A Complex and Fragmented U.S. Health System: An Overview of Primary Components and Issues

Presented to the Canadian Law Student Society

Health Care Panel: Discussion of Canadian and American Health Care Systems

UND School of Law
Baker Courtroom
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Presented by: Brad Gibbens Deputy Director and Assistant Professor

• Established in 1980, at The University of North Dakota (UND) School of Medicine and Health Sciences in Grand Forks, ND
• One of the country’s most experienced state rural health offices
• UND Center of Excellence in Research, Scholarship, and Creative Activity
• Home to seven national programs
• Recipient of the UND Award for Departmental Excellence in Research

Focus on
– Educating and Informing
– Policy
– Research and Evaluation
– Working with Communities
– American Indians
– Health Workforce
– Hospitals and Facilities

ruralhealth.und.edu
We checked your insurance and the only thing it covers is one visit from a Care Bear.

“I really should have paid more attention to the company’s health care coverage options before I accepted a job here.”
Objective for Today

- **Structure of the U.S Health Delivery System**
  - Types of Providers
  - Types of Organizational Structures
  - Structural Changes

- **Financing of the System**
  - Public and Private blend
  - Costs – who pays

- **Key Issues/Challenges/Strengths**
  - Equity and Access
  - Finance and Costs
  - Quality and Health Outcomes
### Structure: A Complex and Fragmented Health System

<table>
<thead>
<tr>
<th>Providers</th>
<th>Payers/Insurers</th>
<th>Government</th>
<th>Ed/Research</th>
<th>Suppliers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
<td>Medicare</td>
<td>Public Ins. Financing (e.g. Medicare + Medicaid)</td>
<td>Fed (NIH, AHRQ, CDC, FDA, HRSA, SAMHSA, CMS, NSF)</td>
<td>Pharmaceutical companies</td>
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<tr>
<td>Acute Care</td>
<td>Medicaid</td>
<td>Health regulations</td>
<td>Medical Sch.</td>
<td>Biotechnology companies</td>
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<td>Sub-acute</td>
<td>VA Tricare and CHAMPVA</td>
<td>Health policy</td>
<td>Nursing Sch.</td>
<td>Medical Equipment and Technology (Including HIT)</td>
</tr>
<tr>
<td>Long Term Care</td>
<td>BCBS</td>
<td>Health and Medical research and development funding</td>
<td>Private Fd.</td>
<td>Basic HC Supplies</td>
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<tr>
<td>Preventive</td>
<td>Employers</td>
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<td>Trade Assoc.</td>
<td>Additional information: Brad Gibbens</td>
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<tr>
<td>Rehab. Ser.</td>
<td>Managed Care Plans</td>
<td></td>
<td>Universities</td>
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<tr>
<td>Auxiliary Ser.</td>
<td>Public Employ.</td>
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<td>Health System</td>
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<td>Integrated</td>
<td>Out-of-Pocket</td>
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### Center for Rural Health

**U.S. Health Care Financing and Costs**

- Public and Private payers (Between 2009 and 2010, the percentage of people covered by private health insurance declined from 64.5 percent to 64.0 percent, while the percentage covered by government health insurance increased from 30.6 percent to 31.0 percent. The percentage covered by employment-based health insurance declined from 56.1 percent to 55.3 percent.)

- Employer coverage down from 64% in 2000

- 2011 projection was for all health care spending to increase by 5.8% from 2010-2020 (Health Affairs) but in 2012 health care spending was increasing at 3.7% - 4th consecutive year of low growth

- Since 1960, health spending has increased, on average, 2.3% higher than GDP

- In 2012, GDP grew at 4.6% relative to health care growth, 3.7% (1st time)

- Health care as percentage of GDP is finally declining (positive)
  - 17.9% in 2010
  - 17.3% in 2011
  - 17.2% in 2012 ($2.8 Trillion)

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4. National Health Spending In 2012: Rate of Health Spending Growth Remained Low for the Fourth Consecutive Year, Health Affairs, January 2014.
U.S Health Care Financing and Costs

• Still U.S. spends more on health care than any other country (U.S 17.3% in 2011)
  - Australia 9.0% (2011)
  - Canada 11.2% (2011)
  - China 5.2% (2011)
  - France 11.6% (2011)
  - Germany 11.1% (2011)
  - Netherlands 12.0% (2011)
  - United Kingdom 9.3% (2011)
  - OECD average was 9.3% (Organization for Economic Cooperation and Development -34 countries) 5

• U.S spends roughly twice as much as any other country, per capita (2011) 6
  - US $8,508
  - OECD average $3,339
  - Norway $5,669
  - Switzerland $5,643
  - Canada $4,522

5 http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS
6 OECD Health Data 2013 “How Does the United States Compare?”

Health Insurance

• Health Insurance
  - 47,951 million Americans without health insurance (2012) (15.4%) 7
  - 48,613 (2011) (15.7)

Factors contributing to US Health Care Spending 8

• Hospital costs increasing
• Physician prices
• Medical technology
• Waste
• Unhealthy lives
• Aging population

7 http://www.census.gov/hhes/www/hlthins/data/historical/HIB_tables.html
Key Issues/Challenges/Strengths

- **Equity and Access Concerns**
  - Almost 48 million Americans do not have health insurance (including about 7 million under 17 years)
  - ACA estimate is about 30-33 million additional people insured so there will be about 15-18 million still uninsured
  - About 1.5 million families lose their homes every year due to unaffordable medical costs
  - 26% of Americans report they or family member had problems paying medical bills in last year.  
  - 58% of American report foregoing or delaying medical care due to cost in past year.
  - 23% of people without health insurance have been contacted by bill collector
  - 47% of uninsured and 15% of insured have postponed accessing health care due to cost
  - 35% of uninsured and 9% of insured needed care and did not get it
  - 42% of uninsured and 9% of insured do not have a regular source of health care
  - Research has shown that people who have a steady primary care provider have better health outcomes.
  - A key focus of the ACA is prevention, along with primary care, and targeting payment more to outcomes rather than just volume
  - Is an individual mandate fair? Ethical consideration within context of policy formulation
    - For some the ACA is too much government “socialized medicine” but for others it is too little as they sought a single or all payer system (somehow the ACA is uniquely American as it maintains that blend of public and private)

- **Finance and Cost**
  - History of health policy is, in part, a history of health cost control (and access)
    - Blue Cross hospital insurance plans in the 1930’s
    - WWII federal wage/price controls – business offers health benefit plans as R/R
    - HMO Act of 1973 (beginning of managed care)
    - CON – state level regulation
    - PPS in 1982
    - Heavy focus on MCO (HMO/PPO/IPA/EPO) in ’90’s – discounting of payments, negotiation of fees?, managed “costs” vs. managed “care”
    - Physicians and RBRVS (1990’s to 2000’s), SGR (early 2000’s)
  - How to control cost and improve access and equity
    - Re-engineer the system – ACO, Value Based Purchasing “value over volume”, consumer choice
    - Restrict services
  - Does the ACA do enough to address cost issues?
    - Bend the cost curve or actually lower costs
  - Population and Aging
    - Numbers eligible for Medicare will double over next 30 years (42 million to 86 million)
  - Ability to address health status, chronic disease – emphasis on prevention and care coordination

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*Kaiser Family Foundation, 2006*
Key Issues/Challenges/Strengths

- Quality and Health Outcomes
  - U.S. (in 2011) ranked 32nd in life expectancy (28th in 2008) in comparison to other countries\(^5\)
  - 21st in age standardized mortality rate for cardiovascular disease (2008)*
  - 14th in age standardized mortality rate for cancer (2008)*
  - The Commonwealth Fund rates the U.S. last in overall health care system performance when compared to a group of six countries that include Australia, Canada, Germany, Netherlands, New Zealand, and the United Kingdom. The U.S. spends twice as much as these six countries on a per-capita basis, yet it is last on dimensions of efficiency and equity and 6th on quality and 6.5th on access.\(^b\)
  - Under ACA, movement to value (outcome payments) over volume (fee-for-service)

Martin A B et al. Health Aff 2014;33:67-77

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Factors Accounting For Growth In Per Capita National Health Expenditures And Personal Health Care Expenditures, Calendar Years 2008–12.

Per capita spending growth
Medical prices
Age and sex factors
Other nonprice factors

Martin A B et al. Health Aff 2014;33:67-77

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