those standards. There are higher expectations for improved health outcomes at the individual and community levels. The concept of continual quality improvement has also received much emphasis in managing healthcare institutions.

As an example, the accountable care organization (ACO) model advocated by the Centers for Medicare and Medicaid Services (CMS) and the Center for Medicare and Medicaid Innovation aims at improving the quality of patient care while maintaining or reducing expenditures for Medicare services. This model rewards ACOs that can lower their healthcare spending growth while fulfilling quality of care performance standards with additional Medicare payments; conversely, it penalizes those that overspend their expected limit.

Another example of the quest for quality and value is value-based health care (VBHC), which provides financial incentives for achieving specified health outcomes. Bundled-payment models and pay-for-performance (P4P) models are two applications of VBHC. Bundled-payment models, such as the Bundled Payment for Care Improvement Initiative under Medicare, target specific treatments or conditions. P4P models provide incentives

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for measurable value, as is the case with the Hospital Value-Based Purchasing Program. To achieve high-value care, VBHC not only needs to incentivize high-quality care in conditions or treatments that can be measured but also stimulate cost-conscious behavior, well-coordinated care, and preventive aspects (Cattel & Eijkenaar, 2019).

Trends and Directions

Since the 1980s, the U.S. healthcare delivery system has continued to undergo fundamental shifts in emphasis, summarized in **Figure 7-4**. Other chapters discuss these transformations in greater detail and focus on the factors driving them.

FIGURE 7-4 Trends and directions in healthcare delivery.
Description

One major shift in emphasis has been toward the implementation of integrated delivery systems (IDS). In a healthcare system plagued by fragmentation and lack of coordination, patients and providers alike seek to coordinate care more efficiently, create smoother transitions, reduce overlap, and control costs. Integrated delivery has emerged as an important component of healthcare delivery, particularly for patients with comorbidities. It has proven to have positive effects on cost and quality and is gradually being incorporated into various healthcare systems across the country.

Examples of integration include single-specialty group practices, where physicians with a common specialty (e.g., cardiology) come together to form an alliance; multispecialty group practices, where primary and specialty care physicians share common

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administrative oversight and resources as they make referrals to patients to receive other services within the organization; virtual physician networks, where the Internet is used to facilitate access to physicians remotely particularly for rural and underserved communities; physician–hospital organizations, where hospitals and their affiliated physicians form a partnership to contract health plans; management services organizations, where administrative and infrastructure support services are provided to contracted physicians; and clinically integrated networks, where physicians, hospitals, and providers form a joint venture and provide integrated services (Heeringa et al., 2020). The core functions of IDS are to provide comprehensive healthcare services, be accountable for the cost of the services and outcomes for patients, and improve healthcare coordination and integration. Well-known integrated delivery systems include Kaiser Permanente, Mayo Clinic, and Cleveland Clinic.

Another shift in trends has been toward the concept of pay-for-value. Pay-for-value, as the name implies, is a method of payment in which providers are reimbursed based on the quality of health care they deliver. A few studies indicate that pay-for-value systems have, on average, reduced hospital readmissions and improved emergency department use. However, other strategies that have been used to implement such a system have generated mixed results (Cross et al., 2017; Cross et al., 2019; Rosenthal et al., 2016). Many of these mixed results can be attributed to the fact that pay-for-value systems are as various and diverse in their approaches as the settings in which they have been implemented, and this heterogeneity in turn leads to heterogeneous results.

Value-driven programs developed by CMS have demonstrated these mixed impacts in recent years (Figueroa et al., 2016; Gupta et al., 2018; Ody & Cutler, 2019; Ody et al., 2019; Papanicolas et al., 2017). Nevertheless, in 2019, CMS rolled out a plan for a new value-based program targeting primary care, called CMS Primary Cares. The hope is that by targeting a provider group that often acts as a first point of contact and strongly influences the trajectory of how patients' illnesses progress thereafter, CMS can significantly reduce costs by incentivizing primary care physicians to provide higher-quality care from the outset (CMS, 2019). Time and research are necessary to determine the long-term implications of this strategy.

ACOs incorporate aspects of both integrated delivery and pay-for-value (Gold, 2015). They exist in both the public and private sectors of the healthcare industry, although the most well known and heavily scrutinized are those in the Medicare ACO program created under the ACA. The value of ACOs has been contested through the years, with some studies claiming decent impact and cost reductions and others showing inconsistent results (Lam et al., 2018; Markowitz et al., 2019; Trombley et al., 2019; Zhang et al., 2019). Organizations of higher quality prior to entry tend to have more success when instituting such a program (Diana et al., 2019; Parasrampuria et al., 2018).

In 2018, CMS announced an overhaul of its primary ACO program, the Medicare Shared Savings Program (MSSP), in response to initial results from the previous six years. Titled "Pathways to Success," the overhaul advances five goals: accountability, competition, engagement, integrity, and quality. Previous research done by CMS indicates that ACOs that took on higher risk showed better outcomes. Therefore, the new rule reduces the amount of time that ACOs can remain in the program without assuming higher levels of risk, but also increases flexibility by expanding access to telehealth services. As of July 2019, the first cycle of ACOs had begun participating in the updated program (CMS, 2018; Verma, 2018, 2019).

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The shift toward IDS, pay-for-value, and ACOs has been primarily driven by the desire to promote health while reducing costs. Another driving factor is a fundamental shift in the concept of health itself. Health is now increasingly seen as the presence of wellness rather than solely as the absence of illness. Such a change requires new methods for wellness promotion, although the treatment of illness remains the primary goal of the healthcare delivery system. The ACA has partially shifted the focus from disease treatment to disease prevention, better health outcomes for individuals and communities, and lower healthcare costs.

At present, the greatest challenge to the U.S. healthcare system is the quest to control costs while still meeting the increasing healthcare demands of an aging population—a population with more chronic diseases and comorbidities. Patients with multiple chronic conditions use the most health services (Sporinova et al., 2019). Managing chronic diseases has been a major focus of efforts to control healthcare costs. In particular, the patient-centered care approach founded on the chronic care model and continuous care is being implemented as a means to improve healthcare delivery performance, quality, and patient health outcomes. It represents a paradigm shift from the traditional hospital- and professional-centric approach to health care to an increasingly community- and consumer-centric approach (Donaldson, 2018; Miller & Baumgartner, 2016).

Traditionally, the complexity and various access points from which patients come into contact with the system have made it difficult to transition between providers, specialties, and locations of care. Chronically ill individuals with comorbidities who require treatment from various providers may, therefore, experience fragmentation and uncoordinated care. As a result, treatments may overlap, duplications may occur, and health outcomes may worsen (Frandsen et al., 2015; Juo et al., 2019).

The patient-centered care approach, however, strives to overhaul this pattern. As an example, patient-centered medical homes and ambulatory intensive care units are being incorporated into ACOs. The main objective in establishing these programs is to better manage chronic conditions exclusively within a "clinically integrated, financially accountable primary care practice" (DeVore, 2014). Ultimately, providers hope these measures can address behavioral health needs, lower hospital utilization rates, decrease inpatient bed-days, shorten lengths of stay, limit admissions and readmissions, and minimize emergency department visits.

Nurse practitioners and physician assistants and health coaches are important for managing chronic conditions and reducing costs. Health coaches, for example, complement medical professionals by getting to know patients through one-on-one contact and can keep the clinical staff apprised of financial struggles, issues with housing, family concerns, or other obstacles that may stand in the way of the patient following a prescribed care plan (DeVore, 2014). Health coaches do not need a medical degree, can be recruited from various professional backgrounds, and help improve the effectiveness and efficiency of care.

The advancement of health information technology (HIT) has also helped improve access (Deloitte, 2017). The market for telemedicine and remote monitoring applications was estimated to double from $11.6 billion in 2011 to $27.3 billion in 2016 (DeVore, 2014). During the COVID-19 pandemic, telemedicine received an even greater boost in growth. After Medicare expanded coverage of telehealth during the pandemic, utilization rates surged over 2000% from January to June (Patel et al., 2021). This growth, although partially borne out of necessity during the pandemic, is also in part driven by the increased

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demands for care owing to expansion of insurance coverage through the ACA; the health system may not have the capacity to treat each individual in person. For example, the Johns Hopkins Hospital at Home program delivers acute care services at the homes of patients with chronic illnesses who might otherwise need inpatient care. In this way, HIT increases access to care, particularly for patients living in rural areas where distance to the closest hospital is a major barrier.

Electronic health records (EHRs) have helped provide clinical measures and decision support tools, enabled providers to automate processes to reduce redundancy, and captured more clinical data (DeVore, 2014). Trends toward greater interoperability of health information systems, along with open-source interfaces, will allow for greater transparency, increased availability of data, and more creative use of data.

With the advancement in HIT and widespread Internet access, patients are becoming increasingly independent in making healthcare decisions and are more capable of communicating and interacting with health providers (Deloitte, 2020). HIT also helps streamline clinical processes and manage patients' health and payment information (Kelly, 2015). This technology can be used to monitor clinical quality and utilization measures to identify where improvements can be made (Kraschnewski & Gabbay, 2013). It has also demonstrated success in improving health outcomes and patient safety (Furukawa et al., 2017). On a community level, HIT provides a way for health professionals to keep track of population-level data and observe broader community trends. In all of these ways, it is further promoting the shift toward consumer- and community-centered care.

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Significance for Healthcare Managers

An understanding of the healthcare system has specific implications for both private and public health services managers, who must understand the macro environment in which they make critical planning and management decisions. Such decisions will ultimately affect the efficiency and quality of services delivered. The interactions between the system's key components and the implications of these interactions must be well understood because the operations of healthcare institutions are strongly influenced, either directly or indirectly, by the financing of health services, reimbursement rates, insurance mechanisms, delivery modes, new statutes and legal opinions, and government regulations.

For the foreseeable future, the environment of healthcare delivery will remain fluid and dynamic. The viability of delivery and the success of healthcare managers often depend on how the managers react to the system dynamics. Timeliness of action is often a critical factor that can make the difference between failure and success. Following are some more specific reasons why understanding the healthcare delivery system is indispensable for healthcare managers.

Positioning the Organization

Managers need to understand their own organizational position within the macro environment of the healthcare system. Senior managers, such as chief executive officers, must constantly gauge the nature and impact of the fundamental shifts illustrated in Figure 7-4. Managers need to consider which changes in the current configuration of financing, insurance, payment, and delivery might affect their organization's long-term stability. Middle and first-line managers also need to understand their roles in the current configuration and how these roles might change in the future.

How should resources be realigned to effectively respond to those changes? As an example, managers need to evaluate whether certain functions in their departments must be eliminated, modified, or added. Would the changes involve further training? Which processes are likely to change, and how? Which steps do the managers need to take to maintain the integrity of their institution's mission, the goodwill of the patients they serve, and the quality of care? Well-thought-out and appropriately planned changes are likely to cause less turbulence for both the providers and the recipients of care.

Handling Threats and Opportunities

Changes in any of the functions of financing, insurance, payment, and delivery can present new threats or opportunities in the healthcare market. Healthcare managers will be more effective if they proactively deal with any threats to their institution's profitability and viability. Managers need to find ways to transform certain threats into new opportunities.

Evaluating Implications

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Managers are better able to evaluate the implications of health policy and new reform proposals when they understand the relevant issues and appreciate how such issues link to the delivery of health services in the establishments they manage. Healthcare reform has brought more individuals into the U.S. healthcare system, creating greater demand for health services. Planning and staffing to ensure that the right mix of healthcare workers are available to meet this anticipated surge in demand are critical.

Planning

Senior managers are often responsible for strategic planning regarding which services should be added or discontinued, which resources should be committed to facility expansion, and what should be done with excess capacity. Any long-range planning must take into consideration the current makeup of health services delivery, the evolving trends, and the potential impact of these trends.

Capturing New Markets

Healthcare managers will be in a better position to capture new health services markets if they understand emerging trends in the financing, insurance, payment, and delivery functions. New opportunities must be explored before any newly evolving segments of the market become crowded with competition. An understanding of the dynamics within the system is essential to forging new marketing strategies that will let the institution stay ahead of the competition and, in some cases, find a new service niche.

Complying with Regulations

Delivery of healthcare services is heavily regulated. Healthcare managers must comply with numerous government regulations, such as standards of participation in government programs, licensing rules, and security and privacy laws regarding patient information, and they must operate within the constraints of reimbursement rates. On a periodic basis, the Medicare and Medicaid programs have made drastic changes to their reimbursement methodologies that have triggered the need for operational changes in the way services are organized and delivered. Private agencies, such as the Joint Commission, also play an indirect regulatory role, mainly in monitoring the quality of services. Healthcare managers have no choice but to play by the rules set by the various public and private agencies that regulate the healthcare marketplace. Hence, it is paramount that healthcare managers acquaint themselves with the rules and regulations governing their areas of operation.

Following the Organizational Mission

Knowledge of the healthcare system and its development is essential for effective management of healthcare organizations. By keeping up to date on community needs, technological progress, consumer demand, and economic prospects, managers will be in a better position to fulfill their organizational missions to enhance access, improve service quality, and achieve efficiency in the delivery of services.

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Healthcare Systems of Other Countries

Except for the United States, the 25 wealthiest nations in the world all have some form of universal healthcare coverage (Rodin & de Ferranti, 2012). Canada and Western European nations have used three basic models for structuring their national healthcare systems:

1. In a system based on *national health insurance (NHI)*, such as that found in Canada, the government finances health care through general taxes, but the actual care is delivered by private providers. In the context of the quad-function model, NHI requires a tighter consolidation of the financing, insurance, and payment functions coordinated by the government. Delivery is characterized by detached private arrangements.
2. In a *national health system (NHS)*, such as that found in the United Kingdom, in addition to financing a tax-supported NHI program, the government manages the infrastructure for the delivery of medical care. Thus, the government operates most of the country's medical institutions. Most healthcare providers, such as physicians, either are government employees or are tightly organized in a publicly managed infrastructure. In the context of the quad-function model, NHS requires a tighter consolidation of all four functions.
3. In a *socialized health insurance (SHI)* system, such as that found in Germany, government-mandated contributions from employers and employees finance health care. Private providers deliver healthcare services. Private, not-for-profit insurance companies, called sickness funds, are responsible for collecting the contributions and paying physicians and hospitals (Santerre & Neun, 1996). The insurance and payment functions are closely integrated in a SHI system, and the financing function is better coordinated with the insurance and payment functions than in the United States. Delivery is characterized by independent private arrangements, but the government exercises overall control of the system.

In this text, the terms "national healthcare program" and "national health insurance" are used generically and interchangeably to refer to any type of government-supported universal health insurance program. Following is a brief discussion of healthcare delivery in selected countries from various parts of the world to illustrate the application of the three models discussed and to provide examples of the variety of healthcare systems in the world.

Australia

In the past, Australia had switched from a universal national healthcare program to a privately financed system. In 1984, it returned to a national program—called Medicare—financed by income taxes and an income-based Medicare levy. This system is built on the philosophy that everyone should contribute to the cost of health care according to his or her capacity to pay. In addition to being insured by Medicare, approximately 55% of Australians carry private health insurance (Australian Department of Health, 2019) to cover gaps in public coverage, such as dental services and care received in private

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hospitals (Willcox, 2001). Although private health insurance is voluntary, it is strongly encouraged by the Australian government through tax subsidies for purchasers and tax penalties for nonpurchasers (Healy, 2002). Public hospital spending is funded by the government, but private hospitals offer better choices. Costs incurred by patients receiving private medical services, whether in or out of the hospital, are reimbursed in whole or in part by Medicare. Private patients are free to choose and change their doctors. The medical profession in Australia is composed mainly of private practitioners, who provide care predominantly on a fee-for-service basis (Hall, 1999; Podger, 1999).

In 2011, the Council of Australian Governments (COAG) signed the National Health Reform Agreement, which established the architecture for national health insurance reform. In particular, the agreement provides for more sustainable funding arrangements for Australia's health system. In the same year, the National Health Reform Act 2011 established a new Independent Hospital Pricing Authority and a National Health Performance Authority. The Pricing Authority determines and publishes the national price for services provided by public hospitals. The Commonwealth Government determines its contribution to funding public hospitals on the basis of these prices. The Performance Authority is charged with monitoring and reporting on the performance of local hospital networks, public and private hospitals, primary healthcare organizations, and other bodies or organizations that provide healthcare services. The 2011 act also provides a new statutory framework for the Australian Commission on Safety and Quality in Health Care (Australian Government, 2013).

Australia focuses on developing various health service delivery models to contain costs and provide quality and accessible care (Brownie et al., 2014). Notably, this country has encouraged interprofessional practice as a means to enhance socioeconomic development and improve health outcomes (Brownie et al., 2014). COAG defined new Australian Health Care Agreements, under which each state and territory funds a portion of the public hospital operation costs, commits to providing equitable access to free public hospital services based on clinical need, and agrees to match the rate of growth in the Australian government's hospital funding (Australian Institute of Health and Welfare, 2016). Australia has also developed a National Primary Health Care Strategy to better incentivize prevention, promote evidence-based management of chronic disease, support the role of general practitioners in healthcare teams, encourage a focus on interprofessional team-based care, and address the increased need for access to various health professionals such as practice nurses and allied health professionals. Other health reforms seek to achieve continuity of care, provide high-quality education and training for existing and incoming healthcare workers, and embed a culture of interprofessional practice (Brownie et al., 2014).

Canada

Canada implemented its national health insurance system—referred to as Medicare—under the Medical Care Act of 1966. Medicare consists of 13 provincial and territorial health insurance plans, sharing basic standards of coverage, as defined by the Canada Health Act (Canada Minister and Attorney General, 2022). The bulk of financing for Medicare comes from general provincial tax revenues; the federal government provides a fixed amount that is independent of actual expenditures. Public-sector health expenditures account for 70% of the total Canadian healthcare expenditures. The remaining 30%

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consists of private-sector expenditures, which include household out-of-pocket expenditures, commercial and not-for-profit insurance expenditures, and nonconsumption expenditures (Canadian Institute for Health Information, 2012). Many employers also offer private insurance that gives their employees supplemental coverage.

Provincial and territorial departments of health have the responsibility to administer medical insurance plans, determine reimbursement for providers, and deliver certain public health services. Provinces are required by law to provide reasonable access to all medically necessary services and to provide portability of benefits from province to province. Patients are free to select their providers (Akaho et al., 1998). According to Canada's Fraser Institute, specialist physicians surveyed across 12 specialties and 10 Canadian provinces reported a total waiting time of 20.0 weeks between referral from a general practitioner and delivery of treatment in 2016—an increase from 18.3 weeks in 2015. Patients had to wait the longest to undergo neurosurgery, which had a wait time of 46.9 weeks (Barua et al., 2016).

Nearly all Canadian provinces—Ontario is one of the exceptions—have resorted to regionalization of healthcare services, through the creation of administrative districts within each province. The objective of regionalization is to decentralize authority and responsibility so as to more efficiently address local needs and promote citizen participation in healthcare decision making (Church & Barker, 1998). The majority of Canadian hospitals operate as private nonprofit entities run by community boards of trustees, voluntary organizations, or municipalities, and most physicians are in private practice. Most provinces use global budgets and allocate set reimbursement amounts for each hospital. Physicians are paid at fee-for-service rates, which are negotiated between each provincial government and medical association (MacPhee, 1996; Naylor, 1999).

In 2004, Canada created the 10-Year Plan to Strengthen Health Care, which focuses on problems with wait times, health human resources, pharmaceutical management, EHRs, health innovation, accountability and reporting, public health, and Aboriginal health. Overall, progress has been made in these areas, but the goals have not yet been fully achieved (Health Council of Canada, 2013).

Although most Canadians are quite satisfied with their healthcare system, sustaining the current healthcare delivery and financing remains a challenge. Spending on health care has increased dramatically in recent decades, from approximately 7% of program spending at the provincial level in the 1970s to almost 41% in 2015 (Barua et al., 2016). It is expected to continue growing at a rate of about 5.3% annually through 2031 (Barua et al., 2017).

In line with global pressure for health reforms, Canada is also transitioning to patient-centered care (Dickson, 2016). Since 2013,

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